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# Medicare Part D Common Questions: Definitions

**WHAT IS MEDICARE PART D?**

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 added a voluntary prescription drug program to Medicare, referred to as Medicare Part D. Medicare Part D contains provisions that:

- Make prescription drug coverage available, starting Jan. 1, 2006;
- Establish standards for beneficiary eligibility, access, benefits and protections;
- Create standards for organizations participating in the voluntary Medicare prescription drug program; and
- Require entities to provide a disclosure of creditable coverage status to all Part D Eligible Individuals and to the Centers for Medicare & Medicaid Services (CMS).

**WHAT IS CMS?**

The Centers for Medicare & Medicaid Services (CMS) is a federal agency within the U.S. Department of Health and Human Services. CMS administers the Medicare program and works in partnership with states to administer Medicaid, the State Children's Health Insurance Program (SCHIP), and health insurance portability standards. CMS works closely with the Social Security Administration to provide information about Medicare to beneficiaries applying for or currently receiving retirement or disability benefits.

**WHO MUST COMPLY WITH MEDICARE PART D?**

Generally, employer-sponsored Group Health Plans offering prescription drug coverage to individuals who are eligible for coverage under Part D must comply with mandates on 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 PART D ELIGIBLE INDIVIDUAL UNDER MEDICARE PART D?**

An individual is a Part D Eligible Individual if:

- The individual is entitled to Medicare Part A and/or enrolled in Part B, as of the effective date of coverage under the Part D plan; 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 simply when the person is first eligible.

**WHAT IS THE INITIAL ENROLLMENT PERIOD UNDER MEDICARE PART D?**

The Initial Enrollment Period is the period during which a Medicare beneficiary is first eligible to enroll in a Part D plan.

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**UNDER MEDICARE PART D, WHAT IS THE LATE ENROLLMENT PENALTY?**

Part D Eligible Individuals who go without any creditable prescription drug coverage for any continuous period of 63 days or longer after the end of their Initial Enrollment Period in Part D, and then enroll in Part D, must pay a Late Enrollment Penalty. This higher lifetime premium charge is based upon the number of months that the individual did not have creditable coverage. The premium that would otherwise apply is increased by at least one percent for each month without creditable coverage.

**WHAT IS CREDITABLE COVERAGE UNDER MEDICARE PART D?**

Coverage is Creditable Coverage under Medicare Part D 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 CMS guidelines. In general, this actuarial determination 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 Medicare prescription drug benefit.

**WHAT IS THE CREDITABLE COVERAGE DISCLOSURE NOTICE UNDER MEDICARE PART D?**

Most plan sponsors that currently provide prescription drug coverage to Medicare beneficiaries must disclose whether the sponsor's coverage is creditable prescription drug coverage. A Creditable Coverage Disclosure Notice is required regardless of whether the entity's coverage is primary or secondary to Medicare. Disclosure of whether prescription drug coverage is creditable provides Medicare beneficiaries with important information relating to their Medicare Part D enrollment. Beneficiaries who are not covered under creditable prescription drug coverage and who choose not to enroll before the end of their Initial Enrollment Period for Part D will likely pay a higher premium on a permanent basis, or a Late Enrollment Penalty, if they subsequently enroll in Part D.

Plan sponsors that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified prescription drug coverage are exempt from the disclosure requirement.

**UNDER MEDICARE PART D, WHAT IS A GROUP HEALTH PLAN?**

In general, a Group Health Plan is an entity that offers prescription drug coverage on a group basis to active and retired employees and beneficiaries who are Medicare-eligible individuals. The requirement to provide the Credible Coverage Disclosure Notices applies to employers or unions that sponsor retiree coverage, regardless of whether those entities are eligible for, and elect to apply for, the Retiree Drug Subsidy.

For purposes of the Creditable Coverage Disclosure Notice requirement, Group Health Plans include coverage provided by the following entities: employers, unions, account-based medical plans such as an HRA, multiple employer welfare arrangements (MEWAs), churches, federal/state/local governments, Department of Veterans Affairs, military coverage (including TRICARE) and qualified retiree prescription drug plans.

**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 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.

**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 (for example, drug spending between $310 and $6,350 for 2014 and drug spending between $320 and $6,600 for 2015). 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 health care reform law, employers that receive the subsidy cannot take a tax deduction for the subsidy amount starting in 2013.

**WHAT IS A QUALIFYING COVERED RETIREE, FOR PURPOSES OF THE RETIREE DRUG SUBSIDY UNDER MEDICARE PART D?**

A Qualifying Covered Retiree means a Part D Eligible Individual who is a participant or the spouse or dependent of a participant, covered under employment-based retiree health coverage that qualifies as a qualified retiree prescription drug plan, and who is not enrolled in a Part D plan.

**UNDER MEDICARE PART D, WHAT IS THE ACTUARIAL EQUIVALENCE STANDARD?**

"Actuarial Equivalence" is determined by the completion of a two-part test:

- *Total or "gross value" test*: To meet this requirement, the expected amount of paid claims for Medicare beneficiaries in the retiree drug coverage offered by the sponsor must be at least equal to the expected amount of paid claims for the same beneficiaries under the defined standard Medicare coverage.
- *"Net" value test*: This requirement takes into account the sponsor's contribution toward the financing of the retiree drug coverage. The net value of the sponsor's retiree plan, which is calculated by subtracting the expected retiree premium from the expected amount of paid claims under the sponsor's drug program, must be at least equal to the net value of the Part D standard drug benefit.

**UNDER MEDICARE PART D, WHAT ARE TRUE OUT-OF-POCKET (TROOP) COSTS?**

True Out-of-Pocket (TrOOP) costs are costs actually paid by the beneficiary, another person on behalf of the beneficiary, or a qualified State Pharmaceutical Assistance Program (SPAP) and not reimbursed by a third-party (such as a supplemental insurance plan sponsored by a former employer). The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and its regulations create a distinction between all beneficiary out-of-pocket expenditures and those that will be counted toward the annual Part D out-of-pocket threshold—the latter are known as "true" out of pocket (TrOOP) expenditures.