

Medicare Part D Frequently Asked Questions (FAQs) for Employers

I. GENERAL OVERVIEW

1. What is Medicare Part D?

Medicare Part D is the Medicare prescription drug program which began January 1, 2006. Under this program, Medicare beneficiaries receive prescription drug coverage. Medicare beneficiaries receive extensive information from the government about this program as they become eligible for Medicare. The “Medicare & You” handbook for 2010 contains an entire section on Medicare Part D coverage (pages 62-72.) See www.medicare.gov/publications/pubs/pdf/10050.pdf or call 1-800-MEDICARE (1-800-633-2048).

2. I don't have a retiree plan – do Medicare Part D requirements even apply to me?

Yes, employers providing drug coverage as part of their plan are required by law to inform all Medicare-eligible individuals if their current plan provides creditable or non-creditable coverage. See Questions 7 and 8 below regarding creditable coverage and Section II regarding Notice Requirements.

3. Who is eligible for Medicare Part D?

Individuals entitled to Medicare Part A and/or enrolled in Part B are eligible for Medicare Part D. If an individual would like to get prescription drug coverage through a Medicare Advantage Plan, he/she must have Medicare Part A **and** Part B. The individual must also live in the service area of the Medicare drug plan he/she wants to join.

4. Are Part D eligible individuals required to enroll in Part D?

No, a Medicare beneficiary who has another source of prescription drug coverage that is at least as good as the Medicare drug plan (creditable coverage) can remain in that plan, and not enroll in Part D. A Medicare beneficiary who has another source of prescription coverage that is not as good as the Medicare drug plan, (non-creditable coverage), would want to consider enrolling in Part D, but is not required to do so. If an eligible individual doesn't enroll during one of these times, they will likely pay a higher premium penalty for late enrollment.

5. How does Medicare Part D enrollment work for an individual?

Newly eligible individuals are eligible during the 3 months before their Medicare eligibility date (for Parts A and B), the month of their eligibility date, and until 3 months after that date. There is also an annual open enrollment period November 15th continuing through December 31st. If an eligible individual doesn't enroll during one of these times, they will likely pay a higher premium penalty for late enrollment unless the individual has creditable coverage.

6. How does this impact me as an employer?

If you offer drug coverage to Medicare eligible individuals, you are required by the Centers for Medicare and Medicaid Service (CMS) to do the following:

- Determine if your group plan provides “creditable coverage” or “non-creditable coverage”. In general, creditable coverage is defined as coverage at least as good as the standard Medicare Part D benefit.
- You must communicate the status of your plan to Part D eligible individuals by November 14th, regardless of whether your plan is creditable or non-creditable. See Question 8. for Medica’s communication plan for fully-insured and self-funded plans.

If you are a group that offers prescription drug benefits for Medicare eligible Part D employees, retirees and dependents, you should review and make decisions about available options in offering prescription drug benefits. Options are outlined in Section III. below titled Employer Group Options. If you elect to apply for a subsidy in lieu of offering Part D, application and required documentation must be submitted to CMS, following CMS requirements and timelines.

7. What guidelines can I follow to determine if the coverage provided under our plan is creditable coverage?

CMS has simplified the process for an employer to determine if its prescription drug plan is creditable. If an employer is not applying for the retiree drug subsidy, its plan is creditable if the plan design meets all four of the following standards:

- i) Provides coverage for brand and generic prescriptions;
- ii) Provides reasonable access to retail providers and, optionally, for mail order coverage;
- iii) The plan is designed to pay on average at least **60%** of participants’ prescription drug expenses; and
- iv) Satisfies at least one of the following:
 - a) For entities that have stand-alone prescription drug plans, the plan must satisfy one of the following:
 - 1) The prescription drug coverage has no maximum annual benefit or a maximum annual benefit payable by the plan of at least \$25,000, or
 - 2) The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least \$2,000 annually per Medicare Part D eligible individual.
 - b) 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 \$1,000,000 lifetime combined benefit maximum. An integrated plan is a plan that: (i) is offered to a Medicare eligible individual; (ii) has one or more benefits combined, such as medical and prescription drug, medical, dental and prescription drug, etc and (iii) has all of the following provisions: a combined plan year deductible for all benefits under the plan, a combined annual benefit maximum for all benefits under the plan and a combined lifetime benefit maximum for all benefits under the plan.

8. Is my plan with Medica creditable coverage?

It depends upon the group’s plan design. Generally, Medica’s standard, non-HSA plans in which the deductible does not apply to pharmacy benefits are creditable. HSA plans may be creditable or non-creditable, depending on the deductible and coinsurance levels. Please contact your Medica Account Manager or Sales Executive with specific questions.

II. NOTICE REQUIREMENTS

1. Who must receive the notice?

All Part D eligible individuals who are covered by, or who apply for, an employer health plan with outpatient prescription drug coverage must receive a notice, regardless of whether the employer coverage is primary or secondary to Medicare. The notice must be provided to all Part D eligible individuals, whether covered as active employees, retirees, COBRA recipients, disabled individuals, or as dependents. It is acceptable to send the notice to all plan participants.

2. What is the purpose of providing the notice?

The purpose of the notice is to help individuals decide whether to enroll in the Medicare prescription drug coverage. If an eligible individual is covered under a plan that is providing prescription drug coverage that is comparable to the coverage available under Medicare Part D (called creditable coverage), they will not be charged a late enrollment penalty if they choose to continue their employer sponsored coverage and enroll in a Medicare prescription drug program at a later open enrollment date. If the coverage for prescription drugs under their plan is not as good as the standard Medicare prescription drug coverage (called non-creditable coverage) and they do not enroll in a Medicare prescription drug plan during their initial open enrollment period, they may be subject to a late enrollment penalty once they do enroll for the rest of the time they are enrolled in the Medicare prescription drug program.

3. Does the notice have to be sent separately? Does a notice have to be sent to spouses and dependents as well?

The notice does not have to be sent as a separate mailing. CMS has provided for flexibility in distribution of the notice. It may be sent with other plan participant materials. If the notice is included with other plan participant materials, it 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. The employer may provide the notice through electronic means, but only if the Medicare beneficiary has indicated that he or she has adequate access to electronic information. In addition, before individuals agree to receive their information via electronic means, they must be informed of the right to obtain a paper version, how to withdraw their consent, how to update address information and any hardware or software requirements needed to access and retain the creditable coverage disclosure.

One notice for the eligible individual and all covered dependents is permitted, unless it is known that a Medicare eligible spouse or dependent resides at a different address.

4. What must be included in the notice?

CMS has developed sample model notices for creditable and non-creditable coverage. The list of Resources in Section IV. below provides you with the links to both of these model notices.

5. When should the employer disclosure notices be distributed?

- ❑ Prior to the Medicare Part D Annual Coordinated Election Period beginning November 15th each year;
- ❑ Prior to an individual's initial enrollment period for Part D;
- ❑ Prior to the effective date of coverage for any Medicare eligible individual that joins the plan;
- ❑ Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and
- ❑ Upon a beneficiary's request.

Note: The first two bullets above will be deemed to be met if the notice is provided to all plan participants at least once a year, prior to November 15. The third bullet will be met if the employer distributes pre-enrollment materials, including the applicable notice, to new members joining the plan. An annual notice, along with the notice included in pre-enrollment materials, are options to ensure all eligible individuals receive the first three required notices.

Medica will send creditable/non-creditable coverage notices to fully-insured groups and **all** subscribers (this includes MCHA and Conversion plans.)

Medica will provide this service for a fee for self-funded groups who request this service. For self-funded groups choosing annual notices only, \$.05/employee/month will be built into admin fee (therefore eliminating the need for a one-time manual billing). For self-funded groups choosing annual and ongoing notices, \$.10/employee/month will be built into admin fee.

6. Must I notify CMS of our plans' creditable coverage status?

Yes, you must provide notification of creditable coverage status to CMS on an annual basis and upon any change that affects whether the drug coverage is creditable. This information is to be provided to CMS via submission of an on-line form. At a minimum, the notice must be filed within: (a) 60 days after the commencement of the group's plan year (For example, for January 1st renewal dates, the annual notice must be filed no later than March 1st); (b) 30 days after termination of the prescription drug plan and (c) 30 days after any change in the creditable coverage status of the prescription drug plan. See "Disclosure to CMS Guidance and Instructions" at: https://www.cms.hhs.gov/CreditableCoverage/40_CCDisclosure.asp#TopofPage

PLEASE NOTE: Both fully-insured and self-insured employer groups are accountable to meet this requirement; **Medica will not perform this notification on behalf of a group.** Also, a group that has been approved for the retiree drug subsidy is exempt from filing the disclosure to CMS form with respect to those qualified covered retirees for which the sponsor is claiming the retiree drug subsidy. The retiree drug subsidy application serves as the disclosure to CMS.

III. EMPLOYER GROUP OPTIONS

1. If our group currently offers prescription coverage to retirees, what are the options under Medicare Part D?

- ❑ Obtain coverage through a Part D Plan authorized by CMS or sponsor a Part D plan on their own.
- ❑ Transfer retirees into a fully insured Medicare retiree product, such as Medica Group Prime Solution®, which covers medical and pharmacy claims (see #2 below).

- ❑ Cancel coverage for prescription drug benefits and encourage retirees to enroll in a Part D plan of their choice. A group may choose to provide a financial contribution toward the cost of that plan. ***Please note: this is not an option for a fully insured group on Medica's commercial products. Cancelling only prescription benefits from their Medica plan is not allowed.***
- ❑ Maintain present coverage as it currently operates. Employers can apply for the CMS employer drug subsidy (See Retiree Drug Subsidy Option – #3 below).

2. High level description of Medica Group Prime Solution®:

- ❑ Medica will administer Medicare Part D coverage as part of a fully insured product known as Medica Group Prime Solution®. This product, which covers medical and pharmacy claims, allows some flexibility in benefit design.
- ❑ Medica assumes financial responsibility for plan benefits and is responsible for ensuring compliance with Medicare Part D requirements for this fully insured product.

Call Medica's Center for Healthy Aging at 952-992-2345 or toll-free at 1-800-906-5432 for more information on this option.

3. High level description of the Retiree Drug Subsidy Option for employers:

- ❑ Your plan's share of pharmacy coverage must be at least actuarially equivalent to Medicare Part D coverage to qualify for the subsidy.
- ❑ You must submit an application which includes an actuarial certification that your prescription drug plan meets CMS guidelines. The application can be found by going to <http://rds.cms.hhs.gov>
- ❑ You submit enrollment data to CMS
- ❑ You submit aggregate claims data to CMS on a monthly, quarterly, or annual basis.
- ❑ Eligible subsidy paid to the you as the employer or plan sponsor
- ❑ For plan years ending in 2008, Medicare pays to the employer 28% of the cost of pharmacy claims between \$275 and \$5,600 for retirees eligible for, but not enrolled in a Medicare Part D plan, (for plan years ending in 2009, these numbers are \$295 and \$6000). This subsidy is exempt from federal tax, but state tax treatment may vary. It is Medica's understanding that no tax exemption applies in MN. Employers should consult their tax advisors for more specific information regarding the tax consequences of the subsidy.
- ❑ A rule of thumb actuaries are using: the costs associated with collecting the subsidy may outweigh the revenue available under the subsidy unless 20 or more Medicare eligible participants are on the plan.

Actuarial Certifications

- ❑ If you are interested in the 28% subsidy and would like a contact for actuarial certifications, Milliman is available to assist you. Milliman (or other actuary) will perform the actuarial analysis required to support the subsidy application. You will be responsible for the cost of the certification.

The contact person at Milliman is Rick Lassow at 952-820-2409.

IV. RESOURCES

Information regarding the Medicare Part D Program is updated on the CMS web site on an ongoing basis. We encourage you to review the CMS web site frequently for the most up-to-date information.

The CMS Web site: <http://www.cms.hhs.gov>

Call 1-800-MEDICARE (1-800-633-2048)

“Medicare & You” handbook (for 2010):
www.medicare.gov/publications/pubs/pdf/10050.pdf

Prescription Drug Coverage General Information:
<http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/>

Employer Information and Model Notices:
http://www.cms.hhs.gov/CreditableCoverage/08_CCafterJanuary1.asp#TopOfPage

Creditable Coverage Guidance:
<http://www.cms.hhs.gov/CreditableCoverage/>

Employer Retiree Drug Subsidy Application Process:
<http://rds.cms.hhs.gov/>