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Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

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SUBJECT: Chapter 9, "Employer/Union Sponsored Group Health Plans"

I. SUMMARY OF CHANGES: This manual chapter incorporates all employer/union sponsored group health plan guidance for Medicare Advantage Organizations. It includes policy guidance and clarifications made in Call Letters, HPMS memoranda, and other guidance documents.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: November 7, 2008
IMPLEMENTATION DATE: November 7, 2008

Disclaimer for manual changes only: Normally red italicized font identifies new material. However, since this release is a new chapter in this manual, normal black text font is used for this initial chapter release.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	9/10/Introducation
N	9/10.1/Application of CMS Employer Group Waiver Authority
N	9/10.2/Employer/Union Group Health Plan Sponsorship of Employer/Union-only Group Waiver Plans (EGWPs)
N	9/10.3/Employer/Union Group Health Plan Sponsorship of Individual MA Plans
N	9/10.3.1/Actuarial Equivalence of Part C Benefits
N	9/10.3.2/Actuarial Swapping of Part C Benefits Not Covered by Original Medicare
N	9/10.4/Identification of Employer/Union Sponsored Group Health Plan Enrollees
N	9/10.5/Private Reinsurance Arrangements with Employer/Union Group Health Plan Sponsors
N	9/10.6/Employer/Union-Only Group Waiver Plans and COBRA
N	9/10.7/EGWP Application Procedures
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III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

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***Unless otherwise specified, the effective date is the date of service.**

Medicare Managed Care Manual

Chapter 9 – Employer/Union Sponsored Group Health Plans

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(Rev.90, 11-07-08)

APPENDICES

Note: This manual currently reflects CY 2006 through 2009 guidance, and is subject to change for both periodic and annual updates.

10 – Introduction

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

10.1 – Application of CMS Employer Group Waiver Authority

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

CMS has statutory authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in, employer/union sponsored Medicare Advantage (MA) plans. This statutory authority, set forth in Section 1857(i) of the Social Security Act (the Act), provides:

> [Medicare Advantage] Program Compatibility with Employer or Union Group Health Plans. –
>
> (1) CONTRACTS WITH MA ORGANIZATIONS. – To facilitate the offering of [Medicare Advantage] plans under contracts between [Medicare Advantage] organizations and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such [Medicare Advantage] plans.
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> (2) EMPLOYER SPONSORED MA PLANS. -- To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans. Notwithstanding §1851(g), an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

Under this specific statutory authority, in order to facilitate the offering of MA plans to employer/union group health plan sponsors, CMS may grant waivers and/or modifications to MA Organizations (MAOs). When exercising its discretion to grant these waivers or modifications, each waiver or modification will be conditioned upon the MAO meeting a set of defined circumstances and complying with a set of conditions. MAOs offering employer group plans must comply with all MA and/or Part D requirements unless those requirements have been specifically waived or modified.

Waivers/modifications may be granted to MAOs offering "individual" MA plans or MAOs offering customized employer group MA plans offered exclusively to employer/union group health plan sponsors. Individual MA plans are open to both individual Medicare beneficiaries and employer/union sponsored group health plans' MA eligible beneficiaries. Customized employer group MA plans offered exclusively to employer/union group health plan sponsors include: (1) plans offered by MAOs to employers/unions (these plans are hereinafter referred to as "800 series" plans because their plan benefit packages are enumerated in the CMS Health Plan Management System (HPMS) with identifiers in the 800s to distinguish them from individual plans offered by MAOs); and (2) plans offered by employers/unions that directly contract with CMS (hereinafter referred to as "Direct Contract" plans). These "800 series" and Direct Contract MAOs are referred to collectively as employer/union-only group waiver plans ("EGWPs").

Note that CMS' employer group waiver authority only applies to the Part D portion of the coverage provided by Cost Plans, not Parts A and B. Thus, Cost Plans may only use the Part D waiver authority to offer Part D EGWPs as an optional supplemental benefit. Although the MA employer group waiver authority does not apply, a Cost Plan may negotiate with employer/union group health plan sponsors to offer extra benefits in addition to Medicare Part A and Part B benefits (including allowing the employer/union group to buy-down cost sharing for Medicare Part A and B benefits). These benefits are not supplemental benefits and are not subject to CMS review or approval. See §60 of Chapter 17 (Cost Based Payment), Subchapter F (Benefits and Beneficiary Protections) of this manual.

10.2 – Employer/Union Group Health Plan Sponsorship of Employer/Union-Only Group Waiver Plans (EGWPs)

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

As stated above, all EGWPs must restrict enrollment to employer/union group health plan Medicare eligible members and/or their Medicare eligible spouses and dependents (hereinafter referred to as "Medicare eligibles"). The final benefit packages of "800 series" EGWPs are typically developed through private contractual negotiations between the MAO and employer/union group health plan sponsors of employment-based coverage.

CMS has issued specific guidance waiving or modifying a number of Part C and Part D requirements that apply to these two kinds of MA plans which are detailed below. However, Direct Contract and "800 series" EGWPs must comply with all Part C and Part D requirements unless those requirements have been specifically waived or modified.

10.3 – Employer/Union Group Health Plan Sponsorship of Individual MA Plans

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

As stated above, in addition to EGWPs, employer/union group health plan sponsors may choose to enroll their Medicare eligibles in individual MA Plans. These MA Plans do not qualify for all of the employer/union group health plan waivers outlined below in this chapter. Those waivers that apply to employer/union group sponsorship of individual MA Plans will be specifically identified below in §20 (e.g., group enrollment/disenrollment process, special enrollment periods (SEPs), and the annual open enrollment period waiver). In addition to identifying these waivers/modifications, the modifications outlined in §§10.3.1 and 10.3.2 immediately below (actuarial equivalence and swapping) only apply to employer/union group sponsorship of individual MA Plans.

10.3.1 - Actuarial Equivalence of Part C Benefits

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

MAOs have the flexibility when negotiating with employers/unions to raise cost sharing (coinsurance, copayments and/or deductibles) for plan benefits by providing a higher benefit level and/or a modified premium compared to what is offered for non-employer/union group members. Following is an example of actuarially equivalent benefits:

> An MAO might offer a plan to individual beneficiaries with a $10 copayment for all physician office visits (primary care and specialist). The MAO might want to offer employers/unions an MA plan that includes a $5 copayment for primary care physician visits and a $20 copayment for specialist physician visits.

An MAO may take advantage of this flexibility by informing CMS of its intentions when it submits its bid proposals and providing supporting documentation for the MA plans it intends to offer to employer/union sponsors. In its supporting documentation to CMS, the MAO must identify the following:

- The cost sharing amounts the MAO intends to change and the MA plan containing the cost sharing;
- Any modification to the premium charged; and
- Any improvement in the benefit related to the changed cost sharing.

An MAO is permitted to modify the cost-sharing, benefit level and/or premium offered only to employers/unions from the levels of cost-sharing, benefits and premiums offered to individual enrollees as long as the minimum required Medicare coverage levels are met and as long as the modification does not have the effect of denying or discouraging

access to covered medically-necessary health care items and services. Unlike the actuarial swapping flexibility outlined below, this customization can apply to both Medicare-covered benefits and non-Medicare-covered benefits.

10.3.2 - Actuarial Swapping of Part C Benefits Not Covered By Original Medicare

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Medicare Advantage Organizations may swap different types of Part C supplemental benefits not covered under original Medicare that are of equal actuarial value for employer/union group plan sponsors. The swaps may be used if an employer/union prefers a different benefit package for its members than the MAO offers to individual beneficiaries under the MA plan. An example of actuarial swapping is:

> An employer may prefer a vision benefit as opposed to the dental benefit the MAO offers to individual beneficiaries. The MAO may design a vision benefit for the employer that has equal actuarial value to the dental benefit and swap these benefits in the plan it offers to the employer.

Prior to January 1, 2006, prescription drug benefits not included in Part A and Part B coverage were considered a Part C supplemental benefit not covered under original Medicare and could be swapped. Beginning in 2006, however, this exchange is not permitted as prescription drugs not covered under Parts A and B are considered Medicare covered benefits under Part D.

Medicare Advantage Organizations do not need to obtain specific advance approval from CMS in order to take advantage of actuarial swapping for particular employer/union group plan sponsors. Rather, when an MAO submits bids for the MA plans it intends to offer to individuals, the MAO must inform CMS at that time of its intention to make actuarial swaps. In its supporting documentation to CMS, the organization must identify the benefits that might be swapped during negotiations with employers/unions. After CMS gives the MAO its general approval for the possible swaps, the organization can make specific swaps in negotiations with employers/unions without obtaining further approval from CMS.

10.4 – Identification of Employer/Union Sponsored Group Health Plan Enrollees

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The EGHP (Employer Group Health Plan) Flag field must be set to “Y” when submitting enrollment transactions for any beneficiary who is a Medicare eligible member of an employer/union sponsored group health plan (this includes Direct Contract and “800 series” enrollments and employer/union group health plan sponsored enrollments in

individual MA Plans). This flag should be set to "Y" for all enrollment transaction codes (including 60, 61, 71 and 72 transactions). This designation is especially important when employer/union group health plan Medicare eligibles are enrolled in individual MA Plans to differentiate them from individual beneficiaries. For more details, see Medicare Advantage and Prescription Drug Plans - Plan Communications User's Guide and Appendices.

10.5 – Private Reinsurance Arrangements with Employer/Union Group Health Plan Sponsors

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Medicare Advantage Organizations must meet state licensure and financial solvency requirements under 42 CFR 422, Subpart I and, if applicable, 42 CFR 423, Subpart I. With regard to these requirements, all MAOs are permitted to obtain reinsurance or make other arrangements for the cost of coverage provided to any enrollee (including arrangements with employers/unions) to the extent that the MAO is at risk for providing the coverage. See 42 CFR 423.401(b). Similarly, Medicare requirements do not prohibit MAOs offering "800 series" or individual MA Plans to employer and union group health plan sponsors from entering into these kinds of reinsurance arrangements with self-insured (i.e., self-funded) employers/unions.[1] Notwithstanding these arrangements, the MAO retains the responsibility for meeting all Medicare requirements.

10.6 – Employer/Union-Only Group Waiver Plans and COBRA

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employer group health plans with at least 20 employees to offer continuation coverage to plan enrollees who experience a COBRA qualifying event such as termination of employment, death of the participant or a divorce. COBRA requirements apply to active employee plans and retiree plans. Employer/union sponsored group Medicare plans that meet the definition of "group health plan," as that term is defined at Section 5000(b)(1) of the Internal Revenue Code, may be subject to COBRA requirements.

The basic Part A and Part B benefits and any other benefits financed by Medicare through rebate dollars are not subject to COBRA continuation of coverage requirements. Employer/Union sponsors, however, may be required by COBRA to offer continuation of coverage for supplemental benefits that are financed outside of Medicare to beneficiaries enrolled in their plans that experience a COBRA qualifying event. For example, if an

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[1] Similarly, employer group plans may enter into administrative services only (ASO) arrangements with MAOs whereby the entity provides certain administrative services to a self-funded employer group plan, such as claims adjudication and enrollment services.

employer offered a vision benefit that was integrated into a customized EGWP (Direct Contract or "800 series" plan) but was solely paid for by employer premiums, the employer/union sponsor may be required to offer continuation of coverage only for the vision benefit when a beneficiary enrolled in the plan experiences a COBRA qualifying event.

However, there is nothing in either the Medicare law or the COBRA law that prohibits an employer/union sponsor from electing to provide continuation coverage for the entire employer sponsored group health plan (the Medicare benefits along with the non-Medicare supplemental benefits). In doing so, however, an employer/union sponsor must adhere to Medicare requirements. These include the following requirements:

(1) When an MAO offering an employer/union sponsored group plan receives notification that an individual is no longer eligible for the employer/union group sponsored plan because a COBRA qualifying event has occurred, it must follow the termination procedures documented in §50.7 of Chapter 2 of this manual (Medicare Advantage Enrollment and Disenrollment), which only allows prospective termination. Terminations can be effective only at the end of a calendar month; and

(2) Although COBRA permits a group health plan to charge up to 102% of the applicable premium for continuation of coverage, an employer/union sponsor that offers COBRA coverage can charge no more than 100% of the premium for the Medicare portion of the benefits offered (Medicare will continue to pay its portion of the cost). If an employer/union sponsor can segregate the premium for the non-Medicare supplemental benefits offered, it can charge up to 102% of the portion of the premium that is attributable to the non-Medicare supplemental benefits.

Since employer/union sponsors in some instances have up to 44 days after a qualifying event to provide a notice to an enrollee of a right to elect continuation of coverage, and an enrollee has up to 60 days after receiving the notice to elect continuation of coverage, an enrollee may make the election to continue this coverage after the effective date of termination. Under COBRA law, an enrollee who elects continuation of coverage is entitled to have coverage reinstated retroactively back to the date of the termination of coverage. For employer/union sponsors that wish to reinstate beneficiaries who elect continuation of coverage back to the effective date of termination, MA Organizations offering such plans should submit such reinstatements using Transaction Code 60 where possible and/or by submission to the CMS retroactive adjustment contractor when necessary.

10.7 – EGWP Application Procedures

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Entities that seek to offer an MA or MA-PD EGWP must enter into a contract with CMS. An applicant must meet certain requirements before CMS can consider entering into a contract with the entity. In addition, an applicant must have an acceptable bid before it may enter into a contract to offer an MA or MA-PD plan (for bidding instructions see §§20.10 and 20.11 below). Information on the application process can be found at http://www.cms.hhs.gov/EmpGrpWaivers/01_Overview.asp.

20 – Approved Employer/Union Sponsored Group Health Plan Waivers

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Set forth below is a list of waivers or modifications approved for MAOs offering employer/union sponsored group health plans. As noted above, as a condition of CMS granting the particular waiver or modification, MAOs must demonstrate that they meet the criteria established by CMS as outlined in the specific waiver. For each waiver, CMS has noted whether the waiver/modification applies to "800 Series" MA Plans, Direct Contract MA Plans, or employer/union sponsored group health plan enrollments in individual MA Plans. Each of these waivers/modifications will automatically apply to those MAOs approved to offer EGWPs or individual plans that satisfy the applicable criteria; thus, they do not need to be granted on an individual basis. However, some waivers may be restricted to particular kinds of entities and/or a particular set of circumstances as noted below.

In addition to the waivers that have been granted, MAOs have the ability to request additional waivers or modifications of Part D requirements on a case-by-case basis. If a waiver or modification is granted, it will apply to all similarly situated entities. Details on how to request additional waivers or modifications can be found in Appendix IV.

20.1 - Enrollment in Employer/Union Sponsored MA Plans

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

20.1.1 - Enrollment Eligibility

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

"Employment-Based" Group Health Plan Requirement

Employer/union group health plan enrollment in EGWPs and individual MA Plans is only available to beneficiaries who are Medicare eligibles of an employer/union sponsored group health plan. Thus, a beneficiary's enrollment in one of these MA Plans must be based on receiving "employment-based" health coverage from an employer/union group health plan sponsor that has entered into a contractual arrangement with a Medicare Advantage Organization to provide coverage or that has contracted directly with CMS to provide coverage for its Medicare eligibles.[2] Membership in a State Pharmaceutical Assistance Program (SPAP) would not make an individual eligible for enrollment into these types of plans. Similarly, coverage obtained through a professional or other type of group association would not make a beneficiary eligible for these kinds of plans, except to the extent that the coverage obtained through the association can properly be characterized as "employment-based" group health plan coverage.

Active Employees and Retirees Eligible for Enrollment

Under Section 1857(i) of the Social Security Act, MAOs may offer employer/union-only group plans to both retirees and current (i.e., active) employees of a particular employer/union group plan sponsor who are Medicare eligible. However, when enrolling active employees into these employer/union group sponsored MA plans, MAOs must comply with all applicable Medicare program requirements including the Medicare Secondary Payer (MSP) requirements. MAOs must ensure that employers do not enroll actives in an MA plan offered by the MAO in a manner contrary to MSP rules. See Section 80 of Chapter 4 of this manual. For active employees receiving benefits from a group health plan of an employer that employs at least 20 employees, the MSP rules establish that the non-Medicare group health plan is the primary payer and Medicare is the secondary payer. If the enrollee or enrollee's spouse is an active employee, the enrollee must be enrolled in the employer/union sponsored and/or contributed-to non-Medicare group health plan in order to also be enrolled in the employer/union sponsored MA plan. In other words, active employees cannot be enrolled in an employer/union sponsored MA plan unless they also retain their employer/union sponsored primary coverage. In these situations, Medicare payments to MAOs for these actives are adjusted accordingly to account for the presence of the primary group health plan payer. See §70.4 of Chapter 8 of this manual. More detailed information on MSP requirements is available at 42 CFR 411.100 and 42 CFR 422.108 or in the Medicare Secondary Payer Manual on the CMS website at: http://www.cms.hhs.gov/Manuals/IOM/list.asp.

Restricted Enrollment Requirement

In general, MAOs have to accept all Medicare-eligible beneficiaries who reside in their service area as set forth in 42 CFR 422.60(a). EGWPs are not subject to this requirement. Instead, under the CMS eligibility rules for these kinds of plans, EGWPs must restrict enrollment solely to those Medicare eligible individuals who are also eligible for the employer/union sponsor's employment-based health coverage. See

[2] *See* 42 CFR 422.106.

Section 1857(i) of the Act. Note that, aside from having Medicare eligibility, the employer/union sponsor's eligibility rules exclusively govern a beneficiary's enrollment entitlement in these plans. Under the employer/union sponsor's eligibility requirements, for example, Medicare eligible spouses and dependents of participants in the employer/union sponsor's plan may be permitted to enroll in these EGWPs based on the employer/union sponsor's eligibility rules regardless of whether or not the participant is Medicare eligible.

Employer/Union Group Health Plan Medicare Eligibles Must Permanently Reside In the Service Area of the MA Plan As Defined By the MAO Within HPMS

In addition to the above eligibility requirements, the eligibility requirements set forth in Chapter 2, Section 20 of this manual (Medicare Advantage Enrollment and Disenrollment) apply to all employer/union group health plan sponsored individual MA Plan and EGWP enrollments in the same manner applicable to individual enrollments in individual MA Plans. Therefore, in order for a beneficiary to be eligible to enroll in an employer-sponsored individual MA Plan or EGWP, he/she must permanently reside in the defined service area of the individual MA Plan or EGWP. See also §50.2 (Required Involuntary Disenrollment) of Chapter 2 of this manual.

Medicare Advantage Organizations offering EGWPs are eligible for extended geographic service areas for certain kinds of MA plans under service area waivers issued by CMS. See §20.2 of this chapter. Therefore, eligible MAOs offering EGWPs should ensure that their EGWP defined service area includes all geographic areas in which employer/union sponsored group health plan Medicare eligibles may permanently reside (e.g., national service area) during the contract year. No mid-year service area expansions will be permitted.

20.1.2 - Minimum Enrollment Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In general, MAOs must meet minimum enrollment standards as set forth in 42 CFR 422.514(a). These minimum enrollment requirements do not apply to EGWPs.

20.1.3 - Enrollment of End Stage Renal Disease (ESRD) Members

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

CMS has granted an additional waiver of 42 CFR 422.50(a)(2) to allow employer/union group members who have ESRD to enroll in employer/union sponsored MA plans, under certain circumstances. Specifically, CMS has granted a modification of the existing employer/union group waiver guidance contained in Section 20.2.3 of Chapter 2 of this

manual to allow employer/union group beneficiaries with ESRD who age into Medicare to be enrolled in MA plans sponsored by employers or unions regardless of prior commercial coverage affiliation. Note that, as with the employer/union group waiver issued in 2003, this waiver will apply to enrollment of employer/union sponsored group members in both "800 series" plans and in individual MA plans. The MAOs that choose to apply one of the ESRD enrollment waivers must agree to apply it consistently in accordance with the requirements contained in §20.2.3 of Chapter 2 of this manual (i.e., the MAO must consistently allow enrollment of employer/union group ESRD beneficiaries in all plan benefit packages offered by the MAO under a particular MA contract). See §20.2.3 of Chapter 2 (Enrollment and Disenrollment) of this manual for specifics on this waiver.

20.1.4 - Enrollment of Part B-Only Members

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Certain state and local employers do not deduct Federal Insurance Contributions Act (FICA) taxes. Therefore, their beneficiaries may not have earned entitlement to Part A of Medicare. Sometimes these employers would like to offer enrollment in a MA plan for their Part B-only beneficiaries. The MAOs can develop plans for Part B-only Medicare beneficiaries who are members of employer/union groups. In permitting such plans, CMS is waiving the existing regulations that prohibit individuals only eligible for Part B from enrolling in MA plans. See 42 CFR 422.50(a)(1). In order to enroll new Part B-only employer/union group members in a MA plan, the MAO must create a separate Part B-only employer/union-only "800 series" plan in accordance with CMS requirements. See Chapter 2 (Medicare Advantage Enrollment and Disenrollment) of this manual for more on enrollment of Part B-only individuals.

20.1.5 - Annual Open Enrollment Periods

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

CMS has waived the requirement to comply with the Medicare annual coordinated election period described in 42 CFR 422.62(a)(2) for employer/union group health plan sponsored enrollments in EGWPs or individual MA plans. Thus, employer/union group sponsored enrollments in EGWPs or individual MA plans may have different annual open enrollment periods. However, such plans must accept valid requests for disenrollment at any time.

20.1.6 – Group Enrollment/Disenrollment

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

All MAOs may group enroll/disenroll employer/union sponsored group health plan Medicare eligibles. This waiver applies to both EGWPs and individual MA plans offered to employer/union group health plan Medicare eligibles. The group enrollment/disenrollment procedures are outlined in §§20.4.3, 40.1.7 and 50.1.6 of Chapter 2 of this manual (Medicare Advantage Enrollment and Disenrollment).

20.1.7 – Special Election Periods (SEPs)

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Employer/union members enrolled in EGWPs and individual MA plans are eligible for special election periods (SEPs). These SEPs apply to employer-sponsored enrollments in an individual MA Plan or an EGWP. The employer/union sponsor's eligibility rules would determine when the SEP may be used. These SEPs also apply to beneficiaries disenrolling from an employer-sponsored EGWP or individual MA plan in order to enroll in an individual MA plan not sponsored by an employer/union. These SEP procedures are outlined in §30.4.4 of Chapter 2 of this manual (Medicare Advantage Enrollment and Disenrollment).

20.1.8 - Transaction Reply Code (TRC) 127 Procedures When Transitioning Employer/Union Group Health Plans from the Retiree Drug Subsidy (RDS) to Employer/Union Sponsored Individual MA Plans or EGWPs

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Section 40.2.5 of Chapter 2 of this manual (Medicare Advantage Enrollment and Disenrollment) requires a MAO to follow certain procedures when the entity receives a Transaction Reply Code (TRC) 127 after submitting an electronic enrollment transaction to CMS. TRC 127 indicates that the beneficiary is being claimed for the Retiree Drug Subsidy (RDS) by a particular employer/union during the same period of time identified in the Part D enrollment request. An employer/union group health plan sponsor cannot claim the RDS for a beneficiary simultaneously enrolled in Part D. In accordance with CMS instructions, before effectuating the enrollment request, a Part D Plan that receives TRC 127 is required to contact the beneficiary to prevent inadvertent Part D enrollments and potential loss of employer/union coverage caused by the required notification to the employer/union of the beneficiary's enrollment in Part D.

Where the MAO is working directly with an employer/union group health plan sponsor to enroll its Medicare eligibles into an individual MA plan or EGWP and receives TRC 127 for these Medicare eligibles, the notification procedures identified above are not needed

to protect these beneficiaries from possible loss of that employer/union group health plan coverage. Accordingly, the MAO in this situation is not required to provide each beneficiary with the notification letter or other contact specified in CMS enrollment guidance. The MAO can immediately resubmit the enrollment with the proper employer subsidy override flag. The MAOs should maintain records to support the use of this alternate process for these Medicare eligibles.

Note that, in some rare instances, the employer/union group health plan Medicare eligible may have other drug coverage through another employer/union group health plan sponsor receiving the RDS (i.e., as a spouse or dependent of a retired participant). In these instances, the employer/union group health plan Medicare eligible may potentially lose this other coverage upon enrollment in Part D. CMS strongly recommends that the MAO work closely with employer/union group health plan sponsors to communicate about this possibility, identify affected Medicare eligibles (if possible) prior to enrollment into Part D, and properly communicate with all Medicare eligibles about their opt-out rights in accordance with the CMS group enrollment notification procedures.

20.1.9 - Beneficiary Enrollment Notification Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In general, the notice requirements contained in Appendix 1 (Summary of Notice Requirements) of Chapter 2 of the Medicare Managed Care Manual apply to all employer/union group health plan sponsored enrollments in individual MA plans or EGWPs, with the following clarifications:

- Each of the model beneficiary notices which are applicable to employer/union sponsored group health plans can be customized to the extent the modifications will more clearly and accurately reflect the employer group plan being offered by each individual employer/union group health plan sponsor (in accordance with the waivers/modifications set forth in §20.3.2.1.1 of this chapter).

- The MAO retains the ultimate responsibility for the proper and timely disclosure of the notices. However, the MAO and the employer/union group health plan sponsor can enter into an agreement where the employer/union group health plan sponsor agrees to disseminate particular notices to its Medicare eligibles on behalf of the MAO.

Note that certain notices contained in Appendix 1 are not applicable to employer/union group health plan sponsored enrollments in individual MA plans or EGWPs, as identified below:

- Exhibit 27: MA Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in MA-PD Plan.

- Exhibit 27a: MA-PFFS Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP.

- Exhibit 28: MA Model Notice to Inform Member of Facilitated Enrollment into MA-PD Plan.

- Exhibit 28a: MA Model Notice to Inform Member of Facilitated Enrollment into PDP.

- Exhibit 29: Acknowledgement of Request to Opt-Out of Auto/Facilitated Enrollment.

20.1.10 – Permitting Employer/Union Sponsors to Enroll Beneficiaries in Both an "800 series" Local MA-Only Coordinated Care Plan and an "800 Series" Standalone PDP (Waiver Effective Beginning Contract Year 2009)

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Subject to certain exceptions, a Medicare eligible person who is enrolled in a Medicare Advantage (MA) plan may not be simultaneously enrolled in a standalone Prescription Drug Plan (PDP). See Section 1860D-1(a)(1)(B)(ii) of the Act, and 42 CFR 423.30(b). Beginning in 2009, CMS has granted a modification of a previously issued 2007 waiver policy which will permit all employer/union sponsors to enroll beneficiaries in both an EGWP (i.e., "800 series") local MA-Only plan and an "800 series" standalone PDP.

Beginning with the 2007 contract year, CMS granted a limited waiver for certain public employers to simultaneously enroll their Medicare eligibles in an "800 series" local coordinated care MA-Only plan and an "800 series" standalone PDP under certain limited circumstances. In order to be eligible for the waiver, the public employer was required to have a longstanding, pre-existing partnership with separate vendors. Also, the vendors were required to have been working closely with the employer to provide coordinated care and disease management services between the medical and prescription drug portions of the benefit similar to the kind of coordination that would be offered if the employer purchased the medical coverage and drug coverage from a single MA-PD vendor.

Beginning with the 2009 contract year, all employer/union group health plan sponsors will be allowed to enroll their Medicare eligibles in both an "800 series" local coordinated care MA-Only plan (i.e., HMO, HMO/POS, Local PPO) and an "800 series" standalone PDP. Like the previous waiver, as a condition of this expanded waiver, CMS will require the separate medical and prescription drug vendors to work closely together with the employer/union sponsor to provide coordinated care and disease management services between the MA and PD portions of the benefit. This coordination is similar to

the kind that would be offered if the employer/union purchased the medical coverage and the drug coverage from a single local MA-PD vendor.

20.1.11 - Medical Savings Account (MSA) Employer/Union Sponsored Group Health Plans

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

No Requirement to Offer Corresponding Individual Plans Beginning In 2007

In 2007, only MAOs offering demonstration "800 series" Medical Savings Accounts (MSAs) can offer "800 series" plans without offering corresponding individual demonstration MSA plans. Beginning in 2008, an MAO can offer "800 series" Regular or Demonstration MSA plans without offering corresponding individual plans (see §20.2.1.2 below).

Note that CMS has not issued any waivers permitting MAOs to offer non-calendar year MSA plan benefit packages. Therefore, MAOs may only offer calendar year "800 series" MSA plans.

Special Election Periods

Under Section 1851(e)(5) of the Social Security Act, an individual's election to enroll in an MSA plan is restricted to: (1) the beneficiary's initial open enrollment period; or (2) the annual, coordinated election period (November 15-December 31). See also §§30.7 and 50.8 of Chapter 2 of this manual. To facilitate the offering of employer/union sponsored group MSA plans, CMS has modified the enrollment rules for employer/union sponsored group enrollments in Regular and Demonstration MSA plans to allow a special election period (SEP) for these plans. Specifically, §30.4.4.1 of Chapter 2 of this manual now applies to employer/union sponsored group enrollments into "800 series" Regular and Demonstration MA MSA plans. This SEP also applies to employer/union sponsored group plan enrollments in individual MA MSA plans open to general enrollment. Like the employer group SEP for all other MA plans, this will allow a SEP for individuals making MA elections into or out of employer/union sponsored MA MSA plans.

Enrollment of Active Employees in Certain Circumstances

A Medicare beneficiary that is an active employee (i.e., working aged) enrolled in an employer/union sponsored group plan that covers any part of an MSA deductible (aside from the permitted preventive care and supplemental coverage) should not be permitted to enroll in an MSA plan. However, there will be instances when an employer/union sponsored group plan will not cover any part of the deductible of the MSA High Deductible Health Plan (HDHP). For example, an employer/union sponsor could offer a HDHP with a deductible that is the same or higher than the MSA deductible. In that scenario, since the employer/union sponsored group HDHP does not offer coverage in the

MSA deductible, the Medicare eligible active employees in the employer/union sponsored group plan should be permitted to enroll in an MSA plan. See §20.1.1 of this chapter for information on how the MSP rules may apply in this situation.

Flexibility to Vary Benefits Provided to Employer/Union Groups (Applies to EGWP MSA Demonstration Plans Only)

The MAOs can vary MSA Demonstration Plan offerings to employer/union groups within the same plan benefit package (PBP) provided the following conditions are met:

- The amount of the deposit into the beneficiary's MSA account cannot vary from the amount in the filed bid.

- The deductible for the MSA plan can be lowered from what is in the bid for an employer/union group either by having the employer/union paying a premium or by raising the cost-sharing amount above the deductible (or a combination of both). The "buy down" must be actuarially equivalent, however, to the additional benefit.

- The deductible for the MSA can be raised by lowering the cost-sharing above the deductible.

- The cost sharing above the deductible can vary by specific benefit provided it is actuarially equivalent to the cost sharing above the deductible in the filed bid.

- The benefit packages offered to individual employer/union groups must meet the minimum deductible, the minimum spread between the deposit and the deductible and the maximum out-of-pocket limit requirements, and must be at least actuarially equivalent to the benefit package in the filed bid.

20.2 – Service Areas

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

20.2.1 – "800 series" EGWP Service Areas

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

20.2.1.1 - Service Area Waiver for Local MA-Only and Local MA-PD Plans To Offer Coverage Up to State

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

If an MAO provides coverage to individuals in any part of a State, it can offer an EGWP in any area within that State or throughout the entire State (provided the EGWP service area is properly requested and defined in HPMS). For Part C benefits, the MAO is responsible for ensuring that CMS provider network adequacy requirements are met and that consistent benefits are provided to an employer/union group plan sponsor's enrollees. For Part D prescription drug benefits, the MAO must ensure that its all pharmacy access (retail, long term care, home infusion and I/T/U) is sufficient to meet the needs of its employer/union-only group population, including situations involving emergency access.

20.2.1.2 - Elimination of the "Nexus Test" for Non-Network PFFS and All MSA Plans (Regular and Demonstration) (Waiver Effective Beginning Contract Year 2008)

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As detailed below, beginning in 2008, MAOs offering certain kinds of MA plans are not required to offer MA plans to individual beneficiaries as a condition of offering corresponding "800 series" EGWPs.

For contract years 2006 and 2007, CMS employer/union group waiver policy required MAOs to offer MA plans to individual Medicare beneficiaries as a condition of being able to offer "800 series" plans associated with the same contract. Also, during 2006 and 2007, if individual coverage was offered in the service area where the most substantial portion of an employer's employees reside, non-network Private Fee-For-Service (PFFS) plans offered by MAOs were permitted to extend their "800 series" plan service area and enroll an employer/union sponsor's retirees that resided outside of the individual plan service area. (This service area extension policy is commonly known as the "nexus test.")

Beginning with the 2008 contract year, MAOs offering non-network PFFS plans are not required to offer these plans to individual beneficiaries as a condition of offering associated "800 series" plans. This change includes the elimination of the "nexus test." In addition, beginning with the 2008 contract year, MAOs offering Regular "800 series" Medical Savings Account (MSA) plans will be treated the same as MAOs offering "800 series" Demonstration MSA plans and therefore will also not be required to offer plans to individual beneficiaries as a condition of offering these kinds of "800 series" MSA plans. The changes described above will apply to entities renewing "800 series" plan benefit packages in 2008, as well as to entities offering "800 series" plans for the first time in 2008.

Notwithstanding these changes, entities offering these plans will continue to have to meet all CMS requirements that are not otherwise waived or modified, including the requirement to be licensed as a risk bearing entity eligible to offer health insurance or health benefits. For entities that choose to only offer "800 series" plans for a particular MA PFFS or MA MSA contract, this requirement will be met if the entity is licensed in at least one state.

For more details on the service area waiver policies (including the "nexus test" policy) that applied to EGWPs in contract years 2006 and 2007, see Appendix I below.

20.2.1.3 - Service Area Extension for Certain MA Local Coordinated Care Plans

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

For contract year 2008 CMS will retain the current requirement that all MAOs (other than those offering non-network PFFS, Regular and Demonstration MSA plans) and Section 1876 Cost Plan sponsors offer plans to individual beneficiaries as a condition of offering "800 series" plans. The design and operation of these plans differ appreciably from non-network MA PFFS plans and MA MSA plans. For example, MAOs generally must furnish Medicare Parts A and B health care services through local networks that they must establish and maintain and that are approved by CMS and therefore it is important to continue to provide incentives for these entities to offer these plans and promote greater choice and robust availability for Medicare beneficiaries.

However, to enable employers/unions to offer coordinated care plans to all their Medicare-eligible members wherever they reside, CMS will grant a waiver of service area requirements for the 2008 contract year to MAOs offering local coordinated care plans (e.g., local PPOs and HMOs) under certain circumstances. An MAO offering a coordinated care plan in a given service area (i.e., state) can extend coverage to an employer/union sponsor's beneficiaries residing outside of that service area when the MAO, either itself or through partnerships (i.e., arrangements) with other MAOs, is able to meet CMS provider network adequacy requirements and provide consistent benefits to those beneficiaries. Note that Part C and Part D access sufficient to meet the needs of employer group enrollees must be in place once the MAO enrolls members of an employer or union group residing in particular geographic locations outside of its individual plan service area.

The MAOs offering "800 series" local coordinated care plans that desire expanded service areas (e.g., national service areas) to utilize this waiver policy must request an expanded "800 series" service area in accordance with CMS requirements to ensure their service area is properly defined in HPMS and must bid accordingly. No mid-year service area expansions will be permitted.

20.2.1.4 – Modification of Service Area Extension for Certain MA Local Coordinated Care Plans

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

For contract year 2009 CMS has issued a modification of the service area extension waiver policy in §20.2.1.3 above. Beginning with the 2009 contract year, an MAO offering a local coordinated care plan will be afforded limited flexibility, as outlined below, in a portion of an expanded "800 series" service area outside a State where it is unable to secure contracts with an adequate number of network providers to satisfy CMS' MA coordinated care network adequacy requirements that otherwise would apply. Note that CMS is not waiving or modifying any Part D network adequacy requirements. As a condition of receiving this waiver, the MAO must meet each of the following requirements:

(1) The MAO must be able to meet CMS' MA coordinated care network adequacy requirements for at least the majority of a particular employer or union group's beneficiaries enrolled in the "800 series" coordinated care plan. In those instances where the MAO cannot meet this requirement for a particular employer or union group's beneficiaries, CMS will require information, including MA network adequacy information for the particular employer or union group, to be submitted for review and approval by CMS;

(2) All of an employer or union group's beneficiaries, including those beneficiaries that do not have access to contracted MA network providers, must receive the same covered benefits, at the preferred in-network cost sharing for all covered benefits offered by the coordinated care plan;

(3) The MAO must provide payment to noncontract providers in accordance with the requirements of 1852(a)(2)(A) of the Social Security Act (i.e., the MAO must provide "payment in an amount so that – (i) the sum of such payment amount and any cost sharing provided under the plan is equal to <u>at least</u> (ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing under such parts [emphasis added])"). Note that, unlike private fee-for-service MA plans, MAOs offering local coordinated care plans have the ability to pay more than the required above-mentioned statutory amounts to any particular noncontract provider (See also 42 CFR 422.214; and 42 CFR 489.53(a)(2) (hospitals and other institutional providers with Original Medicare fee-for-service provider agreements that place certain restrictions on treating any Medicare beneficiaries may be subject to having those agreements terminated by CMS));

(4) The MAO must take whatever steps are necessary to ensure that beneficiaries residing in areas where the MAO is unable to secure contracts with an adequate number of a specific type of provider(s) to satisfy CMS' MA network adequacy requirements will have access to providers, including providing assistance to these beneficiaries in locating providers and/or utilizing its ability, as outlined above, to pay noncontract providers more than the statutory minimum required in section 1852(a)(2)(A) of the Social Security Act;

(5) In addition to assisting enrollees residing in non-network areas of the local coordinated care plan in finding providers who will furnish services, the MAO must also establish a program to specifically assist these enrollees in the coordination of their health care service. Areas that should be addressed in its coordination plan for its non-network enrollees are discussed in §20.3 of Chapter 4 of this manual;

(6) In order to minimize any adverse effects on beneficiaries residing in areas where the MAO is unable to satisfy CMS' MA network adequacy requirements, the MAO also must have in place an effective communication plan with employer groups prior to transitioning these employer group beneficiaries to the local coordinated care plan. This must include the following key communications: (a) ensure employer sponsors and their beneficiaries understand how the plan will work for those enrollees residing in areas where MA network providers are not available, including that noncontract providers are generally not required to accept the plan and furnish services; (b) ensure the MAO has a targeted communication strategy and provides information and assistance for beneficiaries affected by lack of access to network providers (i.e., whom they contact if they have difficulties locating a provider that will furnish services, etc); (c) conduct targeted education and outreach to the current providers of beneficiaries affected by lack of access to network providers prior to transitioning the group to the local coordinated care plan, explaining how the local coordinated care employer group product works, how claims are submitted, etc.; and (d) assure all noncontract providers that they will receive prompt and accurate payment; and

(7) MAOs offering "800 series" local coordinated care plans that desire expanded service areas (e.g., national service areas) to utilize this modified waiver policy must request an expanded "800 series" service area in accordance with CMS requirements to ensure their service area is properly defined in HPMS and must bid accordingly. No mid-year service area expansions will be permitted.

20.2.2 – Direct Contract EGWP Service Areas

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In general, MAOs can only cover beneficiaries in the service areas in which they operate. However under CMS waiver authority, for employers/unions which directly contract with CMS to sponsor their own MA Plan, coverage can extend to all of their Medicare eligibles, regardless of where they reside in the nation. However, in order to meet the enrollment eligibility requirements described in Chapter 2, §20, of this manual (Medicare Advantage Enrollment and Disenrollment), which includes the requirement that the beneficiary must permanently reside in the EGWP-specific service area, all Direct

Contract MAOs should ensure their defined service area includes all geographic areas in which their plan Medicare eligibles may reside (e.g., national service area).

20.3 – Marketing and Disclosure

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

20.3.1 – Prior Review and Approval of Marketing Materials and Election Forms

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Direct Contract and "800 series" Plans

CMS has waived the prior review and approval requirements for marketing materials and election forms contained in 42 CFR 422.2262 and 42 CFR 423.2262 for all EGWPs. These include all "800 series" plans as well as Direct Contract plans. This waiver applies to all marketing materials, including the marketing materials requirements contained in the Medicare Marketing Guidelines.

Note that as a result of this waiver, Direct Contract plans and MAOs offering "800 series" EGWPs or employer-sponsored individual MA Plans are not subject to the annual restriction against communicating to Medicare eligible beneficiaries before October 1st. Rather, CMS strongly encourages employer/union sponsors and entities offering these plans to employers/unions to begin the communication process early with these beneficiaries and to continue to communicate about their benefits as frequently as possible prior to their particular annual open enrollment period (which may differ from Medicare's annual coordinated election period). More specifically, employers/unions and/or entities that offer employer-sponsored "800 series" or individual plans to employers/unions should be prepared to direct beneficiaries to available resources and should explain their coverage and how it works with Medicare.

Employer/Union Group Plan Sponsored Individual MA Plans

Note that the waiver of prior review and approval requirements for marketing materials and election forms contained in 42 CFR 422.2262 and 42 CFR 423.2262 will also apply to a MAO that elects to use the waiver outlined in §20.3.2.1.1 below which allows MAOs to customize disclosure materials. More specifically, the waiver will apply to those MAOs that elect to customize disclosure materials for a particular employer/union group health plan sponsor that offers coverage to its Medicare eligibles using an individual MA plan (e.g., individual MA plan paired with non-Medicare supplemental coverage designed to "wrap around" or enhance the individual MA plan).

20.3.2 – Timing and Content of Employer/Union Sponsored Group Health Plan Disclosure Materials

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

20.3.2.1 – Employer/Union Sponsored Group Plans Subject to Medicare Disclosure Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In general, disclosure materials for employer/union sponsored enrollees in Direct Contract plans, "800 series" plans or individual MA plans are subject to all applicable Medicare disclosure regulatory requirements (42 CFR 422.111) and sub-regulatory guidance (including any requirements related to the timing and content of these materials) unless waived or modified as outlined below. This also includes all of the disclosure requirements contained in the Medicare Marketing Guidelines unless those requirements have been explicitly waived or modified.

20.3.2.1.1 – Customizing Medicare Disclosure Materials and Election Forms

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In order to meet the requirements of 42 CFR 422.111(a)(2) and 42 CFR 423.128(a)(2), which require a Part D sponsor to disclose information about the plan in a clear, accurate and standardized form, MAOs should provide customized disclosure materials to "800 series" and Direct Contract MA plan enrollees to reflect the modified/supplemental benefits being provided to that particular employer/union group health plan enrollees, if any. More specifically, CMS has waived any rules that would otherwise prohibit these entities from offering customized disclosure materials to the extent those customized materials will more clearly and accurately describe the benefits available to employer/union group Medicare eligibles (for example, when the supplemental coverage is taken into account). Note that this waiver also allows customization of disclosure materials for employer-sponsored enrollments in individual MA plans (e.g., where an employer/union group health plan sponsors coverage to its members using an individual MA plan and a non-Medicare supplemental plan designed to "wrap around" or enhance the individual MA plan or where the employer/union sponsor is subsidizing or paying premium amounts for its Medicare eligibles enrolled in an individual MA plan).

With regard to premium amounts (including premium amounts for low-income premium subsidy eligible individuals) that are required to be accurately reflected on any customized beneficiary disclosure materials (e.g., Evidence of Coverage, LIS Rider), MAOs should ensure these materials accurately reflect the actual premium amount the

beneficiary pays when the supplemental coverage, if any, and any corresponding employer/union premium subsidization (or subsidization by CMS in the case of low-income premium subsidy eligible beneficiaries) is taken into account. Alternatively, if accurate premium information concerning the amount the beneficiary actually pays is not available to the MAO, the MAO may substitute language in lieu of providing actual premium amounts (e.g., "For information concerning the actual premiums you will pay, please contact [insert employer/union group health plan sponsor name] or your employer group benefits plan administrator.")

As provided in §20.3.1 above, all customized employer/union group health plan materials are not required to be submitted for review and approval by CMS prior to use. Customized materials must not be submitted through HPMS.

Also, beginning with contract year 2009, MAOs are no longer required to submit informational copies of these disclosure materials to CMS at the time of use (for details on the previous waiver policies in effect for contract years 2006 through 2008 requiring informational copies of employer/union group health plan disclosure materials to be submitted to CMS, see Appendix II) . However, as a condition of CMS providing these particular waivers or modifications, CMS reserves the right to request and review these materials in the event of beneficiary complaints or for any other reason it determines to ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan.

The MAOs also will be required to retain these disclosure materials and provide access to these written materials to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e). If the materials for multiple employer/union sponsors are identical except for employer group sponsor identifier information, CMS will not require an MAO to retain materials for each employer group (i.e., retention of one "template" version of disclosure materials used for particular employer groups is permissible).

20.3.2.1.2 – Timing for Issuance of Employer/Union Sponsored Group Plan Medicare Disclosure Materials

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Employer sponsored "800 series" plans, Direct Contract plans or individual MA plans that are subject to Medicare marketing and disclosure requirements are also subject to any applicable timing requirements for issuance of these materials. However, CMS has waived or modified applicable timing requirements in certain circumstances. These include those circumstances where a particular employer/union sponsor has an open enrollment period that differs from Medicare's Annual Coordinated Election Period (ACEP). In this situation, the timing for issuance of any disclosure materials that are based on the ACEP should be based instead on the employer/union sponsor's open enrollment period. For example, for contract year 2008, in accordance with applicable timing requirements for these materials, if an employer/union sponsor's open enrollment

period began on December 1, 2007, the ANOC and Summary of Benefits (SB), LIS Rider and Formulary must have been received by beneficiaries no later than November 16, 2007 (15 days before the beginning of the employer/union group health plan's open enrollment period). Beginning in 2009, a combined Annual Notice of Change/Evidence of Coverage (ANOC/EOC), LIS rider, and Formulary are required to be received by beneficiaries no later than 15 days before the beginning of the ACEP. Therefore, for contract year 2009, if an employer/union sponsor's open enrollment period begins on December 1, 2008, these documents must be received by beneficiaries no later than November 16, 2008 (15 days before the beginning of the employer/union group health plan's open enrollment period). The timing for other disclosure materials that are based on the start of the Medicare plan (i.e., calendar) year should be appropriately based on the employer/union sponsor's plan year. If the employer/union sponsor does not have an open enrollment period, then disclosure materials that are based on the ACEP must be received by beneficiaries no later than 15 days before the beginning of the plan year.

20.3.2.2 - Plans with Employer/Union Sponsors Eligible for Waiver of Medicare Disclosure Requirements ("Alternative Disclosure Standards Waiver")

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

CMS has waived the specific disclosure requirements at 42 CFR 422.111 and 42 CFR 423.128 for employer/union group health plan beneficiaries when the employer/union sponsor is subject to alternative disclosure requirements (e.g., those required by the Employee Retirement Income Security Act of 1974 ("ERISA")), and the employer/union sponsor complies with such alternative requirements. However, these alternative disclosure materials (including summary plan descriptions and all other beneficiary communications that provide descriptions of the Medicare benefit offerings) must be provided by the Direct Contract MAO, or the MAO offering the "800 series" plan or employer-sponsored individual MA Plan to beneficiaries on a timely basis.

Similarly, for an employer/union sponsor plan eligible for the alternative disclosure standards waiver referenced above in §20.3.2.2, a MAO that offers "800 series" plans to these employer/union sponsors may provide copies of the alternative disclosure materials or, alternatively, the information that would be necessary to satisfy its reporting and disclosure obligations under 42 CFR 422.516(d) and 423.514(d). Sections 42 CFR 422.516(d) and 423.514(d) provide that entities must furnish, upon request, the information that any employees' health benefits plan needs to fulfill its reporting and disclosure obligations under ERISA.

However, as a condition of CMS providing these particular waivers or modifications, CMS reserves the right to request and review these materials in the event of beneficiary complaints or for any other reason it determines to ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan. MAOs also will be required to retain these dissemination materials and provide

access to these written materials to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e).

20.3.3 - Identification Card (ID) Card Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Direct Contract MAOs and MAOs that offer "800 series" plans may provide enrollees with one combination member Identification (ID) card which incorporates medical, Part D, and employer sponsored non-Medicare supplemental medical and/or drug benefits. However, entities must comply with all other CMS ID card requirements, including the requirements contained in the Medicare Marketing Guidelines. Note that this same waiver applies when a MAO elects to use the waiver outlined in §20.3.2.1.1 above to customize disclosure materials for a particular employer/union sponsor that offers coverage to its members using an individual Medicare plan paired with a non-Medicare supplemental plan designed to "wrap around" or enhance the individual Medicare plan.

Note that it is also permissible to include the name and/or logo of the employer/union sponsor on the ID card. This activity is not considered "co-branding".

20.3.4 - "Doing Business As" (DBA) Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The MA Plans that offer "800 series" plans may use different names for "doing business as" purposes. However, for HPMS purposes only, these entities will be restricted to entering one "doing business as" name.

20.3.5 - Special Marketing/Disclosure Requirements For Employer Group Sponsored Private Fee-For-Service Plans

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Private Fee-For-Service (PFFS) plans are a growing segment of the Medicare Advantage (MA) program. In May 2007, CMS provided additional model documents and required new outreach processes to ensure individual Medicare beneficiaries and providers are informed about the distinctive features of Medicare PFFS plans offered to individual Medicare beneficiaries. See Memorandum from Abby L. Block, Ensuring Beneficiary Understanding of Private Fee-For-Service Plans, Actions and Best Practices, May 25,

2007 and memorandum from David A. Lewis, Information on PFFS Marketing Oversight, November 28, 2007.

The PFFS plans also represent a viable option for employer and union group plan sponsors seeking to offer a Medicare Advantage plan as part of employment-based retiree health care coverage. All the requirements of the May 25, 2007 memorandum and the November 28, 2007 memorandum mentioned above apply to employer-sponsored PFFS plans unless waived or modified. The following requirements outlined in the above-referenced memoranda apply to employer group sponsored PFFS plans:

- Use of disclaimer language;
- Must not imply PFFS functions as a Medicare supplement (Medigap) plan;
- Beneficiary and provider education leaflet must be included in all enrollment kits (may be customized for employer group);
- Provider outreach and education;
- Provider access to terms and conditions of payment; and
- Timely and accurate claims processing.

The following requirements outlined in the above-referenced memoranda have been waived and do not apply to employer group sponsored PFFS plans:

- Outbound education and verification calls verifying enrollment; and
- Lists of marketing and sales events.

There are several unique and important considerations in the areas of marketing/disclosure and provider access when these MA plans are offered to employer and union group plan sponsors. As a condition of receiving these waivers, MAOs offering these plans are required to take into account several key actions and implement the specific disclosure requirements outlined below:

Key Communications with Employer and Union Group Sponsors

The PFFS plans may be attractive to employer/union group sponsors for several reasons, including that certain kinds of PFFS MA plans do not require established networks of providers and allow employers to cover retirees wherever they may reside in the United States. For example, in addition to existing MA employer group extended service areas, beginning in 2008 the elimination of the "nexus test" creates more opportunities to offer "800 series" non-network PFFS plans to employer group sponsors on a national basis. However, entities offering national coverage to employer and union group health plan enrollees may face some potentially unique challenges (e.g., provider access).

When employer and union group health plan sponsors are considering PFFS plans as an option, MAOs are required to accentuate the following key aspects of offering these kinds of plans to employer and union sponsors:

- **Ensure Employer Sponsors Understand How PFFS Plans Work Prior To Considering These Options For Their Retirees**. When marketing a PFFS option to employer sponsors, it is important to ensure that the employer sponsor understands that the product works differently from other MA plans. This includes that enrollees may only receive services from providers that accept the plan's terms and conditions of payment and providers have the right to decide if they will accept the plan's terms and conditions of payment each time the enrollee seeks treatment from the particular provider. These conditions would apply equally to all providers, including those that retirees may be accustomed to receiving treatment from under the previous employer-sponsored health care option (e.g., Original Medicare plus a supplemental employer-sponsored wrap).

- **Ensure Employer Sponsors Understand The Importance Of Developing A Targeted Communication Strategy For Retirees And Providers Prior To Transitioning From Existing Health Care Options.** The PFFS plans should accentuate the need for employer sponsors to communicate to their retirees and their existing providers how the PFFS plan works. It is essential to explain to retirees how the plan is different from the current employer-sponsored health care option, including how the plan works with providers as outlined above. (Targeted education and outreach to retirees, using applicable model documents and outreach processes identified for individual beneficiaries outlined in the May 25, 2007 Memorandum and referenced below, should continue for new entrants and their providers). Also, these communications should encourage retirees to check whether their existing providers will accept the PFFS plan's terms and conditions before the effective date of the PFFS plan to facilitate effective outreach activities. If employers use consultants or other intermediaries to purchase retiree coverage from your organization, MAOs must ensure that the employer/union sponsor understands the PFFS product and the effect it will have on retirees.

- **Ensure Employer Sponsors Understand The Importance of Developing An Up-Front, Agreed-Upon Process In The Event There Is Insufficient Provider Access In Particular Geographic Areas.** As stated above, an important difference in employer-sponsored PFFS plans is that coverage may be offered on an extended geographic basis. MAOs offering these plans to employer group sponsors should stress the importance of developing an employer-specific process and retiree communication strategy to address those instances where a retiree cannot obtain access to any providers of a particular type in a specific geographic area and therefore the employer-sponsored PFFS plan does not meet the individual's health care needs. Solutions may include an agreement between the PFFS plan and the employer sponsor to offer an alternative or "fall back" health care option such as offering another kind of MA plan (e.g., local PPO) or

disenrolling the retiree from the PFFS plan and returning them to Original Medicare with employer "wrap around" supplemental coverage.

Key Communications with Employer-Sponsored PFFS Enrollees And Their Providers

The MAOs are required to take the following actions for beneficiaries enrolled in employer-sponsored PFFS plans:

- **Assure Providers That They Will Receive Prompt And Accurate Payments.** PFFS plans must conduct effective outreach to providers to help them understand how employer/union sponsored PFFS plans work and to overcome any resistance that may be particularly caused by concerns about the timeliness and accuracy of payments. PFFS plans and employer sponsors should ensure that the plan's terms and conditions of payment are easily accessible to providers. In addition to these important communications, it also may be helpful in some instances to explain to providers the way that employer-sponsored coverage works (i.e., employers typically choose the plan choice for their retirees; the retiree may risk losing their coverage or their family's employer coverage if they elect another plan; one claim is submitted for retirees in employer-sponsored PPFS plans vs. two with Original Medicare plus employer-sponsored supplemental coverage, etc.).

- **Ensure Retiree Communications Explain How PFFS Works Prior to Transitioning.** As with individual beneficiaries, retirees in PFFS plans must be similarly informed about how PFFS plans work. All communications with retirees should clearly outline how the PFFS plan differs from their existing retiree health care option (providers must agree to accept the plan's terms and conditions of payment, the retiree's existing providers may not accept these terms and conditions, and retirees may have to choose new providers who will accept the terms and conditions). Employer-sponsored PFFS plan communications must prominently include the following disclaimer:

  A Medicare Advantage Private Fee-for-Service plan works differently than your existing plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, or otherwise agree to treat you, you will not be able to receive covered services from them under this plan. Providers can find the plan's terms and conditions on our website at: [insert link to PFFS terms and conditions].

- **Utilize Existing CMS-Approved Model Materials For Provider And Retiree Outreach and Education.** Outreach and education to providers and enrollees in employer-sponsored PFFS plans must adhere to the same basic educational requirements applicable to individual plans. For example, a model two-sided leaflet that PFFS plans may provide to enrollees (and that enrollees may in turn provide to their health care providers) to facilitate understanding of PFFS plans

has been developed (see Attachment 2 of the May 25, 2007 Memorandum referenced above). The contents of the leaflet must be included in all key retiree and provider communications received from employer sponsors and/or PFFS plans. These materials may be customized for particular employer sponsors as needed in accordance with existing employer group waivers concerning employer group marketing/dissemination materials. See §20.3.2.1.1 above.

20.3.6 - Agent and Broker Licensure and Training Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

All agents and brokers (employed and contracted) selling "800 series" plans to employer/union group plan sponsors on behalf of an MAO must be licensed to sell these products as required by state law. However, representatives of an MAO or those representatives of employer/union group plan sponsors or others acting on their behalf (e.g., their employees, benefit consultants, third party administrators) who conduct educational, enrollment or informational events for retirees of employer/union sponsors are not required to be licensed for these purposes as these activities would not constitute marketing or sales activities.

To ensure that employer/union group sponsors are receiving accurate and reliable information to make informed decisions on behalf of its retirees, it is critical that health plan representatives such as agents and brokers (employed and contracted) performing these marketing and sales activities are knowledgeable about the products they are selling, including "800 series" plans. CMS expects that the MAO sponsors will ensure brokers and agents are knowledgeable about the products they are selling by requiring they are trained on Medicare rules, regulations and on plan details specific to the plan products being sold. However, the broker/agent testing requirements do not apply under these circumstances.

Note that beginning with the 2007 contract year, the Marketing and Disclosure guidance contained in this Manual Chapter (Section 20.3) supersedes the EGWP Marketing and Disclosure/Dissemination guidance located in Section 13 of the Medicare Marketing Guidelines (released on July 25, 2006).

20.4 - Mid-Year Benefit Customization/Enhancements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The EGWP program is designed explicitly to allow flexibility for MAOs to negotiate different customized plans with particular employer/union groups throughout the year. This design also takes into account that employers/unions offering group health plans may operate on different bidding and negotiation timelines. Therefore, MAOs are allowed to offer "800 series" customized plans at any time during the contract year (i.e., MAOs are implicitly allowed to offer enhanced benefits throughout the year to individual employers/unions that differ from the benefits reflected in their bid). Also, when

utilizing individual MA plans open to general enrollment for their members, employer/union sponsors are also free to enhance benefits mid-year for the part of the package that is a "wrap-around" or enhancement to the MA plan and that is only available to employer/union members since this "wrap around" benefit is not subject to review and approval by CMS. See 422 CFR 106.

20.5 - Part C and Part D Premium Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Waiver of Uniform Premium Requirement

The uniform premium requirement (see 42 CFR 422.100(d)(2)) has been waived for entities offering "800 series" plans under certain circumstances. Under this waiver of the uniform premium requirement, entities offering "800 series" plans serving multiple counties, regions or the nation will be allowed to vary premium and cost sharing between defined market areas within the same employer/union sponsored group plan. This waiver is contingent on the requirement that the market areas (geographic areas) within the employer sponsored group plan with premium variation are based on objective market information demonstrating verifiable differences in medical costs between these market areas. The MAO must have documentation validating the medical cost variation in these market areas comprising the plan. The MAOs will be required to retain all of these documents and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements at 42 CFR 422.503(d) and 422.504(d) and (e). Even though entities offering "800 series" plans that serve multiple counties which do not represent separate market areas in terms of medical costs may not utilize this waiver, these entities may consider using the plan segmentation rules at §422.262(c)(2) to vary premium between an "800 series" plan's payment areas (i.e. counties).

Premium Subsidization by Employer/Union Group Health Plan Sponsors

Under its waiver authority, CMS will allow the employer/union sponsoring the MA plan flexibility in determining how much of a plan enrollee's Part C and Part D monthly beneficiary premium it will subsidize, subject to the conditions set forth below.

First, an employer/union sponsor can subsidize different amounts for different classes of enrollees in a plan provided such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly). Different classes cannot be based on eligibility for the Part D Low-Income Subsidy. Second, the premium cannot vary for individuals within a given class of enrollees. Third, with regard to the Part D premium, an employer/union cannot charge an enrollee for prescription drug coverage provided under the MA plan more than the sum of his or her monthly beneficiary premium attributable to basic prescription drug coverage and 100% of the monthly beneficiary premium attributable to his or her non-Medicare Part D benefits (if any). The

employer/union must pass through any direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or in those instances where the subscriber to or participant in the employer/union-only plan pays premiums on behalf of a Medicare eligible spouse or dependent, the amount the subscriber or participant pays).

As a condition of CMS providing these particular waivers, MAOs that offer "800 series" MA plans to employers/unions will be required to obtain in writing from such employers/unions their agreement that they will satisfy the requirements of this waiver with respect to the premiums charged to their participants. Also, MAOs will be required to retain these agreements with employers/unions and provide access to these written agreements to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e), and 42 CFR 423.504(d) and 423.505(d) and (e).

Charging Different Premiums to Different Employer/Union Group Health Plan Sponsors

In addition to the flexibilities outlined above for employers/unions to subsidize different amounts of an enrollee's premium contribution, "800 series" MAOs have the flexibility to negotiate with and vary the premium charged to particular employer/union group health plan sponsors. This includes the ability to "experience rate" "800 series" employer/union group health plan sponsors in determining these premiums.

20.6 - Premium Withhold

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The MAOs must permit their enrollees, at their option, to pay their premium through deductions from their Social Security checks, Railroad Retirement checks, or Federal annuity. When employers/unions also contribute to the beneficiary's premium, in whole or in part, it is not feasible for both MAOs and CMS to factor in the employer/union sponsor's contribution and adjust the amount of the premium that should be deducted from the beneficiary's Social Security or other check.

Because of these operational obstacles, as a condition of sponsoring an EGWP, CMS has waived the requirement that MAOs offering "800 series" and Direct Contract EGWPs must provide beneficiaries the option to pay their premium through withholding. Thus, the premium withhold option will not be available for enrollees in EGWPs. MAOs offering these plans will be required to bill the beneficiary and/or the employer/union directly. This waiver is not applicable to employer-sponsored enrollments in individual MA plans (employer-sponsored group beneficiaries enrolled in these MA plans will have the option to pay premiums through withholding).

20.7 - Providing Information to CMS about the MA Program

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

CMS has waived the requirements contained in 42 CFR 422.64 and 42 CFR 423.48 for all EGWPs. These regulatory provisions require plans to report certain information annually to CMS to enable it to provide current and potential beneficiaries the information they need to make informed decisions concerning their available choices for Medicare coverage. This would include information to be included in the CMS "Medicare and You" publications and on the CMS website (e.g., "Medicare Options Compare"). Since these plans are not available for general enrollment, these requirements do not apply and are therefore waived.

20.8 - Requirement for MA Organization to Provide Specific Information via an Internet Website

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

To the extent an MAO has a Web site or provides information through the Internet, 42 CFR 422.111(f)(12) requires MAOs to post copies of the plan's Evidence of Coverage, Summary of Benefits and information on the network of contracted providers on the web site. In turn, 42 CFR 423.128(d)(2) requires MAOs to provide certain Part D information on an Internet web site (e.g., current formulary, notice regarding the removal or change in the preferred or tiered cost sharing status of a Part D drug on its formulary, etc.).

CMS has waived both the requirements of 42 CFR 422.111(f)(12) and 42 CFR 423.128(d)(2) for all "800 series" plans. MAOs will not be required to provide any information concerning these EGWPs on the MAO's Internet website. Since these kinds of employer-sponsored MA plans are not available for general enrollment, these requirements do not apply and are therefore waived.

20.9 - Access to Covered Part D Drugs

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The MAOs cannot limit coverage to only mail order prescription drugs and must meet specific standards in 42 CFR 423.120(a)(1) regarding the assembling of broad networks of retail pharmacies to provide convenient access to beneficiaries. While waivers of the mail order-only prohibition will not be granted, CMS also recognizes different circumstances surrounding employer/union group health plan coverage as compared to other MA plans. For example, an employer/union arrangement may have only a small number of Part D eligibles concentrated in a local area within a large region. Employers/unions also have an interest in ensuring their Part D eligibles have adequate pharmacy access.

To facilitate the offering of such plans and maximize flexibility, CMS has waived the specific Part D retail pharmacy access standards contained in 423.120(a)(1) for "800 series" and Direct Contract EGWPs as long as the MAO attests that its networks are and will continue to be sufficient to meet the needs of its Part D eligibles, including situations involving emergency access. However, CMS may review the adequacy of the pharmacy networks and potentially require expanded access in the event of beneficiary complaints or for other reasons in order to ensure that the plan's network is sufficient to meet the needs of its enrollee population.

Note that other than the waiver of the retail pharmacy access requirements described above, no other waivers or modifications of the Part D pharmacy access requirements have been granted for EGWPs. Thus, all MAOs offering EGWPs must adhere to all other CMS pharmacy access requirements (e.g., the requirements for long term care, home infusion, and I/T/U pharmacy access). See 42 CFR 423.120(a).

20.10 - Submission of Part C EGWP Bids

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The MAOs have the option of preparing Part C bids by either using the expected composite benefit plan (an average of all of the actual expected benefit designs offered to different employer/union groups), or by basing the bid on the Medicare fee-for-service benefit provisions.

For MAOs that have a monthly beneficiary rebate amount described in 42 CFR 422.266:

(a) The MAO may vary the form of rebate for a particular plan benefit package so that the total monthly rebate amount may be credited differently for each employer/union group to whom the MAO offers the plan benefit package, with the exception of a rebate credited toward the reduction of the Part B premium as stated below;

(b) MA bids submitted by MAOs cannot reflect an allocation of A/B rebates to buy down Part D basic premium or Part D supplemental premium. Even though this kind of specific allocation is prohibited in the bid submission, MAOs still retain the flexibility to allocate rebates to buy down Part D basic premium or Part D supplemental premium on an individual employer/union basis for each PBP;

(c) The MAO must:

(i) Ensure Part B premium reductions are the same for all enrollees in a particular "800 series" plan benefit package. MAOs may not offer particular employer/union groups enrolled in the same "800 series" plan

benefit package (e.g., “801”) different Part B premium reductions from that established by their MA bids and also cannot offer to separately refund Part B premiums outside of the CMS established bidding and rebate allocation process;

(ii) Ensure that the total monthly rebate amount per enrollee is uniform across all employer/union groups in a particular “800 series” plan benefit package. All employer/union groups in a particular “800 series” plan benefit package must receive supplemental benefits equal to the amount of the A/B rebate allocation; however, supplemental benefits provided to each employer/union group may be customized;

(iii) Ensure that all rebates are accounted for and used only for the purposes provided in the Act; and

(iv) Retain documentation that supports the use of all of the rebates on a detailed basis for each employer/union group in a particular “800 series” plan benefit package and provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR 422.503(d) and 422.504(d) and (e).

See also CMS Instructions for Completing the Medicare Advantage Bid Pricing Tool For Contract Year 2008.

20.11 - Submission of Part D EGWP Bids and Requirements Concerning Providing EGWP Supplemental Coverage

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Note that beginning with the 2008 contract year, MAOs are no longer required to submit Part D EGWP bids. MAOs are still required to take certain actions with the PBP software. See Appendix III for detailed bidding instructions for Part D EGWPs. For the 2006 and 2007 contract years, MAOs submitted Part D bids for “800 series” and Direct Contract EGWPs in a manner similar to the flexible method offered to MA Organizations offering “800 series” plans in the past. Under this approach, CMS required MAOs to submit bids for EGWPs only for the standardized Part D coverage. Entities were not required to submit separate bids for each employer/union benefit design variation.

For “800 series” EGWPs, any supplemental (i.e., additional non-Medicare Part D) prescription drug coverage is provided separately pursuant to a private agreement between the MAO and the employer/union sponsor. However, any EGWP supplemental coverage offered cannot reduce the value of the basic standardized Part D benefit design. For example, supplemental coverage cannot impose a cap that would preclude employer group health plan Part D eligibles from realizing the full value of coverage under the standard Part D benefit. To assure that the actuarial equivalence of the standard Part D

benefit design is maintained, CMS requires all MAOs offering EGWPs to ensure that the total employer/union sponsored plan (including adjusting for any supplemental coverage) provides at least the standard Part D coverage, including a deductible no higher than that of defined standard Part D (for 2008 - $275), and catastrophic coverage after the true out-of-pocket limit (for 2008 - $4,050) is met.

Beginning in 2006, no employer/union Part D EGWP bids were included in the calculation of the Part D national average monthly bid amount or in the low-income regional benchmark premium amounts.

20.12 – Part C EGWP Cost Sharing and Coverage Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The MAOs are permitted to modify the cost-sharing, benefit level and/or premium offered only to employers/unions from the levels of cost-sharing, benefits and premiums offered to individual enrollees as long as the minimum required Medicare coverage levels (i.e., benefits and coverage equivalent to Original Fee-For-Service (FFS) Medicare) are met and as long as the modification does not have the effect of denying or discouraging access to covered medically-necessary health care items and services. See Sections 1852(a)(1)(A) and 1852(b) of the Act; 42 CFR 422.101. EGWPs can be structured with higher cost sharing for some Medicare services (assuming that overall covered cost sharing is not in excess of Original FFS Medicare), but enrollees cannot be denied the same benefits and coverage as Original FFS Medicare (for example, it would not be permitted for an EGWP to limit coverage to less than 100 days of skilled nursing care because Original FFS Medicare requires such coverage levels). See Chapter 4 of this manual for details.

Also, to the extent that there are specific Medicare Advantage requirements concerning cost-sharing or benefit coverage requirements, these requirements apply equally to EGWPs unless explicitly waived or modified (e.g., MAOs offering EGWPs must meet the requirement of 42 CFR 422.113(b)(2)(v) to limit charges to enrollees for emergency department services to $50 or what it would charge the enrollee if he or she obtained the services through the MAO, whichever is less).

20.13 – Part D EGWP Cost Sharing

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In general, a Part D plan offered to individual Medicare beneficiaries can offer actuarially equivalent standard, basic alternative or enhanced alternative prescription drug coverage (i.e., coverage that differs from defined standard prescription drug coverage) if certain actuarial equivalence standards are met. For example, 42 CFR 423.104(e)(5) requires that the coverage be designed to provide for the payment of costs incurred for covered

Part D drugs equal to the initial coverage limit defined in 42 CFR 423.104(d)(3) ($2,510 in 2008) that is equal to or greater than what a Part D plan offering defined standard prescription drug coverage would pay between such limit and the deductible at section 42 CFR 423.104(d)(1) ($275 in 2008). (Throughout that range, defined standard prescription drug coverage covers on average 75 percent of the costs and beneficiaries pay on average 25 percent.) See §§20.3.2, 20.4.1 and 20.4.2 of Chapter 5 of the Prescription Drug Benefit Manual for more information.

Employer/union group health plan coverage has often differed from the defined standard benefit design in Part D. For example, many arrangements offer lower deductibles or provide coverage for claims incurred in the Part D coverage gap. By contrast, within the deductible and the initial coverage limit range, these designs may provide somewhat less coverage than defined standard prescription drug coverage under Part D. Therefore, to provide beneficiaries with more choices and enable employer/union group health plans to continue offering Part D eligibles their familiar coverage, CMS has waived the 42 CFR 423.104(e)(5) prong of the actuarial equivalence test for EGWPs offered exclusively to employer/union group health plan Part D eligibles. Absent this waiver, this provision requires defined standard coverage for costs incurred between the deductible and initial coverage limit.

However, this guidance is not intended to waive other actuarial equivalence standards in 42 CFR 423.104(e), including (but not limited to) the requirement in 42 CFR 423.104(e)(3) that the total or gross value of the coverage be at least equal to the total or gross value of defined standard coverage and the requirement in 42 CFR 423.104(e)(2) regarding catastrophic reinsurance coverage. Thus, for example, an EGWP that requires beneficiary coinsurance that on average is greater than 25 percent may still satisfy actuarial equivalence by instead offering a lower deductible, or by providing coverage above the initial coverage limit, if the gross value coverage standard, the catastrophic coverage, and other requirements are satisfied.

20.14 - CMS EGWP Part C Payment

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The MAOs offering EGWPs will be paid in the same manner as they are paid for their non-group MA plans. However, MAOs offering Regional PPO EGWPs are not eligible for any of the risk sharing payments set forth at 42 CFR 422.458. Note that unlike Part D, Part C Regional PPO EGWP bids are included in the calculation of the MA Regional benchmark calculations.

20.15 - CMS EGWP Part D Payment

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

20.15.1 - Direct Subsidy

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The Part D risk adjusted direct subsidy payment for all EGWPs will be based on the national average monthly bid amount and the national base beneficiary premium (not on bids amounts as for plans offered to individual Medicare beneficiaries).

20.15.2 - Reinsurance Subsidies

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In addition, CMS will modify the way catastrophic reinsurance is paid for all EGWPs. CMS will not make a prospective payment for reinsurance, and instead will include all EGWPs in the normal Part D reinsurance reconciliation at year end. Since no prospective payments will have been made during the year, the year-end process will result in the full reinsurance payment being paid to the plan. Since most employers/unions will be providing enhanced drug coverage through supplemental arrangements (which raises the threshold for catastrophic coverage), the reinsurance payments to these MAOs are expected to be small as a result of the application of the True Out of Pocket Costs (TrOOP) rule.

20.15.3 - Low-Income Subsidies

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Information concerning low-income subsidy requirements as they relate to EGWPs is set forth in §20.16 below

20.15.4 - Risk Sharing Arrangements (“Risk Corridors”)

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Risk corridor payments assist MAOs entering a new market without any experience in mitigating any losses or gains by sharing these losses or gains with Medicare. Risk corridor payments are not available for EGWPs.

The following table summarizes the differences in payment between EGWPs and plans offered to individual Medicare beneficiaries.

	Part D EGWP Payments			
Plan Types	**Direct Subsidy** 42 CFR 423.329(a)(1)	**Low-Income Premium Subsidy and Cost Sharing Amounts** 42 CFR 423.780 42 CFR 423.329(c)	**Reinsurance** 42 CFR 423.329(c)	**Risk-Sharing** 42 CFR 423.336
Part D Calendar Year Plans	The national average monthly bid amount is multiplied by the individual's risk score. This amount is then reduced by the rounded base beneficiary premium ($27.90 for 2008)	Payment methodology is the same as for plans offered to individual Medicare beneficiaries, except that the rounded base beneficiary premium ($27.90 for 2008), will be used in the low-income premium subsidy regional benchmark comparison. Note that beginning in 2008, because of the elimination of the requirement to submit Part D EGWP bids, Low-Income Cost Sharing (LICS) amounts will be paid retrospectively at year-end reconciliation (rather than prospectively as in 2006 and 2007). See Section 20.16.2 below.	Reinsurance is paid retrospectively at year-end reconciliation (rather than being paid prospectively).	Not Available
Part D Non-Calendar Year Plans	Same as above (payments are on calendar year basis; plan may be administered on non-calendar year basis)	Same as above	No reinsurance payments.	Not Available

20.16 - Low-Income Subsidies

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

For each beneficiary entitled to the low-income subsidy (LIS), CMS pays the beneficiary's premium (up to the plan's low-income premium subsidy amount) and cost sharing

obligations minus the beneficiary's cost-sharing responsibilities under the LIS rules. However, for EGWPs there are a number of important additional requirements that must be adhered to concerning both the low-income premium subsidy and the low-income cost-sharing subsidy as set forth below.

20.16.1 - Premium Subsidy

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Low-Income Premium Subsidy Pass Through Requirements

MAOs offering EGWPs are required to comply with the same low-income premium subsidy amount requirements that apply to MAOs offering plans to individual Medicare beneficiaries. See 42 CFR 423.800(b). Thus, EGWP Part D sponsors are responsible for identifying employer/union group health plan LIS Part D eligibles and passing through the low-income premium subsidy amount payments made by CMS on behalf of these Part D eligibles to reduce their premium contributions.

Premiums charged (to the beneficiary and/or the employer/union) for a particular "800 series" MA plan benefit package can vary between different employer/union group health plan sponsors and also among a particular employer group health plan's Part D eligibles based on legitimate criteria such as years of service. See §20.5 of this chapter. CMS does not take into account these variations in premiums because CMS does not receive information on these variations during the annual Part D bidding process. Even though premium amounts may vary among and between employer/union group health plan enrollees as described above, the LIS premium subsidy amounts paid by CMS to all EGWPs for all enrollees of a particular "800 series" or Direct Contract plan benefit package do not vary.

As a condition of receiving the waivers and modifications described above, CMS requires that all MAOs offering EGWPs ensure that any low-income premium subsidy amount paid on behalf of a LIS beneficiary accrues first to the benefit of the LIS-eligible employer/union group health plan Part D eligible. Specifically, the low-income premium subsidy must first be used to reduce any portion of the MA-PD monthly beneficiary premium paid by the Part D eligible (or in those instances where the subscriber to or participant in the employer/union plan pays premiums on behalf of a low-income eligible spouse or dependent, the amount the subscriber or participant pays), with any remaining portion of the premium subsidy amount then applied toward the portion of any MA-PD monthly premium paid for by the employer/union. However, if the sum of the enrollee's MA-PD monthly premium (or the subscriber's/participant's MA-PD monthly premium, if applicable) and the employer/union sponsor's MA-PD monthly premiums (i.e., total monthly premium) is less than the monthly low-income premium subsidy amount, any portion of the low-income premium subsidy amount above the total MA-PD monthly premium must be returned directly to CMS.

Similarly, if there is no MA-PD monthly premium charged to the beneficiary (or subscriber/participant, if applicable) or employer/union, the entire low-income premium subsidy amount must be returned directly to CMS and cannot be retained by the MAO, the employer/union, or the employer/union group Part D eligible (or the subscriber/participant, if applicable). If low-income premium subsidy amounts need to be returned to CMS for any employer/union group sponsor enrollees that meet the above criteria, MAOs are required to immediately contact their CMS account/plan manager for instructions on how to return these amounts.

As stated in §10.5, MAOs may enter into reinsurance or administrative services arrangements with self-insured (i.e., self-funded) employers/unions. Therefore, instead of paying an insurance premium to the MAO, the employer/union group typically pays an administrative fee to the MAO. In these kinds of arrangements, in order to properly administer the low-income premium subsidy requirements outlined above, the MAO must develop an "illustrative premium." The "illustrative premium" is equal to the premium the employer/union group plan sponsor would have paid if they had purchased an equivalent product offered by the MAO. The same rules outlined above would be applied using the illustrative premium in the place of actual premium. The MAO will be required to develop and apply an "illustrative premium" for each self-insured or self-funded employer/union group plan sponsor.

Note that if the low-income premium subsidy amount for which an enrollee is eligible is less than the portion of the Part D monthly beneficiary premium paid by the Part D eligible (or subscriber/participant, if applicable), then the employer/union should communicate to the enrollee (or subscriber/participant) the financial consequences of the low-income subsidy eligible individual enrolling in the employer/union-only group MA-PD plan as compared to enrolling in another Part D plan with a monthly beneficiary premium equal to or below the low-income premium subsidy amount.

Ability to Refund Low-Income Premium Subsidy Amounts

In accordance with 42 CFR 423.800, where the MAO offering the EGWP directly bills the employer/union sponsor's Part D eligibles for their premium contributions, the Part D sponsor is required to reduce up-front the premiums charged to reflect the low-income premium subsidy payments paid to the MAO by CMS on behalf of these individuals.

If, however, the MAO does not or cannot directly bill an employer/union group health plan's Part D eligibles, CMS will waive this up-front reduction requirement and permit the MAO to directly refund the amount of the low-income premium subsidy to the LIS beneficiary. This refund must meet the above requirements concerning beneficiary premium contributions; specifically, that the amount of the refund not exceed the amount of the MA-PD monthly premium contribution by the Part D eligible (or subscriber/participant, if applicable) and/or the employer/union sponsor. In addition, the MAO must refund these amounts to the beneficiary within a reasonable time period. However, under no circumstances may this time period exceed forty five (45) days from

the date that the MAO receives from CMS the low-income premium subsidy amount payment for the low-income subsidy eligible enrollee.

Alternatively, the MAO and the employer/union may agree that the employer/union will be responsible for reducing up-front the MA-PD premium contribution required for enrollees eligible for the Low-Income Subsidy. In those instances where the employer/union is not able to reduce up-front the MA-PD premiums paid by the enrollee (or subscriber/participant, if applicable), the MAO and the employer/union may agree that the employer/union shall directly refund to the Part D eligible (or subscriber/participant, if applicable) the amount of the low-income premium subsidy up to the MA-PD monthly premium contribution previously collected from the Part D eligible (or subscriber/participant, if applicable). The employer/union is required to complete the refund on behalf of the MAO within forty-five (45) days of the date the MAO receives from CMS the low-income premium subsidy amount payment for the low-income subsidy eligible enrollee.

Note that in some cases the LIS beneficiary may not be the subscriber to or participant in an employer/union sponsored group health plan, but the spouse or dependent of the subscriber/participant. In these instances, where the MAO or employer/union refunds low-income premium subsidy amounts to LIS enrollees, it may refund such amounts directly to the employer/union group health plan subscriber/participant on behalf of a spouse or dependent who is an LIS-eligible beneficiary.

Requirement to Retain and Provide Documents

As a condition of receiving the waivers and modifications described above and to support the MAO's compliance with the low-income pass-through requirements, CMS requires that all MAOs offering EGWPs retain documents and/or working papers that support their adherence to these requirements. These include documents evidencing that low-income premium subsidy amounts were properly passed through or refunded by either the MAO or the employer/union group plan sponsor and documents or working papers evidencing the calculation of "illustrative premium" for each self-insured/self-funded employer/union group plan sponsor. Also, MAOs will be required to retain all of these documents and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements at 42 CFR 422.503(d) and 422.504(d) and (e).

Requirement to Obtain and Provide Written Agreements With Employer/Union Group Plan Sponsors

As a condition of receiving the waivers and modifications described above, CMS also requires that all MAOs offering EGWPs enter into written agreements with employers/unions which require the employer/union to comply with the above requirements and to retain and provide documents upon request to the MAO evidencing the employer/union group plan sponsor's adherence to such requirements. This includes the requirement that any low-income premium subsidy amount paid to the

employer/union sponsor on behalf a LIS beneficiary is first used to reduce any portion of the monthly premium paid for by the Part D eligible (or subscriber/participant, if applicable). Also, if the employer/union assumes responsibility for either reducing up-front LIS beneficiaries' monthly premiums or refunding to LIS beneficiaries their monthly premium contributions, the MAO shall ensure that its written agreement with the employer/union also reflects the employer/union sponsor's assumption of these duties consistent with the above requirements (including a provision requiring that any refunds to a LIS beneficiary be completed within forty-five (45) days of the date the MAO receives the low-income premium subsidy amount payment for that beneficiary from CMS). MAOs will be required to retain all of these written agreements with employers/unions and must provide access to these written agreements for inspection or audit by CMS (or its designee) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e).

CMS Payment of LIS Premium Amounts to All EGWPs

Beginning in 2007, HPMS included a new table that provides all Part D sponsors with the monthly payments they are receiving to subsidize their low-income enrollees' premiums. These same payment amounts are reflected in the electronically generated reports received by all MAOs on a regular basis from CMS. HPMS will continue to have a separate table providing the low-income premiums that beneficiaries pay in the plans. However, HPMS will no longer display the low-income premiums for EGWP enrollees in this table. These amounts will be reflected as "N/A" for all EGWPs because, as stated above, the premiums for beneficiaries enrolled in these plans can vary, and CMS does not collect this information.

Note that beginning in 2007, the following rounding rules were used in determining EGWP LIS premium payment amounts: the base beneficiary premium ($27.35) was rounded to the nearest $.10 ($27.40) and was used as the Direct Contract or "800 series" plan premium. See 42 CFR 423.780(b)(1). The rounded base beneficiary premium was compared to the un-rounded low-income benchmark premium amount for the PDP region. If the low-income benchmark premium amount was less than the rounded base beneficiary premium, the low-income benchmark premium amount was rounded to the nearest $.10 to derive the low-income premium subsidy amount.

20.16.2 – Cost-Sharing Subsidy

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Benefits provided to EGWP enrollees cannot vary based on the Part D eligible's LIS eligibility. In addition, for an LIS Part D eligible enrollee in an EGWP, CMS will subsidize only those cost-sharing obligations actually imposed on the Part D eligible under the plan, which includes any supplemental prescription drug coverage offered by the employer/union group health plan sponsor, with the supplemental coverage primary to the LIS program.

For example, an "800 series" MA-PD Plan that provides benefits exclusively to employer X's Part D eligibles has a $100 deductible. For expenses incurred by a full subsidy eligible individual, CMS' payments to the plan will be determined based on that $100 deductible (minus any minimal co-pays an individual is responsible for under 42 CFR 423.782(a)). CMS payments will not be based on the plan having a $265 deductible (as reflected in Part D defined standard prescription drug coverage).
As noted above, beginning with the 2008 contract year, MAOs are no longer required to submit Part D EGWP bids. As a result, beginning in 2008, CMS will not pay interim prospective LIS cost sharing amounts to EGWPs because these amounts are directly derived from Part D bids. Instead, as a condition of the waiver of the requirements to submit a Part D bid, CMS will make LICS payments during the normal year-end reconciliation process.

20.17 - Non-Calendar Year EGWPs

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Many employers, particularly public employers, determine benefits and enroll individuals in plan years that differ from the calendar year. Many of these plan years are mandated by state laws, federal law or union contracts.

CMS has granted a waiver to permit MAOs offering EGWPs to establish non-calendar year plan benefit packages in HPMS in order to allow employer groups to determine benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis. However, for these non-calendar year plan benefit packages, most submissions to CMS, along with CMS payments, will be determined on a calendar year basis in a process similar to the process historically used for "800 series" MA plans.

Non-calendar year EGWPs will be subject to the following rules:

- All required submissions to CMS, including applications and formularies for such plans must be submitted at the same time as calendar-year EGWPs;

- With regard to Part D coverage, the plan must be actuarially equivalent to defined standard coverage for the portion of its plan year that falls in a given calendar year. A plan will meet this standard if it is actuarially equivalent for the calendar year in which the plan year starts and no design change is made for the remainder of the plan year. In no event can a plan increase during the plan year the out-of-pocket limit at which catastrophic coverage begins;

- Medicare direct subsidy payments will be based on the national average monthly bid amount for the calendar year for which the direct subsidy is being paid;

- Part D LIS payments and reconciliations will be determined based on the calendar year for which the payments are made;

- Prescription Drug Event (PDE) data will be reported to CMS on a plan year (i.e., non-calendar year) basis. Reconciliation, however, will be done on a calendar year basis;

- Certain benefits parameters (e.g., premium, cost sharing amounts) may be administered on a non-calendar plan year basis; however, other items such as formulary, deductible, gross covered drug spend and TrOOP may be administered on a calendar year basis; and

- Like all other EGWPs, CMS will allow Part D eligibles of an employer/union sponsored group PDP that operates on a non-calendar year basis to disenroll from such plan and enroll in another plan through a special enrollment period (SEP) (see Section 20.1.5 above).

Reinsurance and Risk Sharing Payments Not Available

With regard to Part D coverage, catastrophic reinsurance payments and risk corridor payments will not be made available to non-calendar year EGWPs (risk corridor payments are also not paid to calendar year EGWPs). However, the waiver of catastrophic reinsurance payments does not change the requirement for such plans to provide catastrophic coverage comparable to the standard benefit, though eligibility for such catastrophic coverage under the plan can be determined on a plan year basis.

Administration of Non-Calendar Year Plans

With regard to TrOOP and gross covered drug cost balance transfer requirements under the current TrOOP balance transfer process, two TrOOP and gross covered drug cost accumulations are necessary for Part D EGWPs. Plans must report TrOOP and gross covered drug cost balance transfers to a new plan of record as a calendar year accumulation when a beneficiary switches plans mid-year. However, plans will also be required to track TrOOP and gross covered drug cost on a non-calendar plan year basis in order to properly administer the non-calendar year benefit. If a beneficiary joins a non-calendar year plan during the middle of the plan year, any TrOOP and gross covered drug cost accumulation for costs incurred under a different plan between the beginning of the non-calendar plan year and the effective date of enrollment in the plan must carry over with the beneficiary.(Refer to discussion of non-calendar year plans and sample scenarios in the guidance on automated TrOOP balance transfer dated October 20, 2008.) Explanation of Benefit (EOB) beneficiary dissemination materials must reflect the benefit design and TrOOP and gross covered drug cost accumulation coinciding with the non-calendar plan benefit year. Note that once the new Financial Reporting Transaction process is implemented, non-calendar year EGWPs will no longer need to track TrOOP and gross covered drug cost accumulations on a separate, calendar year track since this

new method of TrOOP balance transfer will involve tracking these amounts on a month-by-month basis.

Note that if an employer/union group sponsor's plan year starts mid-calendar year and ends on December 31st, renewing on January 1 of the subsequent year, the EGWP is **not** considered a non-calendar year plan. Also, PDP sponsors are not allowed to extend an employer/union only group health plan year longer than 12 months. The PDP sponsor must offer the EGWP for a portion of the contract year which ends on December 31st and renews on January 1st of the subsequent year.

20.18 - Part D Formularies

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

The MAOs will not be required to submit to CMS every formulary variation offered to Part D eligibles enrolled in EGWPs. Rather, MAOs are permitted to submit a base formulary for use with its employer/union sponsored group health plans. After submission and approval of a base formulary, MAOs may enhance the formulary (add new drugs or make positive changes to cost sharing) without having to resubmit the formulary for review and approval by CMS. These formularies may not be modified to remove any drugs from the list, or to add any restrictions or limitations unless these modifications or removals are otherwise consistent with CMS requirements.

20.18.1 - Formularies for Non-Calendar Year Plans

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

CMS allows MAOs offering Part D to offer benefits on a calendar year and on a non-calendar year basis (if MAOs are approved to offer non-calendar year Part D EGWP plan benefit packages). Negative formulary change requests for non-calendar year Part D EGWPs are required to follow the same review and approval process as calendar year plans. Thus, the time frame for non-calendar year Part D EGWPs to make negative changes is the same as calendar year plans.

Non-calendar year Part D EGWPs may elect to convert to the conditionally approved formulary for the next calendar year on January 1st. The MAOs offering non-calendar year EGWPs that choose this option must provide appropriate beneficiary notice as specified in 42 CFR 23.120(b)(5). Alternatively, MAOs offering non-calendar year Part D EGWPs whose plan start date occurs after conditional approval of the formulary for the following calendar year (CY) may elect to use that formulary for the entire non-calendar plan year. Any further changes for the rest of the non-calendar year would have to be consistent with the process for updating CY 2008 formularies and requesting negative formulary changes as described in the HPMS memorandum, Updating CY 2008 Formularies, November 28, 2007.

The following example illustrates the above-stated policy. A non-calendar year Part D EGWP with a start date of October 1, 2008 could either:

- Use its CY 2008 conditionally approved formulary throughout the employer/union sponsor's plan year (October 1, 2008 –September 30, 2009) and make no negative changes;
- Use its CY 2008 conditionally approved formulary from October 1, 2008 – December 31, 2008 and its CY 2009 conditionally approved formulary from January 1, 2009 – September 30, 2009) and request negative changes through July 31, 2009 in accordance with the above-stated policy; or

- Use its CY 2009 conditionally approved formulary throughout the employer/union sponsor's plan year (October 1, 2008 – September 30, 2009) ;and request negative changes through July 31, 2009 in accordance with the above-stated policy.

20.19 - Beneficiary Customer Service Call Center Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

CMS has granted a waiver of the Part D beneficiary customer service call center hour requirements for all Direct Contract and "800 series" EGWPs offered by MAOs. See Addendum 2 - Customer Service Call Center Requirements of the Medicare Marketing Guidelines (as revised 7/25/06). These entities will be allowed to operate beneficiary customer service call center hours for their employer/union group health plan only enrollees that differ from the Part D requirements for plans offered to individual beneficiaries. These entities must ensure that a sufficient mechanism is available to respond to beneficiary inquiries and must provide customer service call center services to these Part D eligibles during normal business hours. However, CMS may review the adequacy of these call center hours and potentially require expanded beneficiary customer service call center hours in the event of beneficiary complaints or for other reasons in order to ensure that the entity's customer service call center hours are sufficient to meet the needs of its enrollee population. Also, CMS has granted a waiver of the Part D call center performance requirements for all Direct Contract and "800 series" EGWPs.

20.20 - Waivers Only Applicable to Direct Contract EGWPs

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

20.20.1 - Governmental Entities

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In general, governmental entities are not permitted to be PDP sponsors (Section 1860D-41(a)(13) of the Act). Therefore, CMS waived the prohibition against governmental entities applying to sponsor a PDP for their retirees, such as for state retirement funds and municipal or local government plans. Note, however, that such a waiver is unnecessary for MAOs. Section 1859(a)(1) of the Act allows a public (i.e., governmental) entity to become a Medicare Advantage Organization.

20.20.2 - State Licensure

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In general, an MAO must be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers coverage (42 CFR 422.400(a) and 42 CFR 422.503 (b)(2)). However, an employer/union applying to become an MAO solely for purposes of providing coverage to its members will not have to meet the state licensing requirements set forth at 42 CFR 422.400(a) and 42 CFR 422.503(b)(2) as a condition of being a Medicare Advantage Organization.

20.20.3 - Financial Solvency

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

An MAO generally must be licensed as a risk-bearing entity eligible to offer health insurance or health benefits coverage under State law. See 42 CFR 422.400(a). CMS waived the licensure requirement for employer/union direct contract MAOs that provide coverage to their own members pursuant to its waiver authority. However, as a condition of this waiver, CMS requires that these entities meet certain financial solvency standards.

The financial solvency requirements for employer/union direct contract MA PFFS plans are set forth in Appendix I of the 2009 Initial Application for Employer/Union Direct Contract Private Fee-for-Service (PFFS) Plans, dated January 24, 2008. CMS requires that the entity demonstrate that its fiscal soundness is commensurate with its financial risk, and that through other means, the entity can assure that claims for benefits paid for by CMS and beneficiaries will be covered. In all cases, CMS will require that the employer/union sponsor's contracts and sub-contracts contain beneficiary hold harmless provisions as described in Appendix I and in other CMS guidance. The employer/union may request waivers/modifications of the requirements in Appendix I by completing

Appendix III. CMS may, in its discretion, approve requests for such waivers/modifications on a case-by-case basis.

A MAO offering a PFFS plan may include Part D drug coverage (see 42 CFR 422.4(c)(3). If an employer/union direct contract PFFS Plan includes Part D coverage, it also must meet the separate financial solvency requirements set forth in Appendix I to the 2009 Solicitation for Applications for New Employer/Union Direct Contract Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors, January 24, 2008.

20.20.4 - Bonding and Insurance

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

An employer/union directly contracting with CMS as an MAO must meet the bonding and insurance standards described at 42 CFR 422.503(b)(4)(iv)-(v). However, CMS may, on a case-by-case basis, provide flexibility to an employer/union directly contracting with CMS as an MAO by waiving these requirements upon a demonstration that different federal or state legal standards (such as the Employee Retirement Income Security Act (ERISA) bonding requirements) are satisfied.

20.20.5 - Management and Operations

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In general, an entity seeking to contract with CMS as an MAO must have administrative and management arrangements that demonstrate the following pursuant to 42 CFR 422.503 (b)(4)(i)-(iii):

- Policy-making bodies exercising oversight and control to ensure that management actions are in the best interest of the organization and its enrollees;
- A quality improvement program and external quality review;
- Administration and management; and
- An executive manager whose appointment and removal are under the control of the policy-making body.

An employer/union directly contracting with CMS as an MAO may be subject to other potentially different standards governing its management and operations, such as fiduciary requirements under the Employee Retirement Income Security Act of 1974 (“ERISA”), state law standards, and certain oversight standards created under the Sarbanes-Oxley Act. To reflect these issues and avoid imposing additional (and

potentially conflicting) government oversight that may hinder employers/unions from considering MA direct contracts with CMS, the requirements at 42 CFR 422.503(b)(4)(i)-(iii), as noted above, are waived if the employer/union (or to the extent applicable, the business associate with which it contracts for benefit services) is subject to ERISA fiduciary requirements or similar state or federal law standards. However, such entities (or their business associates) are not relieved from the record retention standards applicable to other MAOs set forth at 42 CFR 422.504(d).

20.20.6 - Reporting Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

In general, MAOs must report certain information to CMS, to their enrollees, and to the general public (such as the cost of their operations and financial statements) under 42 CFR 422.516(a). To avoid imposing additional and possibly conflicting public disclosure obligations that would hinder the offering of employer/union sponsored group plans, CMS will modify these reporting requirements for Direct Contract EGWPs to allow information be reported to enrollees and to the general public to the extent required by other law (including ERISA or securities laws), or by contract.

30 - Employer/Union Sponsored PFFS Plans

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

30.1 – Requirement for All Employer/Union Sponsored PFFS Plans to Use Contracts with Providers Beginning 2011

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Section 162(a)(2) of Medicare Improvements for Patients and Providers Act (MIPPA) amended Section 1852(d) of the Act by adding a new requirement for employer/union sponsored PFFS plans. For plan year 2011 and subsequent plan years, MIPPA requires that all employer/union sponsored PFFS plans under Section 1857(i) of the Act meet the access standards described in Section 1852(d)(4) of the Act only through entering into written contracts or agreements in accordance with section 1852(d)(4)(B) of the Act, and not, in whole or in part, through establishing payment rates meeting the requirements under Section 1852(d)(4)(A) of the Act. Section 42 CFR 422.114(a)(4) describes this requirement.

In order to meet the access requirements beginning plan year 2011, an employer/union sponsored PFFS plan must establish written contracts or agreements with a sufficient number and range of health care providers in its service area for all categories of services in accordance with the access and availability standards described in Section 1852(d)(1)

of the Act. An employer/union sponsored PFFS plan will not be allowed to meet access requirements by establishing payment rates for a particular category of provider that are at least as high as rates under Medicare Part A and Part B. While an employer/union sponsored PFFS plan must meet access standards through signed contracts with providers, providers that have not signed contracts can still be deemed to be contractors under the deeming procedures in Section 1852(j)(6) that currently apply.

Sections 162(a)(2) of MIPPA is effective for plan year 2011 and subsequent plan years. Additional guidance on the implementation of these provisions will be provided in the 2010 Call Letter.

APPENDIX I

"800 series" EGWP Service Area Waivers Applicable for Contract Years 2006 and 2007 (Superseded by Subsequent Contract Year Employer Group Waivers)

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

I. Waivers Applicable in 2006 and 2007

A. Service Area Waiver for Non-Network Private Fee-For-Service (PFFS) Plans To Extend Coverage Beyond State (The "Nexus Test")

Private Fee-for-Service (PFFS) employer/union-only group plans are subject to the same service area rules as for other local MA plans. Thus, an MA organization offering EGWPs is limited to providing coverage to an employer/union sponsor's beneficiaries that reside within the State where the plan is licensed and where the plan offers non-group coverage.

Beginning in CY 2006, CMS granted a waiver of this service area requirement to allow employer/union-only group non-network PFFS plans to extend coverage beyond the normal service area to all Medicare beneficiaries of a particular employer/union group, regardless of where they reside in the nation. This waiver applied when the most substantial portion of the employer's employees (or in the case of a union, participants) reside in a State where the PFFS plan - either itself or through subcontractors or other partners - is a provider of non-group coverage. This waiver only applied to non-network PFFS MA-Only and PFFS MA-PD plans providing non-network MA coverage and Part D coverage (which requires networks).

EXAMPLE 1: An employer has 600,000 employees, of whom 400,000 live in California and 200,000 live in Florida. An MAO that serves the non-group market in California (or that contracts or partners with an entity serving the non-group market in California) can offer a PFFS plan sponsored by the employer that not only serves the employer's California members, but also those members in Florida or any other state in the nation.

EXAMPLE 2: An employer has 100,000 employees, of whom 45,000 live in New York, with the remainder spread out in smaller numbers among 20 other states. An MAO that serves the non-group market in New York (or that contracts or partners with an entity serving the non-group market in New York) can offer a PFFS plan sponsored by the employer that not only serves the employer's New York members, but also the members residing in the other 20 states where they reside.

Medicare beneficiaries in these plans can only be covered in areas where a corresponding bid has been submitted. No mid-year service area expansions are allowed. A "national" bidding approach allows non-network PFFS plans meeting the requirements of the waiver to cover Medicare eligible beneficiaries in any area of the country.

II. Waivers Applicable in 2007

A. Service Area Waiver for Local MA-Only and Local MA-PD Plans To Expand Coverage Beyond State For Certain Employer/Union Group VEBA Members

Beginning in CY 2007, CMS granted a waiver of the service area restrictions for MA Organizations offering local coordinated care "800 series" employer/union only group plans (i.e., local PPOs and HMOs) to employer/union members of a Voluntary Employee Beneficiary Association ("VEBA"). This waiver allowed an MAO to enroll employer/union VEBA members residing outside of their state service area when: (1) the individuals are beneficiaries of a VEBA that is headquartered in a state in which the MA Organization offers an MA-PD plan to individuals; (2) the MA Organization meets network access standards in the areas outside of their defined service area where these VEBA beneficiaries reside; and (3) the state allows the MA Organization to provide coverage to individuals in that state when the individuals are members of an employer/union plan contracted with the MA Organization in a state in which it is licensed as a risk bearing entity. Existing EGWP service area requirements will continue to apply for all other local coordinated care MA Organizations that do not meet the requirements of this specific waiver.

B. Service Area Waiver for Local MA-Only and Local MA-PD Plans To Expand Coverage Beyond State For Certain Public Employer Groups with Non-Calendar Year Benefit Plans

CMS granted a waiver of service area requirements for the 2008 contract year to MAOs offering local coordinated care plans (i.e., local PPOs and HMOs) under certain circumstances. Beginning in 2008, the waiver allows a MAO offering a coordinated care plan in a given service area (i.e., state) to extend coverage to an employer/union sponsor's beneficiaries residing outside of that service area when the MAO, either itself or through partnerships with other MAOs, is able to meet CMS provider network adequacy requirements and provide consistent benefits to those beneficiaries.

However, in order to accommodate employers whose plan benefit years operate on a non-calendar year cycle, beginning with the 2007 contract year, a MAO is allowed to extend its service area in the same manner outlined in the 2008 service area extension waiver policy under a specific set of circumstances. For those public employers (i.e., governmental entities) with plan benefit years operating on a fiscal year beginning in 2007, a MAO will be able to offer a local coordinated care plan (i.e., local PPOs and HMOs) in a given service area (i.e., state) to beneficiaries residing outside of that service area when the MAO, either itself or through partnerships or other arrangements with

other MAOs, is able to meet CMS provider network adequacy requirements and provide consistent benefits to those beneficiaries. This modification of the 2008 waiver policy was necessary to facilitate the offering of coverage for public employers that may have less flexibility to modify its plan benefit year and the coverage offered because of procedural or contractual requirements (e.g., the public sector legislative process).

APPENDIX II

Instructions for Providing Copies of Disclosure Materials to CMS for Contract Years 2006-2008

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

What Materials to Send

For contract years 2006, 2007 and 2008, all Direct Contract MAOs and MAOs that offer "800 series" plans must provide copies of all disclosure materials to the CMS Central Office at the time of use. If the materials for multiple employer/union sponsors are identical except for sponsor identifier information, CMS will not require duplicate submissions of such materials (i.e., submission of one "template" version is permissible). Note that these same requirements to provide copies of customized disclosure materials at the time of use will apply to MAOs that elect to utilize the waiver outlined in Section 20.3.2.1.1 above on behalf of employers/unions that sponsor an individual MA plan (e.g., use an individual Medicare plan paired with a non-Medicare supplemental plan designed to "wrap around" or enhance the individual Medicare plan to provide coverage to members).

For an employer/union sponsor plan eligible for the alternative disclosure standards waiver referenced above in Section 20.3.2.2, a MAO that offers "800 series" plans to these employer/union sponsors may provide copies to CMS of the alternative disclosure materials or, alternatively, the information that would be necessary to satisfy its reporting and disclosure obligations under 42 CFR 422.516(d) and 423.514(d). 42 CFR 422.516(d) and 423.514(d) provide that entities must furnish, upon request, the information that any employees' health benefits plan needs to fulfill its reporting and disclosure obligations under ERISA. All information intended to satisfy 42 CFR 422.516(d) and 423.514(d) must be provided to CMS prior to November 1st.

How to Send the Materials

All marketing and disclosure materials must be sent to CMS via e-mail (in Microsoft Word or PDF format) to the following e-mail address: EGWPdisclosure@cms.hhs.gov. If the materials are subject to Medicare standards, include in the subject line of the e-mail "Medicare Disclosure Materials for Contract #xxxxx". If the materials are subject to alternative disclosure standards in accordance with the waiver outlined in Section 20.3.2.2 above, include in the subject line of the e-mail "Alternative Disclosure Materials for Contract #xxxxx". For all materials, also provide in the body of the e-mail the type of document being submitted (e.g., Summary Plan Description, Information Required to Satisfy 42 CFR 422.516(d) and 423.514(d), etc.) and contact information (a contact name, phone number and e-mail address) if there are questions concerning the materials.

Materials must not be submitted through HPMS for any Direct Contract or "800 series" plan. Employer group plan sponsored materials also must not be submitted through HPMS when a MAO elects to use the waiver outlined in Section 20.3.2.1.1 above to customize disclosure materials for a particular employer/union sponsor that offers coverage to its members using an individual Medicare plan paired with a non-Medicare supplemental plan designed to "wrap around" or enhance the individual Medicare plan.

APPENDIX III

HPMS Technical Plan Bidding Instructions for Organizations Offering Part D Employer/Union-Only Group Waiver Plans in Contract Year 2009

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Starting in contract year (CY) 2008, Part D entities that offer employer/union-only group waiver plans (EGWPs) were no longer required to complete Part D Bid Pricing Tool (BPT) submissions. Please see 2008 Employer Group Waiver Policy – Elimination of the Requirement for Entities Offering EGWPs to Submit Part D Bids, February 28, 2007. This waiver policy has been extended to CY 2009. As noted in the memo, this waiver policy applies to all MA, PDP, and 1876 Cost organizations offering Part D EGWPs (i.e., "800 series" EGWPs) as well as to employers/unions that directly contract with CMS to offer Part D benefits to their retirees (i.e., "Direct Contract" EGWPs).

NOTE: CMS' employer group waiver authority applies only to Part D, not to Parts A or B of the Cost Plan. Thus, section 1876 Cost Plan Sponsors may only offer "800 series" Part D coverage as an optional supplemental benefit and may not offer customized "800 series" A/B benefits.

CMS has also modified the corresponding Plan Benefit Package (PBP) submission requirement for all EGWPs offering Part D.

The following table outlines the HPMS PBP and BPT submission requirements for each type of Part D EGWP for the 2009 contract year:

	A	B
PBP Section/BPT	**MA-PD "800 series" EGWP and Direct Contract MA-PD EGWP**	**PDP and 1876 Cost "800 series" EGWP and Direct Contract PDP EGWP**
PBP Section A	Yes	Yes
PBP Sections B, C, and D	Yes	No
PBP Rx Section	No	No
MA BPT	Yes	No
PD BPT	No	No

Plans that fall under column A will download and install the 2009 PBP software, create their 2009 plans, and download their plan-specific data into the software, per the usual process. Column A plans will complete sections A, B, C, and D of the 2009 PBP software, but the Rx Section of the PBP will be disabled. Column A plans will also complete the MA BPT.

Plans that fall under column B will download and install the 2009 PBP software, create their 2009 plans, and download their plan-specific data into the software, per the usual

process. While no actual data entry is required in Section A of the PBP for PDP plan types, plans are still required to open Section A, review the plan information, and exit Section A with validation.

All plans outlined in column A and B are required to upload their plans into HPMS, per the usual process. In addition, these plans are still required to meet all applicable pre-upload submission requirements to upload plans into HPMS.

NOTE: Plans that fall under column B are required to complete the upload process as a mechanism for establishing their official set of plan IDs for the 2009 contract year in HPMS.

APPENDIX IV

Instructions for MA Organizations and PDP Sponsors Requesting Additional Waiver/Modification of Requirements

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

Medicare Advantage organizations and PDP sponsors may submit individual waiver/modification requests at any time to CMS. The Applicant should submit these additional waiver/modification requests to their Account Manager.

These requests must be identified as requests for additional waivers/modifications and must fully address the following items:

- Specific provisions of existing statutory, regulatory, and/or CMS policy requirement(s) the entity is requesting to be waived/modified (please identify the specific requirement (e.g., "42 CFR 422.66," or "Section 40.4 of Chapter 2 of the Medicare Managed Care Manual (MMCM)") and whether you are requesting a waiver or a modification of these requirements);
- How the particular requirements hinder the design of, the offering of, or the enrollment in, the employer-sponsored group plan;
- Detailed description of the waiver/modification requested including how the waiver/modification will remedy the impediment (i.e., hindrance) to the design of, the offering of, or the enrollment in, the employer-sponsored group plan;
- Other details specific to the particular waiver/modification that would assist CMS in the evaluation of the request; and
- Contact information (contract number, name, position, phone, fax and email address) of the person who is available to answer inquiries about the waiver/modification request.