

Packet "E"

For Prescription Drug coverage provided for Medicare eligible retirees and the current funding arrangement will continue.

Step 1: Identify Plans providing prescription drug benefits. For Plans with multiple benefit options the regulation requires that entities apply the actuarial value test separately for each benefit option.

Step 2: Determine whether the drug coverage is "creditable" or "non-creditable" for Disclosure Notice

A.) Employers sponsoring group health plans with prescription drug coverage for Medicare eligible retirees must notify Medicare eligible participants (and those seeking to enroll who are Medicare eligible) by November 15, 2005 as to whether or not the group health Plan's prescription drug coverage is "creditable". A Medicare eligible participant is an individual who has coverage under Medicare Part A or Part B. These individuals may include active workers and their spouses and dependents.

B.) A Plan can use the following simplified methods to determine its prescription drug coverage is creditable:

(1) For Prescription Drug coverage provided by a stand-alone Plan or via a Pharmacy Benefit Management Vendor (e.g. Restat, Medco, Caremark, etc.), the drug coverage is deemed to be creditable if:

- (a) Provides coverage for brand & generic prescriptions;
- (b) Provides reasonable access to retail providers and, optionally, for mail order coverage;
- (c) Is designed to pay on average at least 60% of participants' prescription drug expenses; and
- (d) Satisfies at least one of the following standards:
 - i. The prescription drug coverage has no annual maximum benefit or a maximum annual benefit payable by the Plan of at least \$25,000; or
 - ii. 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 in 2006.

(2) For Prescription Drug coverage provided as part of an Integrated Plan (i.e. the Plan provides drug benefits along with other benefits, such as medical or dental benefits), the drug coverage is deemed to be

creditable if:

- (a) Provides coverage for brand & generic prescriptions;
- (b) Provides reasonable access to retail providers and, optionally, for mail order coverage;
- (c) Is designed to pay on average at least 60% of participants' prescription drug expenses; and
- (d) Has (a) no more than a \$250 deductible per year; (b) no annual benefit maximum or a maximum annual benefit payable by the Plan of at least \$25,000; and (c) no less than a \$1,000,000 lifetime combined benefit maximum.

Step 3: Send Disclosure Notices

- A) Review model notice for the initial disclosure to determine what customization may be needed. The model Notices provided by CMS are only to be used for the *initial* notification which participants should receive by November 15, 2005. CMS sample *initial* Disclosure Notices for both "creditable" and "non-creditable" coverage are available at the EBC website.
- B) Since it is possible for the Plan to have a plan participant, particularly a dependent, who is eligible or may become eligible for Medicare Part D, it is recommended that the Disclosure Notice be sent to **all** plan participants (and those seeking to enroll). The entity may provide a single Disclosure Notice to the covered Medicare individual and all Medicare eligible dependents 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 the participant/employee.
- C) Subsequent Disclosure Notices must be provided to eligible individuals at the following times:
 - (1) Prior to the individual's initial enrollment in Medicare Part D;
 - (2) Prior to commencement of the Annual Coordinated Election Period (November 15-December 31) of each year;
 - (3) Prior to the effective date of enrollment in the prescription drug coverage;
 - (4) Whenever prescription drug coverage ends or changes so that it affects whether the coverage is "creditable"; and
 - (5) Upon request by the individual.

Recent guidance issued by CMS clarifies that if the Disclosure Notice is provided annually to all plan participants, items (1) and (2) will be met. According to CMS "prior to" means that the beneficiary must have been provided the Disclosure Notice within the

past twelve months. CMS will provide model Disclosure Notices to be used after the initial Notice deadline of November 15, 2005.

Step 4: Provide Disclosure Notice to CMS (Centers for Medicare & Medicaid Services) A Notice must be provided annually and upon any change that affects whether or not the coverage is creditable. The form for this notice has not yet been provided.

Step 5: Document whether or not the prescription drug coverage is “creditable” and that the initial notices have been provided.

Step 6: Establish policies and procedures for providing notices to the Plan participants as indicated in Step 3, C.

Step 7: Establish policies and procedures for providing CMS with an annual notice and upon any change that affects whether or not the coverage is creditable.

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