



LEGISLATIVE BRIEF

Medicare Prescription Drug Program – Final Regulations Released

On April 15, 2011, the Centers for Medicare & Medicaid Services (CMS) released final regulations for Medicare Part D prescription drug plans and Medicare Advantage plans that include prescription drug coverage. The regulations implement changes made to the Medicare prescription drug program by the Patient Protection and Affordable Care Act (PPACA), the health care reform bill that was passed in March 2010. The regulations also make other changes to the Medicare prescription drug program based on CMS's experience in administering the program since its inception in 2006. With a few exceptions, the regulations become effective on **June 6, 2011**.

This issue of the Benefit Management Solutions Inc. Legislative Brief provides an overview of key provisions of the final Medicare prescription drug program regulations.

Health Care Reform Changes

Cost-Sharing Restrictions

Effective for 2011, cost-sharing under Medicare Advantage plans is limited to the cost-sharing imposed under original Medicare for the following: chemotherapy administration services, renal dialysis services and skilled nursing care. The final regulations do not extend this cost-sharing restriction to additional services under Medicare Advantage plans, but note that CMS has the authority to designate additional services subject to the cost-sharing restriction in the future.

In addition, effective for 2011, health care reform provides a free, annual wellness visit and personalized prevention plan services for original Medicare beneficiaries and eliminates cost-sharing for preventive services. The final regulations extend this mandate further by requiring Medicare Advantage plans to provide in-network Medicare-covered preventive benefits without cost-sharing, consistent with original Medicare.

Annual Coordinated Election Period

The final regulations codify health care reform's change to the annual coordinated election period. Under health care reform, the annual coordinated election period changes to the period from Oct. 15 to Dec. 7, effective for the 2012 plan year. Group health plans — or entities that offer prescription drug coverage on a group basis to active and retired employees and to Medicare Part D eligible individuals — must provide a notice of creditable or non-creditable prescription drug coverage prior to the annual coordinated election period each year. Thus, for the 2012 plan year, the creditable or non-creditable coverage notices are due by **Oct. 14, 2011**.

Increased Premiums for High-Income Individuals

Effective Jan. 1, 2011, high-income individuals are required to pay an income-related increase to their monthly Medicare Part D premiums, similar to the premium adjustment under the Medicare Part B program. High-income individuals are those with annual incomes of more than \$85,000 for singles and \$170,000 for married couples. The final regulations codify this change and provide technical details for administering the premium increase.



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Closing the Coverage Gap

Health care reform gradually closes the gap that occurs in Medicare prescription drug coverage between the initial coverage limit and the out-of-pocket maximum (the “donut hole”) by providing drug discounts and subsidies. Additional drug discounts and subsidies will be phased in to completely fill the coverage gap by 2020. Health care reform also reduces the growth in the annual out-of-pocket maximum from 2014 to 2019. The final regulations codify health care reform’s changes to close the coverage gap, and include technical guidance on implementing these changes.

Other Changes

In addition to the health care reform changes, the final regulations make changes to the Medicare prescription drug program’s system and operations. More specifically, the final regulations:

- Clarify various program participation requirements, such as prohibiting participation by Medicare Advantage organizations and Part D sponsors whose owners or directors served in a similar capacity with another organization that terminated its Medicare contract within the previous two years;
- Strengthen beneficiary protections, for example, by requiring Medicare Advantage organizations and Part D sponsors to translate key plan marketing materials into any primary language spoken by at least 5 percent of the population in a given service area and provide interpreters in customer call centers; and
- Strengthen Medicare’s ability to identify strong applicants for Medicare Parts C and D program participation and remove consistently poor performers by, for example, setting financial solvency requirements.

For a copy of the final regulations, see: <http://edocket.access.gpo.gov/2011/pdf/2011-8274.pdf>

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