Employee Benefits Alert

Willis

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Creditable Prescription Drug Coverage Disclosure Notices

The Centers for Medicare and Medicaid Services (CMS) has released new model disclosure notices and guidance for use on or after May 15, 2006. Employers will use these model notices to communicate to plan participants whether prescription drug coverage provided by employers' health plans is "creditable."

Background

The *Medicare Prescription Drug, Improvement, and Modernization Act of 2003* required that plan sponsors provide creditable or non-creditable disclosure notices to Part D eligible individuals covered by any of their health plans. (A Part D eligible individual is a person enrolled in Medicare Part A or B as a result of age, disability, or end stage renal disease.) *All* sponsoring employers and unions are generally subject to this notice distribution requirement — not just those that sponsor retiree plans. A Part D eligible individual who does not enroll in a Medicare prescription drug plan when first eligible will likely pay a higher premium later unless he or she has creditable coverage (coverage at least as good as the Medicare standard Part D benefit) and does not incur a break in creditable coverage of 63 days or longer. Eligible individuals may submit a copy of the personalized disclosure notice as proof of creditable coverage when enrolling in a Part D plan. (Please see *Willis EB Alerts* #34, #38, #42, and #46 for additional information about Medicare Part D and the notice distribution requirements.)

The New Model Notices

Employers were required to distribute the initial model notices prior to November 15, 2005 and there are ongoing distribution requirements during the year and on an annual basis. Plan sponsors should continue using the current model disclosure notices through May 14, 2006. In general, employers do not need to redistribute the notices; rather the requirement is to use the new format and guidance on a prospective basis for notices distributed on or after May 15th.

Sponsors are not required to use the model notices but many have adopted the model documents as the basis for their own tailored notices. If an organization has taken this approach, it should carefully review the new guidance and ensure that it is fully capturing and communicating all required information.

CMS' newest guidance includes the following key changes:

- Revised model creditable and non-creditable generic notices;
- New model personalized disclosure notice (adaptable for indicating creditable or non-creditable coverage); and
- New definition of integrated health plan for creditable coverage simplified determination test.

The new notices and guidance are available on the CMS website at http://www.cms.hhs.gov/CreditableCoverage/02_CCafterMay15.asp .

Revised Disclosure Notices

The wording in the new creditable and non-creditable notices is very similar to that used in the initial model documents. Parts were rewritten for clarification and to remove now-dated references to the Medicare prescription drug program as being "new." The revised notices also emphasize that, if the recipient loses creditable coverage with the plan sponsor and then fails to enroll (on a timely basis) in a Medicare prescription drug plan, he or she may pay more for Part D coverage.

As before, CMS recommends that plan sponsors clearly communicate the options available under the employer's

plan to individuals considering enrollment in a Medicare prescription drug plan. Options may include keeping existing coverage and not enrolling in a Medicare prescription drug plan, or enrolling in a Part D plan as a supplement to (or in lieu of) the other coverage. In fact, the notices refer the plan sponsor to certain sections of the accompanying guidance for sample wording to describe certain situations. In addition to special wording applicable to Medigap policies, CMS offers specific suggested language to describe:

- Whether an individual or a covered dependent will still be eligible to receive all of the current health benefits and prescription drug benefits if he or she enrolls in Medicare Part D, or

- Whether an individual who drops current prescription drug coverage and enrolls in Medicare will be allowed to enroll in the employer's plan.

Plan sponsors should keep in mind that the Medicare Secondary Payer (MSP) rules continue to apply and any polices regarding ending coverage through an employer's plan (or having an employer's plan pay benefits on a supplemental basis) are only acceptable to the extent permitted under applicable MSP rules. For detailed information about Medicare Secondary Payer requirements, please see Chapter Six of the online *Willis Compliance Manual*.

Personalized Notice

CMS' new personalized notice should be provided if the beneficiary requests a personalized notice; otherwise the plan sponsor may send the generic notices. Incoming notice requests will likely be generated by beneficiaries who enroll in Part D at a date later than when they were first eligible; the personalized notices may be needed to help fulfill an insurance carrier's creditable coverage documentation request.

The personalized notice contains the following specific information:

- Medicare eligible individual's full name;
- Individual's social security number or health insurance claim number;
- Statement that the individual has [has not] been covered under prescription drug coverage that is creditable;
- The periods of creditable coverage that occurred after May 15, 2006; and
- Entity name and contact information.

The personalized notice can be adapted for use as a creditable or non-creditable notice. For example, the wording states "Because your existing coverage is [is not] on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and you will not [will] pay extra if you later decide to enroll in Medicare prescription drug coverage." As with the generic model notices, CMS refers the plan sponsor to its guidance for recommended wording regarding plan options. Therefore, the key difference between the personalized notice and the generic notice is the individual information included in the personalized notice.

A plan sponsor may distribute the personalized notice instead of the generic creditable or non-creditable notices.

Distribution Requirements

The times when notices must be distributed have not changed. Notices must be distributed:

1. Prior to the Medicare Part D Annual Coordinated Election Period from November 15 through December 31 each year;
2. Prior to an individual's Initial Enrollment Period (IEP) for Part D — this IEP aligns with the IEP for Medicare Part B which is the seven-month period that begins three months before an individual first meets the eligibility requirements for Parts A and B and ends three months after the month of first eligibility;
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the sponsor's plan;
4. Whenever coverage ends if the entity no longer offers prescription drug coverage, or if the entity changes the coverage offered so that it is no longer creditable, or becomes creditable; and
5. Upon a beneficiary's request.

If the plan sponsor provides the notice to all plan participants annually, the plan is considered to have met the requirements in both (1) and (2) above. The term "prior to" means that the notice was provided within the past 12 months. Therefore, presuming a plan continues unchanged, notices would be distributed annually, during the year to newly hired employees, and upon request by those eligible to enroll in a Part D plan.

CMS provides no guidance regarding how requests must be made or how much time an employer has to respond to a request for a notice. Employers should therefore respond to all incoming requests (including oral requests)

and provide those notices within a reasonable amount of time of the request.

The government provides for flexibility in the manner of distributing the notices. CMS guidance suggests mailing the materials — but does not state that as an exclusive method. The disclosure notices may be included with other materials as long as a reference to the disclosure notice is prominently displayed on the first page of the other materials. In addition, the sponsor may provide a single notice to the Medicare beneficiary and all dependents covered under the plan unless the sponsor has knowledge that they reside at different addresses (in which case separate deliveries are required). Although electronic distribution of the notice is technically permitted there are a number of difficult and burdensome requirements that must first be satisfied before sending the information in this manner.

Creditable Status Determination

An employer (or union) applying for the drug subsidy payment must obtain an actuarial attestation of equivalency. For an employer that is not claiming the subsidy, the simplified determination test described below may be used to determine whether the prescription drug coverage is creditable or not. The simplified test is different depending on whether coverage is "integrated." The testing is required for each benefit option offered by a plan. A benefit option is a particular design, category of benefits, or cost-sharing arrangement offered within a group health plan.

Simplified Determination Test

A prescription drug plan is creditable if it:

- Provides coverage for brand and generic prescriptions;
- Provides reasonable access to retail providers and reasonable access to mail order service (only if the prescription drug plan has a mail order component);
- Is designed to pay (on average) at least 60 percent of participants' prescription drug expenses; and
- Satisfies (a) or (b) below; however, a plan with integrated health coverage (defined below) must satisfy item (c) instead:

  (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 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.

As described above, the test itself did not change. CMS however, has added a definition of "integrated plan." A sponsor of a plan that meets this definition must use step 4(c) as part of the simplified determination test — otherwise the sponsor applies step 4(a) or 4(b).

Integrated Plan Definition

An integrated plan is any plan of benefits offered to a Medicare eligible individual under which the prescription drug benefit is combined with other coverage offered by the entity (such as medical, dental, vision, etc.) and the plan contains *all* of the following plan provisions:

- A combined plan year deductible for all benefits under the plan;
- A combined annual benefit maximum for all benefits under the plan; and
- A combined lifetime benefit maximum for all benefits under the plan.

Possible Change in Status as Result of New Definition

Certain plans that were reasonably assumed to be "integrated plans" previously may not meet the above definition. For example, the plan may have a combined deductible and lifetime maximum, but not a combined annual benefit maximum for all benefits covered by the plan. The result may be a change in creditable status as of the effective date of this guidance (May 15, 2006) for some plans.

Although CMS does not provide specific instructions to plans that may have been initially determined to be non-creditable but which become creditable as a result of this new definition, presumably the plan would need to follow the requirements that apply whenever there is a change in creditable status. We believe this means that *new* notices must be distributed to plan participants and the plan's new status must be reported to CMS (within 30 days after any change in status) on its website at http://www.cms.hhs.gov/creditablecoverage. On an ongoing basis, this new definition may make it easier for some plans with combined deductibles to qualify as creditable coverage.

If, for some reason, an employer (or union) cannot use the simplified determination test to determine the creditable status of the prescription drug plan offered to Part D eligible individuals, then it must make an actuarial determination annually of whether the prescription drug plan's expected amount of paid claims under its prescription drug plan is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit. We suspect that this would be a rare occurrence since the simplified test can be used to determine if coverage is creditable or not.

Subsidy Payment Reminder

On a different but related Medicare topic, plan sponsors intending to apply for the subsidy payment are reminded that they must reapply every year. The deadline date for the application is no later than 90 days prior to the first day of the new plan year. For plans that operate on a non-calendar year basis, this deadline may be approaching. For example, the application (or a request for a one-time 30-day extension) for a plan year beginning October 1 is due by July 3rd.

Conclusion

With this guidance, plan sponsors will need to change to the new format for notices distributed on or after May 15, 2006 and be prepared to provide personalized notices upon request for such a notice. Plan sponsors should also recognize that this new guidance did nothing to change any of the requirements for reporting creditable status to CMS.

U.S. Benefit Office Locations

Anchorage, AK
(907) 562-2266

Atlanta, GA
(404) 224-5000

Austin, TX
(800) 861-9851

Baltimore, MD
(410) 527-1200

Birmingham, AL
(205) 871-3871

Boston, MA
(617) 437-6900

Cary, NC
(919) 459-3000

Charlotte, NC
(704) 376-9161

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(312) 621-4700

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(817) 335-2115

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(713) 625-1023

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