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Medicare Part D Prescription Drug Benefit

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. The MMA also created a subsidy to encourage employers with retiree prescription drug plans to maintain this coverage even after the Medicare Part D program went into effect.

This Legislative Brief provides an overview of the Medicare prescription drug program for health plan sponsors, and addresses some changes made to the program by the Affordable Care Act (ACA).

MEDICARE PART D PROGRAM

Medicare beneficiaries may purchase prescription drug coverage by joining a Medicare Prescription Drug Plan or a Medicare Advantage Plan that includes Medicare drug coverage. The monthly premium and drug coverage varies according to the plan in which the Medicare beneficiary enrolls.

Under the Medicare Part D Program:

- The Medicare beneficiary pays an annual deductible of no more than $320 ($360 for 2016), plus 25 percent of prescription drug costs between the annual deductible and the initial coverage limit ($2,960 for 2015 and $3,310 for 2016).
- Where the Medicare beneficiary's out-of-pocket expenses reach the catastrophic coverage threshold ($4,700 for 2015 and $4,850 for 2016), the Medicare beneficiary pays the greater of a five percent coinsurance or a copayment of $2.65 for generic drugs ($2.95 for 2016) or $6.60 for any other prescription drug ($7.40 for 2016).
- Beginning in 2011, the ACA started closing the coverage gap, or donut hole, that Medicare beneficiaries experience between the initial coverage limit and the catastrophic coverage threshold. The coverage gap will be closed mainly through the use of drug discounts and subsidies, until the gap is completely closed in 2020.

Medicare beneficiaries with limited income and resources may qualify for Medicare subsidies to help pay prescription drug costs. In addition, the ACA requires high-income individuals to pay higher Medicare Part D premiums, similar to the Medicare Part B program.

Medicare beneficiaries who are not covered by creditable prescription drug coverage and who choose not to enroll in Medicare Part D before the end of their initial enrollment period may be required to pay higher premiums if they enroll in Medicare Part D at a later date.

EMPLOYER REQUIREMENTS

Health plan sponsors whose plans cover Medicare-eligible individuals are required to address a number of issues related to Medicare Part D, regardless of whether they provide retiree coverage. Medicare-eligible individuals include those persons who are entitled to Medicare benefits under Part A or who are enrolled in Medicare Part B.

For example, employers with group health plans that provide prescription drug coverage to individuals who are eligible for coverage under Medicare Part D must comply with certain annual disclosure requirements. Each year, Medicare Part D requires group health plan sponsors to disclose to individuals who are eligible for Medicare Part D and to the Centers for Medicare and Medicaid Services (CMS) whether their prescription drug coverage is creditable.

Also, plan sponsors should expect to receive requests for information from their enrollees regarding Part D plan coordination, since Part D plans are required to coordinate benefits with other health plans that provide prescription drug coverage to Medicare-eligible individuals.

Required Notices

To Individuals

Employers that offer prescription drug coverage to active or retired employees who are eligible for Medicare, 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.

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. In general, the actuarial equivalence test measures whether the expected amount of paid claims under the plan sponsor's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Part D benefit. Plans with multiple benefit options must apply the actuarial value test for each benefit option. The determination of creditable coverage does not require an attestation by a qualified actuary, unless the plan sponsor is electing the retiree drug subsidy.

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

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

To CMS

In addition, 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.

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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 Disclosure website, which is the sole method for compliance with the requirement.

Retiree Drug Subsidy

Employers that provide prescription drug coverage to Medicare-eligible retirees may be entitled to receive subsidies of up to 28 percent of prescription drug costs between $320 and $6,600 (for 2016, prescription drug costs between $360 and $7,400). Employers must meet the following requirements to be eligible for the retiree drug subsidy (RDS):

- The employer must provide coverage of retiree health care costs, including prescription drugs, under a group health plan;
- The plan's retiree prescription drug coverage must be creditable coverage (notices of creditable coverage must be provided); and
- The employer must submit an attestation that the actuarial value of the plan's retiree prescription drug coverage is at least equal to the actuarial value of the defined standard prescription drug coverage under Part D.

Employers receiving RDS payments do not pay federal income tax on the subsidy payments. In addition, employers receiving the RDS may generally take a tax deduction for their retiree prescription drug costs. However, under the ACA, employers are not allowed to take a deduction for the subsidy amount starting in 2013.

Additional information about the RDS program is available from CMS through its RDS webpage.

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