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INSURANCE MANAGEMENT SERVICES
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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA")

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare. Prescription drug coverage under Medicare became available starting January 1, 2006 and allows all Medicare beneficiaries to sign up for drug coverage through a Prescription Drug Plan (PDP) or a Medicare Health Plan.

What impact do these Medicare regulations have on employer-sponsored benefits?

1. A Group Health Plan, hereinafter referred to as "Plan", must disclose whether or not its Rx coverage available is "creditable" and must coordinate coverage with Medicare Part D. "Creditable" coverage would be coverage that is equal to or better than coverage offered by Medicare Part D.

2. If a Plan offers a retiree plan with Rx coverage, the group may be eligible to receive a tax-free government subsidy if they continue providing coverage to retirees.

Medicare Part D Notice Requirements Impact All Employers

The Medicare Part D Regulations require that a Plan notify its Medicare beneficiaries who are active employees, disabled, on COBRA, retired, and dependents whether or not its drug coverage is "creditable".

For Retiree Plans that apply for the Retiree Drug Subsidy, the determination of creditable coverage requires an attestation by a qualified actuary.

For all other plans or Retiree Plans that are not applying for the Retiree Drug Subsidy, the determination of creditable coverage can be done without an attestation by a qualified actuary, if the plan design meets all four of the following standards. However, the standards listed under 4 (a) and 4 (b) may not be used if the Plan has prescription drug benefits that are integrated with benefits other than prescription drug coverage (i.e. Medical, Dental, etc.) 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 and generic prescriptions;

2) Provides reasonable access to retail providers and, optionally, for mail order coverage;

3) The Plan is designed to pay on average at least 60% of participants' prescription drug expenses; and

4) Satisfies at least one of the following:

   a) The prescription drug coverage has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000; or

   b) The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,960 per Medicare-eligible individual in 2010.

   c) For entities that have integrated health coverage, the integrated health plan has no more than a $320 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.

It is important to remember that the purpose of the "Creditable Coverage" notice is to give Medicare Part D-eligible individuals an opportunity to make an informed decision about whether they want to enroll in Part D. If a Medicare Part D-eligible individual enrolls in Part D after his or her initial Part D enrollment opportunity, the individual will pay an ongoing late-enrollment premium penalty. The penalty will be waived, however, if the individual moves to Part D from another drug coverage that is considered "creditable coverage".

All Plans must provide the notice to every person (employee, former employee, COBRA or dependent), who is covered by the Plan (or is seeking coverage under the plan) and who is enrolled in Medicare part A or B, **EVEN IF THE PLAN DOES NOT OFFER RETIREE DRUG COVERAGE**. The plan must give the notice whether the plan is primary or secondary to Medicare. A notice is also given to CMS on an annual basis. The notice obligation is excused for retiree plans that contract with Medicare Part D program to provide drug coverage (see (4.) under "Choices for Employers with Retiree Prescription Drug Coverage" below).

CMS has indicated that the notice need not be in a separate mailing, but rather can be included with other member information materials, such as initial- and open-enrollment materials. However, if the notice is included in other materials, it must be prominent and conspicuous, and a reference to the notice must appear on the first page of the document. This reference must be in 14-point font and be in a separate box, or must be bold-faced and contain a reference to the appropriate page or section. Only one notice per family is required unless the Plan is aware of a family member residing elsewhere. Electronic delivery is sufficient within specific guidelines.

More information regarding the "creditable coverage" test and notice guidelines is available on the CMS website at: http://www.cms.hhs.gov/CreditableCoverage/.

BASED UPON THE STANDARDS PREVIOUSLY LISTED, INSURANCE MANAGEMENT SERVICES WILL DETERMINE WHETHER OR NOT YOUR COVERAGE IS CREDITABLE AND IS PROVIDING A DISCLOSURE NOTICE TO BE DISTRIBUTED TO YOUR PARTICIPANTS.

Choices For Employers With Retiree Prescription Drug Coverage

1. Keep their retiree prescription drug coverage and take the tax-free 28 percent federal subsidy.

2. Apply for the subsidy from CMS, which should be worth about $600 per retiree per year—resulting in a potential savings of 25 to 45 percent, depending in part on the employer's tax status.

3. Eliminate their Plan's prescription drug coverage for all retirees, including Medicare Part D enrollees, or

4. Limit their Plan's prescription drug coverage for all Medicare Part A and/or B enrollees to supplement Part D prescription drug coverage, thereby effectively forcing the Medicare enrollees to elect Part D prescription drug coverage.

5. Very large Plans may apply to CMS to handle payment of all prescription drug coverage, including what Part D prescription drug coverage would have provided. (Plan sponsor must have already submitted an application to become a Prescription Drug Program (PDP).

Tax-Free Government Subsidy

A Plan must obtain an attestation by a qualified actuary if the group desires to elect the retiree drug subsidy, and the Plan may also be subject to audits from HHS, as requested. Individuals must be eligible for *but not* enrolled in either a stand-alone PDP or a Medicare Health Plan, and benefits must be actuarially equivalent to the Medicare standard plan.

A Plan will be eligible to receive a subsidy on behalf of the following individuals as long as they do not enroll in a Part D plan: a) a Part D-eligible retiree; b) Part D-eligible spouses and dependents of the Part D-eligible retiree; and c) individuals entitled to Medicare based on a disability or ESRD (end stage renal disease) who do not have current employment status.

A Plan will not be eligible to receive a subsidy on behalf of the following individuals: a) individuals who have "current employment status" under the Plan with regard to the MSP rules, and b) dependents who are Medicare Part D-eligible individuals, but whose covered employee has "current employment status" (i.e. spouses and dependents of active employees). **There is no subsidy payment for active employees or their dependents.**

The subsidy will be 28% of the allowable prescription drug costs incurred between $295.00 and $6,000.00. CMS estimates that the average subsidy will be about $1,600.00 per year per individual. The allowable prescription drug costs are based on non-administrative actual incurred costs for Part D prescription drugs excluding discounts, rebates, and other price concessions. Employers may receive the subsidy monthly, quarterly, or annually, and the amount received is not taxable.

Five Steps to Receive the Subsidy

Step One: Submit (electronically or otherwise) an application by September 30, 2005, to qualify for the retiree drug subsidy beginning January 1, 2006. In subsequent years, calendar-year plans submit applications by September 30 of each year; non-calendar year plans submit applications 90 days prior to the beginning of each plan year.

Step Two: Attach to the application an actuary's attestation that the Plan meets the MMA's actuarial equivalence standard. Actuaries have considerable flexibility in the use of simplified actuarial calculations, treatment of multiple benefit options, and allocation of premiums between drug and non-drug coverage. Once the actuarial equivalence standard is satisfied, Plan Administrators have full flexibility in Plan design. This means most Plan Administrators can maintain their current high-quality, comprehensive coverage without changing Plan design or cost-sharing.

Step Three: Certify that the creditable coverage status of the Plan has or will be disclosed to participants and CMS. This disclosure can be incorporated into other plan communications (e.g. those provided in accordance with ERISA reporting and disclosure requirements).

Step Four: Electronically submit and periodically update enrollment information about retirees and dependents. Entering into a voluntary data-sharing agreement with CMS makes the process even easier.

Information on how to enter into these voluntary data-sharing agreements (VDSA) with CMS is available online at: http://www.cms.hhs.gov/.

Step Five: Electronically submit aggregate data about drug costs incurred and reconcile costs at year-end; submission of detailed individual claims data is not required (though claims records must be maintained for audits). Plan Administrators can choose whether to submit data and receive payment monthly, quarterly, or annually.