McGraw Wentworth

SPECIAL Alert

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In This Issue

In this first Special Alert for 2006, we discuss the recent guidance issued by the Centers for Medicare and Medicaid Services (CMS) that addresses notifying CMS of the status of your active and retiree group health plans. Any health plan that covers a Medicare-eligible individual must file the status of their prescription drug plan. The plan's status must be disclosed by March 31, 2006 following the procedures outlined in this Special Alert.

We welcome your comments and suggestions regarding this issue of our Special Alert. For more information on this article, please contact your Account Manager or visit the McGraw Wentworth web site at www.mcgrawwentworth.com.

"Creditable Coverage Notice to CMS"

The Medicare Prescription Drug Improvement and Modernization Act (MMA) of 2003 added a voluntary benefit for outpatient prescription drugs to the Medicare program. The new prescription benefit was effective on January 1, 2006.

This Special Alert discusses recent guidance issued by CMS that requires organizations to notify the government of the coverage status of their active and retiree group health plans.

Historical Overview

The implementation of Medicare Part D, the prescription drug benefit, impacted employers in a number of ways. Employers that provide outpatient prescription drug coverage to retirees needed to make certain decisions regarding their retiree health coverage. Additionally, employers without retiree coverage also were impacted by the MMA. Any employer that covered a Medicare-eligible participant on either an active or retiree group health plan was required to notify that Medicare-eligible participant of the coverage status of their plan. The plan was required to send one of the following notices to Medicare-eligible participants:

- **Notice of Creditable Coverage:** This notice advised the participant that the prescription drug benefits provided under the group health plan were as good as or better than the standard Medicare benefit plan.
- **Notice of Not-Creditable Coverage:** This notice advised the participant that the prescription drug benefits provided under the group health plan were **not** as good as the standard Medicare benefit plan.

The purpose of these notices was to provide information to Medicare beneficiaries to help them make informed decisions about their prescription drug coverage with the launch of Medicare Part D.

Determining if your prescription coverage was creditable could be accomplished in two ways:

- **Gross Test (Actuarial Attestation):** If a retiree plan chose to apply for the government subsidy, one step in the application process was to actuarially determine the retiree plan's equivalence to the standard Medicare benefits. The

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determination had to be completed by an actuary and was comprised of two tests, the gross test and the net test. If a retiree plan passed the gross test, it could be considered creditable coverage.

- **Simplified Determination**: The government offered an alternative determination method for those retiree plans that decided not to apply for the subsidy and for active plans, which are also subject to the notice requirements. The government did not want to burden all plans with the expense of having the plan benefits actuarially evaluated for equivalency with the Medicare standard plan. Simplified determination was offered as a secondary option for determining actuarial equivalency for plans that were not applying for the subsidy.

The simplified determination was intended to be a help to employers, but it was not as simple a calculation as employers would have liked. Thankfully, some insurance carriers and McGraw Wentworth worked with actuaries to determine which plan designs could be considered creditable or not creditable.

Employers were required to provide the notice to all Medicare-eligible participants covered under the plan by November 15, 2005.

The New Notice Requirement

The MMA also required that employers provide CMS with a notice regarding the status of their prescription drug plan. The regulations did not include any details on this requirement, and merely noted that more guidance would be issued at a later date.

This guidance was issued by CMS at the end of 2005. Most entities will need to complete the disclosure notice required by CMS. The only entities not subject to this requirement are approved Prescription Drug Plans. In addition, retiree health plans that have applied for the government subsidy are exempt from completing the disclosure on their retiree plans. It is the government's view that since these entities had to provide an actuarial attestation as part of the subsidy application process, they have already notified the government of their plans' status.

Timing of Notice

The disclosure must be made to CMS on an annual basis and upon any changes to coverage that affect creditable status. CMS is requiring that the initial notice be provided by March 31, 2006.

At a minimum, the disclosure notice to CMS must occur at the following times:

- For plan years that end in 2006, disclosure of plan status must be provided no later than March 31, 2006.
- For plan years that end in 2007 and beyond, disclosure of plan status must be provided within 60 days after the beginning date of the plan year.
- Within 30 days following the termination of prescription drug coverage.
- Within 30 days following any change in the creditable coverage status of the prescription drug plan.

Content and Process for Notice

CMS will only take disclosure notices via the Internet; there is no alternative method to providing this information to the government. The disclosure notice can be accessed at http://www.cms.hhs.gov/creditablecoverage.

For entities that have multiple subsidiaries, one notice may be filed for the entity as a whole, as long as the plan year is the same for all entities. If the plan year differs across subsidiaries, a separate notice must be completed for each.

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Notable Thoughts

You may have to fight a battle more than once to win it.

Margaret Thatcher

The government guidance discusses the following data fields that are included on the notice:

- **Name of entity offering coverage**: This field should be completed with the employer's name, not the carrier providing benefits.
- **Federal tax ID number of the entity**: If an organization has multiple subsidiaries but is filing one form because they have the same plan year, the tax ID of the parent company should be used.
- **Address of entity**
- **Phone number of entity**
- **Type of coverage**: This section has a number of options to choose. In many cases, you will look under the group health plan heading and choose "employer-sponsored group health plan."
- **Number of options offered by entity**: This speaks to the number of benefit options your organization offers. For example, an organization may offer two PPO plan options and one HMO option. In this case, the entity offers three options.
- **Creditable coverage status of options**: If the plans your organization offers are creditable, you can select "All Options Are Creditable." If not, you will need to specify which of your options are creditable and which are not.
- **Period covered by disclosure notice**: Your organization must provide the beginning and ending dates of the plan year for which the disclosure covers. Typically, this will be your group health plan year.
- **Number of Part D-eligible individuals expected to be covered at the beginning of the plan year**: CMS does recognize that many organizations will not be able to provide an exact number of Part D-eligible covered plan participants. They are simply requesting your estimate.
- **Estimate of the number of individuals expected to be covered by a group retiree health plan (if applicable)**: This is again an estimate. If your organization does not offer retiree health care coverage, you can enter "0."

- **Date the Notice of Creditable Coverage was provided to Part D-eligible individuals**: For most organizations, it will be the date notices were last sent out (hopefully, prior to November 15).
- **Change in creditable coverage status of previously disclosed information to CMS**: This must be completed if there is a change in any of your coverage options that affects the creditable coverage status.
- **Name, Title and E-Mail Address of Authorized Individual**: This is the information of the individual completing the form.
- **Date of Disclosure**: Date the form is submitted to CMS

In reviewing the notice on the website, all the fields noted above are not included at this point. However, the government may update this form in the future, so be prepared to provide all of the above information.

Conclusion

Since most group health plans provide coverage to at least one Medicare-eligible participant, this disclosure will apply to most organizations. The deadline for completing the disclosure is March 31, 2006.

To expedite the process, it may make sense to collect the information included on the form prior to logging on to the website. Be patient, this site will receive a great deal of traffic as employers around the country make the necessary disclosure. The website might have some difficulties as a result of the excessive traffic.

If you have any questions regarding this disclosure requirement, please contact your McGraw Wentworth Account Manager. MW

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