Medicare Part D: Creditable Coverage Disclosures

Entities such as employers with group health plans that provide prescription drug coverage to individuals that are eligible for Medicare Part D have two major disclosure requirements that they must meet at least annually:

- Provide annual written notice to all Medicare eligible individuals (employees, spouses, dependents, retirees, COBRA participants, etc.) who are covered under the prescription drug plan.
- Disclose to the Centers for Medicare and Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage."

Because there is often ambiguity regarding who in a covered population is Medicare eligible, it is best practice for employers to provide the notice to all plan participants.

CMS provides guidance for disclosure of creditable coverage for both individuals and employers.

Who Must Disclose?

These disclosure requirements apply regardless of whether the plan is large or small, is self-funded or fully insured, or whether the group health plan pays primary or secondary to Medicare. Entities that provide prescription drug coverage through a group health plan must provide the disclosures. Group health plans include:

- Group health plans under ERISA, including health reimbursement arrangements (HRAs), dental and vision plans, certain cancer policies, and employee assistance plans (EAPs) if they provide medical care
- Group health plans sponsored for employees or retirees by a multiple employer welfare arrangement (MEWA)
- Qualified prescription drug plans

Health flexible spending accounts (FSAs), Archer medical savings accounts, and health savings accounts (HSAs) do not have disclosure requirements. In contrast, the high deductible health plan (HDHP) offered in conjunction with the HSA would have disclosure requirements.

There are no exceptions for church plans or government plans.

Determining if Coverage is Creditable

The Medicare Modernization Act (MMA) provides that coverage is creditable if it provides prescription drug "coverage of the cost of the prescription drugs the actuarial value of which . . . to the individual equals or exceeds the actuarial value of standard prescription drug coverage."

Plans can determine if they are creditable or not by meeting the plan design safe harbor or by actuarial determination. Practically speaking, many carriers for fully insured plans provide employers with creditable coverage information; however, employers are still responsible for the applicable disclosures to participants and CMS.

CMS guidance offers a design-based safe harbor for determining creditable coverage status. Specifically, a plan is deemed to be creditable if it:

1. Provides coverage for brand 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 annual benefit maximum 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.
    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.

An integrated plan is any plan of benefits that is offered to a Medicare eligible individual where the prescription drug benefit is combined with other coverage offered by the entity (for example, medical, dental, vision, etc.) 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
- A combined lifetime benefit maximum for all benefits under the plan

If a plan does not meet the safe harbor based on its design, it will need to obtain an actuarial determination. Only plans that are seeking the retiree drug subsidy must provide CMS with the actual attestation documents from the actuary; however, employers should consider retaining the documents as best practice.

Disclosures to Plan Participants

The MMA penalizes individuals for late enrollment in Medicare Part D if they do not maintain "creditable coverage" for a period of 63 days or longer following their initial enrollment period for drug benefits. Therefore, individuals must be informed if the employer-provided coverage is, in fact, creditable. CMS provides model notices for creditable coverage and non-creditable coverage disclosures in both English and Spanish.

Disclosures to individuals must be made:

1. Prior to the Medicare Part D Annual Coordinated Election Period (ACEP) which runs from October 15 through December 7 of each year;
2. Prior to an individual's Initial Enrollment Period (IEP) for Medicare Part D;
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan;
4. Whenever the entity no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; and
5. Upon request by the individual.

If the creditable coverage disclosure notice is provided to all plan participants annually, prior to October 15 of each year, CMS will consider items 1 and 2 above to be met.

Method of Delivery

Employers can provide participants with separate notices, or, under certain conditions, can provide the notice with enrollment materials or summary plan descriptions (SPDs).

If the disclosure is provided with other information (such as in the SPD), it must be "prominent and conspicuous," which means it must be in "at least 14 point font, in a separate box, bolded, or offset on the first page" of the other information provided.

Tip: An SPD is the document provided to participants to explain their rights and obligations under the plan. It is intended to provide a summary of the plan's terms and should be written in a way the average participant can understand it. However, it has become increasingly common for plans to use a combination plan document/SPD and most Department of Labor (DOL) offices permit this. The group insurance policy or certificate is not an SPD.

Employers may provide the notice by mail, or electronically if electronic distribution method requirements are met. Disclosures should not be handed out in person.

Recipients of electronic disclosures are divided into two groups – those with work-related computer usage, and those who do not use computers as part of their jobs. An employee is considered to have work-related computer usage if:

- The employee is able to access documents that are sent in electronic format at any location where the employee performs his or her job duties, and
- The employee is expected to access the employer's electronic information system as part of his or her key job duties

An employee who uses a computer as part of his or her job does not need to consent to receive disclosures electronically.

Individuals who do not access a computer as part of their work for the employer must specifically consent to receive disclosures electronically. This would include retirees, as well as active employees in many types of jobs. The written consent requirements are fairly complicated. Prior to providing consent, an individual must be given a clear statement that explains:

- The types of documents to which the consent will apply
- That the consent can be withdrawn at any time without charge

- The procedures for withdrawing consent and for updating the address used for receipt of electronically furnished documents
- The right to request and obtain a paper version of an electronically distributed document, and whether the paper version will be provided at no charge
- The hardware or software needed to access and retain the documents delivered electronically

The individual must provide an email address for delivery of the documents. The individual must provide consent in a manner that demonstrates his or her ability to access the information in the electronic format that will be used, so many employers require that the consent be provided electronically. An employer may not simply provide a kiosk for employees who do not use computers as part of their jobs. Likewise, it may not provide thumb drives of documents to employees who do not use computers as part of their jobs unless it obtains the employee's consent.

Delivery to Spouses and Dependents

If an employee and an employee's spouse or dependents are covered under the same plan, a single notice is sufficient for the eligible individual and the individual's family. However, if an employer knows that a spouse or dependent is Part D eligible and has a different address, the employer is obligated to send a separate notice to the spouse or dependent.

Disclosures to CMS

Employers must provide CMS with a "Disclosure to CMS Form" that is completed and sent electronically through the CMS website. The form must be provided annually and:

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

CMS provides an instruction guide with screen shots for completing the form online. Employers should gather the information necessary to complete the form prior to beginning to complete the form, as some of the questions may require preparation on the part of the employer. For example, employers must estimate how many Part D eligible individuals they expect to be covered as of the first day of the plan year.

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