

PRESCRIPTION DRUG COVERAGE UNDER THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT AND MODERNIZATION ACT OF 2003 (MMA)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare. Prescription drug coverage under Medicare will be available starting January 1, 2006.

Group medical plans that currently provide prescription drug coverage to Medicare beneficiaries must disclose whether the plan's coverage is "creditable prescription drug coverage." A disclosure is required whether the plan's coverage is primary or secondary to Medicare. However, plans that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified prescription drug coverage are exempt from the disclosure requirement. Therefore, for example, an employer that provides prescription drug coverage to retirees through a Part D plan is exempt from the disclosure requirement.

Disclosure of whether prescription drug coverage is creditable provides Medicare beneficiaries with important information relating to their Medicare Part D enrollment. Beneficiaries who are not covered under creditable prescription drug coverage and who choose not to enroll before the end of their initial enrollment period for Part D likely will pay a higher premium on a permanent basis if they subsequently enroll in Part D.

The Act establishes certain requirements regarding disclosure notices, including rules regarding timing and general content requirements.

OVERVIEW OF REGULATORY REQUIREMENTS

Who Receives the Disclosure Notice?

The disclosure notice must be provided to **all** Part D eligible individuals who are covered under, or who apply for, the group medical plan's prescription drug coverage. There is no exemption based on whether prescription drug coverage is primary or secondary to Medicare Part D. **Therefore, the disclosure requirement applies with respect to Medicare beneficiaries**

who are active employees and those who are retired, as well as Medicare beneficiaries who are covered as spouses under active or retiree coverage.

Group medical plans must also provide a disclosure of creditable coverage status to the Centers for Medicare & Medicaid Services (CMS) on an annual basis. CMS will provide future guidance relating to disclosure to CMS.

Who Are Part D Eligible Individuals?

An individual is a Part D eligible individual if:

- The individual is entitled to Medicare Part A and/or enrolled in Part B, as of the effective date of coverage under the Part D plan; and
- The individual resides in the service area of a prescription drug plan (PDP) or of a Medicare Advantage plan that provides prescription drug coverage (MA-PD). An individual who is living abroad or is incarcerated is not eligible for Part D because he or she is not considered to reside in the service area of a Part D plan.

Please note that in general, an individual becomes entitled to Medicare Part A when the person actually has Part A coverage, and not simply when the person is first eligible. A person has Part A coverage without being subject to monthly premiums if the person has attained age 65 and has monthly social security benefits or is a qualified railroad retirement beneficiary. Individuals under age 65 may also become entitled to Medicare Part A benefits if they receive at least 24 months of social security or railroad retirement benefits based on disability. An individual who is eligible for social security benefits but has not applied for such benefits becomes entitled to Medicare Part A only upon the filing of an application for Part A benefits.

Detailed information about Medicare Part A and Part B eligibility and enrollment is

provided in the CMS publication *Enrolling in Medicare*. Medicare beneficiaries should be directed to their local Social Security (or Railroad Retirement) office for questions about when and how to enroll in Medicare.

Enrollment in Part D

At the beginning of the Part D program, there is an initial open enrollment period for Part D for all Medicare beneficiaries that begins on November 15, 2005 and extends through May 15, 2006. Subsequently, when an individual's Part B initial enrollment period extends beyond May 15, 2006, the initial enrollment period for Part D is concurrent with the individual's initial enrollment period for Part B. The initial enrollment period for Part B is the 7-month period that begins 3 months before the month an individual first meets the eligibility requirements for Part B and ends 3 months after the month of first eligibility.

If, by the end of an individual's initial enrollment period for Part D, the individual has not enrolled in a Medicare prescription drug plan and does not have creditable coverage for any period of 63 days or longer, the individual will likely have to pay a higher premium charge for late enrollment.

Late Enrollment Penalty

There is a late enrollment penalty for Part D eligible individuals who go without any creditable prescription drug coverage for any continuous period of sixty-three days or longer after the end of their initial enrollment period in Part D, and then enroll in Part D. The higher premium charge is based on the number of months that the individual did not have creditable coverage. The premium that would otherwise apply is increased by at least 1% for each month without creditable coverage. While this percentage will apply for as long as the individual remains enrolled in Part D, the higher premium charge will actually increase each year because the percentage increase will be applied to each subsequent year's base premium. If Part D eligible individuals are covered under a plan that is providing creditable prescription drug coverage, they will not be assessed a late enrollment penalty if they choose to enroll in Medicare prescription drug coverage at a later date. However, they will be assessed late enrollment penalties if they choose to drop

coverage before they can enroll in a Medicare prescription drug plan (or lose coverage and do not promptly take advantage of the resulting special enrollment period), and they go without any creditable coverage for a continuous period of sixty-three days or longer.

If Part D eligible individuals are covered under a plan that is providing non-creditable prescription drug coverage, they will need to enroll in a Part D plan during the initial open enrollment period if they do not want to pay a late enrollment penalty. There are limited times in the year in which beneficiaries can enroll (November 15 – December 31), and if they do not enroll during the initial open enrollment period, they will likely pay a late enrollment penalty if they choose to join at a later time, unless they had another source of creditable coverage.

Creditable Coverage Definition and Determination

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 CMS actuarial guidelines. In general, this actuarial determination measures whether the expected amount of paid claims under the group plan's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

POLICY GUIDANCE

The following are clarifications and other guidance relating to the above regulatory requirements.

Attestation

The determination of creditable coverage status does not require an attestation by a qualified actuary unless the group plan provides qualified retiree prescription drug plan coverage for its retirees and is electing the retiree drug subsidy. Refer to the section entitled **SUBSIDY PAYMENTS APPLICABLE ONLY TO EMPLOYERS PROVIDING QUALIFIED RETIREE PRESCRIPTION DRUG BENEFITS** on page 5 for additional information.

Benefit Designs for Simplified Determination of Creditable Coverage Status

If a group plan is not applying for the retiree drug subsidy, it can determine that its prescription drug plan's coverage is creditable if the plan design meets all four of the following standards. However, the standards listed under 4(a) and 4(b) may not be used if the entity's plan has prescription drug benefits that are integrated with benefits other than prescription drug coverage (i.e. medical 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 and generic prescriptions;
2. Provides reasonable access to retail providers and, optionally, for mail order coverage;
3. The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
4. Satisfies at least one of the following:
 - (a) the prescription drug coverage has no annual benefit maximum or a maximum annual benefit payable by the plan of at least \$25,000; or (b) the prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least \$2,000 per Medicare eligible individual in 2006. (c) For plans 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 \$1,000,000 lifetime combined benefit maximum.

Form, Manner and Content of Creditable Coverage Disclosure from Plan to CMS

All group medical plans are required to disclose to CMS whether their prescription drug coverage is creditable or non-creditable. The disclosure must be made to CMS on an annual basis, and upon any change that affects whether the coverage is creditable. CMS will provide the timing, format, and model language for disclosure statements to CMS in further guidance.

Form and Manner of Creditable Coverage Disclosure from the Group Medical Plan to Beneficiaries

A model disclosure notice for creditable coverage and a model disclosure notice for non-creditable coverage is available from MedCost Benefit Services, LLC. The notice need not be sent as a separate mailing. The disclosure notice may be provided with other group medical plan participant information materials (including enrollment and/or renewal materials). However, if the disclosure notice is incorporated with other plan participant information, then the creditable coverage disclosures must be prominent and conspicuous. This means that the statements (or a reference to the section in the document being provided to the beneficiary that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded, or offset on the first page that begins the plan participant information being provided. The group plan may provide a single disclosure notice to the covered Medicare individual and all Medicare eligible dependent(s) covered under the same plan. However, the group plan 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 where the group plan participant's materials were mailed.

Electronic Disclosure Notice Requirements

The group plan can provide a disclosure notice through electronic means only if the Medicare beneficiary has indicated to the group plan that he or she has adequate access to electronic information. The group plan must not take the right to provide beneficiary material via electronic means as a permissible way to deliver documents to all beneficiaries. Before beneficiaries agree to receive their information via electronic means, they must be informed of their right to obtain a paper version, how to withdraw their consent, update address information, and identify any hardware or software requirements to access and retain the creditable coverage disclosure notice.

If the beneficiary consents to an electronic transfer of the notice, a valid e-mail address must be provided to the group plan and the consent from the beneficiary must be submitted electronically to the group plan. This ensures the beneficiary's ability to access the information as

well as ensure that the system for furnishing these documents results in actual receipt. In addition to having the disclosure notice sent to the beneficiary's email address, the notice must be posted on the group plan's website, if applicable, with a link to the creditable coverage disclosure notice on the group plan's home page.

When Must the Group Plan Make Creditable Coverage Disclosures to Part D Eligible Individuals?

The regulations specify the times when creditable coverage disclosures must be made to Part D eligible individuals. At a minimum, disclosure must be made at the following times:

1. Prior to the beginning of the first initial enrollment period, which is November 15, 2005.
2. Prior to the Medicare Part D Annual Coordinated Election Period (ACEP) – beginning November 15th through December 31st of each year.
3. Prior to an individual's initial enrollment period for Part D.
4. Prior to the effective date of coverage for any Medicare eligible individual that joins the group plan.
5. Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable.
6. Upon a Medicare beneficiary's request.

If the creditable coverage disclosure notice is provided to all plan participants, CMS will consider items 1, 2 and 3 to be met. CMS has clarified that "prior to" means that the Medicare beneficiary must have been provided the disclosure notice within the past twelve months.

Additional Guidance

Additional guidance will be issued on the required disclosure statement from the group plan to CMS and on any modifications to the creditable coverage disclosure content that will be required beyond November 15, 2005. CMS may also release Questions and Answers relating to creditable coverage issues from time to time on the CMS website under the MMA Questions and Issues Database website which can be found at

<http://www.cms.hhs.gov/medicarereform/drucoveragefaqs.asp>

Contact For Further Information

If you would like further information on creditable coverage, you can contact the CMS Employer Policy and Operations Group at **epog@cms.hhs.gov**

You can also visit the CMS website link related to creditable coverage issues at: **www.cchomepage.com**

SUBSIDY PAYMENTS APPLICABLE ONLY TO EMPLOYERS PROVIDING QUALIFIED RETIREE PRESCRIPTION DRUG BENEFITS

Employers, as plan sponsors of plans that provide qualified retiree prescription drug plan benefits for their retirees, may be able to receive a tax-free subsidy from Medicare. To be a qualified retiree prescription drug plan, the employer's plan must provide "creditable coverage" based on a review of the benefits provided under the employer's plan compared to those provided by the standard Medicare Part D prescription drug coverage. Employers who satisfy the creditable coverage requirement must provide benefits that are actuarially equivalent to the standard Part D coverage based on a comparison of the net cost to the retirees covered under the employer's plan and the standard Medicare Part D program.

Employers that provide qualified retiree prescription drug coverage may apply annually for the tax-free subsidy by attesting that the drug benefits of the retiree plan are actuarially equivalent to the standard Part D coverage. Employers who want to apply for the subsidy must file their 2006 application by September 30, 2005. The amount of the tax-free subsidy beginning in 2006 will be 28% of certain allowable costs based on the actual claims of qualifying covered retirees. The employer is not eligible to receive a subsidy for those retirees who are actually enrolled in Medicare Part D. Also, the employer is not eligible to receive a subsidy for active employees who are enrolled in Medicare.

The primary steps in the retiree drug subsidy process include:

Step One: Submit (electronically or otherwise) an application by September 30, 2005 to qualify for the retiree drug subsidy beginning January 1, 2006. In subsequent years, calendar year plans submit applications by September 30th of each year; non-calendar year plans submit applications 90 days prior to the beginning of each plan year.

Step Two: Attach to the application an actuary's attestation that the plan meets the Medicare Modernization Act's actuarial equivalence standard. Actuaries have considerable flexibility in the use of simplified actuarial calculations, treatment of multiple benefit options, and allocation of premiums between drug and non-drug coverage. Once the actuarial equivalence standard is satisfied, plan sponsors have full flexibility in plan design. This means most plan sponsors can maintain their current high quality, comprehensive coverage without changing plan design or cost sharing.

Step Three: Certify that the creditable coverage status of the plan has or will be disclosed to plan participants and CMS. This disclosure can be incorporated into other plan communications (e.g., those provided in accordance with ERISA reporting and disclosure requirements). CMS will be providing guidance on how to provide these disclosures. This guidance will include sample language.

Step Four: Electronically submit and periodically update enrollment information about retirees and dependents. Entering into a voluntary data sharing agreement with CMS makes the process even easier. Information about how to enter into these voluntary data sharing (VDSA) agreement with CMS is available online at: <http://www.cms.hhs.gov/medicare/cob/>

Step Five: Electronically submit aggregate data about drug costs incurred and reconcile costs at year-end; submission of detailed individual claims data is not required (although claims records must be maintained for audits for six years). Plan sponsors can choose whether to submit data and receive payments monthly, quarterly or annually. CMS will be providing additional guidance on the details of how to submit data electronically.

Where To Go For More Information

The Center for Medicare and Medicaid Services (CMS) has published a Retiree Drug Subsidy Center at <http://rds.cms.hhs.gov> to provide information, guidance and instructions on the subsidy application process.

Plan sponsor guidance and summaries documents are available online at: <http://www.cms.hhs.gov/medicarereform/pdbma/employer.asp>

For email notification of new developments, subscribe to CMS-EMPLOYER-PDBMA-L listserv at <http://www.cms.hhs.gov/maillinglists/default.asp?audience=15>

You can submit questions about MMA and the final regulation, including issues relating to plan sponsors at: <http://mmaissuesform.cms.hhs.gov>

To request a speaker on plan sponsor issues, or request copies of related materials, email the Employer Policy and Operations Group at: epog@cms.hhs.gov