Compliance Overview

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Medicare Part D Common Questions

Effective Jan. 1, 2006, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) added a voluntary outpatient prescription drug benefit to the Medicare program, known as Medicare Part D. Medicare beneficiaries can receive subsidized prescription drug coverage through the Medicare Part D program.

Employers with group health plans that provide prescription drug coverage to individuals who are eligible for Medicare Part D must comply with disclosure notice requirements. Medicare Part D requires employers to disclose whether their prescription drug coverage is "creditable" to the Centers for Medicare and Medicaid Services (CMS) and to Medicare Part D eligible individuals. These disclosures must be made on an annual basis and at certain other designated times.

In addition, the MMA created a subsidy—the Retiree Drug Subsidy—to encourage employers to provide prescription drug coverage to their Medicare-eligible retirees.

General Information

Who is required to comply with Medicare Part D?

Generally, employer-sponsored group health plans offering prescription drug coverage to individuals who are eligible for coverage under Medicare Part D must comply with mandates on the disclosure of creditable coverage and coordination of benefits. A group health plan sponsor may also voluntarily choose to comply with certain requirements in order to apply for a federal tax-free subsidy (the Retiree Drug Subsidy).

Who is a Medicare Part D eligible individual?

An individual is eligible for Medicare Part D if:

- The individual is entitled to Medicare Part A and/or enrolled in Part B; and
- The individual resides in the service area of a prescription drug plan (PDP) or a Medicare Advantage plan that provides prescription drug coverage (MA-PD).

In general, an individual becomes entitled to Medicare Part A when the person actually has Part A coverage, and not just when the person is first eligible.

What is coordination of benefits under Medicare Part D?

Coordination of benefits is a program that determines which plan or insurance policy will pay first if two health plans or insurance policies cover the same benefits. If one of the plans is a Medicare health plan, federal law may decide who pays first. In the event that an employer-sponsored group health plan is providing coverage to any individuals who are enrolled in a Part D plan, the group health plan will need to cooperate with Part D plans in order to coordinate benefits. Part D eligible individuals must provide and consent to the release of information regarding reimbursement for Part D costs through insurance, group health plans or other third-party payment arrangements.

Creditable Coverage Disclosures to Individuals

What notices must employers provide to Medicare Part D eligible individuals?

Employers that offer prescription drug coverage to active or retired employees who are eligible for Medicare Part D, or their spouses/dependents, must notify each Part D eligible individual who is enrolled in or seeks to enroll in this coverage whether the coverage qualifies as creditable coverage under the Part D rules. If the coverage is not creditable, the notice must explain that there are limits on when the individual may enroll in a Part D plan during a year, and that he or she may be subject to a lifetime late enrollment penalty under Part D.

Why must plan sponsors tell Part D eligible individuals whether their prescription drug coverage is creditable?

Plan sponsors must tell Part D eligible individuals whether their prescription drug coverage is creditable so that the Medicare-eligible individuals can compare their existing coverage with the coverage provided under a Part D plan. Part D eligible individuals who are not covered under creditable prescription drug coverage may be subject to a permanent late enrollment penalty in the form of higher premiums in the event that they choose to enroll in Part D coverage at any time after the end of their Initial Enrollment Period.

What must be included in the creditable coverage disclosure notices provided to Medicare Part D eligible individuals?

CMS has provided model language that can be used when disclosing creditable coverage status to beneficiaries.

When must the creditable coverage disclosure notices be provided?

The notices must be provided to Part D eligible individuals annually, before **Oct. 15** of each year. Furthermore, the notices must be provided:

- Before the individual's Initial Enrollment Period for Part D;
- Before the effective date of enrollment in the prescription drug coverage;
- Upon any change that affects whether the coverage is creditable prescription drug coverage; and
- Upon request.

How must the creditable coverage disclosure notices be provided?

Health plan sponsors have flexibility in the form and manner of providing creditable coverage disclosure notices to beneficiaries. The notice need not be sent as a separate mailing. It may be provided with other plan participant information materials, including enrollment and/or renewal materials. The sponsor may provide a single disclosure notice to the covered Medicare individual and all Medicare-eligible dependent(s) covered under the same plan. However, the sponsor is required to provide a separate disclosure notice if it is known that any spouse or dependent who is Medicare-eligible resides at a different address than from where the participant materials were provided.

If a plan sponsor chooses to incorporate the creditable coverage disclosure notice with other plan participant information, then the disclosure must be prominent and conspicuous. This means that the disclosure notice portion of the document, or a reference to the section in the document that contains the disclosure notice portion, must be prominently referenced in at least 14-point font in a separate box, bolded, or offset on the first page of the provided plan participant information.

Also, CMS has indicated that group health plan sponsors may deliver creditable coverage disclosure notices **electronically** if they follow the Department of Labor's standards for electronic disclosure. If the notices are provided electronically, the sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare-eligible dependents covered under the group health plan.

Creditable Coverage Disclosure to CMS

What notice must employers provide to CMS?

Employers must notify CMS regarding whether the prescription drug coverage they offer constitutes creditable coverage. This notification must be made on an annual basis, no later than 60 days from the beginning of a plan year. It also must be provided within 30 days after termination of a prescription drug plan, and within 30 days after any change that affects whether the coverage is creditable.

CMS has provided guidance on the timing, format and language of the disclosure that employers must make to CMS. An entity is required to provide the disclosure notice through completion of the disclosure form on the CMS creditable coverage webpage, which is generally the sole method for compliance with the requirement.

Creditable Coverage Determination

How does a plan sponsor determine whether prescription drug coverage is creditable for purposes of the creditable coverage disclosure notice requirement?

Before preparing creditable coverage disclosure notices, a plan sponsor must determine whether the coverage is creditable. A health plan's prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with guidelines developed by CMS. In general, to be creditable, the expected amount of paid claims under the plan sponsor's prescription drug coverage must be at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

For plans that have multiple benefit options, the plan sponsor must apply the actuarial value test separately for each benefit option. A benefit option is defined as a particular benefit design, category of benefits or cost-sharing arrangement offered within a group health plan.

There is no exception from the actuarial equivalence requirement for small employers. However, certain plan designs may qualify for a simplified determination of creditable coverage status without having to perform the actuarial determination.

The determination of creditable coverage status does not require an attestation by a qualified actuary unless the plan sponsor is an employer or union electing the Retiree Drug Subsidy.

What benefit designs qualify for a simplified determination of creditable coverage status?

If a plan sponsor is not an employer or union that is applying for the Retiree Drug Subsidy, the sponsor may be eligible to use a simplified determination that its prescription drug plan's coverage is creditable. The standards for the simplified determination are described below. However, the standards listed under 4(a) and 4(b) may not be used if the sponsor's plan has prescription drug benefits that are integrated with benefits other than prescription drug coverage (for example, medical or dental benefits). Integrated plans must satisfy the standard in 4(c).

A prescription drug plan is deemed to be creditable if it:

1. Provides coverage for brand-name and generic prescriptions;
2. Provides reasonable access to retail providers;
3. Is designed to pay, on average, **at least 60 percent** of participants' prescription drug expenses; and
4. Satisfies at least one of the following:
    - The prescription drug coverage has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000;
    - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare-eligible individual; or
    - For entities that have integrated health coverage, the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000 and has no less than a $1 million lifetime combined benefit maximum.

**The Affordable Care Act (ACA) prohibits health plans from imposing lifetime and annual limits on the dollar value of essential health benefits.*

If an entity is applying for the Retiree Drug Subsidy, it cannot use the simplified determination of creditable coverage status. It must instead consult with an actuary to perform an actuarial equivalence determination before preparing its creditable coverage disclosure notices.

Enforcement

Are there any consequences to an employer for failing to provide creditable coverage disclosure notices or for failing to comply with coordination of benefits requirements?

There are currently no direct penalties or other sanctions available to CMS in the event that an employer fails to provide the required creditable coverage disclosure notices or fails to comply with coordination of benefits requirements. However, employers who are also claiming the Retiree Drug Subsidy will not qualify for the subsidy unless they provide compliant disclosure notices. Furthermore, other federal laws such as ERISA may indirectly provide consequences to a noncompliant employer. Also, failing to comply with these requirements may have a negative impact on employee relations, especially if an individual later incurs a late enrollment penalty because he or she was unaware that their prescription drug coverage through the employer was not creditable.

Retiree Drug Subsidy

What is the Retiree Drug Subsidy under Medicare Part D?

Eligible employers that sponsor group health plans with retiree prescription drug benefits can obtain a Retiree Drug Subsidy, which is exempt from federal income tax.* The subsidy is available to employers with creditable prescription drug coverage that covers retirees who are entitled to enroll in Part D, but who elect not to do so. The subsidy is meant to encourage employers to maintain or begin offering retiree prescription drug coverage.

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. Gross costs are costs incurred for Part D, which are any drugs that can be covered under the Medicare prescription drug benefit. Gross costs include dispensing fees but exclude administrative costs. Allowable costs are actual incurred costs.

**Under the ACA, employers that receive the subsidy cannot take a tax deduction for the subsidy amount. This change became effective in 2013.*

Under Medicare Part D, what is required of an employer who wishes to apply for the Retiree Drug Subsidy?

Each plan sponsor that seeks the Retiree Drug Subsidy must electronically complete the application through the Retiree Drug Subsidy Center. Applications for the Retiree Drug Subsidy are due at least 90 days before the beginning of the plan year, unless CMS approves a request for a 30-day application deadline extension. Plan sponsors must apply each year they wish to claim this subsidy.

LINKS AND RESOURCES

- For general information on the Medicare Part D program, including covered benefits, see the Medicare Part D webpage.
- Visit CMS' creditable coverage webpage for information about creditable coverage disclosure notices.
- More information about the retiree drug subsidy is available on CMS' Retiree Drug Subsidy webpage.