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CREDITABLE COVERAGE NOTICE TO CMS GUIDANCE

INTRODUCTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare. Regulations to implement Medicare prescription drug coverage were published January 28, 2005 (70 FR 4193). This guidance pertains to section 1860D-13 of the MMA, and the regulation at 42 CFR §423.56(e).

Under those provisions, most entities that currently provide prescription drug coverage to Medicare Part D eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage" (Disclosure Notice). A disclosure is required whether the entity's coverage is primary or secondary to Medicare. Entities that must comply with these provisions are listed in the regulation at 42 CFR §423.56(b) and are also referenced on the creditable coverage homepage at http://www.cms.hhs.gov/creditablecoverage. However, entities 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. See 42 CFR 423.56(e).

The regulation at 42 CFR §423.56(e) states that CMS will provide additional information concerning Disclosure Notices, including the required form and manner of disclosure. This guidance provides such additional information concerning those rules, including the form, manner, and timing of providing Disclosure Notices to CMS, and related instructions.

OVERVIEW OF REGULATORY REQUIREMENTS

Creditable Coverage Definition and Determination

As defined in the regulation at 42 CFR §423.56(a), drug 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 entity's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit. See 70 FR 4225.

This determination is identical to the first step (the "gross test") in calculating actuarial equivalence for purposes of 42 CFR §423.884, which applies when an employer or union applies for the Retiree Drug Subsidy (RDS). The gross test does not take into account the extent to which the coverage is financed by the beneficiary or by the entity. See 42 C.F.R. §423.884(d)(5)(ii)(A).

For plans that have multiple benefit options, the regulation requires that entities apply the gross test separately for each benefit option. See 42 CFR §423.884(d) (5) (iv). A benefit option is defined at 42 CFR §423.882 as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan. Benefit option refers to the different categories of benefits and different plan design options under a given Type of Coverage (e.g., HMO, PPO, Indemnity). Benefit options are referenced on the disclosure form as "Options".

For purposes of the Disclosure Notice to CMS, we require a separate disclosure for each Type of Coverage sponsored by an Entity (e.g., Medicaid, SPAP, Employer Plan, Church Plan, Standardized Medigap Plan, Pre-standardized Medigap Plan).

III. POLICY GUIDANCE

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

Creditable Coverage Disclosure from Entity to CMS

The regulation at 42 CFR §423.56(e) requires all entities described in the regulation at 42 CFR §423.56(b) disclose to CMS whether the prescription drug coverage that is offered to Medicare Part D eligible individuals is creditable or non-creditable.

Form and Manner of Creditable Coverage Disclosure from Entity to CMS

An entity is required to provide the Disclosure Notice through completion of the disclosure form on the CMS Creditable Coverage Disclosure Web Page at http://www.cms.hhs.gov/creditablecoverage. As you answer the questions on the electronic Disclosure to CMS form, an additional box will appear where you should enter the required disclosure information. This method of transmission is convenient and will take minimal time to complete, and is the sole method for compliance with the requirement.

Who Must Provide the Disclosure Notice to CMS

The Disclosure Notice is required to be provided to CMS by certain entities listed at 42 CFR §423.56(b) that are not excluded at §423.56(e). These include:

1. Group health plans, including those offered by employers; union/Taft-Hartley plans; church, Federal, State and local government, and other group-sponsored plans;
2. Governmental sponsored plans, including Medicaid; State Pharmaceutical Assistance Programs (SPAPs); State High Risk Pools;
3. Military Coverage, including the Veterans' Administration coverage and TRICARE;

4. Individual health insurance;
5. Indian Health Service; Tribe or other Tribal Organizations; Urban Indian Organizations; and
6. Medigap (Medicare Supplement) plans, including standardized plans H, I or J; pre-standardized plans; waiver State plans; and plans with innovative benefits.

The entities exempted under 42 CFR §423.56(e) include PDPs, MA-PDs, and PACE or cost-based HMOs or CMPs that provide "qualified Part D coverage" within the meaning of 42 CFR §423.100.

The regulation at 42 CFR §423.884(c)(2)(iv) requires that a plan sponsor provide an attestation that its prescription drug coverage is at least actuarially equivalent to the standard prescription drug coverage under Part D as part of the application for the Retiree Drug Subsidy (RDS) . Therefore, because the actuarial equivalence standard includes the creditable coverage standard, a sponsor that has been approved for the Retiree Drug Subsidy is exempt from filing the Disclosure Notice with CMS with respect to those qualified covered retirees for which the Sponsor is claiming the Retiree Drug Subsidy. The sponsor's RDS application serves as its disclosure to CMS under 42 CFR §423.56(e).

Timing of Creditable Coverage Disclosure from Entity to CMS

The Disclosure Notice must be made to CMS on an annual basis, and upon any change that affects whether the drug coverage is creditable. The initial Disclosure Notice must be provided by March 31, 2006.

At a minimum, disclosure to CMS must be made at the following times:

1. For plan years that end in 2006, disclosure of creditable coverage status must be provided no later than March 31, 2006.
2. For plan years that end in 2007 and beyond, disclosure of creditable coverage status must be provided within 60 days after the beginning date of the plan year for which the entity is providing the disclosure to CMS.
3. Within 30 days after the termination of the prescription drug plan ; and
4. Within 30 days after any change in the creditable coverage status of the prescription drug plan.

Additional Guidance

CMS may release Question 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/

IV. CONTENT OF THE DISCLOSURE NOTICE TO CMS

Listed below are the required data fields in the Disclosure Notice form that must be populated in order to generate the Disclosure Notice. For entities with subsidiaries (division, line of business, operating unit, control group, etc.), one disclosure form can be

submitted to CMS for the entire entity if the plan year is the same for all subsidiaries/divisions, or an additional form can be submitted for each subsidiary (division, line of business, operating unit, control group, etc.) with the subsidiary-specific information. \

NOTE: As you answer the questions on the electronic Disclosure to CMS form, an additional box will appear where you should enter the required disclosure information.

Name of Entity Offering Coverage. This is the name of the entity that is providing or sponsoring the plan of benefits to Medicare eligible individuals such as an employer, a union, the Veterans' Administration, or a Medigap issuer. It is not the name of any carrier that the entity may have contracted with for insurance coverage or for administration of its benefit plan.

Federal Tax Identification Number of the Entity. For entities that have multiple subsidiaries (divisions, line of businesses, operating units, control groups, etc.) that are all covered under the same type of coverage, the Federal Tax Identification Number (also known as the Employer Identification Number, or EIN) for the Parent Company may be used when completing the entity's EIN information for the entire company. If the form is completed separately for individual subsidiaries (divisions, line of businesses, operating units, control groups, etc.), the EIN for each subsidiary should be provided.

Street Address, including the City, State and Zip Code of the Entity. For entities that have many subsidiaries (divisions, line of businesses, operating units, control groups, etc.) under the same type of coverage, the Street Address for the Parent Company may be used when completing the entity's information.

Phone Number of the Entity. For entities with many subsidiaries (divisions, line of businesses, operating units, control groups, etc.) that have the same type of coverage, the phone number for the Parent Company may be used when completing the entity's information.

Type of Coverage. The Type of Coverage (e.g., Medicaid, VA, SPAP) that must provide disclosure are those listed under the regulation at 42 CFR §423.56(b) that are not excluded under 42 CFR §423.56(e).

Number of Options offered by the Entity. This is the total number of benefit options as defined under 42 CFR §423.882 that the entity is offering to Medicare eligible individuals. For example, an employer plan may offer an HMO option, a PPO option and an indemnity option, and a Medigap issuer may offer multiple Medigap policies that include prescription drug coverage.

Creditable Coverage Status of Options offered by the Entity. If the Options offered by the entity are either all creditable or all non-creditable, the entities/plan sponsors may provide aggregated data in the Disclosure Notice for all options under the Plan. If some of the Options offered are creditable and some are not creditable, entities/plan sponsors may combine the data for Options that are creditable and combine the data for those Options that are not creditable in the Disclosure Notice.

Period covered by Disclosure Notice. An entity is required to provide the Disclosure Notice to CMS on an annual basis. Each entity must provide the beginning and ending calendar date(s) of the Plan Year for which such entity is providing the disclosure to CMS. For purposes of the Disclosure Notice to CMS, CMS defines "Plan Year" as the beginning and ending date of the entity's annual renewal or contract period.

Number of Part D Eligible Individuals expected to be covered under these Plan(s) as of the Beginning Date of the Plan Year. While CMS recognizes that many entities will not be able to provide an exact number of Part D eligible individuals, entities should estimate the number of covered Part D eligible individuals under the Options offered under the type of coverage for which they are providing the Disclosure Notice to CMS.

Estimate Number of individuals expected to be covered through an Employer/Union group health Retiree Plan. Group Health Plans entities should estimate the number of Part D eligible individuals covered under retiree plans for which they are providing the Disclosure Notice to CMS. All other entities offering other Types of Coverage should indicate a zero (0) in this field.

Date of Notice of Creditable Coverage provided to Part D Eligible Individuals. An entity must disclose to CMS the latest calendar date on which it provided the required disclosure to Part D eligible individuals of creditable or non-creditable coverage (i.e., mailed, personally distributed to Part D eligible individuals, etc.) as required under 42 CFR §423.56 (c), (d) & (f).

Change in Creditable Coverage status of previously disclosed information to CMS. Entities also must provide a Disclosure Notice to CMS if the creditable coverage status of a Type of Coverage or any of the Options previously disclosed to CMS undergoes a change in creditable coverage status. This includes an entity changing the coverage offered so that it is no longer creditable or terminating a creditable coverage plan or option.

An entity must disclose to CMS the date that on which it provided the required disclosure to Part D Eligible Individuals under 42 CFR §423.56 (f)(2). The date should be the calendar date that disclosure of a Change in Creditable Coverage status was provided (i.e., mailed, posted, personally distributed to Part D Eligible Individuals, etc.)

Name, Title and Email of the Entity's Authorized Individual. An individual employed by the entity and completing the form must provide his or her name, title and email.

Date of Disclosure to CMS. The entity's authorized individual must provide the date on which he or she is submitting the disclosure to CMS.

V. CONTACT FOR FURTHER INFORMATION

You should visit the CMS website link related to creditable coverage issues at: http://www.cms.hhs.gov/creditablecoverage