

# MEDICARE PART D CREDITABLE COVERAGE

## How it works

### What are employer and union groups required to do regarding creditable coverage?

Under the Medicare Modernization Act of 2003, Medicare Part D prescription drug coverage went into effect on January 1, 2006. Under the legislation at 42 CFR §423.56, employer and union groups that provide pharmacy coverage to their Medicare-eligible population, must annually disclose whether the pharmacy plan provided is “creditable” or “not creditable.” Employers are required to provide this notice even if they choose not to apply for the Retiree Drug Subsidy (RDS). The only exception is for plans that provide coverage under a Medicare Part D Employer Group Waiver Plan (EGWP). Further, employer and union groups must complete and provide an annual disclosure to the Centers for Medicare & Medicaid Services (CMS) with their plan’s creditable or non-creditable coverage status.



Complete official guidance regarding creditable coverage can be found at: [www.cms.gov/CreditableCoverage/](http://www.cms.gov/CreditableCoverage/).

### What is creditable coverage?

“Creditable” means the non-Medicare Part D prescription drug coverage provided meets or exceeds the Medicare Part D standards for a given year.

### Who is Medicare eligible?

This notification requirement applies to all active, COBRA, disabled, and retired Medicare eligible employees, former employees, and their dependents who are entitled to Medicare due to age, disability, or end-stage renal disease (ESRO).

- ▶ Individuals are Medicare eligible if entitled to Medicare Part A and/or enrolled in Part B.
- ▶ Medicare eligibility could be the result of age, disability, railroad board entitlement, or end-stage renal disease.

### What is the purpose of the creditable coverage disclosure?

The purpose of the disclosure is to advise the Medicare-eligible population whether or not the group-sponsored plan is creditable. If the group-sponsored plan is not creditable, the Medicare-eligible population must enroll in a creditable plan or a Part D plan, to avoid paying penalties on their Part D premiums for the rest of their lives.

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## What is the late enrollment penalty?

If a Medicare-eligible beneficiary goes without creditable coverage for more than 63 days, when the person enrolls in a Part D plan, premium penalties are assessed at a rate of 1% per month that the person was without creditable coverage.

## Why must creditable coverage notices be done annually?

Even though the employer or union group may not have changed their pharmacy coverage offered to their Medicare-eligible population, Medicare Part D standard benefits do change each year. Therefore the changes to the Medicare Part D benefits necessitates an annual reevaluation for creditability.

## Who is responsible for sending out creditable coverage notices?

In general, entities that offer prescription drug coverage on a group basis to active and retired employees and beneficiaries who are Medicare eligible individuals. **NOTE:** This requirement applies to employers or unions that sponsor retiree coverage, regardless of whether those entities are eligible for, and elect to apply for, the retiree drug subsidy under section 1860D-22 of the Social Security Act, 42 U.S.C. § 423.884.

- ▶ **Employers and unions** that sponsor group health plans for employees or retirees.
- ▶ **Multiple employer welfare arrangements (MEWAs)** that sponsor group health plans for employees or retirees.
- ▶ **Churches** that provide health coverage to employees or retirees.
- ▶ **Federal, state and local governments** that sponsor group health plans for employees or retirees.
- ▶ **Department of Veterans Affairs** that sponsor group health plans for employees or retirees. (this requirement applies to all Department of Veterans Affairs [VA] sponsored group health plans that offer prescription drug

coverage to Medicare eligible veterans, survivors and dependents under Chapter 17 of Title 38, U.S.C).

- ▶ **Military coverage, including TRICARE**, that sponsors group health plans for employees or retirees (this requirement applies to all military coverage under Chapter 55 of Title 10, U.S.C., including TRICARE, that sponsors group health plans that offer prescription drug coverage to active or retired Medicare eligible individuals).

## When must notices be sent?

The regulation at 42 CFR §423.56(f) specifies the times when creditable coverage disclosures must be made to Part D eligible individuals. At a minimum, disclosure must be made at the following times:

- ▶ Prior to the beginning of the plan year, but at least prior to October 15 each year, which is the beginning of the Medicare Part D annual coordinated election period (ACEP). For example, plan years running July–June should send their notices prior to July regarding the upcoming plan year. Plan years running January–December should send their notices prior to October 15;
- ▶ Prior to an individual’s initial enrollment period (IEP) for Part D, as described under 423.38(a);
- ▶ Prior to the effective date of coverage for any Medicare-eligible beneficiary that joins the plan;
- ▶ Whenever the entity no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes non-creditable;
- ▶ Upon an individual’s request.

If the creditable coverage disclosure notice is provided to all plan participants, CMS will consider items 1 and 2 to be met. This guidance clarifies that “prior to” means that the beneficiary must have been provided the disclosure notice within the past 12 months.

## What should the notice include?

The employer or union group will need to decide if the coverage offered to their employees and retirees is impacted if an individual enrolls in an individual Part D plan. This information should be included in the notice as it is an employer-specific decision.

CMS has developed templates that can be used for providing Notice of Creditable or Notice of Non-Creditable coverage to the Medicare-eligible population. These are not required, but if used, ensure satisfaction of the requirements of disclosure. These templates can be found at [www.cms.gov/CreditableCoverage/](http://www.cms.gov/CreditableCoverage/).

## How should notices be sent?

The notice need not be sent as a separate mailing. The disclosure notice may be provided with other customer materials (including enrollment and/or renewal materials). The entity may provide a single disclosure notice to the covered Medicare beneficiary and all Medicare-eligible dependent(s) covered under the same plan. However, the entity is required to provide a separate disclosure notice if it is known that any spouse or dependent that is Medicare eligible resides at a different address than where the customer/policyholder materials were mailed.

Cigna can distribute notices as a direct mailing using optional service approval.

## How is creditable coverage determined?

The determination of creditable coverage status does not require an attestation by a qualified actuary unless the entity is an employer or union electing the retiree drug subsidy. A simplified test is available to determine creditability of an employer or union group's prescription drug plan.

A prescription drug plan is deemed to be creditable under the simplified test if it:

- 1) Provides coverage for brand and generic prescriptions. All standard Cigna Pharmacy Management plans meet this requirement; and
- 2) Provides reasonable access to retail pharmacies or, optionally, for mail order coverage. Cigna Pharmacy Management's pharmacy network provides broad access to retail pharmacies and includes mail order; and
- 3) The plan is designed to pay, on average, at least 60% of participants' prescription drug expenses. Cigna Pharmacy Management standard plans typically meet this standard. If the plan's individual contribution level is richer than the copay levels listed, it is deemed creditable. Using this simplified test, if an individual's cost share is 40% or higher, this standard is not met and the plan cannot be deemed creditable using the simplified test; 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 (most Cigna pharmacy plans meet this standard); or
  - b) The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least \$2,000 per Medicare-eligible individual (Cigna can support this evaluation where needed); 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 \$1,000,000 lifetime combined benefit maximum.

If the plan fails the simplified test stated above, then the employer 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 (exclusive of coverage gap coverage).

The employer is ultimately responsible for determining the creditability of the plan, and may wish to employ a consultant to incorporate additional information to determine creditability.

### How do HRA, FSA and HSA plans impact creditable coverage?

A group-plan-sponsored Flexible Spending Account (FSA), Health Savings Account (HSA) or Medical Savings Account (MSA) does not impact the determination of whether a plan has creditable coverage.

For Health Reimbursement Account (HRA) plans, amounts credited to an individual's HRA in a given year are treated as increasing the expected prescription drug claims payable from a non-account benefit, i.e., high-deductible health plan or other type of health plan, for that year. At the same time, funds that have been rolled over from previous years are disregarded in determining the value of the HRA. A reasonable portion of a year's expenses from an HRA may be allocated to prescription drugs in cases where the HRA pays for both prescription drugs and medical costs.

If the HRA is a stand-alone plan, not used in conjunction with any non-account benefits, then the HRA is treated as a plan with no deductible and an annual limit equal to the amount of the credit for a given year. In all probability, this type of plan will not meet the safe harbor requirements and will probably have non-creditable prescription coverage.

### How to disclose creditable coverage to CMS

Employers and union groups are also required to annually disclose information to CMS about the pharmacy plans offered to the Medicare-eligible population. The disclosure form is online and must be completed online. The form can be found at [www.cms.gov/CreditableCoverage/45\\_CCDisclosureForm.asp](http://www.cms.gov/CreditableCoverage/45_CCDisclosureForm.asp). Instructions for completing the form can be found at [www.cms.gov/CreditableCoverage/40\\_CCDisclosure.asp#TopofPage](http://www.cms.gov/CreditableCoverage/40_CCDisclosure.asp#TopofPage).

At a minimum, disclosure to CMS must be made at the following times:

- ▶ Disclosure of creditable coverage status must be provided 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 the prescription drug plan;
- ▶ Within 30 days after any change in the creditable coverage status of the prescription drug plan.



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