Memorandum

To: South Dearborn Health Subscribers – All health care plans

From: Charlotte McClure – H/R and Payroll Director

Date: 9/11/2024

Re: Anthem Blue Cross/Blue Shield Prescription Drug Coverage & Medicare

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Enclosed you will find an important notice from Anthem concerning the prescription drug coverage you currently have with your current coverage. It has been determined that your current coverage is a "creditable" coverage and therefore **nothing else is required from you at this time.**

The attached information only applies if you or any of your dependents are Medicare eligible. To be Medicare eligible, you must be at least 65 or disabled. If you or one of your dependents meet this requirement, please read the attached information on the Medicare Part D program and how this Medicare component might apply to you.

If you have any questions please contact Anthem or your local Medicare Representative.

Important Notice from Southeastern Indiana School Insurance Trust (SISIT) About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Southeastern Indiana School Insurance Trust (SISIT) and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

2. Southeastern Indiana School Insurance Trust (SISIT) has determined that the prescription drug coverage offered by the Southeastern Indiana School Insurance Trust (SISIT) is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th to December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Southeastern Indiana School Insurance Trust (SISIT) coverage will not be affected. You may continue your Southeastern Indiana School Insurance Trust (SISIT) employee coverage and elect Medicare part D and this plan will coordinate with Part D coverage. The Southeastern Indiana School Insurance Trust (SISIT)plan will be primary and Medicare will be secondary if a member is enrolled in both.

If you do decide to join a Medicare drug plan and drop your current Southeastern Indiana School Insurance Trust (SISIT) coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Southeastern Indiana School Insurance Trust (SISIT) of and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information Diane Titchenell at (317) 574-5009.
NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Southeastern Indiana School Insurance Trust (SISIT) changes. You also may request a copy of this notice at any time.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:
Visit www.medicare.gov

- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

- If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September 10, 2024
Name of Entity/Sender: Southeastern Indiana School Insurance Trust (SISIT)
Contact: Diane Titchenell, Director of Trust Operations
Address: 11711 N Meridian St, Suite 100, Carmel IN 46032
Phone Number:317-574-5009

CMS Form 10182-CC **Updated April 1, 2011**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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EMPLOYEE BENEFITS

Changes to Medicare Part D Benefit Payment Parameters as of January 1, 2025

August 2024

Background

Employer group health plans are required to disclose to Medicare-eligible individuals whether the prescription drug plan (if applicable) provides creditable or non-creditable coverage typically by October 15 of each calendar year (in addition to other applicable times during the year). Employers must also report to CMS whether the prescription coverage offered under the group health plan is considered creditable or non-creditable within 60 days following the beginning of the plan year.

An employer's prescription drug plan is considered creditable when the actuarial value (the measurement of how robust a plan is in providing coverage) of the prescription drug plan is the same as, or greater than, the actuarial value of Medicare Part D prescription drug coverage. Non-creditable means an employer's prescription drug plan's actuarial value does not meet or exceed the actuarial value of Medicare Part D prescription drug coverage.

Typically, a Medicare-eligible individual who does not enroll in Medicare Part D or creditable coverage shortly after becoming eligible for Medicare (typically for a period of 63 days or more from the date of Medicare eligibility) will be subject to late enrollment penalties under Medicare.

Creditable Coverage Determination

The actuarial value of an employer's prescription drug plan varies from health plan to health plan. Whether a prescription drug plan is creditable may require an annual "actuarial determination" to determine the creditable/non-creditable status of the plan. Qualifying prescription drug plans may also utilize an alternative to the actuarial determination methodology, referred to as the Simplified Determination methodology[1], which provides a more straightforward process for determining whether a prescription drug plan is creditable. The following describes the Creditable Coverage Simplified Determination methodology (also referred to as the Simplified Determination methodology) under the CMS rules.

Creditable Coverage Simplified Determination

Employers/union health plans that do not apply for the retiree drug subsidy (RDS) may use the Simplified Determination methodology to assess whether their prescription drug plan is creditable under the rules. If the prescription drug plan meets the standards set forth for an integrated or non-integrated plan, the plan would be considered creditable.

[1] *https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/CCSimplified091809.pdf*

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Integrated vs. Non-Integrated Plan

The criteria to determine if a plan is creditable or non-creditable under the Simplified Determination methodology differs depending on whether the plan is considered integrated or non-integrated. Therefore, the first analysis under the Simplified Determination methodology is to determine whether the plan is **integrated** or **non-integrated**. Once a prescription drug plan determines whether it is integrated or non-integrated, the next step is to carefully compare the applicable criteria to the employer's prescription drug plan offerings to determine if the plan qualifies as creditable coverage under the Simplified Determination methodology.

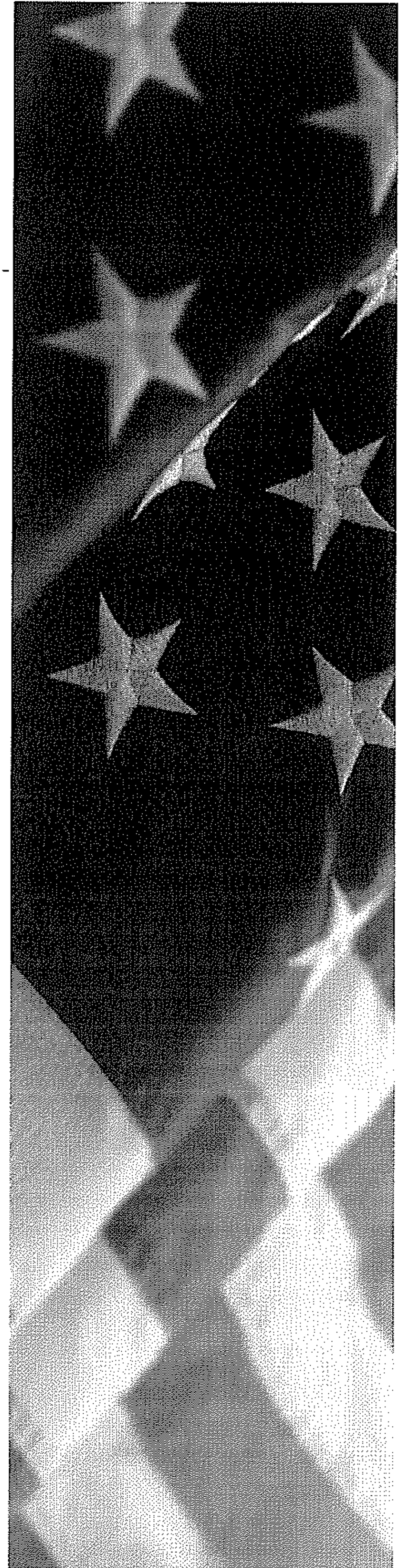
Integrated Plan

A plan is considered integrated if:

- All benefits under the plan have a combined plan year deductible
- All benefits under the plan have a combined annual maximum dollar amount, and
- All benefits under the plan have a combined lifetime maximum dollar amount

Note: The CMS Creditable Coverage Simplified Determination methodology was created before the ACA's prohibition on health plan annual/lifetime dollar maximums for Essential Health Benefits (EHBs). There is some ambiguity as to whether a plan's lack of any annual/lifetime dollar maximum means that the plan has a "combined" annual/lifetime maximum (because a plan could pay an infinite amount towards an individual's medical expenses) and therefore would be considered integrated. Or, in the alternative, it is possible that plans that have no lifetime and annual dollar maximums have no annual/lifetime maximums to "combine" under the plan. The latter interpretation would mean that such plans would be considered non-integrated. Plan sponsors should seek guidance from legal counsel to determine whether their specific plan is considered integrated or non-integrated. Further guidance from CMS on the Simplified Determination methodology post-ACA would be welcome.

In contrast, if a plan has an annual and/or lifetime dollar maximum on a non-EHB, which is allowed under the ACA, the plan should not be considered an integrated plan because the annual/lifetime maximum dollar amount is not combined for all benefits under the plan.



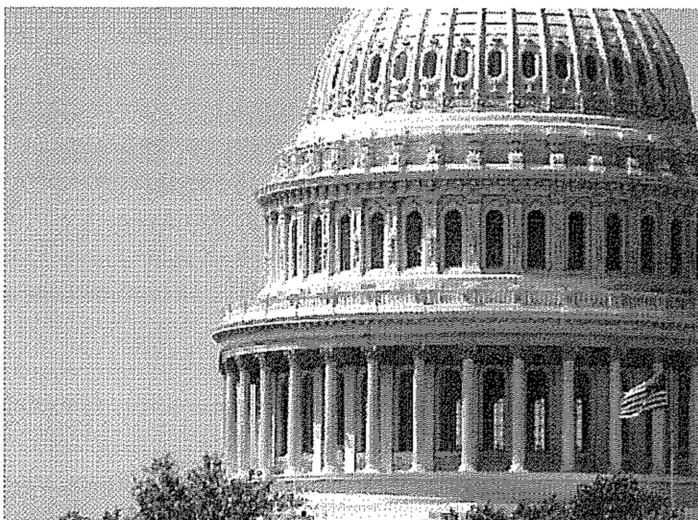
If the plan is **integrated**, then it is considered creditable if:

- Brand name and generic prescriptions are covered under the plan
- There is "reasonable access" to retail providers
- The prescription plan pays, on average, at least 60% of all participants' prescription drug expenses
- The plan (i.e., medical and prescription drug plan) has **no more than a $250 deductible per year**
- The plan has either no annual benefit maximum or a maximum annual benefit of at least $25,000, and
- The annual lifetime combined benefit is no less than $1,000,000

Non-Integrated Prescription Drug Plan

If a prescription drug plan is considered non-integrated under the CMS rules, the prescription drug plan will be considered creditable if it meets the following requirements:

- Brand name and generic prescriptions are covered under the plan
- There is "reasonable access" to retail providers
- The prescription plan pays, on average, at least 60% of all participants' prescription drug expenses; and
- Either one of the two criteria are satisfied:
  - » Prescription drug coverage has either no annual benefit maximum or a maximum annual benefit of at least $25,000, or
  - » There is an actuarial expectation that the amount paid under the prescription drug coverage for each Medicare-eligible individual will be at least $2,000 annually.



Actuarial Determination Methodology

Even when a plan is not creditable under the Simplified Determination methodology, the actuarial determination methodology could still be used to demonstrate that a plan is creditable. This requires using actuarial models to determine the estimated Part D base plan's gross and net costs (or the Gross Costs less the member cost sharing). The net-to-gross cost ratio is the Part D actuarial value. This number is compared to the actuarial value of the employer's plan you are testing. For it to be creditable, the actuarial value of the employer's plan must be equal to, or higher than, the actuarial value of the Part D plan design.

Changes to Medicare Part D in 2024 and January 1, 2025

Beginning in 2024, the primary change to Medicare Part D plans impacting the creditable coverage testing is the removal of the 5%-member coinsurance for catastrophic coverage. This will cap a member's cost at about $3,300 if they are utilizing brand-name drugs (member cost exposure was previously uncapped). After the initial member deductible, the 25%-member coinsurance will remain in place up to the catastrophic phase for all drugs (see 2023 Brand Drug Design, compared to 2024 Brand Drug Design at the end of this article). The shift of the 5% coinsurance from the member to the Part D Plan increases the actuarial value of the base Part D plan design, increasing the threshold to pass as creditable coverage.

Beginning January 1, 2025, the changes to Medicare Part D will dramatically impact the actuarial value more than the 2024 changes. The coverage gap phase is being eliminated, and an out-of-pocket spending cap of $2,000 is being placed on the initial coverage phase (see 2025 Brand Drug Design at the end of this article). This cost shift from the member cost share to the Part D plans further increases the actuarial value and will make it even more difficult for plans to pass creditable coverage testing.

The changes for 2024 and 2025 have caused the Medicare Part D plan's actuarial value to increase from about 68% in 2023 to nearly 74% in 2025. This meaningful difference could cause many existing employer-sponsored plans that were considered creditable in 2023 or 2024 to no longer meet minimum requirements in 2025 subject to an actuarial review.

Simplified Determination Methodology beginning January 1, 2025 and Beyond

CMS recently released guidance[2] that may eliminate the Simplified Determination methodology after the calendar year 2025. At this time, prescription drug plans that are **not** Employer Group Waiver Plans (EGWPs) and have **not** applied for retiree drug subsidies may continue to utilize the Simplified Determination methodology until December 31, 2025 to analyze whether a prescription drug plan is creditable, even if such prescription drug plan would be considered non-creditable under an actuarial review.

However, this relief shall only apply for the 2025 calendar year, so prescription drug plans that have a non-calendar year plan year may want to consider performing an actuarial review to determine the plan's creditable status for non-calendar year plan years beginning in 2025. CMS will either re-evaluate the continued use of the current Simplified Determination methodology or establish a revised version of the Simplified Determination methodology for calendar year 2026 and beyond.

Employer Considerations

Employers should be aware that due to these changes on January 1, 2025, it is quite possible that a plan that was once creditable for many years could become non-creditable on or after January 1, 2025. Prescription drug plans with non-calendar year plan years may also face challenges as to coverage considered creditable during 2024 and regarded as non-creditable after January 1, 2025.

At this time, there is very little guidance on relief provided to health plans with non-calendar year plan years that may no longer be considered creditable as of January 1, 2025. Employers should seek advice from legal counsel on approaching proper disclosure and reporting requirements related to non-calendar year plan years.

Although employers are not required to provide creditable coverage to employees, former employees or their Medicare-eligible spouses and dependents, many of these individuals may be surprised that coverage they have been enrolled in for many years is considered non-creditable as of January 1, 2025. As previously mentioned, certain Medicare-eligible individuals who fail to enroll in Medicare Part D (or an equivalent plan) within a certain timeframe of becoming eligible may be subject to penalties when they eventually enroll in Medicare Part D.

To avoid some confusion to employees and their covered family members, employers may want to consider informing Medicare-eligible beneficiaries of a change in the creditable to non-creditable status of the prescription drug plan before January 1, 2025, to ensure that those eligible for Medicare have the proper information about the effect of delaying enrollment into Medicare Part D.

Action Plan

Plan sponsors should either perform an actuarial review of their prescription drug plan or apply the Simplified Determination methodology to their prescription drug plans prior to the significant changes being made to Medicare Part D as of January 1, 2025. This is to ensure that the applicable creditable/non-creditable notice is being accurately provided to Medicare-eligible individuals and that a plan sponsor accurately reports the plan's creditable/non-creditable status to CMS.

Plan sponsors/employers of fully insured plans should consult with their insurance carrier partners. Plan sponsors/employers of self-funded plans may want to review their prescription drug plans more closely with their third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to see if they will assist with determining the creditable/non-creditable status of the prescription drug plans.

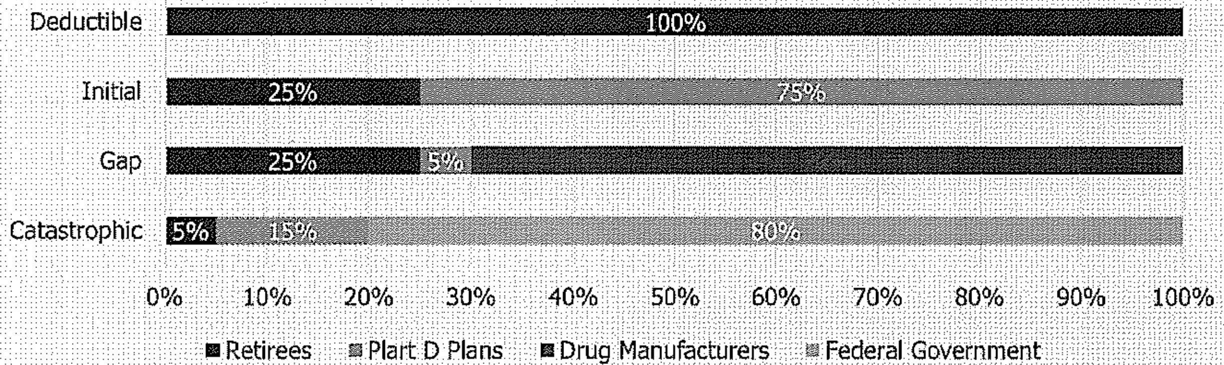
Employers affected by these changes to Medicare Part D may want to consider the following:

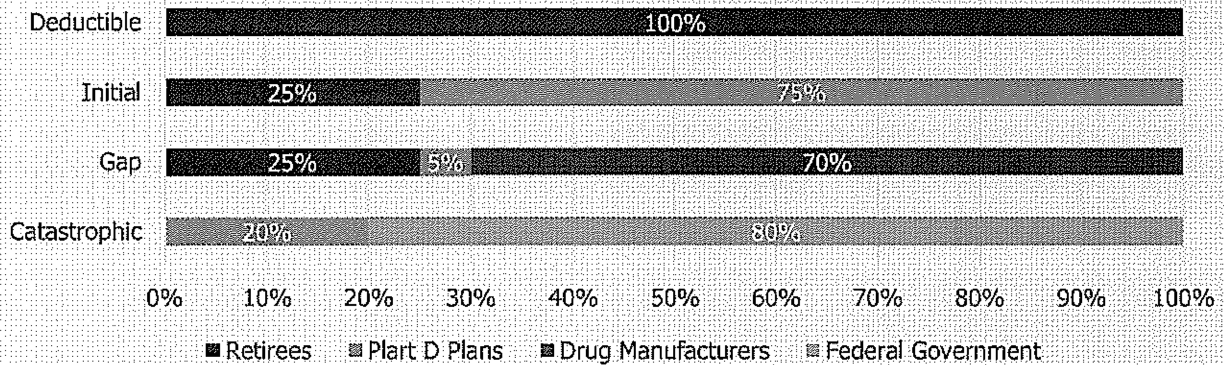
- Change their prescription drug plan design with their insurer/TPA to satisfy creditable coverage standards under the CMS rules if those plans would no longer be considered creditable after January 1, 2025, or
- Notify Medicare-eligible individuals that their prescription drug plans no longer meet the standards for creditable coverage by delivering the non-creditable coverage notice to Medicare-eligible individuals for calendar year plans during the open enrollment period that occurs in 2024 for coverage beginning January 1, 2025, and anytime there are any special/initial enrollments in 2025. For non-calendar year plan years, if the prescription plan was considered creditable in 2024 but considered non-creditable in 2025, the non-creditable coverage notice should be delivered to participants and beneficiaries within 30 days of January 1, 2025, and during any special/initial enrollment periods in 2025 (if applicable).

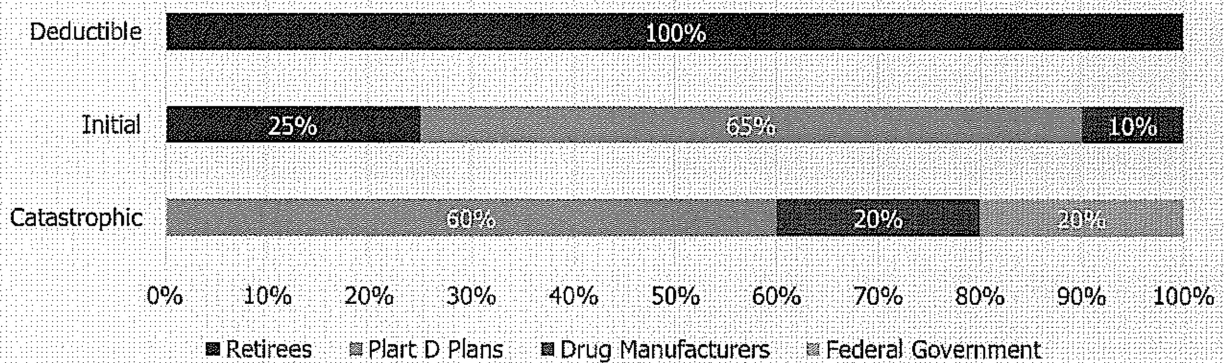
For more information on whether the plan is creditable/non-creditable, health plan sponsors should contact their insurance carriers/TPAs/PBMs (as applicable) and their actuarial team and legal counsel.

[2] *https://www.cms.gov/newsroom/fact-sheets/final-cy-2025-part-d-redesign-program-instructions-fact-sheet*

Exhibits – Brand Drug Designs







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Compliance Overview

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Medicare Part D Common Questions

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. Medicare beneficiaries can receive subsidized prescription drug coverage through the Medicare Part D program.

Employers with group health plans that provide prescription drug coverage to individuals who are eligible for Medicare Part D must comply with disclosure notice requirements. Medicare Part D requires employers to disclose whether their prescription drug coverage is "creditable" to the Centers for Medicare and Medicaid Services (CMS) and to Medicare Part D eligible individuals. These disclosures must be made on an annual basis and at certain other designated times.

In addition, the MMA created a subsidy—the Retiree Drug Subsidy—to encourage employers to provide prescription drug coverage to their Medicare-eligible retirees.

General Information

Who is required to comply with Medicare Part D?

Generally, employer-sponsored group health plans offering prescription drug coverage to individuals who are eligible for coverage under Medicare Part D must comply with mandates on the 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 Medicare Part D eligible individual?

An individual is eligible for Medicare Part D if:

- The individual is entitled to Medicare Part A and/or enrolled in Part B; 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 just when the person is first eligible.

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 that 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.

Creditable Coverage Disclosures to Individuals

What notices must employers provide to Medicare Part D eligible individuals?

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

Why must plan sponsors tell Part D eligible individuals whether their prescription drug coverage is creditable?

Plan sponsors must tell Part D eligible individuals whether their prescription drug coverage is creditable so that the Medicare-eligible individuals can compare their existing coverage with the coverage provided under a Part D plan. Part D eligible individuals who are not covered under creditable prescription drug coverage may be subject to a permanent late enrollment penalty in the form of higher premiums in the event that they choose to enroll in Part D coverage at any time after the end of their Initial Enrollment Period.

What must be included in the creditable coverage disclosure notices provided to Medicare Part D eligible individuals?

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

When must the creditable coverage disclosure notices be provided?

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

How must the creditable coverage disclosure notices be provided?

Health plan sponsors have flexibility in the form and manner of providing creditable coverage disclosure notices to beneficiaries. The notice need not be sent as a separate mailing. It may be provided with other plan participant information materials, including enrollment and/or renewal materials. The sponsor may provide a single disclosure notice to the covered Medicare individual and all Medicare-eligible dependent(s) covered under the same plan. However, the sponsor is required to provide a separate disclosure notice if it is known that any spouse or dependent who is Medicare-eligible resides at a different address than from where the participant materials were provided.

If a plan sponsor chooses to incorporate the creditable coverage disclosure notice with other plan participant information, then the disclosure must be prominent and conspicuous. This means that the disclosure notice portion of the document, or a reference to the section in the document that contains the disclosure notice portion, 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.

Also, CMS has indicated that group health plan sponsors may deliver creditable coverage disclosure notices **electronically** if they follow the Department of Labor's standards for electronic disclosure. If the notices are provided electronically, the sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare-eligible dependents covered under the group health plan.

Creditable Coverage Disclosure to CMS

What notice must employers provide to CMS?

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.

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 webpage, which is generally the sole method for compliance with the requirement.

Creditable Coverage Determination

How does a plan sponsor determine whether prescription drug coverage is creditable for purposes of the creditable coverage disclosure notice requirement?

Before preparing creditable coverage disclosure notices, a plan sponsor must determine whether the coverage is creditable. A health plan's prescription drug coverage is creditable 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 guidelines developed by CMS. In general, to be creditable, the expected amount of paid claims under the plan sponsor's prescription drug coverage must be at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

For plans that have multiple benefit options, the plan sponsor must apply the actuarial value test separately for each benefit option. A benefit option is defined as a particular benefit design, category of benefits or cost-sharing arrangement offered within a group health plan.

There is no exception from the actuarial equivalence requirement for small employers. However, certain plan designs may qualify for a simplified determination of creditable coverage status without having to perform the actuarial determination.

The determination of creditable coverage status does not require an attestation by a qualified actuary unless the plan sponsor is an employer or union electing the Retiree Drug Subsidy.

What benefit designs qualify for a simplified determination of creditable coverage status?

If a plan sponsor is not an employer or union that is applying for the Retiree Drug Subsidy, the sponsor may be eligible to use a simplified determination that its prescription drug plan's coverage is creditable. The standards for the simplified determination are described below. However, the standards listed under 4(a) and 4(b) may not be used if the sponsor's plan has prescription drug benefits that are integrated with benefits other than prescription drug coverage (for example, medical or dental benefits). 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-name and generic prescriptions;
2. Provides reasonable access to retail providers;
3. Is designed to pay, on average, **at least 60 percent** of participants' prescription drug expenses; and
4. Satisfies at least one of the following:
    - The prescription drug coverage has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000;
    - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare-eligible individual; or
    - 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 million lifetime combined benefit maximum.

**The Affordable Care Act (ACA) prohibits health plans from imposing lifetime and annual limits on the dollar value of essential health benefits.*

If an entity is applying for the Retiree Drug Subsidy, it cannot use the simplified determination of creditable coverage status. It must instead consult with an actuary to perform an actuarial equivalence determination before preparing its creditable coverage disclosure notices.

Enforcement

Are there any consequences to an employer for failing to provide creditable coverage disclosure notices or for failing to comply with coordination of benefits requirements?

There are currently no direct penalties or other sanctions available to CMS in the event that an employer fails to provide the required creditable coverage disclosure notices or fails to comply with coordination of benefits requirements. However, employers who are also claiming the Retiree Drug Subsidy will not qualify for the subsidy unless they provide compliant disclosure notices. Furthermore, other federal laws such as ERISA may indirectly provide consequences to a noncompliant employer. Also, failing to comply with these requirements may have a negative impact on employee relations, especially if an individual later incurs a late enrollment penalty because he or she was unaware that their prescription drug coverage through the employer was not creditable.

Retiree Drug Subsidy

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. 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 ACA, employers that receive the subsidy cannot take a tax deduction for the subsidy amount. This change became effective in 2013.*

Under Medicare Part D, what is required of an employer who wishes to apply for the Retiree Drug Subsidy?

Each plan sponsor that seeks the Retiree Drug Subsidy must electronically complete the application through the Retiree Drug Subsidy Center. Applications for the Retiree Drug Subsidy are due at least 90 days before the beginning of the plan year, unless CMS approves a request for a 30-day application deadline extension. Plan sponsors must apply each year they wish to claim this subsidy.

LINKS AND RESOURCES

- For general information on the Medicare Part D program, including covered benefits, see the Medicare Part D webpage.
- Visit CMS' creditable coverage webpage for information about creditable coverage disclosure notices.
- More information about the retiree drug subsidy is available on CMS' Retiree Drug Subsidy webpage.

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