



BENEFIT *Advisor*

In This Issue

In this seventh issue of the McGrawWentworth Benefit Advisor for 2005, we will discuss recently issued guidance that addresses the notice requirements of Medicare Part D. The notice requirements apply to any group health plan that covers a Medicare eligible employee or dependent.

Part D will require your health plan to notify any Medicare eligible participants if your health plan coverage is equal to, better than or not as good as the Medicare benefit. This Advisor will outline the required notice content, notice recipients and delivery requirements.

We welcome your comments and suggestions regarding this issue of our technical bulletin. For more information on this Benefit Advisor, please contact your Account Manager or visit the McGrawWentworth web site at www.mcgrawwentworth.com.

“Medicare Part D Employer Notice Requirements”

The Medicare Prescription Drug Improvement and Modernization Act's prescription drug benefit will become effective on January 1, 2006.

The act requires employers who sponsor retiree health plans to decide how they want their plans to coordinate with this new Medicare program. Employers have several options, including applying for a tax-favored subsidy or paying on a secondary basis to the Medicare program.

The details of the Medicare Part D program can be found in Issue 4 of our Benefit Advisor at http://www.mcwent.com/Benefit_Advisor/2005/BA_Issue4.pdf. The details of Medicare Part D employer options can be found in Issue 6 of our Benefit Advisor at http://www.mcwent.com/Benefit_Advisor/2005/BA_Issue6.pdf.

All group health plans must notify Medicare eligible employees and their Medicare eligible dependents of the status of their prescription plan. CMS (Centers for Medicare & Medicaid Services) recently released more information on the notice content and the delivery requirements.

This Advisor discusses the following aspects of the notices:

- General information
- Recipients
- Content
- Timing and delivery requirements



The Advisor concludes with a list of Action Steps to help your organization meet the new notice requirements.

General Information

The notice requirements apply to covered entities that offer outpatient prescription drug coverage. Covered entities include group health plans. The group health plan definition is very broad and applies to a host of plans, including:

- Employer-sponsored **active** group health plans
- Employer-sponsored **retiree** health plans
- Coverage under a Medigap policy
- Medicaid coverage
- Federal employees' health benefit program
- Other health plans the Secretary of Health and Human Services deems appropriate

The new guidance requires a group health plan to issue one of the following notices regardless of whether Medicare is the primary or the secondary payer.

- A notice of creditable prescription drug coverage
- A notice of **non**-creditable prescription drug coverage

The notice is intended to inform Medicare eligible individuals of the prescription drug coverage your

organization provides and the impact this coverage will have on Medicare Part D enrollment. If an eligible participant enrolls in Medicare Part D after the initial enrollment dead-

line, the participant must pay a late enrollment premium penalty. However, the late enrollment penalty is waived for anyone who has creditable prescription drug coverage. Medicare eligible individuals need to know the consequences of late enrollment and whether their current coverage would be considered creditable.

Determining Whether Coverage is Creditable

Group health plan coverage is considered creditable if the actuarial value of the coverage exceeds the actuarial value of standard Medicare Part D coverage. In other words, your plan's prescription drug coverage is considered creditable if the amount your plan expects to pay for claims is greater than the amount Medicare expects to pay for claims.

Determining the value of the plan does not take into account whether

it is the employer or the Medicare beneficiary who pays for the coverage. The test to determine the actuarial value is similar to the test retiree health plans use to determine gross value in order to certify the plan is the actuarial equivalent of the Medicare Part D when applying for the subsidy. In fact, coverage by plans that meet the gross value test will be considered creditable. If your organization sponsors a retiree health plan and is applying for the subsidy, meeting the gross value test will determine your coverage is creditable.

If your organization does not sponsor a retiree health plan, you are not required

to have an actuary certify your plan is equivalent to the Medicare Part D standard program. To determine coverage status, the prescription drug plan must meet the four standards below to be considered creditable:

1. The plan covers generic and brand name prescription drugs.
2. The plan offers reasonable access to either retail or mail order providers. However, the guidance does not define "reasonable access."
3. The plan is designed to pay on average at least 60% of participant drug expenses.
4. The plan meets one of the following:
 - a. The prescription drug coverage has no annual benefit limit or an annual benefit limit of at least \$25,000.
 - b. Actuarial statistics show the amount the plan will

pay for prescription drug coverage will be at least \$2,000 for each Medicare eligible individual in 2006.

- c. The annual deductible for plans that combine health and prescription coverage is no more than \$250 a person; also, the plan has either no annual benefit limit or an annual benefit limit of at least \$25,000 for prescription benefits and a \$1,000,000 lifetime combined limit.

If the employer offers multiple health plan options, each option must meet the four standards above independently to qualify as creditable coverage.

Once you determine whether your coverage is creditable, you must notify all Medicare eligible individuals. The next two sections describe the eligible individuals and the notice contents.

Recipients of Notice

You must notify all Part D eligible individuals covered by your plan and any Part D eligible individual who applies for coverage as well. The recent guidance defines Medicare Part D eligible individuals as:

- Anyone entitled to Medicare Part A or enrolled in Part B as of the effective date of coverage under the Part D plan.
- Anyone residing in the service area of a Prescription Drug Plan (PDP) or of a Medicare Advantage plan offering qualified prescription drug coverage (for the purposes of Medicare Part D, anyone living abroad or incarcerated is not eligible because he or she

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would not be considered to “reside” in the service area of the PDP).

A person becomes entitled to Medicare Part A when Part A actually covers the person. In general, Part A covers, at no cost, age 65 individuals receiving monthly Social Security income benefits. Medicare Part A will not cover people who do not apply for Social Security income benefits unless they file a separate application.



- An explanation as to why creditable coverage is important and a caution that even though the coverage is creditable, the person may still have to pay higher Medicare Part D premiums if he or she has a 63 or more day lapse in creditable coverage before enrolling in a Part D plan.

CMS also recommends you explain or clarify the following in disclosure notice:

- The beneficiary’s rights to a notice, when a beneficiary can expect a notice and how to request a notice.
- The options the beneficiary will have when the Medicare Part D benefits become available. These options **may** include:
 - Retaining existing coverage and choosing not to enroll in Part D.
 - Enrolling in Part D as a supplement to or instead of other coverage.
- Whether individuals will still be eligible to receive health plan coverage if they enroll in Medicare Part D and are also covered by a retiree health plan that combines health and prescription coverage.
- The circumstances, if any apply, that would allow an individual to re-enroll in the group health plan if the individual drops coverage and elects Medicare Part D.

- How to get extra help to pay for Medicare Part D. CMS recommends the following:
 - *For people with limited income and resources, extra help paying for Medicare Part D is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit the SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778)*

Required Content of Notices

Creditable coverage and non-creditable coverage notices must contain certain information. The guidance provides a model notice for health plans to use. You can access a copy of each notice at www.mcwent.com/medicare/medicare_notices.htm.

Covered entities are not required to use the model, however, their notices must include the following information:

Creditable Coverage Notice

- The entity has determined the prescription drug coverage is creditable.
- A description of the meaning of creditable coverage; for example, the plan expects to pay on average in 2006 the same amount or more for prescription drugs than the standard Part D benefit program would be expected to pay on average.

Non Creditable Coverage

- The entity has determined the prescription drug coverage is **not creditable**.
- A description of the meaning of creditable coverage; for example, the plan expects to pay on average in 2006 the same amount or more for prescription drugs than the standard benefit program offered by Part D would be expected to pay on average. Plans that are not creditable expect to pay **less** for prescription drug benefits on average in 2006 than the standard Part D benefit program.
- An explanation as to why creditable coverage is important and that the individual may have to pay higher Part D premiums if the person fails to enroll in Part D when initially eligible.

CMS also recommends the notice explain the following, although it is not required:

- Beneficiary’s rights to a notice, when a beneficiary can expect

a notice and how to request a notice

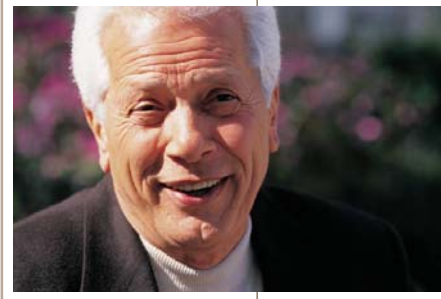
- The options that the beneficiary will have when the Medicare Part D benefits become available. These options **may** include:
 - Retaining existing coverage and choosing not to enroll in Part D.
 - Enrolling in Part D plan as a supplement to or instead of the other coverage.
- Whether individuals will still be eligible to receive health plan coverage if they enroll in Medicare Part D and are also covered by a retiree health plan that combines health and prescription coverage.
- How to get extra help paying for Medicare Part D. CMS recommends the following:
 - *For people with limited income and resources, extra help paying for Medicare Part D is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit the SSA online at www.socialsecurity.gov or call them at 1-800-772-1213 (TTY 1-800-325-0778)*

These forms are only models. Your organization will need to design the forms to accurately reflect your plan options.

Timing and Delivery Requirements

You must notify participants at the following points during the coverage period:

- When they initially become eligible for Part D coverage.
- Every year before the annual coordinated election period (open enrollment) for Medicare Part D.
- Before you launch a new prescription drug benefit or before you make any plan change affecting your group health plan's creditable coverage status.



Initial Part D Eligibility

The initial Medicare Part D enrollment period for all currently covered Medicare beneficiaries begins on November 15, 2005, and ends May 15, 2006. For beneficiaries eligible on or after March 1, 2006, the initial enrollment period begins 3 months before they turn 65 and ends 3 months after they turn 65.

You do have some flexibility in providing notices. For example, they do not need to be mailed separately. They can accompany other plan information if they are prominently and conspicuously displayed. The following statement must appear prominently in at least a 14 point font, in a separate box, bolded or offset on the first page:

If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage starting in 2006. Please see page ## for more details.

You can send a single notice to a Medicare covered employee and any Medicare eligible dependent covered under the plan if they reside at the same address. If you are aware that a Medicare eligible dependent lives at a separate address, you must send a notice to that individual separately.

You can send a notice electronically only if the Medicare beneficiary has a way to access electronic information. Before beneficiaries agree to receive this information electronically, they must be informed of the following:

- Their right to a paper copy.
- How to withdraw their consent.
- How to update their electronic address information with the plan.
- Hardware or software required to access the information.

In order to receive the information electronically, beneficiaries must send you their consent by e-mail and provide a valid e-mail address. If you send information electronically, the notice must also be posted on the company's website, if applicable, with a link to the full text of the disclosure notice.

Action Steps

These notice requirements will place an additional burden on employer group health plans. However, this valuable information will help your Medicare beneficiaries decide whether to enroll in Medicare Part D. Beneficiaries need to understand

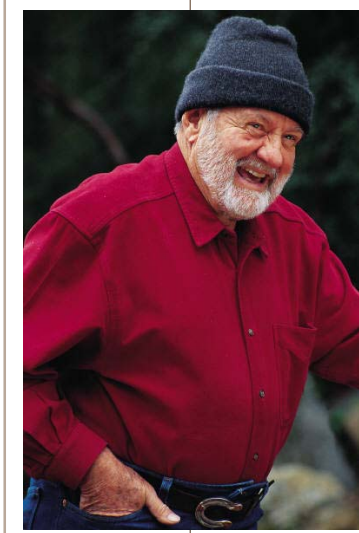
the consequences of not enrolling before the deadline.

CMS specifies that the model notices were designed specifically for the initial launch of Medicare Part D. These details are important because Medicare Part D benefits are new and complicated. CMS will release more details on the specific information that group health plans will need to send to their Medicare eligible members every year.

The guidance also requires group health plans to disclose their creditable coverage status to the Centers for Medicare & Medicaid Services (CMS) every year. CMS will issue more details on this annual disclosure as well.

Because this process is complicated, employers need to take several steps to ensure they are meeting the CMS requirements. As a group health plan, you must notify all Medicare eligible employees and dependents. However, a third party can issue the notices for you. Your health plan vendor may help you:

- Determine whether your current prescription plan benefits meet the CMS creditability requirements. If your organization has a retiree health plan and you intend to apply for the subsidy, your actuary can help you determine whether the gross value of your plan benefits will meet the coverage equivalency require-



ment. Also, if your organization offers employees several benefit plan options, you must evaluate each option separately.

- Draft the required notice or notices. The wording will vary depending on whether the plan option is considered creditable or **not creditable**. Pay close attention to how the notice presents the following:
 - **Your organization's name and your health plan name.** Make sure the name is correct throughout the document. Also, you need to provide contact information for a person to call with questions.
 - **Information on Medicare Part D coverage options.** Make sure the notice clearly explains the options available for your plan members and your retirees. If your **retiree** plan will take a secondary stance to Medicare, clearly state the plan's intentions. Sample wording may be:

The health plan will pay secondary to Medicare Part D. It is your responsibility to enroll in a Medicare Part D "PDP". Even if you do not enroll in a PDP, the group health plan will pay benefits as if you are enrolled.

- Determine your delivery method. If you intend to notify individuals electronically, make sure you have

consent and post the notice on your website if applicable.

- Identify your Medicare eligible plan participants. Remember, this does not apply only to retiree health plans. Your organization also needs to identify active employees and their Medicare eligible dependents. Your vendor should have the most up-to-date coordination of benefits information; this information will help you identify active and retired participants entitled to Medicare.
- Deliver the notices before November 15, 2005.
- Ensure plan members will continue to receive notices after they receive the initial notice announcing the Medicare benefit. Your organization's notice requirements will be ongoing and notices should be sent:
 - To any other plan participant when he or she becomes Medicare eligible.
 - Every year before the annual coordinated election period (open enrollment) for Medicare Part D.
 - Before you launch a new prescription drug benefit or before you make any plan change affecting the group health plan's creditable coverage.

CMS will issue more information on the content and delivery requirements of an annual notice. Your plan will also have to file your creditable coverage status with CMS; guidance is pending on that process as well.

Important Note: CMS just issued additional guidance related to no-

tice requirements and subsidy applications. The guidance is focused solely on account-based health plans. For the purposes of determining creditable coverage, account-based plans are treated as follows:

- **FSAs:** FSAs are to be disregarded when it comes to determining creditable coverage status.
- **HSAs and Archer MSAs:** These accounts due to their nature are not to be considered in determining creditable coverage status. Employers will not have access to distribution information and will not be able to determine what funds are spent on prescription expenses. The underlying medical plan associated with these accounts must meet the creditable coverage criteria.
- **HRAs:** HRAs are generally offered in conjunction with a *catastrophic* health plan. For plans that offer both components, the account and the health plan:
 - Both the account with current year funding and catastrophic health plan must be reviewed in determining creditable coverage status. This means any rollover amounts accumulated in previous years do not count in the evaluation.
 - If the HRA and the health plan only cover prescription drugs, the creditable coverage evaluation would be based on the following logic:
 - ♦ \$1,000 plan deductible with \$500 account funding

- ♦ The coverage would be treated as a prescription plan with a \$500 deductible
- If the HRA and the health plan cover health services and Rx, then a portion of the HRA funding should be reasonably allotted to the prescription coverage and a reasonable amount allocated to the comprehensive health coverage. Using the same example above, let's assume half of the plan expenses are Rx and half of the expenses are comprehensive medical services, then half of the account funding can apply to Rx. So the \$1,000 deductible is offset by \$250 (half of the funding for the HRA) and the plan is treated like a \$750 deductible plan.

If a plan only has a HRA and no underlying catastrophic health plan, the plan is treated like a limited benefit plan. For example, if my employer funds \$2,000 in an HRA for retiree medical expenses, the plan is treated as a \$0 deductible plan with a maximum benefit of \$2,000 for the purpose of determining creditable coverage status.

HRAs are the only account-based plan that is considered in determining creditable coverage.

Account-Based Plans Retiree Subsidy

If your organization is applying for the subsidy, FSAs, HSAs and MSAs are disregarded when calculating the subsidy amount. However, HRAs are considered group health plans. Therefore, any reimbursement made for an eligible prescription plan expense from HRA can be filed as a prescription expense for subsidy purposes.

It is important your plan provides these notices to each medical beneficiary covered by your plan. The notice must be delivered by November 15.

If you have any questions, please contact your Account Manager. **MW**

Our technical bulletins are written and produced by McGraw Wentworth staff and are intended to inform our clients and friends on general information relating to employee benefit plans. They are not intended to provide either legal or tax advice. Before implementing any welfare or pension benefit program, employers are urged to consult with their benefits advisor and/or legal counsel for advice that is appropriate to their specific circumstances.

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