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# Medicare Part D: Disclosure Notice to CMS

Employers with health plans that provide prescription drug coverage to individuals who are eligible for Medicare Part D are subject to certain disclosure requirements. One of these requirements provides that plan sponsors must disclose to the Centers for Medicare and Medicaid Services (CMS) on an annual basis and at other select times, whether the plan's prescription drug coverage is creditable or non-creditable.

This disclosure is required regardless of whether the health plan's coverage is primary or secondary to Medicare. Plan sponsors are required to use the online form on the CMS Creditable Coverage webpage to make this disclosure.

The plan sponsor must complete the online disclosure within 60 days after the beginning of the plan year. For calendar year health plans, the deadline for the annual online disclosure is March 1 (Feb. 29 for leap years).

## LINKS AND RESOURCES

Employers that are required to report to CMS should work with their advisors to determine whether their prescription drug coverage is creditable or non-creditable.

For more information, employers should also visit CMS' Creditable Coverage webpage, which includes links to the online disclosure form and related instructions.

## HIGHLIGHTS

### ANNUAL DISCLOSURE

- Each year, employers with health plans that provide prescription drug coverage to Medicare-eligible individuals must disclose to CMS whether that coverage is creditable or non-creditable.
- The annual disclosure must be provided **within 60 days after the start of the plan year.**

### CREDITABLE COVERAGE

- A group health plan's prescription drug coverage is considered creditable if it is at least as generous as Medicare Part D prescription drug coverage.
- There are two permissible methods to determine whether coverage is creditable—a simplified determination method and an actuarial determination method.



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## DISCLOSURE TO CMS

Group health plan sponsors are required to disclose to CMS whether their prescription drug coverage is creditable or non-creditable. This disclosure is required regardless of whether the health plan's coverage is primary or secondary to Medicare.

If an employer's group health plan does not offer prescription drug benefits to any Medicare Part D eligible individuals as of the beginning of the plan year, the group health plan is not required to submit the online disclosure form to CMS for that plan year.

Also, a plan sponsor who has been approved for the retiree drug subsidy is exempt from filing the CMS disclosure notice with respect to those qualified covered retirees for whom the sponsor is claiming the subsidy.

The disclosure must be made to CMS on an annual basis and whenever any change occurs 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.

## ONLINE DISCLOSURE METHOD

Plan sponsors are required to use the online disclosure form on the CMS Creditable Coverage webpage. This is the sole method for compliance with the disclosure requirement, unless the entity does not have Internet access.

The disclosure form lists the required data fields that must be completed in order to generate the disclosure notice to CMS, such as types of coverage, number of options offered, creditable coverage status, period covered by the disclosure notice, number of Part D-eligible individuals covered, date the creditable coverage disclosure notice is provided to Part D-eligible individuals, and change in creditable coverage status. CMS has also provided instructions for detailed descriptions of these data fields and guidance on how to complete the form.

## 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 annual benefit maximum 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.

## DISCLOSURES TO INDIVIDUALS

In addition to the annual disclosure to CMS, group health plan sponsors must disclose to individuals who are eligible for Medicare Part D whether the plan's prescription drug coverage is creditable. At a minimum, creditable coverage disclosure notices must be provided to individuals at the following times:

- ✓ Prior to the Medicare Part D annual coordinated election period—beginning Oct. 15 through Dec. 7 of each year
- ✓ Prior to an individual's initial enrollment period for Part D
- ✓ Prior to the effective date of coverage for any Medicare-eligible individual who joins the plan
- ✓ Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable
- ✓ 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.

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.