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**CENTERS FOR MEDICARE & MEDICAID SERVICES
RETIREE DRUG SUBSIDY (RDS) PROGRAM GUIDANCE**

ACTUARIAL EQUIVALENCE STANDARD

Introduction

This document provides guidance for plan sponsors (sponsors) in the Retiree Drug Subsidy (RDS) Program on how to determine whether the sponsor's group plan's actuarial value is at least equal to the actuarial value of Medicare Part D defined standard prescription drug coverage as required by 42 CFR §423.884(d). This guidance also further clarifies several issues relating to the methodology for actuarial equivalence attestations in order to make it less burdensome for actuaries to complete the actuarial attestation.

This document incorporates previously existing guidance published in April 2005 in a document that was titled "CMS Guidance on the Actuarial Equivalence Standard for the Retiree Drug Subsidy," and adds two new sections that discuss (1) the period of time the attestation must cover, and (2) submission of an actuarial attestation upon a material coverage change. (NOTE: The requirements in these two sections apply to Plan Sponsors with RDS plan years that start on or after January 1, 2009, unless Federal regulations apply any such requirement as of an earlier date). This document also clarifies the circumstances under which it is permissible to combine benefit options for purposes of the actuarial equivalence net test.

This guidance document supersedes the above-mentioned April 2005 guidance document.

Background

Subpart R of Title I of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA), published on January 28, 2005, implements §1860D-22 of the Social Security Act, which authorizes subsidy payments to sponsors of qualified retiree prescription drug plans. In order for a plan to participate, a qualified actuary must submit an attestation to CMS that the sponsor's retiree prescription drug plan's actuarial value is at least equal to the actuarial value of defined standard prescription drug coverage under Medicare Part D

The standard for actuarial equivalence in Subpart R is a two-prong test. The first prong

is the “gross value” test in which the expected amount of paid claims for Medicare beneficiaries under the sponsor’s plan must be at least equal to the expected amount of paid claims for the same beneficiaries under the defined standard prescription drug coverage, including catastrophic coverage available when an individual’s out-of-pocket expenses exceed a specified threshold (e.g. \$4,050 in 2008). *See* 42 CFR §423.884(d)(1)(i).

The second prong is the “net value” test in which the net value of the sponsor’s plan must be at least equal to the net value of the defined standard prescription drug coverage. *See* 42 CFR §423.884(d)(1)(ii). The net value of the sponsor’s plan is calculated by subtracting the retiree premium/contribution from the gross value of the sponsor’s plan. *See* 42 CFR §423.884(d)(5)(ii)(B)(1). The net value of defined standard prescription drug coverage under Part D is calculated by subtracting the national average monthly base beneficiary premium (defined in 42 CFR §423.286) from the gross value of the defined standard prescription drug coverage.

For those sponsors that intend to supplement the coverage provided under Part D for their retirees that choose Part D, an additional adjustment to the net value of Part D is permitted that accounts for the impact that the sponsor’s supplemental coverage will have on the value of defined standard prescription drug coverage under Part D. *See* 42 CFR §423.884(d)(5)(ii)(B)(2). By delaying the point at which the individual receives catastrophic coverage under Part D, the supplemental coverage will lower the value of defined standard prescription drug coverage to a sponsor’s plan participants. This anticipated reduction in the value of the defined standard prescription drug coverage under a Medicare Part D plan to the sponsor’s retirees resulting from the supplemental plan will be referred to in this guidance as the “Medicare Supplemental Adjustment” value.

Calculating the Value of Drug Coverage of the Sponsor’s Plan

Which Drugs are Taken into Account?

In calculating the gross value of the sponsor’s plan under 42 CFR §423.884(d)(1)(i), this guidance clarifies that only prescription drugs that are Part D drugs as defined in 42 CFR §423.882 can be considered. However, these drugs do not necessarily have to be in any Part D plan’s formulary to be included in the calculation.

Generally, Part D drugs are prescription drugs that are not covered by Part A or Part B of Medicare and may not be excluded from coverage under §1860D-2(e)(2)(A) of the Social Security Act. *See* discussion of the definition of “gross covered retiree plan-related prescription drug costs” in the Subpart R preamble to the final MMA rule at 70 FR 4403 and Chapter 6 of the Medicare Part D Manual, which can be found at

<http://www.cms.hhs.gov/PrescriptionDrugCovContra/Downloads/PDBMChap6FormularyReqmts.pdf>. Conversely, in calculating the value of defined standard Part D prescription drug coverage, all Part D drugs are considered, including those that the sponsor's plan does not cover.

Benefit Options within a Plan

A benefit option is defined in 42 CFR §423.882 as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan.

42 CFR §423.884(d)(5)(iv) provides sponsors with plans with multiple benefit options the flexibility to submit the actuarial equivalence attestation either for each benefit option separately or in the aggregate for options that meet the "gross value" test. That is, each benefit option must separately pass the gross test, but the plan can pass the net test by testing benefit options on an aggregated or separate basis.

This guidance clarifies that, to the extent a sponsor wishes to pass the net test by testing two or more benefit options on an aggregate basis, each such benefit option must be listed as a separate benefit option within the same RDS application. It is not permissible to aggregate separate benefit options for different RDS applications. Also, to the extent a sponsor has created several different benefit options for purposes other than RDS, but lists them as one benefit option on its RDS application, it is considered one benefit option for purposes of RDS. Therefore, in such cases, the sponsor should not indicate on its application that it is combining benefit options for purposes of the net test (unless it is combining that one benefit option identified on its RDS application with other benefit options that are separately identified within the same RDS application).

This guidance also clarifies that the sponsor's attestation can aggregate either all of the benefit options that meet the gross value test or one or more subsets of those options for purposes of applying the "net value" test and submitting the actuarial attestation. (On April 15, 2008, CMS published in the *Federal Register* final revisions to the RDS regulations. The final revisions, which become effective June 9, 2008, codify this existing clarification. (73 FR 20486, April 15, 2008)). The sponsor (working with its attesting actuary) determines the number of options to be aggregated for this purpose. If the sponsor aggregates two or more benefit options, the sponsor may not claim the subsidy for those benefit options excluded from the net value calculation, even if those options meet the gross test (unless the excluded benefit options each individually meet the net test).

In applying the gross value and net value test to each benefit option separately (or in the aggregate to a subset of the options), it will be within the discretion of the attesting actuary, in accordance with actuarial standards, to determine the applicability of plan experience across benefit options. For example, an actuary may determine that aggregate plan experience is not applicable to each benefit option even if these benefit options are

being aggregated for testing purposes and instead may apply the plan experience unique to each benefit option. Conversely, an actuary may decide to apply the aggregate plan experience to each individual benefit option if the experience segregated by individual benefit option is non-existent or is an unreliable indication of costs.

Integrated Health and Drug Situations

Sponsors of plans that charge a single, integrated premium or contribution to their retirees for both medical and drug coverage have the discretion and flexibility to allocate any portion of the premium to the drug coverage for the purpose of the net value test of actuarial attestation. *See* 42 CFR §423.884(d)(5)(ii)(B).

For plans that have integrated cost sharing for medical and prescription benefits, cost sharing is based on plan experience (unlike premiums, which is a factor of plan design). Accordingly, for benefit plans where the plan design covers both prescription drugs and other medical costs (for example, integrated out-of-pocket limits, integrated deductibles, integrated plan maximums, etc.), an actuary must be able to reasonably estimate and allocate the cost-sharing provisions and cost of benefits for prescription drugs. This allocation can be based upon either actual plan cost experience or on future cost projections. Once this allocation is made, the value allocated to the drug coverage must pass the gross value test of the actuarial attestation.

Period of Time the Attestation Must Cover

RDS plan years of fewer than 12 months

There may be instances where a sponsor's RDS plan year spans a time period of less than 12 months. For example, a sponsor may submit an application for an RDS plan year for the time period spanning February 1, 2009 through December 31, 2009. This guidance clarifies that in such cases, the actuarial attestation must be for a 12-month, or annualized, period, commencing on the first day of the RDS plan year identified in the application (in this case, February 1, 2009).

To the extent the benefits and/or cost sharing of the plan change during the applicable annualized period for which the actuarial equivalence test is being performed, but after the end of the RDS plan year for which the test is being performed, the sponsor should not take that change into account when determining the actuarial value of the RDS plan. Rather, for the period of time starting on the day after the RDS plan year ends, through the last day of the 12-month period for which the annualized test is being performed, the RDS plan should assume that the benefits and cost sharing in effect for that period, for actuarial equivalence purposes, are those that were in effect on the last day of the RDS plan year. For example, a sponsor applies for an RDS plan year of February 1, 2009, through December 31, 2009. The plan's benefits and cost sharing remain stable

throughout that period. However, the plan's benefits and cost-sharing change as of January 1, 2010. The sponsor should annualize the actuarial value of the plan benefits in place for the period of February 1, 2009, through December 31, 2009. In so doing, the sponsor should assume that the benefit structure and cost-sharing for the plan during the period of January 1, 2010, through January 31, 2010, is that which existed on December 31, 2009.

The actuarial value of standard prescription drug coverage under Medicare Part D, against which the plan's actuarial value would be compared, must also represent a 12-month period of standard Part D coverage. The Part D initial coverage limit, cost sharing and out-of-pocket thresholds that would apply in calculating the actuarial value of the standard Part D coverage, would be those that apply under 42 CFR §423.884(d)(5)(iii)(C). (In the previously mentioned April 15, 2008 final revisions to the RDS regulations, CMS gave RDS plan sponsors and their actuaries additional flexibility as to which Part D initial coverage limits, cost sharing and out-of-pocket thresholds would apply, effective June 9, 2008).

Expected changes to benefits and/or cost sharing within the RDS plan year

There are instances where a sponsor, at the time it is filing its RDS application, is aware that its benefits, cost sharing and/or retirees' premium contribution will change during the RDS plan year specified in the application. In such cases, when determining whether or not a sponsor's retiree drug plan's actuarial value is at least equal to the actuarial value of the Medicare Part D defined standard prescription drug coverage, the actuarial equivalence calculation must determine the gross value and net value of the benefit option and/or the plan for the applicable 12-month annualized period. Such calculation must take into account any changes to benefits, cost sharing and/or retiree premium contributions that will take place during the RDS plan year.

It is not permissible for the sponsor to apply the actuarial equivalence test to discrete portions of its RDS plan year. Rather, at a minimum, in order for a sponsor to be eligible for RDS, its plan's benefit options must each pass the annualized gross test and the plan, in total, must pass the annualized net test.

Unexpected changes to benefits and/or cost sharing within the RDS plan year

There are also instances where a sponsor does not know, at the time it is filing its RDS application, that its benefits, cost sharing, and/or retiree premium contributions will change during the RDS plan year. In such instances where there is a change, the sponsor is required to re-determine whether the plan satisfies the actuarial equivalence test for the applicable 12-month annualized period, taking into account any changes to benefits and/or retiree premium contributions that took place. To the extent the sponsor determines that the plan or any benefit options are not actuarially equivalent, the sponsor

is required to notify CMS, and is required to promptly refund all subsidy amounts it received for the plan or benefit options that are not actuarially equivalent. (To the extent the sponsor determines the plan or benefit options still satisfy the actuarial equivalence tests, the sponsor is required to note and maintain records of this determination in its actuary's work papers in accordance with 42 CFR §423.888(d).

Normative Data Sets

Certain retiree prescription drug plans may not have sufficiently reliable plan data to determine whether the plan's coverage is at least actuarially equivalent to Part D defined standard prescription drug coverage. In these instances, it will be within the discretion of the attesting actuary, in accordance with actuarial standards, to determine whether a plan has sufficiently reliable data for the computation. The attesting actuary may find that utilizing an appropriate normative data set is appropriate as indicated in 42 CFR §§423.884(d)(5)(ii)(A) and (d)(5)(iii)(A). Possible normative data sets are:

- The accepted normative data set tools of the industry provided that the data reflect the demographics and other risk characteristics of the group and are appropriately segregated; or
- The vendor "block of business" data set.

The calculation of actuarial equivalence should rely on plan experience to the extent that the experience is reasonable and credible. If reasonable and credible experience is not available, the calculations should reflect reasonable actuarial methods that take into account the demographics and other risk characteristics of the group.

Submission of Actuarial Attestation upon Material Coverage Change

Section 1860D-22(a)(2)(A) of the MMA requires that a plan sponsor submit an actuarial attestation annually or at another time as the Secretary may require. 42 CFR §423.884(d)(6)(ii) requires submission of an attestation no later than 90 days before the implementation of a material change to the coverage. While the term "material change" can be construed broadly to include any change to the value of a sponsor's plan, we indicated in a proposed rule that "[w]e would not require submission of an attestation under §423.884(d)(6)(ii) where a plan sponsor still meets the actuarial equivalence test after the change, and there are no benefit options being added." (72 FR 29403, May 25, 2007). If there is a new benefit option added, however, an attestation of continued actuarial equivalence must be filed no later than 90 days before the implementation of the change, as we interpret the term "material change" to mean the addition of a benefit option that does not have the impact of causing the actuarial value of the retiree prescription drug coverage to fail the actuarial equivalence standards set forth in the

regulations.

We are clarifying that if a change does have the impact of causing the coverage to fail to meet the actuarial equivalence standard, no attestation should be submitted, since an attestation is to be submitted only with respect to a plan that meets actuarial equivalence. Rather, a sponsor must notify CMS no later than 90 days before the implementation of a change to the drug coverage that *does* have the impact of causing the actuarial value of the retiree prescription drug coverage to fail the actuarial equivalence standards set forth in the regulations. To notify CMS for this purpose, or to report a change of Plan Sponsor EIN or Company Name, please contact [CMS' RDS Center Help Line](#).

In the previously discussed April 15, 2008 final revisions to the RDS regulations, CMS codified the above-referenced definition of “material change,” and the clarification to report to CMS when a change to the drug coverage has the impact of causing the actuarial value of retiree prescription drug coverage to fail the actuarial equivalence standard.

Regardless of whether there has been a material change as defined in this document, a sponsor, upon deleting a benefit option for RDS purposes, must provide an update to CMS of its list of individuals for whom it is claiming RDS. *See* 42 CFR §423.884(c)(6).

Calculating the Value of the Standard Medicare Part D Benefit

The Value of Standard Medicare Part D Premium

Pursuant to 42 CFR §423.884(d)(5)(iii)(B)(1), in calculating the net value of Part D defined standard prescription drug coverage for purposes of the second prong of the actuarial equivalence test, the beneficiary premium is subtracted from the gross value of Part D. This guidance clarifies that the national average monthly base beneficiary premium can be used to determine the beneficiary premium for this purpose. One should use the national average monthly base beneficiary premium for the same year from which the Part D coverage limits are being utilized for the test. Alternatively, the beneficiary premium can be determined by multiplying the gross value of Part D by 25.5%. In either case, there is no requirement to account for any reduction in premiums (or enhanced benefits) that some beneficiaries in the plan may receive through the low-income subsidy provisions of Subpart P (42 CFR §423.771 *et. seq.*).

Eligibility for Medicare Supplemental Adjustment

In 42 CFR §423.884(d)(5)(iii)(B)(2), for purposes of the net value prong of the actuarial equivalence test, the value of the Part D defined standard prescription drug coverage can

be adjusted to reflect the impact of a sponsor's plan supplementing Part D for those beneficiaries in the sponsor's plan who enroll in Part D. This guidance clarifies that the adjustment can only be made by those sponsors who actually supplement the Part D coverage of their Medicare-eligible beneficiaries who enroll in Part D. (CMS codified this clarification in the previously discussed April 15, 2008 final revisions to the RDS regulations). A sponsor has flexibility in providing such supplemental coverage. For example, it can design its retiree drug plan to be secondary to any Part D plan selected by a retiree, or it can designate specific Part D arrangements under which the supplemental coverage is provided (including through customized Part D arrangements providing enhanced coverage). The attestation must take into account any restrictions in beneficiary accessibility to the supplemental coverage by prorating for the share of retirees who have access to the supplemental coverage in determining the impact on the Medicare Supplemental Adjustment value.

The regulations do not require that sponsors supplement Part D coverage for their retirees who enroll in a Part D plan. However, they cannot take into account the Medicare Supplemental Adjustment value pursuant to 42 CFR §423.884(d)(5)(iii)(B)(2) if they do not supplement Part D for a retiree who enrolls in Part D.

Sponsors interested in the Medicare Supplemental Adjustment but who are concerned about the ability to coordinate their benefits with Part D coverage should be aware that CMS has facilitated the establishment of a coordination of benefits system (True Out-of-Pocket Cost Facilitator) that provides real time, point-of-sale coordination between Medicare Part D and supplemental plans such as employer and union-sponsored plans. This system was designed to provide cost-effective coordination between Medicare and retiree health plans, including those in which a sponsor is providing the coverage to qualify for the Medicare Supplemental Adjustment.

Sample Calculation and Simplified Computations for the Actuarial Equivalence Test

Sample Calculation

To assist actuaries in determining the Medicare Supplemental Adjustment, the document titled "Appendix: Sample Calculation," found at <http://www.cms.hhs.gov/EmployerRetireeDrugSubsid/>, includes a sample calculation showing the steps for the actuarial equivalence test using the Medicare Supplemental Adjustment. The sample calculation for actuarial equivalence testing utilizes standard actuarial techniques for calculating values of deductibles and coinsurance on a probability distribution, which was previously released by CMS. For plans with co-pay cost-sharing structures, similar techniques would need to be utilized. Further explanation on the techniques and parameters is provided in the appendix.

Simplified Calculations

For those plans that pass the two-prong actuarial equivalence test without the Medicare Supplemental Adjustment, there is no requirement to calculate the adjustment for the “net value” test. Furthermore, if the attesting actuary, in his/her professional judgment, is certain that the sponsor’s plan is at least actuarially equivalent to Part D without performing the calculation of either the “gross value” test or the “net value” test, then it is within the actuary’s professional discretion as to whether the calculations need to be made to support the attestation. For example, a retiree drug plan that covers both brand and generic drugs, has a \$100 deductible, pays 80% of the cost of drugs with the beneficiary paying the remaining 20% as coinsurance, and the sponsor pays 90% of the premium. This plan would clearly be actuarially equivalent to the Part D defined standard prescription drug benefit and there would be no need to do the specific calculations.