



CMS Final Medicare Part D Regulations Affect Retiree Drug Subsidy

CMS recently issued final regulations that make policy clarifications and technical corrections to its earlier final regulations on Medicare Part D. The regulations contain provisions affecting the retiree drug subsidy program, including clarification of rules regarding the timing of applications for the subsidy, submission of actuarial attestations upon a material change and changes to the rules for determining actuarial equivalence.

Background

Although CMS issued [final regulations](#) implementing Medicare Part D in 2005, it continued to issue interpretative guidance. In 2007, CMS issued [proposed regulations](#) to codify this guidance and provide additional policy clarifications. Some of these proposed changes were related to the retiree drug subsidy (RDS) program, which provides payments to employer and union sponsors of qualified retiree prescription drug plans for certain Part D drug costs. CMS has now issued [final regulations](#) that generally adopt the 2007 proposed regulations.

Change to RDS Application Deadline

The 2005 final regulations required a plan sponsor to file an application for the retiree drug subsidy no later than 90 days before the beginning of its plan year, unless CMS granted an extension. The 2008 final regulations replace the 90-day deadline with “a date specified by CMS in published guidance.” CMS indicates that this will allow it to specify an end-of-month deadline, which will be simpler for both plan sponsors and CMS to track.

Submission of Actuarial Attestations Upon a Material Change to Retiree Drug Coverage

The 2005 regulations required plan sponsors to provide an actuarial attestation to CMS “no later than 90 days before the implementation of a material change to the drug coverage of the sponsor’s plan that impacts the actuarial value of the coverage.” The 2008 final regulations attempt to clarify what is meant by a material change, although the “clarifying” language is somewhat convoluted. However, by reading the new language along with the preamble and the language in the 2005 regulations, it becomes apparent that CMS intends that a mid-year attestation is required only if a new benefit option is added to the application. No mid-year attestation is required if there is a change in the benefits offered under benefit options listed in the initial application as long as all of those benefit options remain actuarially equivalent.

BUCK COMMENT. *CMS considers this a clarification of earlier guidance (i.e., that a change within a benefit option that did not affect the result of the gross test or the net test does not require a new attestation.)*

New Notice of Failure to Continue to Meet Actuarial Equivalence Standards

The 2008 final regulations add a new reporting requirement for plan sponsors when a change to retiree drug coverage causes the retiree drug benefit option to no longer be actuarially equivalent to the Part D benefit. Plan sponsors must notify CMS no later than 90 days before the implementation of such a change. However, the regulations provide no additional information regarding the form and manner of this new reporting requirement.

BUCK COMMENT. *Previously, if a mid-year change reduced retiree drug coverage so that the benefit was no longer equivalent to Part D, an employer might have just ceased reporting retirees to CMS as eligible for the retiree drug subsidy. Now, the employer will have to notify CMS regarding such changes whenever made. More importantly, the 90-day requirement means that an employer may be forced to wait longer before making significant cutbacks in benefits.*

Medicare Supplement Adjustment

To qualify for the retiree drug subsidy, a plan must satisfy both a gross test and a net test. A plan sponsor has the option to include a “Medicare supplement adjustment” under the net test if it provides supplemental coverage for its retirees who elect Part D coverage. Supplemental coverage for this purpose means drug coverage over and above standard Part D coverage.

The 2008 final regulations adopt the provision in the proposed regulations requiring a plan sponsor to actually provide supplemental drug coverage for its retirees to take advantage of the Medicare supplement adjustment component of the net test.

BUCK COMMENT. *Again, CMS does not consider this to be new policy, but rather the incorporation of previously issued guidance.*

As a practical matter, most plans do not need this additional calculation to pass the actuarial equivalence test and few plans actually provide supplemental coverage to Medicare Part D. In the past, some employers used the Medicare supplement adjustment because they offered supplemental coverage – even though no retirees actually elected it. Now, employers should only use the Medicare supplement adjustment if they actually have retirees enrolled in the supplemental coverage. If this is available only to some retirees, a prorated Medicare supplement adjustment is allowed.

Aggregation of Subset of Benefit Options for Actuarial Equivalence Net Test

The 2008 final regulations adopt the provision in the proposed regulations that allows plan sponsors to aggregate a subset of benefit options in a qualified retiree drug plan for the net test, in addition to aggregating all benefit options or evaluating each option individually. Previously, a retiree drug plan with benefit options A, B and C

could run the net test on A, B and C individually, or A + B + C in the aggregate. Under the final regulations, A + B may be combined for the net test, with C tested individually (or any other subset combination – the greater the number of benefit options, the greater the number of possible subset combinations). Only options that pass the net test, either individually or as part of a group, will be eligible for RDS.

CMS indicates that this change is necessary to reflect the policy it has followed since the 2005 regulations were issued.

BUCK COMMENT. *The mathematical substance of the testing is unchanged – if all subset combinations pass the net test, the entire plan will automatically pass the combined net test. However, this aggregation provision is administratively more convenient, and eliminates data sharing issues when multiple actuarial firms are involved with the same plan. Each firm can run the net test on the benefit options it is working with.*

Current or Subsequent Year's Medicare Part D Values for Non-Calendar Year Actuarial Equivalence Test

Medicare Part D defined standard drug coverage is based on an initial coverage limit, cost sharing amounts and an annual out-of-pocket threshold. These amounts are increased for each calendar year. The 2008 final regulations permit actuaries to use either the current or subsequent year's values in performing the actuarial equivalence test for a non-calendar year plan when the attestation is submitted within 60 days of the publication of the following year's cost limits. Previously, actuaries were required to use current year numbers unless the attestation was submitted more than 60 days after publication of the new calendar year numbers.

BUCK COMMENT. *This provision gives actuaries more flexibility when working with non-calendar year plans.*

Effective Date

The final regulations take effect June 9, 2008, although many of the revisions are clarifications of existing guidance already in effect.

Conclusion

Under the final regulations, employers will need to allow longer lead times before implementing retiree drug plan benefit design changes that affect a plan's status as actuarially equivalent to the Part D benefit. Buck's consultants are available to assist you with design changes to your retiree drug program or any other issues that arise in connection with the retiree drug subsidy program.

This FYI is intended to provide general information. It does not offer legal advice or purport to treat all the issues surrounding any one topic.