CENTERS FOR MEDICARE & MEDICAID SERVICES
Creditable Coverage Disclosure to CMS
Instructions

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 FR 4193). This guidance pertains to section 1860D-13 of the MMA, and the regulation at 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 Notice). A disclosure is required whether the entity's coverage is primary or secondary to Medicare. Entities that must comply with these provisions are listed in the regulation at 42 CFR §423.56(b) and are also referenced on the creditable coverage homepage at http://www.cms.hhs.gov/creditablecoverage. However, 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 requirement. See 42 CFR §423.56(e).

If an entity does not offer prescription drug benefits to any Medicare Part D eligible individual on the beginning date of their plan year (renewal year, contract year, etc.), the entity is not required to complete the Disclosure to CMS form for that plan year.

In addition, employers and unions that applied and were accepted for the Retiree Drug Subsidy (RDS) are exempt from filing the Disclosure to CMS only for the individuals and plan options for which they are claiming the RDS. If the employer or union offers prescription drug coverage to any other Medicare Part D eligible individual (active, disabled, COBRA or any retirees or dependents who are covered by the employer or union but are not being claimed under the RDS), they must provide a disclosure to CMS for those plan options that cover those individuals and complete the requested information.

The regulation at 42 CFR §423.56(e) states that CMS will provide additional information concerning Disclosure Notices, including the required form and manner of disclosure to CMS. These instructions, in addition to the Disclosure to CMS Guidance, provide such additional information concerning those rules, including the form, manner, and timing of providing a Disclosure Notice to CMS.

OVERVIEW OF REGULATORY REQUIREMENTS

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-NEW. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Creditable Coverage Definition and Determination

As defined in the regulation at 42 CFR §423.56(a), drug coverage is 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 FR 4225.

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 take into account 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 that have multiple benefit options, the regulation requires that entities apply the gross test separately for each benefit option. See 42 CFR §423.884(d) (5) (iv). A benefit 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. Benefit option refers to the 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 form as "Options".

The determination of creditable coverage status does not require an attestation by a qualified actuary except for a benefit option(s) under a Group Health Plan for which an employer or union is electing the retiree drug subsidy. See the regulation at 42 CFR §423.884(d).

For purposes of the Disclosure Notice to CMS, we require a separate disclosure for each Type of Coverage sponsored by an Entity (e.g., Medicaid, SPAP, Employer Plan, Church Plan, Standardized Medigap Plan, Pre-standardized Medigap Plan).

Creditable Coverage Disclosure from Entity to CMS

The regulation at 42 CFR §423.56(e) requires all entities described in the regulation at 42 CFR §423.56(b) disclose to CMS whether the prescription drug coverage that is offered to Medicare Part D eligible individuals is creditable or non-creditable.

Who Must Provide the Disclosure Notice to CMS

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The Disclosure Notice is required to be provided to CMS by certain entities listed at 42 CFR §423.56(b) that are not excluded at §423.56(e). 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” within the meaning of 42 CFR §423.100.

Entities that must provide a disclosure to CMS include sponsors of:

- Group health plans (offered by employers; union/Taft-Hartley plans; church, State and local government, and other group-sponsored plans) including the Federal employees health benefits program; and qualified retiree prescription drug plans as defined in section 1860D-22(a)(2) of the Act;

- Governmental sponsored plans, including Medicaid coverage under title XIX of the Act or under a waiver under section 1115 of the Act; State Pharmaceutical Assistance Programs (SPAPs) as defined at §423.454 and State High Risk Pools as defined under 42 CFR 146.113(a)(1)(vii);

- Plans that provide coverage of prescription drugs for veterans, survivors and dependents under chapter 17 of title 38, U.S.C.;

- Plans that provide Military Coverage under chapter 55 of title 10, U.S.C., including TRICARE;

- Plans that provide individual health insurance coverage (as defined in section 2791(b)(5) of the Public Health Service Act) that includes coverage for outpatient prescription drugs and that does not meet the definition of an excepted benefit (as defined in section 2791(c) of the Public Health Service Act);

- Coverage provided by the medical care program of the Indian Health Service, Tribe or other Tribal Organization, or Urban Indian Organization (I/T/U);

- Plans that provide coverage under a Medicare supplemental policy (Medigap policy), as defined at 403.205, including standardized plans H, I or J; prestandardized plans; waiver State plans; and plans with innovative benefits; and

- Plans that provide other coverage as the Secretary may determine appropriate.

If an entity does not offer outpatient prescription drug benefits to any Medicare Part D eligible individuals on the beginning date of their plan year (renewal year, contract year, etc.), the entity is not required to complete the Disclosure to CMS on-line form for that plan year.

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The regulation at 42 CFR §423.884(c)(2)(iv) requires that a plan sponsor 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 that has been approved for the Retiree Drug Subsidy is exempt from filing the Disclosure Notice with CMS with respect to those qualified covered retirees for which the Sponsor is claiming the Retiree Drug Subsidy. The sponsor's RDS application serves as its disclosure to CMS under 42 CFR §423.56(e).

Timing of Creditable Coverage Disclosure from Entity to CMS

As outlined under 42 CFR 423.56(e) and (f), and the guidance published by CMS on January 10, 2006, a disclosure of creditable coverage status must be made to CMS on an annual basis and upon any change that affects whether the drug coverage is creditable.

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

1. For plan years that end in 2006, disclosure of creditable coverage status must have been provided no later than March 31, 2006.
2. For plan years that end in 2007 and beyond, 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.
3. Within 30 days after the termination of the prescription drug plan ; and
4. Within 30 days after any change in the creditable coverage status of the prescription drug plan.

INSTRUCTIONS FOR PROVIDING DISCLOSURE TO CMS

Form and Manner of Disclosure from Entity to CMS

An entity is required to provide a disclosure to CMS through completion of the disclosure to CMS form on the CMS Creditable Coverage Disclosure web page at <http://www.cms.hhs.gov/apps/ccdisclosure/> As you complete the questions in the electronic on-line Disclosure to CMS form, an additional box will appear where you are required to enter the required disclosure information. This method of transmission is convenient and will take minimal time to complete, and is the sole method for compliance with the requirement.

Important Formatting Information:

- The on-line disclosure to CMS form will not accept an apostrophe in any field when completing the disclosure form. Entities should use a (*) symbol which can be found on the "8" key in place of using an apostrophe.

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- The on-line disclosure form will not accept all capital letters when completing this form. Please be sure that the “Caps Lock” key is not turned on when completing the disclosure form. Entities should use either upper and lower case letters or all lower case letters.

- The on-line disclosure form requires that when completing the date fields that two (2) digits be entered for the month, two (2) digits be entered for the day and four (4) digits be entered for the year and a forward slash (/) be inserted between the fields (MM/DD/YYYY).

NOTE: The Disclosure to CMS form is required to be submitted online and not in hard copy. Hard copy notices will be available upon request for plan sponsors that do not have internet access to complete the notice online. Only sections relevant to the plan sponsor will be displayed online. Some sections of the disclosure form may not actually be presented until the time the disclosure form is being completed online because they may not apply to the entity completing the disclosure form. To assist you in completing the disclosure to CMS form, additional information regarding each section of the online disclosure form can be found in the User Guide and Helpful Hints guidance on the Creditable Coverage CMS web page at: <http://www.cms.hhs.gov/CreditableCoverage/06_CCDislcosure.asp#TopOfPage>.

CONTENT OF THE DISCLOSURE NOTICE TO CMS

All entities must complete *Boxes A, B & F* of the on-line Disclosure to CMS web page form.

If all options offered by your plan are creditable, you must complete ***Box C*** of the Creditable Coverage Notice to CMS.

If all options offered by your plan are non-creditable, you must complete ***Box D*** of the Creditable Coverage Notice to CMS.

If there are some creditable or non-creditable options offered by your plan, you must complete ***Box E*** of the Creditable Coverage Notice to CMS.

BOX A

Listed below are the required data fields in the Disclosure to CMS web page form that must be populated in order to submit the Disclosure to CMS form. For entities with subsidiaries (division, line of business, operating unit, control group, etc.), one disclosure form can be submitted to CMS for the entire entity if the plan year is the same for all subsidiaries/divisions, or an additional form can be submitted for each subsidiary

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(division, line of business, operating unit, control group, etc.) with the subsidiary-specific information.

NOTE: As you answer the questions on the electronic Disclosure to CMS web page form, an additional box will appear where you should enter the required disclosure information.

1. **Name of Entity Offering Coverage.** This is the name of the entity that is providing or sponsoring the plan of benefits to Medicare eligible individuals such as an employer, a union, the Veterans' Administration, or a Medigap issuer. It is not the name of any carrier that the entity may have contracted with for insurance coverage or for administration of its benefit plan.

2. **Federal Tax Identification Number of the Entity.** For entities that have multiple subsidiaries (divisions, line of businesses, operating units, control groups, etc.) that are all covered under the same type of coverage, the Federal Tax Identification Number (also known as the Employer Identification Number, or EIN) for the Parent Company may be used when completing the entity's EIN information for the entire company. If the form is completed separately for individual subsidiaries (divisions, line of businesses, operating units, control groups, etc.), the EIN for each subsidiary should be provided.

3. **Street Address, including the City, State and Zip Code of the Entity.** For entities that have many subsidiaries (divisions, line of businesses, operating units, control groups, etc.) under the same type of coverage, the Street Address for the Parent Company may be used when completing the entity's information.

4. **Phone Number of the Entity.** For entities with many subsidiaries (divisions, line of businesses, operating units, control groups, etc.) that have the same type of coverage, the phone number for the Parent Company may be used when completing the entity's information.

5. **Type of Coverage.** The Type of Coverage (e.g., Medicaid, VA, SPAP) that must provide disclosure are those listed under the regulation at 42 CFR §423.56(b) that are not excluded under 42 CFR §423.56(e).

6. **Number of Prescription Drug Options offered by the Entity.** This is the total number of benefit options as defined under 42 CFR §423.882 that the entity is offering to Medicare eligible individuals. This is a numeric field and must be filled in with a number.

   For example, an employer plan may offer an HMO option, a PPO option and an indemnity option, and a Medigap issuer may offer multiple Medigap policies that include prescription drug coverage.

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BOX B

7. **Creditable Coverage Status of Options offered by the Entity.** If the Options offered by the entity are either all creditable or all non-creditable, the entities/plan sponsors may provide aggregated data in the Disclosure Notice for all options under the Plan. If some of the Options offered are creditable and some are not creditable, entities/plan sponsors may combine the data for Options that are creditable and combine the data for those Options that are not creditable in the Disclosure Notice. Once the entity clicks on either "All Options Offered Are Creditable" or "All Options Offered Are Non-Creditable" or "There are some Creditable or Non-Creditable Options Offered" in the middle of the Disclosure to CMS form, they will then see the appropriate box (***Box C, D or E***) that needs to be completed which will automatically appear for the entity to complete.

BOXES C, D & E

8. **Period covered by Disclosure Notice.** An entity is required to provide the Disclosure Notice to CMS on an annual basis. Each entity must provide the beginning and ending calendar date(s) of the Plan Year for which such entity is providing the disclosure to CMS.

   For purposes of the Disclosure Notice to CMS, CMS defines “Plan Year” as the beginning and ending date of the entity’s annual renewal or contract period.

   These dates must be entered using two (2) digits for the month, two (2) digits for the day and four (4) digits for the year and the date field must be entered using the forward slash (/) between the month and day and between the day and year. (MM/DD/YYYY). Failure to enter the date in this manner will result in an error message when submitting the disclosure form.

9. **Number of Part D Eligible Individuals expected to be covered under these Plan(s) as of the Beginning Date of the Plan Year.** While CMS recognizes that many entities will not be able to provide an exact number of Part D eligible individuals, entities should estimate the number of covered Part D eligible individuals under the Options offered under the type of coverage for which they are providing the Disclosure Notice to CMS. This estimate should be the <u>total number </u>of Medicare eligible individuals, less any Medicare eligible individual(s) being claimed under the RDS program, that are expected to be covered under the entity’s RDS prescription drug plan options (this includes active, disabled, individuals on COBRA and retired individuals). For purposes of this disclosure question, a “Medicare eligible individual being claimed under the RDS program” is any qualified covered retiree for which the

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entity is expected to collect the retiree drug subsidy. This is a numeric field and must be filled in with a number.

Entities should work with their current vendors (Insurance carrier, TPA, PBM, Consultant, etc.) to verify whether the prescription drug plan(s) offered by entity covers any Medicare eligible individuals (including active, retired, disabled individuals and their dependents or any individuals on COBRA) at the start of each plan year.

If the entity has a plan participant that will be or becomes eligible for Part D coverage during the plan year, the entity should **not** include these individuals on their Disclosure to CMS form if they were not effective on the beginning date of the plan year. These individual(s) should be included on their annual Disclosure to CMS form at the beginning date of the next plan year. Entities are required; however, to provide a disclosure of creditable coverage status to the individual prior to when they become Medicare eligible as outlined in the General Creditable Coverage Guidance at <http://www.cms.hhs.gov/CreditableCoverage/>.

10. Estimated Number of individuals expected to be covered through an Employer/Union group health Retiree Plan. <u>Applicable to Entities sponsoring Group Health Plans only.</u> All other entities offering other Types of Coverage should indicate a zero (0) in this field.

Entities sponsoring Group Health Plans should estimate the number of Part D eligible individuals covered under **retiree** plans for which they are providing the Disclosure Notice to CMS. This estimate should be the <u>total number</u> of Medicare eligible individuals, less any Medicare eligible individual(s) being claimed under the RDS program, that are expected to be covered under the entity’s Retiree RDS prescription drug plan options on the beginning date of the plan year. For purposes of this disclosure question, a “Medicare eligible individual being claimed under the RDS program” is any qualifying covered retiree for which the entity is expected to collect the retiree drug subsidy. This number is a subset of question 9 and cannot be any larger than the number stated in question 9. This is a numeric field and must be filled in with a number.

Entities should work with their current vendors (Insurance carrier, TPA, PBM, Consultant, etc.) to verify whether the Retiree prescription drug plan option(s) offered by entity covers any Medicare eligible individuals at the start of each plan year.

If the entity has a retired plan participant that will be or becomes eligible for Part D coverage during the plan year, the entity should **not** include these retired individuals on their Disclosure to CMS form if they were not effective on the beginning date of the plan year. These retired individual(s) should be included on their annual Disclosure to CMS form at the beginning date of the next plan year. Entities are

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required; however, to provide a disclosure of creditable coverage status to the individual prior to when they become Medicare eligible as outlined in the General Creditable Coverage Guidance at <http://www.cms.hhs.gov/CreditableCoverage/>.

11. **Date of Notice of Creditable Coverage provided to Part D Eligible Individuals.** An entity must disclose to CMS the latest calendar date on which it provided the required disclosure to Part D eligible individuals of creditable or non-creditable coverage (i.e., mailed, personally distributed to Part D eligible individuals, etc.) as required under 42 CFR §423.56 (c), (d) & (f).

    This date must be entered using two (2) digits for the month, two (2) digits for the day and four (4) digits for the year and the date field must be entered using the forward slash (/) between the month and day and between the day and year. (MM/DD/YYYY). Failure to enter the date in this manner will result in an error message when submitting the disclosure form.

12. **Change in Creditable Coverage status of previously disclosed information to CMS.** Entities also must provide a Disclosure Notice to CMS if the creditable coverage status of a Type of Coverage or any of the Options previously disclosed to CMS undergoes a change in creditable coverage status. This includes an entity changing the coverage offered so that it is no longer creditable or terminating a creditable coverage plan or option.

    If you did **not** make a change to your prescription drug plan which resulted in the creditable coverage status changing (i.e.; it went from being creditable to non-creditable or termination), then you should answer this question "No" and skip the rest of the questions.

    Change in Creditable Coverage Status

    If you made a change to your prescription drug plan which resulted in the creditable coverage status changing (i.e.; it went from being creditable to non-creditable) after the disclosure to CMS has been submitted for a plan year, then the entity must answer this question "Yes" and disclose to CMS the date on which it provided the required disclosure to Part D Eligible Individuals under 42 CFR §423.56 (f)(2). The date should be the calendar date that disclosure of a Change in Creditable Coverage status was provided (i.e., mailed, posted, personally distributed to Part D Eligible Individuals, etc.). This date must be entered using two (2) digits for the month, two (2) digits for the day and four (4) digits for the year and the date field must be entered using the forward slash (/) between the month and day and between the day and year. (MM/DD/YYYY). Failure to enter the date in this manner will result in an error message when submitting the disclosure form

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Termination of a Plan or Option

If the entity terminates a creditable coverage option after the disclosure to CMS has been submitted for a plan year, the entity must complete a new disclosure to CMS form. The entity should indicate that the new number of options being offered, the new estimated number of Medicare eligible individuals and retirees that are covered under the plan as of the date of the change, the entity would indicate “Yes” to the question “is this is a change in creditable coverage status to a previously submitted disclosure to CMS form?” and the entity must disclose to CMS the date on which it provided the required disclosure to Part D Eligible Individuals under 42 CFR §423.56 (f)(2). The date should be the calendar date that disclosure of a Change in Creditable Coverage status was provided (i.e., mailed, posted, personally distributed to Part D Eligible Individuals, etc.). This date must be entered using two (2) digits for the month, two (2) digits for the day and four (4) digits for the year and the date field must be entered using the forward slash (/) between the month and day and between the day and year. (MM/DD/YYYY). Failure to enter the date in this manner will result in an error message when submitting the disclosure form.

If the entity is terminating the creditable coverage plan after the disclosure to CMS has been submitted for a given plan year, the entity must complete a new disclosure to CMS form. The entity should indicate that there are zero (0) options being offered, the plan is non-creditable, that there are now zero (0) estimated Medicare eligible individuals and retirees covered under the plan, the entity would indicated “Yes” to the question “is this is a change in creditable coverage status to a previously submitted disclosure to CMS form?” and the entity must disclose to CMS the date on which it provided the required disclosure to Part D Eligible Individuals under 42 CFR §423.56 (f)(2). The date should be the calendar date that disclosure of a Change in Creditable Coverage status was provided (i.e., mailed, posted, personally distributed to Part D Eligible Individuals, etc.). This date must be entered using two (2) digits for the month, two (2) digits for the day and four (4) digits for the year and the date field must be entered using the forward slash (/) between the month and day and between the day and year. (MM/DD/YYYY). Failure to enter the date in this manner will result in an error message when submitting the disclosure form.

A. **How Many Options Offered under this Plan are Creditable.** This is the total number of benefit options as defined under 42 CFR §423.882 that the entity is offering to Medicare eligible individuals that are creditable. For example, an employer plan may offer an HMO option, a PPO option and an indemnity option, and a Medigap issuer may offer multiple Medigap policies that include prescription drug coverage. This is a numeric field and must be filled in with a number.

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B. How Many Options Offered under this Plan are Not Creditable. This is the total number of benefit options as defined under 42 CFR §423.882 that the entity is offering to Medicare eligible individuals that are not creditable. For example, an employer plan may offer an HMO option, a PPO option and an indemnity option, and a Medigap issuer may offer multiple Medigap policies that include prescription drug coverage. This is a numeric field and must be filled in with a number.

BOX E

13. Name, Title and Email of the Entity's Authorized Individual. An "Authorized Individual" is the person completing the disclosure form that is either: a) employed by the entity; or b) contracted with the entity as an Authorized Individual to complete the disclosure on behalf of the entity. The Authorized Individual must provide his or her name, title and email. If the Authorized Individual does not have an email account, the entity can contact CMS to discuss an alternative method to submit the disclosure to CMS form.

Date of Disclosure to CMS. The entity's authorized individual must provide the date on which he or she is submitting the disclosure to CMS. This date must be entered using two (2) digits for the month, two (2) digits for the day and four (4) digits for the year and the date field must be entered using the forward slash (/) between the month and day and between the day and year. (MM/DD/YYYY). Failure to enter the date in this manner will result in an error message when submitting the disclosure form.

Submitting the Disclosure to CMS web page form once it is completed

Entities should print a copy of the completed disclosure to CMS form for their records prior to actually clicking the "Submit the form" button. Once you have clicked the "Submit the form" button on the Disclosure to CMS web page, if you have completed the disclosure form correctly, then you will receive a confirmation message "The form information was inserted successfully." You should print a copy of this page for your records. If you receive an error message after clicking the "Submit the form" button, go back and check your answers and correct the error that was indicated in the error message. If you are unable to submit the form successfully, print a copy of the error page and the screen print of the completed disclosure form and send to CMS via a facsimile to CMS at (410) 786-6301 – Attention: Creditable Coverage Disclosure Team. Entities must provide CMS with a phone number of the Authorized Individual so that CMS can assist the entity with the web page form once CMS has reviewed the facsimile.

Input another Record

If the entity has another disclosure to enter, click on the "Input another Record" button and a new disclosure to CMS web page form will appear for the entity to complete. This feature is available so that entities you will not have to log out of the Disclosure to CMS

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web page and log back in if they have more than one benefit option and they were not able to combine their benefit options due to a different plan year or if the entity offers different Types of Coverage. For instance a State Government entity may have numerous Types of Coverage to disclose to CMS (i.e.: their employee benefit plan, their Medicaid program, a state high risk pool plan and/or a State Pharmaceutical Assistance Program).

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CONTACT FOR FURTHER INFORMATION

Visit the CMS website link related to Creditable Coverage issues at:
<http://www.cms.hhs.gov/CreditableCoverage>

CMS may release Question and Answers relating to Creditable Coverage issues from time to time on the CMS website under the Questions and Issues Database website which can be found at:
<http://questions.cms.hhs.gov/cgi-bin/cmshhs.cfg/php/enduser/std_alp.php?p_sid=uJfxpa7i >

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