COMPLIANCE OVERVIEW

Medicare Part D: Creditable Coverage Disclosure Notices

Employers with group health plans that provide prescription drug coverage to individuals who are eligible for Medicare Part D must comply with certain disclosure requirements.

Group health plan sponsors must disclose to individuals who are eligible for Medicare Part D and to the Centers for Medicare and Medicaid Services (CMS) whether their prescription drug coverage is at least as good as the Medicare Part D coverage (in other words, whether their prescription drug coverage is "creditable"). These disclosures must be provided on an annual basis and at certain other designated times.

There are no specific penalties for employers that fail to comply with the Medicare Part D disclosure requirements, except for employers that are claiming the Retiree Drug Subsidy. However, by not providing creditable coverage disclosure notices, employers may trigger adverse employee relations issues.

LINKS AND RESOURCES

CMS' **creditable coverage webpage** includes information and resources regarding the Medicare Part D disclosure requirements, including:

- The model creditable coverage notices for individuals
- The online disclosure form for CMS and related guidance and instructions

Disclosure to Individuals

- Plan sponsors must provide creditable coverage disclosure notices to individuals each year **before Oct. 15**—the start date of the annual enrollment period for Medicare Part D.
- The disclosure notice alerts individuals as to whether their plan's prescription drug coverage is creditable.
- Model notices are available for employers to use.

Disclosure to CMS

- The disclosure to CMS is due within **60 days** after the start of each plan year.
- For calendar year plans, this deadline is **March 1** of each year (Feb. 29 for leap years).
- Plan sponsors are required to use CMS' online disclosure form.

Disclosure to Individuals

Medicare Part D Enrollment

In order for Medicare Part D eligible individuals to make informed and timely enrollment decisions, group health plan sponsors must disclose the status (creditable or non-creditable) of the plan's prescription drug coverage. If an individual's enrollment in Part D is to be considered timely, the individual must enroll before the end of his or her Initial Enrollment Period.

The Initial Enrollment Period for Part D is concurrent with the individual's Initial Enrollment Period for Medicare Part B. The Initial Enrollment Period is seven months long. It includes the month in which an individual first meets the eligibility requirements for Medicare Parts A and B, as well as the three months before and after the month of first eligibility.

In general, after the Initial Enrollment Period, the individual may only enroll in a Part D plan during the Annual Coordinated Election Period or under certain circumstances that would qualify the individual for a special enrollment period. The Annual Coordinated Election Period begins on Oct. 15 and goes through Dec. 7 of each year.

Late enrollment penalty under Medicare Part D

An eligible individual who fails to enroll in Medicare Part D during the Initial Enrollment Period must maintain "creditable coverage" or pay a late enrollment penalty. The late enrollment penalty will be imposed after a break in creditable coverage that lasts for a period of 63 days or longer (after the Initial Enrollment Period) and will apply for as long as the individual remains enrolled in Part D.

Thus, the disclosure notice is essential to an individual's decision regarding whether to enroll in a Medicare Part D prescription drug plan.

Providing the Disclosure Notice

Disclosure notices must be provided to all Part D eligible individuals who are covered under, or who apply for, the plan's prescription drug coverage, regardless of whether the prescription drug coverage is primary or secondary to Medicare Part D. The disclosure notice requirement applies to Medicare beneficiaries who are active or retired employees, disabled or on COBRA, as well as Medicare beneficiaries who are covered as a spouse or a dependent.

An individual is eligible for Medicare Part D if he or she:

- ☑ 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
- ☑ Resides in the service area of a prescription drug plan or Medicare Advantage plan that provides prescription drug coverage.

To simplify plan administration, plan sponsors often decide to provide the disclosure notice to all plan participants.

Content of Disclosures

CMS has provided **model disclosure notices** for plan sponsors to use when disclosing their creditable coverage status to Medicare beneficiaries. The model disclosure notices are available on CMS' website. Plan sponsors are not required to use the CMS model disclosure notices. If a plan sponsor does not use the CMS model disclosure notices, its notices must meet the content standards described below.

Content of Creditable Coverage Disclosure Notices

When the prescription drug coverage offered by a plan sponsor is creditable, the disclosure notice must contain the following information:

- A statement that the plan sponsor has determined that its prescription drug coverage is creditable;
- An explanation of creditable coverage (that the amount the plan expects to pay, on average, for prescription drugs for individuals covered by the plan in the applicable year is the same or more than what standard Medicare prescription drug coverage would be expected to pay, on average); and
- An explanation of why creditable coverage is important and advice that, even though coverage is creditable, an individual could be subject to higher Part D premiums if the individual subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan.

CMS also recommends that the following additional content be included in the creditable coverage disclosure notice:

- A description of the beneficiary's right to a notice (when a beneficiary can expect to receive a notice and when a beneficiary can request a copy of the notice).
- An explanation of the option(s) available to beneficiaries when the Medicare Part D benefit becomes available, including, for example:
    - Individuals can retain their existing coverage and choose not to enroll in a Part D plan;
    - Individuals can enroll in a Part D plan as a supplement to, or in lieu of, the other coverage; or
    - Individuals cannot have both a Medigap prescription drug policy and a Part D plan.
- An explanation of whether the covered individuals will still be able to receive all of their current health coverage if they choose to enroll in Medicare Part D.
- A description of the circumstances (if any) under which an individual could get prescription drug coverage back if the individual drops the current coverage and enrolls in Medicare Part D. (For Medigap insurers, a clarification that the individual cannot get his/her prescription drug coverage back under such circumstances.)
- Information about receiving financial assistance for Medicare Part D, including the contact information for the Social Security Administration.

Content of Non-creditable Coverage Disclosure Notices

When the prescription drug coverage offered by a plan sponsor is determined to be non-creditable, the disclosure notice must contain the following information:

- Statement that the entity has determined that its prescription drug coverage is not creditable;
- Explanation of non-creditable coverage (that the amount the plan expects to pay, on average, for prescription drugs for individuals covered by the plan in the applicable year is less than what standard Medicare prescription drug coverage would be expected to pay, on average);

- Explanation that, in general, an individual may only enroll in a Part D plan from Oct. 15 through Dec. 7 of each year; and
- Clarification of the importance of creditable coverage, and that the individual may be subject to higher Part D premiums if the individual fails to enroll in a Part D plan when first eligible.

CMS also recommends that the non-creditable coverage disclosure notice include the additional content outlined above for creditable coverage disclosure notices (for example, a description of the beneficiary's right to a notice and an explanation of the options available to beneficiaries when Medicare Part D becomes available).

Personalized Disclosure Notices/Statements

CMS recommends that entities complete the personalized box on the model disclosure notices if an individual requests a copy of a disclosure notice. Individuals may submit a copy of a personalized disclosure notice as proof of prior creditable coverage when enrolling in a Part D plan. If the plan sponsor chooses not to use the model disclosure notices, the sponsor can provide a personalized statement of creditable coverage which contains all of the following elements:

- Individual's first and last name;
- Individual's date of birth or unique member identification number;
- Entity name and contact information;
- Statement that the entity determined that its plan is creditable or non-creditable coverage; and
- The date ranges of creditable coverage.

Form and Manner of Delivering Disclosure Notices

Plan sponsors have flexibility in the form and manner of their disclosure notices. Disclosure notices do not need to be sent in a separate mailing. Disclosure notices may be sent with other plan participant information materials (for example, enrollment and/or renewal materials). If a disclosure notice is incorporated with other participant information, it must meet specific requirements for being prominent and conspicuous within the materials.

As a general rule, a single disclosure notice may be provided to the covered Medicare beneficiary and all of his or her Medicare eligible dependent(s) covered under the same plan. However, if it is known that any spouse or dependent that is Medicare eligible lives at a different address than where the participant materials were mailed, a separate notice must be provided to the Medicare eligible spouse or dependent residing at a different address.

Disclosure notices may be provided through electronic means only if the plan sponsor follows the requirements set forth in Department of Labor regulations addressing electronic delivery.

Timing of Disclosure Notices

At a minimum, disclosure notices must be provided at the following times:

1	Prior to the Medicare Part D annual coordinated election period—beginning Oct. 15 through Dec. 7 of each year

2	Prior to an individual's initial enrollment period for Part D
3	Prior to the effective date of coverage for any Medicare-eligible individual who joins the plan
4	Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable
5	Upon a beneficiary's request

If the creditable coverage disclosure notice is provided to all plan participants annually, before Oct. 15 of each year, items (1) and (2) above will be satisfied. "Prior to," as used above, means the individual must have been provided with the notice within the past 12 months. In addition to providing the notice each year before Oct. 15, plan sponsors should consider including the notice in plan enrollment materials provided to new hires.

Disclosure to CMS

Plan sponsors are also 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, or upon any change that affects whether the coverage is creditable. More specifically, the Medicare Part D disclosure notice must be provided within the following time frames:

- ☑ Within 60 days after the beginning date of the plan year for which the entity is providing the disclosure to CMS;
- ☑ Within 30 days after the termination of a plan's prescription drug coverage; and
- ☑ Within 30 days after any change in the plan's creditable coverage status.

CMS has released additional guidance for making such disclosures (such as timing, format and model language). Plan sponsors are required to provide the disclosure notice to CMS through completion of the disclosure form on the CMS Creditable Coverage webpage. This is the sole method for compliance with the CMS disclosure requirement, unless a specific exception applies.

Creditable Coverage

A group health plan's prescription drug coverage is considered creditable if its actuarial value equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this actuarial determination measures whether the expected amount of paid claims under the group health plan's prescription drug coverage is at least as much as the expected amount of paid claims under the Medicare Part D prescription drug benefit.

The determination of creditable coverage does not require an attestation by a qualified actuary, except when the plan sponsor is electing the retiree drug subsidy for the group health plan. However, employers may want to consult with an actuary to make sure that their determinations are accurate.

For plans that have multiple benefit options (for example, PPO, HDHP and HMO), the creditable coverage test must be applied separately for each benefit option.

There are two permissible methods to determine whether coverage is creditable for purposes of Medicare Part D—a simplified determination method and an actuarial determination method.

Simplified Determination

If a plan sponsor is not applying for the retiree drug subsidy, the sponsor may be eligible to use a simplified determination that its prescription drug coverage is creditable. The standards for the simplified determination, which are described below, vary based on whether the employer's prescription drug coverage is "integrated" with other types of benefits (such as medical benefits).

A prescription drug plan is deemed to be creditable if it:

1. Provides coverage for brand-name and generic prescriptions;
2. Provides reasonable access to retail providers;
3. Is designed to pay on average **at least 60 percent** of participants' prescription drug expenses; and
4. Satisfies at least one of the following*:
    a. The prescription drug coverage has no maximum annual benefit or a maximum annual benefit payable by the plan of at least $25,000;
    b. The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare-eligible individual; or
    c. For entities 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 million lifetime combined benefit maximum.

**The Affordable Care Act (ACA) prohibits health plans from imposing lifetime and annual limits on the dollar value of essential health benefits.*

An integrated plan is a plan where the prescription drug benefit is combined with other coverage offered by the entity (for example, medical, dental or vision) and the plan has 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.

A prescription drug plan that meets the above parameters is considered an integrated plan for the purpose of using the simplified method and would have to meet Steps 1, 2, 3 and 4(c) of the simplified method. If it does not meet all of the criteria, then it is not considered to be an integrated plan and would have to meet Steps 1, 2, 3 and either 4(a) or 4(b).

Actuarial Determination

If a plan sponsor cannot use the simplified determination method to determine the creditable coverage status of the prescription drug coverage offered to Medicare eligible individuals, then the sponsor must make an actuarial determination annually of 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. This determination involves the same standard as the first prong of the "gross value" test for the retiree drug subsidy.

CMS has issued guidance that addresses the extent to which account-based arrangements, such as health reimbursement arrangements (HRAs), may be considered in the creditable coverage determination. In general, this guidance provides that the HRA annual contribution may be taken into consideration when determining creditable coverage status. Existing funds in the HRA that have rolled over from prior years are not taken into account. Also, for HRAs that pay both prescription drugs and other medical costs, a portion of the year's contribution should be reasonably allocated to prescription drugs.

Enforcement

In general, CMS does not have the authority to impose direct penalties or other sanctions in the event that an employer fails to provide the required creditable coverage disclosure notices. However, employers who are also claiming the Retiree Drug Subsidy will not qualify for the subsidy unless they provide the disclosure notices. Other federal laws (such as ERISA's fiduciary duty provisions) may indirectly provide consequences to a noncompliant employer. Also, failing to comply with these requirements may have a negative impact on employee relations, especially if an individual later incurs a late enrollment penalty because he or she was unaware that their prescription drug coverage through the employer was not creditable.