Time to optimize your Medicare Part D subsidies

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By Bruce Shutan

A wave of apprehension spread across Corporate America upon the release of regulations governing the Medicare Part D prescription-drug subsidy program. Employers not only scrambled to understand their options, but also grappled with how to administer their programs. Many searched far and wide for an outsourcing partner to take responsibility; some found they needed to dedicate a full-time staffer to these functions given the complexity and breadth of the task.

"There was a lot of emerging administrivia from the Centers for Medicare and Medicaid Services (CMS) and Retiree Drug Subsidy center (RDS)," recalls Elizabeth A. Dudek, vice president, practice leadership for Thomson Medstat, which delivered a fully outsourced solution for more than a third of its customers who applied for the subsidy.

Now that employers have processed their initial reporting, they are focusing on the gravity of dollars at stake — $600 to $1,000 per retiree each year — and the most efficient way to process subsidy requests. "The subsidy is significant enough to make employers think twice about offering a qualified plan," she says.

Looming deadline

Employers were required to submit benefits eligibility data by the end of last October in order to participate in 2006 — the program's first plan year. Those that missed the deadline have until the end of September to apply for the subsidy next year. When this calendar year ends, they will have 15 months to reconcile all of their records to ensure the accuracy of the information they provided to CMS — and to pay or receive additional funds based on the variances they uncover.

Here's how the subsidy program works: Employers that sponsor an actuarially equivalent plan to the government guidelines, or one that's better, have an opportunity to continue retiree drug benefits they offered prior to the Medicare Modernization Act of 2003. In turn, they receive a 28% subsidy for every qualified Rx dollar spent. Program qualifiers stipulate somewhat of a complex calculation in that the dollars this subsidy is based on must be more than a deductible amount and less than a threshold amount.

During April, Medstat helped its customers receive nearly $60 million. That amount has since swelled to about $144 million.

If calculation errors are made throughout the year, Dudek says corrections still can be made during the reconciliation process in the event that an audit uncovers inaccuracies. Such a scenario may be likely, since Medicare Part D administration "was not an area of existing expertise in employer organizations — nor in PBMs, for that matter," according to Patrick Manders, VP-marketing of Thomson Medstat's employer and health plan market groups.

"We know because we built from scratch our Medicare Part D unit, including audits services, as a core business. In doing so, we made sure to build a high degree of rigor into our processes," he says,

noting that missing just a small percentage of the subsidy opportunities could translate into millions of dollars for some employers. Adds Dudek: "We probably have the most aggressive excluded drug list in the marketplace that has been reviewed by CMS, and believe we are best positioned to maximize the letter of the law to get the most dollars into the hands of our customers."

A matter of expertise

Indeed, Medstat has worked closely with CMS to produce an official list to help guard against employers having to repay excluded drug dollars. Other Medstat services include assistance on filling out the Medicare D subsidy application, aggregating claims from multiple vendors and submitting them to RDS on a monthly or quarterly basis, and matching eligibility with claims information.

Medstat also takes advantage of the program’s so-called voluntary data share arrangement (VDSA) "whereby we speak electronically directly with CMS to identify those retirees who are eligible for the subsidy, which was a manual process for some of our customers," Dudek adds. "So we believe the integrity of the data being submitted is at the highest level possible."

Her expectation for the first initial audits being conducted for customers is that with some PBMs, certain Medicare Part B drugs driven by diagnosis codes shouldn’t have been included under Part D while others should have been excluded and the subsidy taken. The chance for errors mounts for organizations that deal with multiple PBMs that may be using different formulas or approaches to exercising caution.

In short, a "midstream" Medicare D audit can surface numerous opportunities to maximize available CMS subsidy dollars — more than paying for any audit expense. Manders describes this as "a prudent investment," and one that should be considered a standard component of any Medicare D administration solution.

For more information on optimizing your Medicare Part D Subsidies, click here.

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