Retiree Drug Subsidy Support Kit

Blue Cross Blue Shield
Blue Care Network of Michigan

Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association
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Section 1: Foundation Information about the Drug Subsidy Option

Fundamentals

When the Medicare Prescription Drug, Improvement, and Modernization Act was signed into law in 2003, it contained, among other items, a number of options to help employers and unions provide prescription drug benefits to their Medicare-eligible retirees. The Retiree Drug Subsidy (RDS) is one of those options and is the focus of this Kit. (Note: Should you require information about the other options, please advise your sales/marketing contact at the Blues and they will handle that request separately.)

The RDS option is designed to encourage employers and unions to continue providing high quality prescription drug coverage. The RDS option is available to all employers and unions regardless of whether they pay taxes or are tax exempt. It has highly flexible rules that permit employers and unions to continue providing drug coverage to their Medicare-eligible retirees at a lower cost while retaining their current plan designs.

In this kit, we’re concentrating on how to apply for the Retiree Drug Subsidy, which goes into effect on Jan. 1, 2006. Here’s how the retiree Drug Subsidy option works.

- If your retiree plan provides prescription drug coverage that is at least as good as the standard Medicare prescription drug benefit and you have at least one qualifying covered Medicare eligible retiree, Medicare will make a tax-free payment to you, the plan sponsor, to help you cover the costs of your drug plan.

- In 2006, CMS will pay 28 percent of the allowable retiree costs attributed to gross covered prescription drug costs net of rebates/allowances.

- Gross Cost is defined as ingredient cost plus dispensing fees and taxes, if any.

- The allowable retiree costs apply to drug costs incurred for each qualifying retiree between the cost threshold and the cost limit.

- In 2006, the cost threshold is $250 and the cost limit is $5,000.

- The threshold and limit will be indexed and adjusted yearly after 2006.

- The drugs must be on the approved Medicare formulary and must be for qualifying covered Medicare eligible beneficiaries.

- For the Drug subsidy option, an eligible beneficiary is one who is Part A entitled and/or Part B enrolled and who is NOT enrolled in Medicare Part D.
How does the subsidy amount get determined?

Example using three eligible beneficiaries:

The 1st eligible beneficiary has $6,000 in eligible drug costs, net of rebates, during the plan year. The 2nd eligible beneficiary has $3,000 in eligible drug costs, net of rebates, during the plan year. The 3rd eligible beneficiary has $200 in eligible drug costs, net of rebates, during the plan year.

The subsidy amounts for these three cases are $1,330, $770, and $0 respectively.

These amounts were arrived at via a four step process:

- Step 1: Start with the eligible drug cost amount net of rebates
- Step 2: Then subtract the subsidy threshold amount of $250
- Step 3: Then subtract any amount over the subsidy cost limit of $5,000
- Step 4: Then a factor of .28 is multiplied times the result of step 2 to get the subsidy amount

Here is the math:

\[
\begin{align*}
\text{1st beneficiary:} & \quad 6000 - 250 - 1000 = 4750 \\
\text{2nd beneficiary:} & \quad 3000 - 250 - 0 = 2750 \\
\text{3rd beneficiary:} & \quad 200 - 250 - 0 = -50
\end{align*}
\]

Net amount \times 0.28 = the subsidy amount paid

- 1st beneficiary: \(4750 \times 0.28 = 1330\) subsidy amount paid
- 2nd beneficiary: \(2750 \times 0.28 = 770\) subsidy amount paid
- 3rd beneficiary: No subsidy paid

What are the likely savings amounts?

CMS (The Centers for Medicare and Medicaid Services) has used national data to estimate the value of the subsidy as follows:

- $668 per beneficiary for a tax-exempt group
- $891 per beneficiary for a group in the 25-percent tax bracket
- $1,028 per beneficiary for a group in the 35-percent tax bracket

Why are many employer and labor groups selecting the subsidy option for 2006?

There are four major reasons that groups are selecting the drug subsidy option for 2006. These are:

- Transparency – no disruption of the current plan to retirees
- Flexibility – employers and unions retain control over the structure of their drug plans
- Ease of use – realistic deadlines for applying and no regulatory headaches after approval
- Financially attractive – Tax-free subsidy payments are a value for groups subject to taxation
How do employer and labor groups qualify?

In order to qualify for the subsidy, you need to provide CMS with a properly signed, complete electronic application.

Within the application, CMS also requires you to:

- Include a list of the Medicare eligible retirees you cover,
- Provide an attestation that your drug plan or plans are at least as generous as the Medicare Part D prescription drug plan.
  - The attestations must be certified by a properly credentialed actuary, who is a member of the American Academy of Actuaries,
- Certify to CMS that you will notify your retirees of the “creditable” status of your benefit plan or plans. (i.e., whether those plans are as generous as Medicare Part D Prescription Drug Coverage.)
  - We have much more information about Creditable Coverage requirements in Appendix B.
  - Also, in Appendix C, we have included web links to samples of creditable coverage notices from CMS that you can use to fulfill this requirement.

After CMS approves your drug subsidy application:

- You will be required to periodically update enrollment information about retirees and dependents for whom you will be receiving subsidy payments.
- You will also be required to periodically submit aggregate data about drug costs along with a reconciliation of costs within fifteen months after the end of your plan year.

Important Requirement All Groups Need To Understand: You must send creditable coverage notices to your retirees even if you do not apply for the retiree drug subsidy option. However, an actuarial attestation is not mandated for this situation.

All of the elements in the answer to this question are covered in greater detail in later sections of this kit.

When is the due date for the drug subsidy application?

The drug subsidy application process begins August 1, 2005 and ends on September 30, 2005.

There is an option available to extend the due date by thirty days to October 30, 2005 and the Blues highly recommend that you file for this extension.
Retiree Drug Subsidy Support Kit

What else should employer groups know about the application?

The entire application process, including the extension request, is available online through CMS’s secure website.

Other sections of this kit will cover information on:

- How you should approach the decision to apply
- How to prepare for the application process
- A chart on how the Medicare Part D plan works
- What the Blues are going to do to support you
- A checklist and timeline
- Detailed steps on filling out the application
- How to access additional resources

Late Breaking News: 8/1/2005 CMS Announcements about Phasing the RDS Application Process

The CMS Retiree Drug Subsidy (RDS) Center's secure website is available as of August 1, 2005. Employers and unions sponsoring qualified retiree plans will use the secure website to electronically submit their applications for the 28% retiree drug subsidy that was established under the Medicare Modernization Act. The subsidy payments reimburse plan sponsors for drug coverage they provide to retirees in lieu of Medicare drug coverage, encouraging them to continue offering the high quality coverage they have offered in the past.

In order to manage workload and ensure the integrity of the secure website, the application process is being rolled out in three phases. In the first phase (beginning August 1), an Account Manager can request an individual Login ID and establish his/her first Plan Sponsor account. (The same Login ID will be used for other accounts.) It typically takes a couple of days to authenticate some of the information elements included in this request.

In the second phase (beginning August 8), emails will begin going to approved Account Managers notifying them that their Plan Sponsor accounts and Login IDs have been activated. They will then be able to begin establishing additional Plan Sponsor accounts (if applicable). Users will also be able to enter data for most parts of the application.

When the comment period on the program's System of Record Federal Register notice closes on August 15, the third phase will begin. Users can enter remaining data and retiree files and submit their final applications, and the RDS Center will begin processing and validating information.

Sponsors and others assisting with their applications are encouraged to get ready and submit applications as early as they are able. To view the latest information about the program, including relevant deadlines, please visit the RDS website at http://rds.cms.hhs.gov.
Web Links for Additional Fundamental Reference Information

Following is a list of Resources, (including web links), that you can use for additional information and support concerning the Retiree Drug Subsidy Option.

- **General MMA information:**

- **Retiree drug subsidy (RDS) overview:**

- **RDS Web site:**

- **Application help:**

- **RDS Help-line:**
  1-877-RDS-HELP
  TTY: 1-877-737-8890
  (live reps available 8 a.m.-6:30 p.m. EST, Monday-Friday; IVR available 24/7)

- **E-mail help:**
  [Feedback form](http://rds.cms.hhs.gov/how_to_apply/)

- **Frequently Asked Questions**

- **CMS’s Employer’s home page that includes the 5 easy steps**

- **CMS’s Creditable Coverage guidance and examples**
Section 2: What you need to know before you begin

*There is key information still to be published by CMS*

Please refer to the RDS website daily because there are many details still to be announced by CMS. ([www.rds.cms.hhs.gov](http://www.rds.cms.hhs.gov))

As of July 30th, CMS’s final application for applying for the drug subsidy was not viewable by the Blues. So there may need to be some addendums made to this kit once the final information is finally published.

*Is the subsidy the right option for my employer or union group?*

The Retiree Drug Subsidy is not appropriate for every group and it may not be appropriate for yours.

There are other options available to you that range from purchasing a Medicare Advantage product with Drug Coverage to dropping coverage all together. You can discuss these other options with your sales/marketing contact at the Blues.

Before you make the commitment to apply for the Retiree Drug Subsidy, you will need to consider whether the costs involved make good fiscal sense for you and whether you have the human resources to keep up with the federal government’s administrative requirements.

You can use the web links in Appendix C to get a sense of the administrative activities that must be completed. You can also refer to 42 CFR §423.884 of the Medicare Modernization Act.

*What should you do in preparation for the subsidy application process?*

There are a number of decisions to be made and a number of actions for you to take before you can begin the subsidy application process. These are presented in chronological order below. When appropriate, some additional background information is also provided.

**Authorized Representative and Account Manager Decisions**

There are three key drug subsidy roles that you will need to fill. These roles are described below and are **NOT** roles that anyone from the Blues may assume for you.

*Authorized Representative* – Business Owner/Officer of Trustee and employee of the group/plan sponsor. This is the person that is ultimately responsible for all application(s) information. They must sign and submit the finalized application to CMS. They are required to agree and authorize compliance with RDS program requirements. The Authorized Representative will choose the Account Manager.

*Account Manager* - This person has the same authority as the authorized representative but does not sign or officially submit of the application. The authorized representative will work with an account manager to whom he or she will delegate all management tasks in preparing the application and managing the account once it’s approved. They must be an employee or agent of the group/plan sponsor.
Attesting Actuary - The actuary must be a member of the American Academy of Actuaries (AAA). They will sign the attestation of the plan’s actuarial equivalence to Part D. If you wish to proceed with making an application for the subsidy option, you must hire an actuary who is familiar with the RDS standard and can perform the necessary actuarial work to determine whether your benefit plan qualifies.

As your very first steps, you will need to decide who your Authorized Representative will be and who your Account Manager will be.

Once identified, the Account Manager can begin the actual process of completing the application by visiting the RDS Web site at http://rds.cms.hhs.gov.

Potential Actuaries Decision

Next you will need to develop a short list of potential actuaries that you can engage to perform the gross value and net value actuarial equivalency tests and make creditable coverage determinations for your drug coverage benefit options.

To develop this list, if you use a benefit consultant, you may want to discuss ideas with that firm first. You could also consider talking about this with the firm that certifies your pension/benefit statements.

Important Note: If you are not applying for the subsidy, you are not required by CMS to use an actuary for your creditable coverage determinations.

Following is a list of available actuaries, arranged in alphabetical order, that have expressed an interest in providing actuarial support for the Medicare Retiree Drug Subsidy. This should not be viewed as an all inclusive list.

- Hewitt Associates
  Rebecca Feldman (248-740-8900)

- Mercer Human Resource Consulting
  Michael Vaught (313-877-7332)

- Milliman, Inc.
  Jack Burke (610-975-8093) or Alan Huddy (248-936-7605)

- Part D Advisors
  John Eggertson (734-794-7100) or Bruce Liebowitz (248-933-5735)

- Reden and Anders
  Stephen Wood (312-429-3906)

- Towers Perrin
  Bob O’Keefe (248-208-1160)

- Watson Wyatt Worldwide
  John Thompson (610-975-8981)

In addition, there may be other firms to consider listed at CMS’s website: www.cms.hhs.gov/pdps/lntrstd3rdPrtlyInfo.asp
Actuarial Equivalency, Actuarial Attestations, and Attestation Data Decisions

To meet the actuarial equivalency tests, your actuary must be able to attest that “your coverage is as generous as, or more generous than, the defined standard coverage under the new Medicare [Part D] prescription drug benefit.”

The diagram that follows is a simple model that is intended to illustrate the type of coverage included in a typical Medicare Part D Prescription Drug Plan. Your coverage must be actuarially equivalent to this. Your actuary have much more information to share with you and help you understand what this means.

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After you have selected an actuary, you will need to immediately work with that individual to define the number of drug subsidy applications that will be needed.

In some cases, all benefit options can be considered as part of a single plan and in other cases, benefit options must be considered as unique plans. (For example, benefit options that have different plan years or different formularies must be separate plans and will require separate applications.)

Once you and your actuary determine how many plans and benefit options will need to be filed and how to cluster them, you may need data to perform the actuarial attestations. Also, your actuary will need to advise you if he or she has the necessary data needed.

Certain larger groups are required to use their own specific data for the attestations. In this case, you will need to request actuarial attestation data from all insurance carriers that provide retiree drug coverage to you based upon the criteria defined by your chosen actuary.

As a heads up, you should have your attorneys on alert to be ready to quickly review and approve new data privacy and data sharing agreements with your carriers as CMS regulations require such agreements to be in place BEFORE data can be provided by carriers to groups. The Blues will require
you to sign a new written agreement before we can provide you with this data. Remember, you are probably going to need actuarial attestation data as early in August as possible.

**Eligible Beneficiary and Related Data Decisions**

You need to evaluate the completeness and the quality of the data that you have for your eligible beneficiaries. (You will need full names, dates of birth, gender, relationship to the insured information, and social security numbers or HIC numbers for your Medicare beneficiaries, spouses and dependents.)

You will need to decide which method you will use to submit your eligible members to CMS as part of the application and whether you will use a third party to submit your eligible beneficiary data to CMS.

These decisions also pertain on an on-going basis after your application is approved. There are three ways you can submit your retiree list to CMS. You must identify one of these methods as part of the initial application process.

- HTTPS over the secure RDS Website – no setup necessary and CMS will provide a link from the secure RDS Website to use when exchanging files
- Connect Direct – uses AT&T Global Network Services; with an existing AGNS account, setup and testing can be completed in 5 to10 business days; without one, from 30 to 45 days
- VDSA (Voluntary Data Sharing Agreements) – With an existing agreement, no setup time; without one, 60 to 90 days. For more information on VDSA, click: [http://www.cms.hhs.gov/medicare/cob](http://www.cms.hhs.gov/medicare/cob)

Most likely, you will need to use the web based alternative unless you or a vendor you choose are ready to set up for one of the other two approaches. This is because of the amount of lead time required to get the other options set up for your use may extend beyond your application deadline. You can switch to using the other methods for your ongoing eligibility update submissions once you have bet set up to use them.

**Banking Decisions**

You will also need to decide which bank account you will use for receiving your subsidy payments from CMS and you will need to supply the transit number as part of the application process.

This is because all payments will be made by Electronic Funds Transfer (EFT). Paper checks will not be issued.

**Periodic Claim Submission Decisions**

You will need to decide whether you will have your insurance carriers submit periodic claims submissions directly to CMS or whether you plan to receive your data from your carriers and then submit it to CMS yourself or use another third party to do this.

- Consistent with current underwriting policies, the Blues will not provide this data directly to small groups and to certain other fully insured groups. In these cases, we will require that you designate us to submit the periodic and reconciliation claim experience incurred with us directly to CMS. CMS will notify you after they receive this data and you will then need to carefully verify.
review and approve it. Your sales/marketing contact at the Blues can clarify whether you can receive group specific data from us.

Clarification Letter about Part D Enrollment

You should consider sending a letter to all existing retirees advising them that they do not need to sign up for individual drug coverage. This assumes that your coverage is equal to or better than Medicare Part D coverage.

You Are Now Ready To Begin the Application Process

After completing all of the items above, you will be prepared to begin the subsidy application process.

For reference purposes, you can view a sample of the application pages via the following link. http://rds.cms.hhs.gov/events/screens.pdf?cache=n
Section 3: How the Blues Can Support You

Introduction

CMS views the agreement for the Drug Subsidy option to be one that is made between you (the employer or union group) and CMS. As of July 27, 2005, many of the CMS requirements and processes for the Drug Subsidy option have not been defined in detail. This includes some uncertainty about what the Blues will be permitted to do to support you for the Drug Subsidy Program.

However, the Blues do intend to support you wherever permissible and wherever practical throughout both the application phase and the on-going activities phase of the drug subsidy program.

Just like you, the Blues must comply with all of the requirements and processes specified by CMS. In addition, the Blues must also comply with other federal and state regulations, as well as our internal policies.

Listed below is the support the Blues intend to offer subject to any changes mandated by CMS’s final regulations and guidelines with appropriate modifications made as a result of other federal and state regulations or our internal policies. Much of this support is accomplished via this kit.

As the final CMS regulations and guidelines are finalized, the Blues will advise you of any changes to the support activities we can offer you.

Initial Application Process Support

During the initial application process, the Blues intend you to support as indicated below.

Support for Basic application completion

1. Copies of CMS and other reference information via this kit and the web links provided
2. Samples of the application and web screens
3. Line by line application instructions
4. Information that identifies the decisions you will need to make and some suggestions to guide you in making these decisions

Support for actuarial attestations & creditable coverage determinations

1. Copies of CMS and other reference information via this kit and the web links provided
2. Identification of decision points that will be needed
3. Identification of actuarial resources you can consider
4. A new data sharing agreement has been developed to protect your interests and that of the Blues for those select groups that are informed by their actuaries that they must use their own claims
experience for actuarial attestations. (This is typically applicable to very large groups and to large self insured groups.)

A. After this new data sharing agreement is signed by the select groups, the Blues will be able to extract and provide group specific data for these select groups.

1.) A standard format, which has been developed based upon input of major actuarial firms, will be used for this data.

2.) Should you require a customized format, you will need to contact your Blues sales/marketing contact and make a special request. **Please note that depending on the complexity, you may be required to pay additional fees to receive a customized format and that customization extends the completion date for production of you data.**

5. A new data sharing agreement has also been developed to protect your interests and that of the Blues for those select groups that are informed by their actuaries that they must use Normative claims experience from the Blues for actuarial attestations. (This should rarely, if ever happen because most actuaries will have access to other Normative data bases that can be used.)

A. After this new data sharing agreement is signed by the select groups, the Blues will be able to extract and provide Normative data for these select groups.

1.) A standard format, which has been developed based upon input of major actuarial firms, will be used for this data.

2.) Should you require a customized format, you will need to contact your Blues sales/marketing contact and make a special request. **Please note that depending on the complexity, you may be required to pay substantial additional fees to receive a customized format and that customization extends the completion date for the production of your data.**

**Support for developing your initial list of expected eligible beneficiaries**

1. Copies of CMS and other reference information via this kit and the web links provided

2. You can contact your marketing/sales contact at the Blues and request support in compiling your likely Medicare beneficiaries. However, we expect these requests to be extremely rare because you should be the authoritative source for information about your Medicare eligible beneficiaries.

3. Upon receiving this request, the Blues will extract this data and transform it into the format required by CMS and then forward it to you.

   A. The data provided to you will be limited to the data we have on hand and this data may not be complete in many cases and will need to be carefully verified by you for accuracy.

   B. If you will want to have this data sent to a third party, you will need to contact your marketing/sales contact and make a special request. These special requests will be evaluated on a case by case basis.
C. If you require a customized format, please note that you may be required to pay an additional fee and that customization extends the completion date for the production of your data.

D. As the process is currently defined by CMS, the Blues will not be able to submit your data directly to CMS on your behalf.

E. Very important note: You will be required to provide the Blues with a copy of your CMS approved eligible beneficiaries that are covered by the Blues. This must include effective dates and termination dates for each beneficiary. If you do not do so on a timely basis, the Blues will not be able to compile the claims data that you will need to receive and reconcile your drug subsidy payments from CMS.

Support for your retiree creditable coverage notification efforts:

1. Copies of CMS and other reference information via this kit and the web links provided

2. Copies of plan summaries and/or Your Benefit Guides for your Blues coverage

3. Sample creditable coverage materials, including CMS model letters (via web links in this kit)

**On-Going Drug Subsidy Option Support**

After your application for the Drug Subsidy option has been approved by CMS, the Blues intend to support you in each of the following areas.

Support for making on-going eligible retiree data submissions to CMS:

1. Copies of CMS and other reference information via this kit and the web links provided

2. You can contact your marketing/sales contact at the Blues and request support in compiling changes to your Medicare beneficiaries. However, as stated for the initial listing, we expect these requests to be extremely rare because you should be the authoritative source for information about your Medicare eligible beneficiaries.

3. Upon receiving this request, the Blues will extract this data and transform it into the format required by CMS and then forward it to you.

   A. The data provided to you will be limited to the data we have on hand and this data may not be complete in many cases and will need to be carefully verified by you for accuracy.

   B. If you will want to have this data sent to a third party, you will need to contact your marketing/sales contact and make a special request. These special cases will be evaluated on a case by case basis.

   C. If you require a customized format, please note that you may be required to pay an additional fee and that customization extends the completion date for the production of your data.
D. As the process is currently defined by CMS, the Blues will not be able to submit your data directly to CMS on your behalf.

E. Very important note: You will be required to provide the Blues with a copy of your CMS approved eligible beneficiaries that are covered by the Blues. This must include effective dates and termination dates for each beneficiary. If you do not do so on a timely basis, the Blues will not be able to compile the claims data that you will need to receive and reconcile your drug subsidy payments from CMS.

Support for periodic aggregate claim data submissions

1. Copies of CMS and other reference information via this kit and the web links provided

2. A new data sharing agreement has been developed to protect your interests and that of the Blues in this area. There are CMS regulations that we must both comply with that will be addressed via this agreement.

3. After this new data sharing agreement is signed by you:
   A. The Blues will be able to extract and transform your aggregate claims data into the format required by CMS.

      Very Important Note: If you have coverage with the Blues for Master Medical with integrated drug coverage, we do not have the ability to provide you with the claims data needed for the drug subsidy. You can discuss other options with your sales/marketing contact at the Blues.

      1.) For fully insured groups and groups that the Blues do not currently share group specific data with, the Blues must submit aggregate claims experience directly to CMS. (Your sales/marketing contact at the Blues will be able to advise you if you fall into this category.) Since the CMS process for this activity has not been fully defined yet, this area of support will have to be defined more fully in the future.

      2.) For other groups, the Blues will be able to submit your aggregate claims data directly to you or directly to CMS. Once again, since the CMS process for this activity has not been fully defined yet, this area of support will have to be defined more fully in the future.

   B. If you will want to have your aggregate claims experience data sent to a third party, you will need to contact your marketing/sales contact and make a special request. These special cases will be evaluated on a case by case basis.

   C. Aggregate claim data will be compiled and transformed into the required CMS format on an interim annual basis for no additional charge.

      1.) Should you desire to have your data compiled and transformed on a more frequent basis, please contact your Blues sales/marketing contact and make a special request. Please note that groups under 100 will be required to pay an additional fee for these more frequent requests and that customization extends the completion date for the production of your data. For other groups, there may be an additional fee.
Support for your annual reconciliations

1. Copies of CMS and other reference information via this kit and the web links provided

2. This process has very little documentation available from CMS. Until this documentation is finalized, the Blues support is this area is difficult to specify.

3. The Blues do intend to extract the required data, transform it into the CMS required format, and submit the data directly to CMS on your behalf, but we can not offer more details at this time.

Support for Audits from CMS you receive:

1. When appropriate, the Blues will extract the data required, transform it into the required CMS format, and submit it to you for use in closing out your audits.

2. This process has very little documentation available from CMS. Until this documentation is finalized, the Blues support is this area is difficult to specify.
## Section 4: Key Step Checklist for the Retiree Drug Subsidy

### Activities to Complete Prior to Beginning the Drug Subsidy Application

(Underlined Red font indicates situations where information must be shared with the Blues)

<table>
<thead>
<tr>
<th>√</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑</td>
<td>1. Validate that you have enough eligible members to make the drug subsidy option economically feasible for your group. $1330 is the maximum subsidy amount per eligible beneficiary.</td>
</tr>
<tr>
<td>☑</td>
<td>2. Determine who the Authorized Representative will be for your Group</td>
</tr>
<tr>
<td>☑</td>
<td>3. Determine who the Account Manager will be for your Group</td>
</tr>
<tr>
<td>☑</td>
<td>4. Develop short list of potential actuaries for doing your actuarial attestations. Discuss this with your benefit consultant, the firm that certifies your pension / benefit statements, your business peers, or use the list provided by the Blues.</td>
</tr>
<tr>
<td>☑</td>
<td>5. Decide who your Attesting Actuary will be for your Group</td>
</tr>
<tr>
<td>☑</td>
<td>6. Work with your Attesting Actuary to define the number of drug subsidy applications that you will be filing. (i.e. how many plans you have and which benefit options you offer are clustered under each of your plans)</td>
</tr>
<tr>
<td>☑</td>
<td>7. Once your Attesting Actuary determines how many plans you have and which benefit options are clustered under each plan, get guidance from your actuary if you will need to secure claims experience from the Blues (&amp; your other carriers) to conduct the actuarial equivalency tests.</td>
</tr>
<tr>
<td>☑</td>
<td>8. Use the Normative data your actuary has access to. Or if necessary, request actuarial attestation data from the Blues and any other carriers that you use</td>
</tr>
<tr>
<td>☑</td>
<td>9. Have your attorneys available to review and approve the data sharing agreements that the Blues and other carriers will require you to sign in order to receive attestation data.</td>
</tr>
<tr>
<td>☑</td>
<td>10. When applicable, after submitting your written data sharing agreement to the Blues, receive your actuarial attestation data and forward this data to your actuaries.</td>
</tr>
<tr>
<td>☑</td>
<td>11. Analyze the completeness and the accuracy of the data you have for your expected Medicare eligible beneficiaries (full names, dates of birth, gender, relationship to the insured information, and social security numbers and/or HIC numbers for your beneficiaries, their spouses, and their dependents).</td>
</tr>
<tr>
<td>☑</td>
<td>12. Decide which of the three permissible methods you will use to electronically submit your expected eligible beneficiary information to CMS as part of the application process and advise the Blues (and your other carriers)</td>
</tr>
<tr>
<td>☑</td>
<td>13. Decide whether any third parties will be needed to aggregate and submit your expected eligible beneficiary information to CMS as part of the application process. If so, you must name them as designees in application Section 1.</td>
</tr>
<tr>
<td>☑</td>
<td>14. Decide which bank account you will use to receive your subsidy payments via EFT from CMS and secure the transit number for this account</td>
</tr>
<tr>
<td>☑</td>
<td>15. Determine whether you will be submitting your periodic aggregate claim data to CMS and receiving subsidy payments on an annual, quarterly, or monthly basis. Advise the Blues of your decision. Note: If you desire to submit your data monthly or quarterly, you will need to request this from your sales/marketing contact at the Blues. Groups under 100 will be required to pay a charge for data support for this option. Other groups may have to pay an additional charge.</td>
</tr>
</tbody>
</table>
## Activities to Complete As Part of the Drug Subsidy Application Process

(Underlined Red font indicates situations where information must be shared with the Blues)

<table>
<thead>
<tr>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>☑ 1. Advise your sales/marketing contact at the Blues and your other carriers that you intend to apply for the subsidy</td>
</tr>
<tr>
<td>☑ 2. On August 1st, have your Account Manager log onto the RDS website at rds.cms.hhs.gov and begin the application process by submitting the name of your organization to CMS, getting an application number from CMS for each of your plans, submitting his or her name as the Account Manager, and submitting the name of the Authorized representative for your group.</td>
</tr>
<tr>
<td>☑ 3. Have your account manager provide required personal data to CMS via the secure RDS website so this individual can be reviewed and approved by CMS</td>
</tr>
<tr>
<td>☑ 4. Have your authorized representative provide required personal data to CMS via the secure RDS website so this individual can be reviewed and approved by CMS</td>
</tr>
<tr>
<td>☑ 5. When your Account Manager and your Authorized Representative are approved by CMS, have your Account Manager log into the secure RDS web site and request a 30 day extension to the application completion date. (extends the completion date from September 30th to October 30th.) Advise your sales/marketing contact at the Blues that you have done this.</td>
</tr>
<tr>
<td>☑ 6. Complete Part 1 of the application - General Contact Information</td>
</tr>
<tr>
<td>☑ 7. Advise the Blues and other carriers in advance and get their approval for Designee Roles you wish to assign. The desired support may not be permissible as a result of CMS regulations &amp; guidelines, as well as other federal and state regulations and corporate policies.</td>
</tr>
<tr>
<td>☑ 8. Complete Part 2 of the application - Qualified Basic Plan Information</td>
</tr>
<tr>
<td>☑ 9. Complete Part 3 of the application - Attestation of Actuarial Equivalence</td>
</tr>
<tr>
<td>☑ 10. Complete Part 4 of the application - Electronic Fund Transfer Information</td>
</tr>
<tr>
<td>☑ 11. Complete Part 5 of the application - Payment Frequency</td>
</tr>
<tr>
<td>☑ 12. Complete Part 6 of the application - Retiree List Submission</td>
</tr>
<tr>
<td>☑ 13. Complete Part 7 of the application - Plan Sponsor Agreement &amp; Electronic Signature</td>
</tr>
<tr>
<td>☑ 14. Advise the Blues (&amp; other carriers) that your subsidy application has been approved</td>
</tr>
<tr>
<td>☑ 15. Receive the expected eligible response file from CMS</td>
</tr>
<tr>
<td>☑ 16. Share a copy of the response file for beneficiaries covered by the Blues with us so we can use this data to capture the aggregate claims experience and the reconciliation data needed for you to receive your subsidy payments.</td>
</tr>
<tr>
<td>☑ 17. Make corrections to the eligible member records rejected by CMS</td>
</tr>
<tr>
<td>☑ 18. Submit member change transactions to the Blues (and your other carriers) for corrections that need to be made</td>
</tr>
<tr>
<td>☑ 19. Submit an update file that contains corrections to CMS</td>
</tr>
<tr>
<td>☑ 20. Share a copy of the response file for the corrected beneficiaries covered by the Blues with the Blues so we can use this data to capture the aggregate claims experience &amp; the reconciliation data needed for you to receive your subsidy payments.</td>
</tr>
<tr>
<td>☑ 21. Advise the Blues (and your other carriers) of which aggregate claims submission periodic reporting timeframe you will be using (annual, quarterly, or monthly). See page 16 regarding when extra fees apply.</td>
</tr>
<tr>
<td>☑ 22. If you are a fully insured group, advise the Blues (and your other carriers) if you prefer to use method 2 for calculating your periodic subsidy payment amounts. (premium based)</td>
</tr>
</tbody>
</table>
Activities to Complete After Submitting the Drug Subsidy Application

(Underlined Red font indicates situations where information must be shared with the Blues)

<table>
<thead>
<tr>
<th>✓</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>1. Finalize the language and the approach you will use to provide Creditable Coverage notifications to your Medicare Eligible beneficiaries by 11/15/2005</td>
</tr>
<tr>
<td>□</td>
<td>2. Send your Creditable Coverage notifications to your Medicare Eligible beneficiaries by 11/15/2005</td>
</tr>
<tr>
<td>□</td>
<td>3. Ensure your Medicare Eligible Member updates get submitted on a monthly basis to CMS</td>
</tr>
<tr>
<td>□</td>
<td>4. Receive the response file from CMS that identifies which member updates have been rejected</td>
</tr>
<tr>
<td>□</td>
<td>5. Share the approved monthly member update response file with the Blues (and your other carriers)</td>
</tr>
<tr>
<td>□</td>
<td>6. Send membership corrections to the Blues (and your other carriers)</td>
</tr>
<tr>
<td>□</td>
<td>7. Submit membership corrections to CMS</td>
</tr>
<tr>
<td>□</td>
<td>8. Share the response file for the membership corrections with the Blues</td>
</tr>
<tr>
<td>□</td>
<td>9. Review your periodic aggregate claims data provided by your carriers</td>
</tr>
<tr>
<td>□</td>
<td>10. Make corrections to your periodic aggregate claims data and submit this data to CMS.</td>
</tr>
<tr>
<td>□</td>
<td>11. Advise the Blues (and your other carriers) of any changes you make to the periodic claims data submission</td>
</tr>
<tr>
<td>□</td>
<td>12. Determine the date that will be 90 days prior to the beginning of your next plan year. You must re-submit an application for the drug subsidy option each year by 90 days prior to the beginning of your next plan year. You can request a 30 day extension to this due date.</td>
</tr>
<tr>
<td>□</td>
<td>13. Advise the Blues (and your other carriers) that you intend to re-apply for the subsidy.</td>
</tr>
<tr>
<td>□</td>
<td>14. Review and approve your reconciliation data by 15 months after the completion of your plan year</td>
</tr>
<tr>
<td>□</td>
<td>15. Advise the Blues (and your other carriers) of any changes you make to the periodic claims data submission</td>
</tr>
</tbody>
</table>
### Section 5: A schedule of important dates

#### Key 2005 Dates

<table>
<thead>
<tr>
<th>Dates</th>
<th>Event or Deliverable Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>8/1</td>
<td>1. Drug Subsidy on-line application available for plan sponsors (employer and union groups) at <a href="http://www.rds.cms.hhs.gov">www.rds.cms.hhs.gov</a></td>
</tr>
<tr>
<td>By 9/30</td>
<td>2. Deadline for plan sponsors to apply for the retiree drug subsidy or to apply for a 30-day extension.</td>
</tr>
<tr>
<td></td>
<td>3. Key components of the application include:</td>
</tr>
<tr>
<td></td>
<td>▪ Appropriate electronic signatures for actuarial attestations that the retiree plan meets actuarial equivalence standards.</td>
</tr>
<tr>
<td></td>
<td>▪ An electronic submission of the list of expected eligible beneficiaries.</td>
</tr>
<tr>
<td></td>
<td>▪ Certification that the sponsor will disclose the creditable coverage status of its benefit options to its Medicare eligible members by 11/15/05.</td>
</tr>
<tr>
<td></td>
<td>▪ An electronic signature by the Authorized Representative of the plan sponsor agreeing to the provisions of the Plan Sponsor Agreement</td>
</tr>
<tr>
<td>By 10/21</td>
<td>4. The subsidy applications for plan sponsors not requesting a 30 day extension will be approved or rejected by CMS.</td>
</tr>
<tr>
<td>By 10/30</td>
<td>5. Deadline to apply for the retiree drug subsidy for those plan sponsors that requested a 30-day extension.</td>
</tr>
<tr>
<td>By 11/15</td>
<td>6. Plan sponsor must have determined the creditable coverage status of their existing benefit options and all plan sponsors, including those not applying for the subsidy, must provide notice to their Medicare eligible members of their creditable coverage status.</td>
</tr>
</tbody>
</table>

#### Key 2006 Dates

<table>
<thead>
<tr>
<th>Dates</th>
<th>Event or Deliverable Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>Starting 1/1 (After the group’s subsidy application has been approved)</td>
<td>1. Eligible member updates submitted to CMS monthly (quarterly submission with monthly detail allowed with VDSA)</td>
</tr>
<tr>
<td></td>
<td>2. Aggregate drug claim cost data submitted to CMS (annual / quarterly / monthly options)</td>
</tr>
<tr>
<td></td>
<td>3. Subsidy payments made to groups via EFT after receipt of aggregate data</td>
</tr>
<tr>
<td></td>
<td>4. Submit year end reconciliations within 15 months after the end of the plan year</td>
</tr>
<tr>
<td></td>
<td>5. Maintain detailed records for audits for ten years</td>
</tr>
<tr>
<td>90 Days Prior to the New Plan Year</td>
<td>6. Sponsors must re-submit an application for the Drug Subsidy</td>
</tr>
</tbody>
</table>
Section 6: How does the appeal process work

You can appeal a number of items under the Retiree Drug Subsidy program, including:

- The amount of your subsidy payment
- The determination of actuarial equivalence
- Disputes over qualifying covered retirees
- Other determinations as they're made by CMS

There are three levels of appeal available to you:

- An informal written consideration
- An informal hearing
- A review by a CMS administrator

Informal written consideration

You must file for informal written consideration within 15 calendar days of the initial determination. Your filing should include the issues in dispute, the reasons you disagree and any supporting evidence you might have to back your claim. A record is established at this level of appeal and unless you request a hearing, CMS’ decision is final.

Informal hearing

This level is available to you following a reconsideration determination. You must file within 15 calendar days of the initial determination and include the issues in dispute and the reasons for your disagreement. No additional evidence is allowed at this level. The hearing will be conducted by a CMS hearing officer and his or her decision is final unless you request an administrator review.

The hearing may be conducted in person or by telephone and a record will be kept. At this level, no oral argument or other testimony are allowed. You will receive notification of the hearing date at least 10 days before the hearing. You must select this option at the time of filing.

CMS administrator review

This level is available following a decision by a CMS hearing officer. Again, you must file your request for an administrator review within 15 days of receiving your notice of the hearing decision. Your request should include the issues in dispute and your reasons for disagreement. No additional evidence is allowed. The decisions made at this level are final and binding.

Re-openings

After all of your appeal rights have been exhausted, you can request a re-examination of whether a determination, a decision, or a cost report otherwise final have been correctly made. RDS maintains sole discretion over whether it will re-open the issue and a decision not to re-open is considered final and binding.

You can request a reopening within one year of the determination for any reason, within four years for “good cause” and at any time when you believe a determination has been obtained through fraud. “Good cause” is defined as “new and material evidence unavailable at the time of the initial determination, a clerical error in computation of payments or evidence considered in making the determination that was clearly erroneous on its face.” If your only reason for requesting a reopening is a change in legal interpretation or administrative ruling upon which the initial determination was made, that would be considered “not good cause.”

Submitting an appeal

Your authorized representative or account manager must sign on to the RDS Web site and go to the plan sponsor Application Summary page. He or she selects “appeal” from the drop-down list of actions for your application. The form is then completed and sent and any supporting documentation sent by FAX or U.S. mail.
Section 7: How to navigate the drug subsidy application process

Introduction

The purpose of this section is to guide you through the application completion process.

The Drug Subsidy Application is comprised of the following seven sections:

- **PART I.** General Contact Information
- **PART II.** Qualified Basic Plan Information
- **PART III.** Attestation of Actuarial Equivalence
- **PART IV.** Electronic Funds Transfer (EFT) Information
- **PART V.** Payment Frequency
- **PART VI.** Retiree List Submission
- **PART VII.** Plan Sponsor Agreement and Electronic Signature

Important Notes:

Any fields in the application that are not marked “optional” must be filled out or your application will be rejected.

As of July 31, 2005, the Blues had access only to the draft screen shots for the RDS On-Line Application. We have used some of these screen shots in this section, to give you a sense of their look and feel. It is not important for you to be able to see the details of these screens.

**PART I. General contact information**

This section of the application contains the information that will specifically identify your company or union group in the review and approval process. Your Application Number should already be filled in when you access your application.

In Part I.A., some basic information about the organization must be provided:

- Sponsor’s Name
- Employer identification number
- Corporate phone number
- Corporate business address
- Corporate mailing address
- Corporate website address (optional)

Note: Using Blue Cross terms, a Plan Sponsor is an Employer or Labor Group. (i.e., it is the entity that sponsors a health plan. This entity can be an employer, a union, or some other group or organization.)
In Parts I.B. and I.C., the individuals who will hold the roles of Authorized Representative and Account Manager will be identified and their contact information must be supplied. The definitions for these roles are found in Section 2.

The Account Manager will be the person who designates the Authorized Manager and the Account Manager roles. CMS will validate each of these individuals by verifying that they are an appropriate person and that they are not on the debarment list.

For each of these roles, you will declare whether the individual is authorized to view HIPAA PHI or not.

Here is an example of what the first screen in the drug subsidy application may look like.

In Part I.D.:

This section is used to name designees who will have specific roles in completing the application.

In each case, the name and contact information for the designee must be provided.

In addition, the Account Manager must identify several things:

- Identify if the designee can edit and/or submit the following:
  - General Contact information (Part I of the application)
  - Qualified Basic Plan information (Part II of the application)
  - Electronic Funds Transfer Information (Part IV of the application)
  - Payment frequency Information (Part V of the application)
  - Retiree List Submission (Part VI of the application)
Identify whether the designee has the authority to:

- change and/or submit payment requests
- Request an extension for application submission
- Request an appeal

Note: The role of the Benefit Option Administrator, which is what Blue Cross would be, was to be finalized and defined when the final application was delivered by CMS. As of July 27th, this information is not available. When it does become available, we will update this kit as soon as possible.
PART II. **Qualified Basic Plan information**

If your organization has more than one prescription drug program and you are applying for the subsidy for more than one plan, you must fill out a separate application for each plan.

- **The following information about the Plan must be provided:**
  - Sponsor’s name for the plan
  - The start date and end date of the plan year
  - Whether or not the plan combines more than one benefit option for the net actuarial equivalence test

- **Information must also be provided about each benefit option provided under this plan:**
  - Benefit option name (This is a unique identifier defined by you.)
  - Rx group number (This is generally the Rx group number found on member’s ID cards)
  - Option type (self funded, fully insured or both)
  - Contact name for this benefit option, including information about the contact
  - Name of the attesting actuary, their Academy identification number and their contact information

- **If applicable, separate contact information for the actuary attesting to the Net Value of Combined Benefit Options**

Here is an example of the first of several screens that will be completed
Part III. Attestation of actuarial equivalence

In this section, the actuary, selected by your organizations and named as a designee by your account manager, will provide an attestation of the results of his or her evaluation of the benefit option(s) for which you’ve chosen to make an application.

To complete the attestation, the actuary will be required to provide electronic signatures in this section of the application. The actuary, who must be a credentialed member of the American Academy of Actuaries, will certify that the methods used are consistent with the requirements of the law and that he or she will make the relevant records available to CMS.

If you do not know how to contact an actuary with this particular area of expertise, a list of actuaries who have declared themselves as qualified to do the work can be found in Section 1: Foundation Information about the Retiree Drug Subsidy Option

If your benefit plan has multiple benefit options, the regulations require that the actuarial gross value test be applied separately for each benefit option. For reference purposes, the regulation defines a “benefit option” as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan.

Following is an example of one of the several screens that relate to assigning actuaries and actuarial attestations.
PART IV. Electronic funds transfer (EFT) information

In this section of the application, you will also be asked to designate the individual who will serve as the prime contact for any Electronic Funds Transfer issues. In doing this, consider who has direct experience with your organization’s funds and how they are disbursed into your accounts. Remember that all subsidy funds must be submitted through EFT.

If the person with expertise in this area is different from the account manager or authorized representative you’ve made responsible for completing the application, you will need to add that person’s name to the list of Application Designees called for in Part I.

You will also need to supply information about the Bank that you want to have your subsidy payments deposited into via EFT.

This is an example of the EFT screen.
Part V. Payment Frequency

You are allowed to choose how often you would like to receive your subsidy payments. Remember, though, that, once chosen, your frequency cannot be changed mid-year. The Blues recommend that you select the interim annual submission option. If you prefer to choose another option, please advise your sales/marketing contact at the Blues. For groups under 100, there will be an additional charge associated with this. For other groups, there may be a charge.

Here is a sample of what the Payment Frequency screen may look like.
Part VI. Retiree list submission

Your initial submission should include all retirees being claimed under the subsidy. Your application and retiree list must be submitted by Sept. 30, 2005. (October 30th if you have requested a 30 day extension.) For subsequent plan years, you must submit your application and retiree list at least 90 days before the start of the plan year.

There are three ways you can submit your retiree list to CMS. You will select one in the application process:

- **HTTPS over the secure RDS Website** – no setup necessary and CMS will provide a link from the secure RDS Website to use when exchanging files

- **Connect Direct** – uses AT&T Global Network Services; with an existing AGNS account, setup and testing can be completed in 5 to 10 business days; without one, from 30 to 45 days

- **VDSA (Voluntary Data Sharing Agreements)** – With an existing agreement, no setup time; without one, 60 to 90 days. For more information on VDSA, click: [http://www.cms.hhs.gov/medicare/cob](http://www.cms.hhs.gov/medicare/cob)

Following is an example of the Retiree List Submission screen.
These are the data elements you’ll need in order to submit your retiree list:

1.) Plan sponsor ID.
2.) Application ID.
3.) SSN or HICN.
4.) Full name (Middle initial optional).
5.) Date of birth.
6.) Gender.
7.) Coverage effective date.
8.) Coverage termination date.
9.) Rx group number.
10.) Relationship to member (Self, spouse or dependent), and
11.) Action type of record (Add, update or delete).

The Blues can help you with your retiree list.

If requested, the Blues can extract data on your enrollees and put this data into the format required by CMS.

The data we can provide is limited to the data we have on hand, which may or may not be entirely accurate. For example, in some cases, we do not have complete information for spouses and dependents. We may also have data limitations for subscribers. You should carefully verify any enrollment data that is provided to you by the Blues.

A listing of how the Blues plan to help can be found in Section 2: What you should know before you begin ...

A more thorough explanation of the technical aspects of the list and how CMS will verify eligible retirees is at http://rds.cms.hhs.gov/how_to_apply/RetireeListsFromPlanSponsors.pdf
PART VII. Plan sponsor agreement and electronic signatures

In this section, your authorized representative will apply an electronic signature that attests that the information in the application is true and accurate. Note that the authorized representative is the only person who can sign the application. These screens are mock-ups from that portion of the application:
Section 8: Frequently Asked Questions

Q1: **Will the Blues charge for any of the support services associated with the drug subsidy option?**

**Answer:** For plan years ending in 2006, there will be no additional charges from the Blues for the support services that are associated with the Drug Subsidy option if you will:

- Agree to the terms and sign the new data sharing agreement
- Accept the standard format that the Blues are using for extracting and formatting actuarial attestation data, expected eligible beneficiary data, monthly updates to eligible beneficiaries, periodic aggregate claims submission data, and annual reconciliation data
- Select the interim annual payment frequency and periodic aggregate claims submission option when you file your application with CMS.

You will need to advise your sales/marketing contact at the Blues if you will need customized formats for your data and/or if you intend to select a monthly or quarterly payment frequency option. Depending on the complexity, there may be additional charges required and customization will extend the completion date for the production of your data. For groups under 100, there will be an additional fee charged for monthly or quarterly claims submissions. For other groups, there may be a charge.

Q2: **What about other costs I may incur?**

For example, CMS fees or fees from other parties that will be associated with the Retiree Drug Subsidy?

**Answer:** This is more difficult to answer because we will not be involved.

So far, CMS has said that they will not charge any fees for the Retiree Drug Subsidy Option.

You should expect to pay a fee to the actuary who performs your actuarial attestations and/or creditable coverage determinations and you may incur additional fees from your benefit consultant.

You may incur charges from your other insurance carriers.

You will incur costs for producing and distributing creditable coverage notices to your Medicare beneficiaries.
Q3:  *I need actuarial attestation data. What do I do?*

**Answer:** Your first step will be to advise your sales/marketing contact at the Blues. She or he will need to talk to you and complete a form to document your request.

Also, she or he will need to send you an electronic copy of a new data sharing agreement. We must receive back a copy of this agreement that is signed by your Authorized Representative before we can provide you with the attestation data.

For plan years ending in 2006, there will be no charge to you for this support if you will agree to use the standard formats and output media planned by the Blues. There may be a charge if you need to customize either of these and customization will extend the completion date for the production of your data.

Q4:  *I need a listing of my Medicare eligible beneficiaries from the Blues. What do I need to do?*

**Answer:** We believe that this should be an extremely rare occurrence. This is because we believe that your records are the authoritative source of information about your Medicare eligible beneficiaries.

In the extremely rare cases, your first step will be to advise your sales/marketing contact at the Blues. She or he will need to talk to you and complete a form to document your request.

The Blues will extract data from our membership data bases and transform it into the CMS format. Then this information will be forwarded to you either on a CD or in a standard electronic format.

There are important factors to be aware of:

- For plan years ending in 2006, there will be no charge to you for this support if you will agree to use the standard formats and output media planned by the Blues. There may be a charge if you need to customize either of these and customization will extend the completion date for the production of your data.

- The completeness and accuracy of the data the Blues can supply to you is based upon what you have previously submitted to the Blues and what the Blues have in their databases. In some cases, data is not stored or completely accurate for subscribers, their spouses, and their dependents. Thus, you need to carefully check the data that we provide for accuracy and completeness.

Q5:  *Why do I need to sign a new data sharing agreement with the Blues?*

**Answer:** A new data sharing agreement has been developed to protect your interests and that of the Blues in this area. CMS regulations provide that a data sharing agreement must be in place before carriers can provide the data necessary to apply for and perfect a drug subsidy claim. Please refer to 42 C.F.R. 423.884.
Q6: Where can I get a copy of the new data sharing agreement? And, who do I send it to when it is signed?

Answer: Before the end of the first week of August, your sales/marketing contact at the Blues will have access to this document and can forward an electronic copy to you upon receiving your request for a copy.

Once the Authorized Representative of your organization signs it, you should immediately forward a copy to your sales/marketing contact at the Blues.

Q7: Who should be my Authorized Representative and my Account Manager?

Answer: We can provide some general information on this. First, they need to be two separate people and these are not roles that the Blues can play.

Typically an Authorized Representative is the business owner or an officer or trustee of the organization. In many cases, an accounting or finance leader or a corporate compliance leader would assume this role.

The Account Manager is an employee or an agent of the organization. In many cases, a Human Resources leader would assume this role.

Before making your final decisions, we recommend that you refer to the other sections of this kit and also review the authoritative source of information, the RDS web site. (www.rds.cms.hhs.gov)

Q8: I need to find someone to perform my actuarial attestations. What should I do?

Answer: The attesting actuary must be a member of the American Academy of Actuaries.

The Blues recommend that if you have a benefit consultant, you discuss your options with them first. You could also discuss your options with the firm that certifies your pension/benefit statements.

You can consider the actuaries who have contacted the Blues about being interested in supporting you. These actuaries and their contact information can be found on page 9 of this kit.

In addition, there may be other firms to consider listed at CMS’s website: www.cms.hhs.gov/pdps/Intrstd3rdPrtyInfo.asp
Q9: What data will the Blues submit to CMS on my behalf and can I name the Blues as a designee?

**Answer:** The Blues prefer for you to submit your initial expected Medicare beneficiary listing and the monthly updates to the listing directly to CMS. We will require you to forward the appropriate approved and rejected beneficiaries to us every time you receive a response file from CMS so that we will be able to correctly compile your claims experience.

There is much more to be published by CMS regarding the periodic aggregate claims submissions, the annual reconciliation submissions, and the role of the Benefit Option Administrator.

Once this information becomes available, the Blues will be able to give you a more definitive answer for these areas. However, we do expect to have the capability to extract and submit your periodic claims experience and your reconciliation data directly to CMS*. Also, if you are a self insured or large fully insured group, we expect to have the capability to send this data to you directly if you wish to send it to CMS yourself.

* As mentioned earlier in the kit, If you have coverage with the Blues for Master Medical with integrated drug coverage, we do not have the ability to provide you with the claims data needed for the drug subsidy. You can discuss other options with your sales/marketing contact at the Blues.

Q10: Who do I contact for any other questions that I have about the Retiree Drug Subsidy Option?

**Answer:** First and foremost CMS if the authoritative source of facts and information about the Retiree Drug Subsidy Option. They have a website that can be referenced for all of your questions. Just recently, a list of FAQ’s has been added to the web site.

Should you have a Blues specific question, you should direct your questions to your normal sales/marketing contact at the Blues. She or he will coordinate the efforts to get you answers.
Appendix Section
Appendix A: CMS Guidance on the Actuarial Equivalence Standard

Introduction
Subpart R of the Title I Medicare Modernization Act (MMA) Final Rule, published in the January 28, 2005 Federal Register, implements §1860D-22 of the Social Security Act, which authorizes subsidy payments to the sponsor of a qualified retiree prescription drug plan. Among the qualification requirements is that a qualified actuary submit an attestation to CMS that the plan’s actuarial value is at least equal to the actuarial value of defined standard prescription drug coverage under Part D of Medicare. The final rule defines the actuarial equivalence standard, requires that an attestation be based on generally accepted actuarial principles, and states some specific rules on how to apply the attestation in various situations. This guidance is intended to further clarify several issues relating to the methodology for actuarial equivalence attestations and to make it less burdensome for actuaries to complete the actuarial attestation.

Of all the options available for employers and unions under the MMA, the retiree drug subsidy provides the most continuity for existing retiree prescription drug plans. It is the least burdensome option to administer and provides the most design flexibility as long as the sponsor’s plan is at least actuarially equivalent to the defined standard prescription drug benefit under Part D. See the Retiree Drug Subsidy: Why Employers and Union Plan Sponsors Should Consider It, April 6, 2005, paper outlining the 5 easy steps to apply for the retiree drug subsidy.

Background
The standard for actuarial equivalence in Subpart R is a two-prong test in which the sponsor’s retiree prescription drug program must provide coverage to its Medicare beneficiaries the value of which is at least equal to the value of the coverage the same beneficiaries would receive under the defined standard prescription drug coverage. The first prong is the “gross value” test in which the expected amount of paid claims for Medicare beneficiaries under the sponsor’s plan must be at least equal to the expected amount of paid claims for the same beneficiaries under the defined standard prescription drug coverage, including catastrophic coverage available when an individual’s out-of-pocket expenses exceed a specified threshold ($3,600 in 2006). See 42 CFR §423.884(d)(1)(i).

The second prong is the “net value” test in which the net value of the sponsor’s plan must be at least equal to the net value of the defined standard prescription drug coverage. See §423.884(d)(1)(ii). The net value of the sponsor’s plan is calculated by subtracting the retiree premium/contribution from the gross value of the sponsor’s plan. See §423.884(d)(5)(ii)(B)(1). The net value of defined standard prescription drug coverage under Part D is calculated by subtracting the prescribed national beneficiary premium from the gross value of the defined standard prescription drug coverage.

For those sponsors that plan to supplement the coverage provided under Part D for their retirees that choose Part D, an additional adjustment to the net value of Part D is permitted that accounts for the impact that the sponsor’s supplemental coverage will have on the value of defined standard prescription drug coverage under Part D. See §423.884(d)(5)(ii)(B)(2). By delaying the point at which the individual receives catastrophic coverage under Part D, the supplemental coverage will lower the value of defined...
standard prescription drug coverage to their plan participants. This anticipated reduction in the value of the defined standard prescription drug coverage under Medicare Part D plan to the plan’s retirees resulting from supplemental plan will be referred to in this guidance as the “Medicare Supplemental Adjustment” value.

Clarifications to the Regulation Premiums
Pursuant to §423.884(d)(5)(iii)(B)(1), in calculating the net value of the defined standard prescription drug coverage under Part D for purposes of the second prong of the actuarial equivalence test, the beneficiary premium is subtracted from the gross value of Part D. This guidance clarifies that the national average beneficiary premium can be used to determine the beneficiary premium for this purpose. One should use the national average beneficiary premium for the same year from which the Part D coverage limits are being utilized for the test. Alternatively, the beneficiary premium can be determined by multiplying the gross value of Part D by 25.5%. In either case, there is no requirement to account for beneficiaries in the plan who may be eligible for reduced premiums (or enhanced benefits) through the low-income subsidy provisions of Subpart P of the final rule (§423.771 et. seq.).

Calculating the Value of Drug Coverage under the Sponsor’s Plan
In calculating the gross value of the sponsor’s plan under §423.884(d)(1)(i), this guidance clarifies that only prescription drugs that are Part D drugs as defined in §423.882 can be considered; however, the drugs do not necessarily have to be in any Part D plan’s formulary to be included in the calculation. Generally, Part D drugs are prescription drugs that are not covered by Part A or Part B of Medicare and may not be excluded from coverage under §1860D-2(e)(2)(A) of the Social Security Act. See the discussion of the definition of “Gross covered retiree plan-related prescription drug costs” in the Subpart R preamble to the final rule at 70 FR 4403 and a discussion paper titled “Medicare Part B Versus Part D Coverage Issues” which can be found at http://www.cms.hhs.gov/pdps/PARTB-Ddocument.pdf. Conversely, in calculating the value of defined standard prescription drug coverage under Part D, all Part D drugs are considered, including those that the sponsor’s plan does not cover.

Eligibility for Medicare Supplemental Adjustment
In §423.884(d)(5)(iii)(B)(2), for purposes of the net value prong of the actuarial equivalence test, the value of the defined standard prescription drug coverage under Part D can be adjusted to reflect the impact of a sponsor’s plan supplementing Part D for those beneficiaries in the sponsor’s plan who enroll in Part D. This guidance clarifies that the adjustment can only be made by those sponsors who actually supplement the Part D coverage of the Medicare-eligible beneficiaries in their plan who enroll in Part D. A sponsor has flexibility in providing such supplemental coverage. For example, it can design its retiree drug plan to be secondary to any Part D plan selected by a retiree, or it can designate specific Part D arrangements under which the supplemental coverage is provided (including through customized Part D arrangements providing enhanced coverage pursuant to a waiver for the sponsor’s retiree coverage).

The attestation must take into account any restrictions in beneficiary accessibility to the supplemental coverage by prorating for the share of retirees who have access to the supplemental coverage in determining the impact on the Medicare Supplemental Adjustment value. The final rule does not require that sponsors supplement Part D coverage for their retirees who enroll in a Part D plan. However, they cannot take into account the Medicare Supplemental Adjustment value pursuant to §423.884(d)(5)(iii)(B)(2) if they do not supplement Part D for a retiree who enrolls in Part D.
Sponsors interested in the Medicare Supplemental Adjustment but concerned about the ability to coordinate their benefits with Part D coverage should be aware that CMS is facilitating the establishment of a coordination of benefits system that will provide, by January 1, 2006, real time, point-of-sale coordination between Medicare Part D and supplemental plans such as employer and union-sponsored plans. Such a system should provide for cost-effective coordination between Medicare and retiree health plans, including those in which a sponsor is providing the coverage to qualify for the Medicare Supplemental Adjustment.

**Benefit Options within a Plan**
A benefit option is defined in §423.882 of the final rule as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan. The final rule in §423.884(d)(5)(iv) provides sponsors with plans with multiple benefit options the flexibility to submit the actuarial equivalence attestation either for each benefit option separately or in the aggregate for options that meet the “gross value” test. That is, each benefit option must separately pass the gross test, but the plan can pass the net test by testing benefit options on an aggregated or separate basis.

This guidance clarifies that the sponsor’s attestation can combine either all of the benefit options that meet the gross value test or one or more subsets of those options for purposes of applying the “net value” test and submitting the actuarial attestation. The sponsor (working with its actuary) determines the number of options to be combined for this purpose. If the sponsor combines two or more benefit options, the sponsor may not claim the subsidy for those benefit options excluded from the net value calculation, even if those options meet the gross test.

In applying the gross value and net value test to each benefit option separately (or in the aggregate to a subset of the options), it will be within the discretion of the attesting actuary, in accordance with actuarial standards, to determine the applicability of plan experience across benefit options. For example, an actuary may determine that aggregate plan experience is not applicable to each benefit option even if these benefit options are being aggregated for testing purposes and instead may apply the plan experience unique to each benefit option. Conversely, an actuary may decide to apply the aggregate plan experience to each individual benefit option if the experience segregated by individual benefit option is non-existent or is an unreliable indication of costs.

**Integrated Health and Drug Situations**
In the final rule it is indicated that sponsors of plans that charge a single, integrated premium or contribution to their retirees for both medical and drug coverage have the complete discretion and flexibility to allocate any portion of the premium to the drug coverage for the purpose of the net value test of actuarial attestation. See §423.884(d)(5)(ii)(B).

This guidance addresses plans that have integrated cost sharing for medical and prescription benefits. Integrated cost-sharing is based on plan experience (unlike premiums, which is a factor of plan design). Accordingly, for benefit plans where the plan design covers both prescription drugs and other medical costs (for example, integrated out-of-pocket limits, integrated deductibles, integrated plan maximums, etc.), an actuary must be able to reasonably estimate and allocate the cost-sharing provisions and cost of benefits for prescription drugs. This allocation can be based upon either actual plan cost experience or on future cost projections. Once this allocation is made, then the value allocated to the drug coverage must pass the gross value test of the actuarial attestation.
Sample Calculation and Simplified Computations for the Actuarial Equivalence Test

Sample Calculation
To assist actuaries in determining the Medicare Supplemental Adjustment, the appendix to this guidance includes a sample calculation showing the steps for the actuarial equivalence test using the “Medicare Supplemental Adjustment.” The sample calculation for actuarial equivalence testing utilizes standard actuarial techniques for calculating values of deductibles and coinsurance on a probability distribution, which was previously released by CMS. For plans with co-pay cost-sharing structures, similar techniques would need to be utilized.

Simplified Calculations
For those plans that pass the two-prong actuarial equivalence test without the Medicare Supplemental Adjustment, there is no requirement to calculate the adjustment for the “net value” test. Furthermore, if the attesting actuary, in his/her professional judgment, is certain that the sponsor’s plan is at least actuarially equivalent to Part D without performing the calculation of either the “gross value” test or the “net value” test, then it is within the actuary’s professional discretion as to whether the calculations need to be made to support the attestation. For example, if a retiree drug plan that covers both brand and generic drugs, has a $100 deductible, pays 80% of the cost of drugs with the beneficiary paying the remaining 20% as coinsurance, and the sponsor pays 90% of the premium, this plan would clearly be actuarially equivalent to the defined standard prescription drug benefit under Part D and there would be no need to do the specific calculations.

Normative Data Sets
Certain retiree prescription drug plans may not have sufficiently reliable plan data to use to determine whether the plan’s coverage is at least actuarially equivalent to the defined standard prescription drug coverage under Part D. It will be within the discretion of the attesting actuary, in accordance with actuarial standards, whether a plan has sufficiently reliable data for the computation. The attesting actuary may find that utilizing an appropriate normative data set is appropriate as indicated in §423.884(d)(5)(ii)(A) and (d)(5)(iii)(A) of the final rule. Possible normative data sets are:
1. The accepted normative data set tools of the industry provided that the data reflect the demographics and other risk characteristics of the group and are appropriately segregated; or
2. The vendor “block of business” data set.

The calculation of actuarial equivalence should rely on plan experience to the extent that the experience is reasonable and credible. If reasonable and credible experience is not available, the calculations should reflect reasonable actuarial methods that take into account the demographics and other risk characteristics of the group.

Footnote:
A sample of the calculation method is supplied by CMS and is very detailed. Here is the link for that sample calculation mentioned in the previous paragraph.

http://www.cms.hhs.gov/medicarereform/pdbma/employer.asp

After accessing this website, the sample calculation is filed under “Actuarial Equivalence Guidance and Worksheet”. This a large file that has been Zipped, which is why we have not included it in this Kit.
Appendix B: How do I handle creditable coverage notification?

Under the Medicare Modernization Act, a plan sponsor that offers prescription drug coverage must notify all Medicare Part D-eligible individuals with prescription drug coverage under the plan whether their coverage is creditable. The notice must be sent regardless of whether you apply for the subsidy or not. Nor does it matter if your coverage is primary or secondary to Medicare.

“Creditable coverage” means that the plan sponsor’s coverage is “as generous as, or more generous than, defined standard coverage under the new Medicare [Part D] prescription drug benefit.”

This is very important. So let’s say it again, whether you apply for the subsidy or not, if you have Medicare eligible employees, you are required to determine whether your plan’s coverage is creditable”. You must also notify all your Medicare eligible employees (active and retiree) of the result by supplying them with a Notice of Creditable Coverage or Non-creditable Coverage each year. The first such notice must be sent to members by November 15, 2005.

If you offer your own Medicare Part D prescription drug plan or an enhanced Medicare Part D prescription drug plan, you do not need to send a Notice of Creditable Coverage to your members. By your participation in the Part D program you automatically have equivalent and creditable coverage.

Here are the five steps you’ll need to take in order to manage the creditable coverage process:

1. Determine your creditable coverage status

You can determine whether or not your coverage is “creditable” by using either of two methods. You may use the first prong or “gross test,” of the actuarial equivalence attestation. Or, you may use the Simplified Determination test process outlined later in this section. Your actuary can help you understand how the test is applied, but generally it measures whether the expected amount of paid claims under your prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit. The gross test doesn’t take into account who pays for the coverage.

If your plans have multiple benefit options, the regulation requires that the value test be applied separately for each benefit option. The regulation defines a “benefit option” as a particular benefit design, category of benefits, or cost-sharing arrangement offered within a group health plan.

Simplified determination

To help you determine your plan’s status, CMS has provided a simplified creditable coverage determination test for plans not seeking the federal subsidy.

Under this test, the plan design must meet all four of the following standards.

1) It provides coverage for brand and generic prescriptions
2) It provides reasonable access to retail providers and, optionally, for mail-order coverage
3) It’s designed to pay on average at least 60 percent of a participant’s prescription drug expenses.
4) It satisfies at least one of the following:
   (a) The prescription drug coverage has no annual benefit maximum or has 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 per Medicare-eligible individual in 2006.

(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 has 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.

The standards listed under 4(a) and 4(b) may not be used if your plan has prescription drug benefits that are integrated with benefits other than prescription drug coverage (i.e., medical, dental, etc.). Integrated plans must satisfy the standard in 4(c).

2. Identify your Medicare-eligibles

As a plan sponsor, you are required to send the Notice of Creditable Coverage to all Medicare Part D-eligible members, regardless of whether they are active or retiree or whether they are the member or a spouse. The only exception is for those sponsors offering an enhanced or employer PDP (Part D plan).

3. Determine the message you want to send

In deciding what message to send to your Medicare-eligible members, you can choose to use a sample notice prepared by CMS (you’ll find web links to copies in Appendix C) or you can develop your own letter as long as you include the CMS content standards.

4. Determine how you will send your notices

The Notice of Creditable Coverage does not have to be sent as a separate mailing. Here are some of your options:

<table>
<thead>
<tr>
<th>Options</th>
<th>Requirements</th>
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<tbody>
<tr>
<td>Include it with other plan participant information materials, such as enrollment materials, plan change letters</td>
<td>Disclosure must be prominently referenced in at least a 14-point font in a separate box, bolded, or a reference to the section where the notice is located offset on the first page of the plan participant’s information package. <strong>Example:</strong> “If you have Medicare or will become eligible for Medicare in the next 12 months, a new Federal law gives you more choices about your prescription drug coverage, starting in 2006. See page xx for details.”</td>
</tr>
<tr>
<td>Send as a stand-alone mailing</td>
<td>Use CMS standard letter format</td>
</tr>
<tr>
<td>E-mail</td>
<td>• A valid e-mail address and beneficiary consent must be provided to plan sponsor.</td>
</tr>
<tr>
<td></td>
<td>• Before consent, a beneficiary must be informed of the right to withdraw consent, how to update their address, and software requirements.</td>
</tr>
<tr>
<td></td>
<td>• The beneficiary must indicate they have adequate access to e-mail.</td>
</tr>
<tr>
<td></td>
<td>• The notice must be posted on the entity’s website.</td>
</tr>
<tr>
<td></td>
<td>• Beneficiaries must be informed of their right to obtain a paper version.</td>
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NOTE: A separate disclosure notice is required if you know that any Medicare-eligible spouse or dependent resides at a different address than where the participant or policyholder materials were mailed.

Plan sponsors may provide a single disclosure notice to the covered Medicare individual and all Medicare Part D-eligible dependents covered under the same plan. Whenever possible, you should combine your notices into any mailings that will reach your members before the PDP marketing period (Oct. 1, 2005) or at the beginning of PDP enrollment season (Nov. 15, 2005). This will save time and resources needed to identify specific Medicare-eligible individuals, as well as ensure that everyone receives the notice, including spouses or dependents, ESRD, and disabled, Medicare-eligible members. It will also allow you to reach members before they begin to receive other materials from PDPs and CMS. You should also keep on file a record of all creditable coverage mailings you sent to members. This will be useful for any audit requests you might receive and if members request additional copies of the notice.

5. Determine when you will send your notices

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

1) Before* November 15 each year
2) Before an individual's Initial Enrollment Period (IEP) for Part D (as they age in)
3) Before the effective date of coverage for any Medicare-eligible individual that joins the plan
4) Whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable
5) Upon a beneficiary’s request

* In other words, within the last 12 months.

If the creditable coverage disclosure notice is provided to all plan participants, items 1 and 2 are met. A Notice of Creditable Coverage should be sent with plan enrollment materials, prior to October 1, when the PDP and MA-PD sponsors can begin marketing. For off-calendar year plans that have already sent enrollment materials, you should send a as a stand-alone before October 1. Placement in welcome kits is not recommended, as the mail date runs beyond the November 15 deadline.

In order to avoid ongoing mailings to members as they become eligible, it's a good idea to send the Notice of Creditable Coverage to those who will become eligible in the next 12 months along with those who are currently eligible.
Appendix C: Web Links to More CMS Reference Information

By clicking on the links below, you will go to the RDS website and be able to access more detailed reference information on each of the topics identified.

Should you encounter difficulties accessing this information, please contact your sales/marketing contact at the Blues and he or she will be able to send you individual electronic documents for each item that you are interested in receiving.

Appendix C1: Draft Subsidy Application with instructions
http://rds.cms.hhs.gov/ForCommentby070305.pdf

Appendix C2: Transcript from the June 15, 2005 RDS Teleconference about the Drug Subsidy option
http://rds.cms.hhs.gov/events/TeleconferenceTranscript.pdf

Appendix C3: Presentation Material for Day 1 of the RDS Conference for Employers on the Subsidy Option

Appendix C4: Presentation Material for Day 2 of the RDS Conference for Employers on the Subsidy Option
http://rds.cms.hhs.gov/events/national_conference_DayTwo.pdf?cache=n

Appendix C5: File Layouts for retiree list submissions

Appendix C6a and C6b: Sample Creditable Coverage Notices
http://www.cms.hhs.gov/medicarereform/CCguidances.asp