CREDITABLE COVERAGE DISCLOSURE TO CMS GUIDANCE

INTRODUCTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare. Regulations to implement Medicare prescription drug coverage were published January 28, 2005 (70 Fed. Reg. 4193 (2005)). This guidance pertains to Section 1860D-13 of the MMA and 42 CFR §423.56(e).

Under those provisions, most entities that currently provide prescription drug coverage to Medicare Part D-eligible individuals must disclose to the Centers for Medicare & Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage" (Disclosure to CMS). Disclosure to CMS is required whether the entity's coverage is primary or secondary to Medicare. Entities that must comply with these provisions are listed at 42 CFR §423.56(b) and are also referenced on the creditable coverage homepage at http://www.cms.hhs.gov/CreditableCoverage. Meanwhile, entities that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified prescription drug coverage are exempt from the disclosure to CMS requirement. See 42 CFR 423.56(e).

Per 42 CFR §423.56(e), CMS will provide additional information concerning the disclosure to CMS, including the required form and manner of disclosure. This guidance provides such additional information concerning those rules, including the form, manner, and timing of providing the disclosure to CMS.

OVERVIEW OF REGULATORY REQUIREMENTS

Creditable Coverage Definition and Determination

Per 42 CFR §423.56(a), drug coverage is defined as creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare prescription drug coverage, as demonstrated through the use of generally accepted actuarial principles and in accordance with CMS actuarial guidelines. In general, this actuarial determination measures 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. See 70 Fed. Reg. 4225 (2005).

This determination is identical to the first step (the "gross test") in calculating actuarial equivalence for purposes of 42 CFR §423.884, which applies when an employer or union applies for the Retiree Drug Subsidy (RDS). The gross test does not consider the extent to which the coverage is financed by the beneficiary or by the entity. See 42 C.F.R. §423.884(d)(5)(ii)(A).

For plans with multiple benefits options, the regulation requires that entities apply the gross test separately for each benefit option. See 42 CFR §423.884(d)(5)(iv). A "benefits option" is defined at 42 CFR §423.882 as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan, such as different categories of benefits and different plan design options under a given type of coverage (e.g., HMO, PPO, Indemnity). Benefit options are referenced on the Disclosure to CMS Form as "Options".

For purposes of the disclosure to CMS, we require a separate Disclosure to CMS Form for each type of coverage sponsored by an entity (e.g., Medicaid, SPAP, employer plan, church Plan, Standardized Medigap Plan, Pre-standardized Medigap Plan).

POLICY GUIDANCE

Clarifications and other guidance relating to the above requirements follow.

Creditable Coverage Disclosure to CMS Form from Entity to CMS

Per 42 CFR §423.56(e), all entities described in 42 CFR §423.56(b) must disclose to CMS whether the prescription drug coverage that is offered to a Medicare Part D-eligible individual is creditable or non-creditable.

Form and Manner of Creditable Coverage Disclosure to CMS from Entity

An entity is required to provide a disclosure to CMS through completion of the Disclosure to CMS Form (Form CMS-10198) posted on the CMS Creditable Coverage Web Page at http://www.cms.hhs.gov/CreditableCoverage/45_CCDisclosureForm.asp#TopOfPage.
This method of transmission is convenient, takes little time to complete, and is the sole method for compliance with the requirement, unless the entity has no internet access.

Required data fields on the Disclosure to CMS Form must be populated to generate a disclosure to CMS. For detailed descriptions of these data fields and instructions about how to complete the Disclosure to CMS Form, please reference the Disclosure to CMS Form Instructions which are posted on the CMS website at: http://www.cms.hhs.gov/CreditableCoverage.

Who Must Provide the Disclosure to CMS Form

The Disclosure to CMS Form must be provided to CMS by certain entities listed at 42 CFR §423.56(b) that are not excluded at §423.56(e). These entities include the following:

1. Group health plans, including those offered by employers; union/Taft-Hartley plans; church plans; federal, state, and local government plans; and other group-sponsored plans;
2. Government sponsored plans, including Medicaid; State Pharmaceutical Assistance Programs (SPAPs); State High Risk Pools;
3. Military coverage, including the United States Department of Veterans Affairs (VA) coverage and TRICARE;
4. Individual health insurance;
5. Indian Health Service; Tribe or other Tribal Organizations; Urban Indian Organizations; and
6. Medigap (Medicare Supplement) plans, including standardized plans H, I or J; pre- standardized plans; waiver state plans; and plans with innovative benefits.

The entities exempted under 42 CFR §423.56(e) include PDPs, MA-PDs, and PACE or cost-based HMOs or CMPs that provide "qualified Part D coverage" as defined in 42 CFR §423.100.

Per 42 CFR §423.884(c)(2)(iv), a Plan Sponsor must provide an attestation that its prescription drug coverage is at least actuarially equivalent to the standard prescription drug coverage under Part D as part of the application for the Retiree Drug Subsidy (RDS).

Therefore, because the actuarial equivalence standard includes the creditable coverage standard, a sponsor approved for the RDS is exempt from filing the Disclosure to CMS Form with respect to those qualified covered retirees for which the Sponsor is claiming the RDS. The sponsor's RDS application serves as its Disclosure to CMS under 42 CFR §423.56(e). For example: If a plan option has 100 retired beneficiaries and the plan claims RDS for 97 of them, the plan must report the 3 non-RDS participants on the Disclosure to CMS Form, in addition to reporting the non-RDS participants on other plan options.

Timing of Creditable Coverage Disclosure to CMS Form from Entity

The Disclosure to CMS Form must be submitted to CMS annually and upon any change that affects whether the drug coverage is creditable.

At a minimum, the Disclosure to CMS Form must be provided at the following times:

1. For Plan Years that end in 2007 and beyond, the Disclosure to CMS Form must be provided within 60 days after start of Plan Year for which the entity is providing the Disclosure to CMS Form;
2. Within 30 days after the termination of the prescription drug plan; and
3. Within 30 days after any change in the creditable coverage status of the prescription drug plan.

Additional Guidance

CMS may release Questions and Answers relating to Creditable Coverage issues from time to time under the Questions link on the CMS website at: http://www.cms.hhs.gov/.

CONTACT FOR FURTHER INFORMATION

Visit the CMS website link related to creditable coverage issues at:
http://www.cms.hhs.gov/CreditableCoverage