Medicare Part D Notice Reminder

The Annual Notice Deadline is October 14, 2019

Employer group health plans that include prescription drug coverage must provide a Medicare Part D creditable and/or non-creditable coverage notice ("Notice"), as applicable, each year to all Medicare-eligible employees and dependents *before* the annual October 15th Medicare Part D enrollment period. The purpose of this annual Notice is to notify Medicare beneficiaries whether or not their employer's prescription drug coverage is at least as good as Medicare's prescription drug coverage, in order to help them decide whether to enroll in Medicare Part D.

Take Action

Employers should review their prescription drug coverage to determine creditable coverage status and distribute the appropriate Notice on or before October 14th. If a plan has multiple benefit options providing prescription drug coverage, the test must be applied separately for each benefit option.

Take Note and Give Notice

In order to assist employers with Notice requirements, the remainder of this alert provides additional background details including:

- Which employers are subject to Medicare Part D Notice requirements;
- Who is considered a "Medicare Part D eligible individual";
- Model Notices;
- Notice deadlines;
- Methods of delivery;

We will also address how to determine creditability when there is an account-based plan and creditable coverage reporting to CMS.

Employers Subject to Medicare Part D Notice Requirements

An employer is subject to the Notice requirements if it offers prescription drug coverage to its active employees and/or retirees, which includes Medicare Part D eligible individuals (including dependents). As a best practice, we recommend all employers sponsoring a prescription drug benefit to assume it is responsible for providing the Notice and notifying CMS, as discussed below.

Medicare Part D Eligible Individuals

All Medicare Part D eligible individuals who are applying for, or are covered by, the employer's prescription drug benefits plan must receive the Notice. A "Medicare Part D eligible individual" is a person who:

- Is entitled to benefits under Medicare Part A and/or is enrolled in Medicare Part B, as of the effective date of coverage under a Medicare Part D plan (active employees may have Medicare coverage); and
- Resides in a "service area" of a Medicare Part D plan. A "service area" is defined as a location that meets certain pharmacy access standards. Most individuals live in a service area.

"Medicare Part D eligible individuals" may include active employees, employees who are disabled or on COBRA, retired employees, and their covered spouses and dependents. An employer may not know the Medicare eligibility status for all of these individuals, and we recommend employers provide the Notice to all covered individuals. Please see *Method of Delivery* below for delivery to covered families living at the same address.

Model Disclosure Notices

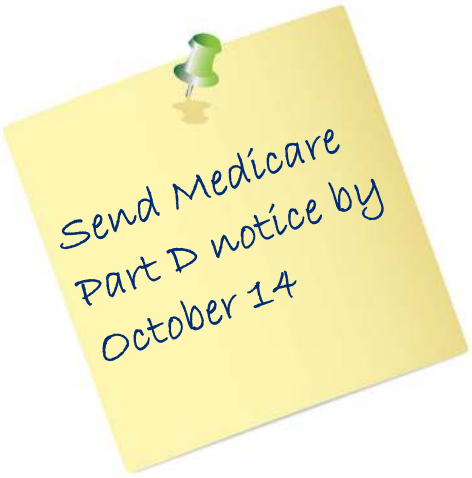
The Centers for Medicaid and Medicare Services (CMS) provides guidance and model creditable and non-creditable coverage disclosure Notices on its website. While the templates are dated April 2011, no changes have been made to the standard language since that time.

An employer may include multiple plan options in the same Notice, so long as the plans have the same creditable (or non-creditable) status.

Notice Deadlines

Although October 14th is the due date most associated with the Medicare Part D Notice, there are other times when Notice must be given to Medicare Part D eligible individuals.

- Prior to an individual's initial enrollment period for Medicare Part D;
- Prior to the effective date of coverage for any Medicare-eligible individual that joins the employer's plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and,
- Within a reasonable amount of time after an individual requests a copy.



Method of Delivery

Plans may provide the Notice with other member information materials (including new hire and open enrollment materials) or in a separate mailing. If the Notice is included in a separate packet of legal notices or in a benefits enrollment guide, the Notice must either appear on the first page (we interpret this to mean it is sufficient if it appears after the table of contents) or a call-out box must appear on the first page indicating this Notice is included in the materials, and a cross-reference to the page where it may be found. When the Notice is provided with other materials, the delivery guidance also indicates the initial disclosure portion of the Notice or the call-out box must appear in 14-point font. The delivery guidance provides the following sample call-out box:

> If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page [XX] for more details.

The Notice may be hand-delivered, mailed (first-class) or sent electronically. For paper delivery, a single Notice can be provided to a family living at the same address. Employers providing the Notice electronically may rely upon this method as long as certain conditions from the Department of Labor (DOL) are satisfied. For electronic delivery without getting consent from the participants, the DOL requires that:

- The employee has work-related computer access and use the computer as an integral part of their job;
- The employee can access the documents in electronic format at their work site;
- Appropriate measures are taken to ensure actual receipt by participants; and,
- Participants must be notified in writing or electronically of their right to receive a paper copy of the Notice free of charge.

If an employee does not use a computer as an integral part of their job, or the employer cannot satisfy all of the above, an employer may rely on electronic delivery if the employee provides advance consent.

In addition, if an employer provides the Notice electronically, it must also notify participants that they are responsible for providing a copy of the disclosure to their Medicare-eligible dependents covered by the group health plan.

Determining Creditability When There is an Account-Based Plan

Health Reimbursement Accounts (HRAs)

Plan sponsors who offer HRAs in conjunction with a major medical plan or on a stand-alone basis must take the HRA into account for Medicare Part D creditable coverage purposes if the HRA can be used to reimburse for the cost of prescription drugs.

- **Participation in Medical Plan + HRA:** If an individual participates in both the HRA and the major medical plan, creditable coverage is determined by increasing the expected prescription drug claims payable from the major medical plan by the amounts credited to the HRA.

  For HRAs that pay for both prescription drug costs and other medical claims, a reasonable portion of the year's HRA contribution may be allocated to prescription drug coverage.

  > **Example 1:** A medical plan has an annual deductible of $1,000. The employer makes an annual HRA contribution of $500. If the HRA can reimburse for both prescription drugs and other medical expenses, only a reasonable portion of the $500 should be allocated to prescription drug coverage for creditability determination purposes. This amount could be based on average reimbursement data and/or other facts and circumstances.

  If an HRA is limited to reimbursement for prescription drugs, the entire HRA contribution should be allocated to prescription drug coverage.

  > **Example 2:** A medical plan has an annual deductible of $1,000. The employer makes an annual HRA contribution of $500. If the HRA can only reimburse prescription drug expenses, then the sponsor is considered to provide drug coverage with a $500 annual deductible.

- **Stand-alone HRA:** If the HRA is offered on a stand-alone basis without requiring participation in a medical plan,[1] creditable coverage is determined as if the HRA were a medical plan with no deductible and an annual limit equal to the amount of the credit for that year.[2]

1. This can present certain compliance issues if the HRA is offered to current employees.

2. CMS, Treatment of Account-Based Health Arrangements under the Medicare Modernization Act," last *updated December 28, 2005: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/EmployerRetireeDrugSubsid/Downloads/AccountBasedPlansGuidanceRev1.pdf.*

Health Flexible Spending Accounts (FSAs)

Health FSAs are not included when determining the creditable coverage status of an underlying medical plan and are not independently subject to the Notice requirement.

Health Savings Accounts (HSAs)

HSAs are not included when determining the creditable coverage status of an underlying HDHP and are not independently subject to the Notice requirement.

Creditable Coverage Reporting to CMS

An often overlooked requirement for the employer is the obligation to report the creditable coverage status of its prescription drug plan(s) to CMS. The Online Disclosure to CMS Form should be completed (i) annually no later than 60 days from the beginning of a plan year (contract year, renewal year), (ii) within 30 days after termination of a prescription drug plan, and (iii) within 30 days after any change in creditable coverage status. Interestingly, there are no penalties for failing to provide this disclosure to CMS.

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