Updated 01/04/06

ADDITIONAL PART D WAIVER GUIDANCE FOR EMPLOYER/UNION RETIREE COVERAGE
April 6, 2005

Introduction

CMS has the authority under sections 1860D-22(b) and 1857(i) of the Social Security Act (Act) to waive or modify Part D requirements added by the Medicare Modernization Act (MMA) that hinder the design of, the offering of, or the enrollment in an employer or union-sponsored Part D retiree plan (including a Medicare Prescription Drug Plan (PDP) or a Medicare Advantage (MA) Plan with prescription drug coverage). Although an employer or union-sponsored MA-PD may be offered to both retirees and active employees (and their dependents) who are Medicare beneficiaries, in accordance with section 1860D-22(b) of the Act, an employer or union-sponsored PDP may only be offered to retirees. In considering the extent to which it will exercise its waiver authority, CMS will consider a number of important goals, including:

- Providing group Part D plan sponsors (defined as Part D Organizations offering group plans and employers or unions who directly contract with CMS) with maximum flexibility and minimum administrative burden with regard to requirements that would hinder the design of, the offering of, or the enrollment in, Part D plans offered to their retirees (and active employees in the case of a MA-PD) so they will keep offering --- and retirees can retain -- high quality retiree prescription drug coverage;
- Adhering to budgetary constraints; and
- Considering the appropriate protections that Medicare enrollees may expect when enrolling in a Part D plan.

This guidance waives or modifies Part D requirements and elements of the Part D application process that CMS believes hinder the design, offering of or enrollment in employer or union-sponsored Part D coverage. Given the erosion of retiree coverage over time, the different ways in which employer and union retiree coverage have historically been regulated and designed as compared to standards for Part D benefits, and the limited time available for employers, unions and Part D Organizations to consider available options under the MMA, CMS believes the guidance is needed to ensure that the customized Part D benefit is a viable option for employers and unions seeking to retain high quality retiree coverage. At the same time, the guidance has been designed to take into account important policy goals and beneficiary protections built into the Part D rules, and budgetary considerations.

The waivers listed below supplement and modify those described in the waiver guidance for employer/union retiree coverage issued on February 11, 2005 and the additional waiver guidance issued on March 9, 2005 at http://www.cms.hhs.gov/EmpGrpWaivers/01_Overview.asp. The waivers will automatically apply and will not need to be granted to each employer or union Part D

plan on an individual basis. Except as noted, the waivers in this guidance apply both to Part D plans in which employers and unions directly contract with CMS to be Part D sponsors, and to other entities contracting with employer or unions to offer employer or union-sponsored Part D plans.

Waivers are not applicable to other MMA options for employers and unions providing prescription drug coverage to their retirees. For example, waivers do not apply to employers or unions electing to receive a tax-free 28% retiree drug subsidy with respect to retirees receiving coverage that is at least as good as Medicare's Part D defined standard prescription drug benefit. This guidance is not intended to address standards that apply under any of those other options.

CMS will consider additional waiver requests relating to specific requirements not addressed in this document or in our prior guidance on a case-by-case basis.

Service Area for Employer/Union Group Plans Offered by MA-PDs and PDPs that Serve the Non-Group Market

Background

Under most MMA options available to employers and unions sponsoring drug coverage – including the 28% retiree drug subsidy program – sponsors can select the entities providing or administering such coverage without Medicare regulation of the regions of the country served by those entities. However, service area conditions apply to drug coverage for Medicare beneficiaries through Medicare Advantage (MA) plans, and through MA plans offering prescription drug coverage (MA-PDs) and prescription drug plans (PDPs), as follows:

- Prior to the passage of the MMA, CMS permitted the service area identified for an employer or union-sponsored MA plan to be larger or smaller than the service area offered by the same MA organization provided the MA organization offered at least one MA plan to individuals somewhere in the same state as it offered the employer or union-sponsored plan. The area offered within the state to individuals could be an area smaller than the state (e.g. at least one county).

- Under the MMA, PDPs and Regional MA-PDs must offer coverage to all individuals who reside in one or more specified regions. The MMA did not change the service area for local MA plans. On February 11, 2005, CMS released guidance that allows employer and union direct contracting PDPs and MA-PDs plans to restrict enrollment to retirees only. Further, the guidance waived service area requirements for an employer/union retiree plan if the employer/union directly contracts with CMS as a PDP sponsor or MA organization. Thus, for these direct contracting employer-union plans, coverage can be extended to all retirees, regardless of where they reside in the nation.

This guidance addresses service area-related issues for employer/union-sponsored Part D arrangements not discussed in the February 11 guidance – i.e., those MA-PDs and PDPs that do not involve direct contracts between CMS and the employer or union.

MA-PDs

Service Area Rules. CMS service area rules for MA plans prior to passage of the MMA will continue to apply to local MA-PD plans (and MA-only plans). Thus, if an MA organization provides coverage to individuals in any part of a State, it can offer an employer/union-sponsored MA-PD plan in any area within that State or throughout the entire State.

An MA Organization offering a MA-PD regional plan to individuals residing in a particular MA region may offer an employer/union sponsored MA-PD plan in any area within the MA region or throughout the entire MA region. CMS may, on a case-by-case basis, grant a waiver to permit a regional MA or MA-PD providing coverage under an employer or union-sponsored retiree plan to extend coverage to the employer or union retirees living outside such region.

Out of Service Area Coverage Options. Employers and unions sponsoring retiree coverage through an MA-PD have several options for providing coverage outside that MA-PD's service area. They include:

- receiving payments under the 28% retiree drug subsidy program for qualifying prescription drug coverage, and providing hospitalization and other health benefits that supplement benefits provided to the retirees under Medicare Parts A and B;
- providing prescription drug coverage for out-of-region retirees through a separate, stand-alone PDP (under rules described below) and providing hospitalization and other health benefits that supplement Medicare Parts A and B; or
- using an MA-PD that partners with or enters into reciprocal arrangements with other MA-PDs that can provide the coverage in those other service areas.

Retiree-Only Group PDPs

Service Area Rules. A PDP sponsor is permitted to offer a retiree–only PDP plan to employers or unions in a given PDP region of the country if the sponsor - either itself or through subcontractors or other partners - provides PDP coverage to Part D eligible individuals (non-retirees) in that region. Moreover, through the waiver authority permitted in section 1860D-22(b) of the Social Security Act, CMS will permit such PDP sponsors to expand coverage under such plans to retirees residing in other regions through contracts and other arrangements it chooses to use in providing such expanded coverage.

For these purposes, an employer is treated as being in the PDP region where the most substantial portion of its employees reside. A multiemployer union fund is treated as being in the PDP region where the most substantial portion of its participants reside.

Example 1. An employer has 600,000 employees, of whom 400,000 live in California and 200,000 live in Florida. A PDP sponsor 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 PDP sponsored by the employer that not only serves the employer's California retirees, but also those retirees 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. A PDP sponsor 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 PDP sponsored by the employer that not only serves the employer's New York retirees, but also the retirees residing in the other 20 states where they reside.

A PDP sponsor that does not meet the substantial portion test described above for a given employer or union may provide retiree-only PDP coverage for the retirees in any region where the PDP provides PDP coverage to individuals (non-retirees).

The foregoing service area rules are summarized in this table:

Region for Non-Retiree Coverage	**Largest Region for Employer/Union Retiree Group Coverage**
No coverage in non-retiree market	Employer/union-sponsored PDP coverage prohibited. However, other MMA options are available for nationwide coverage, including the 28% retiree drug subsidy for qualifying retiree prescription drug plans. (Entities can offer prescription drug coverage that qualifies for the 28% subsidy without being a PDP sponsor.)
Region where most substantial portion of employees (or for union funds, participants) reside	Nationwide
Region other than where most substantial portion of employees (or for union funds, participants) reside	Limited to that same region

Out of Service Area Coverage Options. An employer or union that currently provides retiree prescription drug coverage through an entity that does not meet the above standards has options for continuing to use such entity and receive prescription drug-related assistance under the MMA. For example, the employer or union can:

- receive payments under the 28% retiree drug subsidy program for qualifying prescription drug coverage (as noted above, such rules do not require entities to be PDP sponsors or offer coverage to non-retirees); or
- provide separate prescription drug coverage that supplements PDP coverage obtained by its retirees.

In addition, the prescription drug vendor can use subcontractors or partners that qualify as PDPs as a means of providing PDP coverage under the rules described above.

Submission of Part D Bids

For the non-group market, Part D bids must be submitted to CMS by June 6, 2005 for the 2006 year. In the initial Employer/Union Part D waiver guidance issued by CMS on February 11, CMS extended the dates for submission of notices of intent, applications and formularies for Part D plans offered by an employer or union directly contracting with CMS and employer or union-sponsored Part D plans offered by MA Organizations and PDP sponsors also offering Part D plans to the non-group market. These extended timeframes will give employers and unions more time to consider the various options available to them under the Medicare Modernization Act. With this waiver guidance, CMS will provide flexibility on the timing of submission of employer or union-sponsored Part D plan bids (both direct contract and MA-PD and PDP group plan), with a modified payment method described below.

Timing

Because of the flexibility to retain current drug benefit designs and vendors, CMS expects and encourages most employers to avail themselves of the tax free 28% subsidy for retiree drug coverage in 2006. However CMS recognizes that some employers, such as state and local governments, do not receive the full tax benefits of the subsidy and may prefer to enroll their retirees in a Part D plan. Thus, for 2006, CMS will use the employer/union waiver authority to extend the deadline for submission of Part D bids for employer or union-sponsored retiree plans to July 1, 2005, provided that bids for regional MA-PD employer/union plans will be required by June 6, 2006 to calculate the regional MA benchmark. CMS will not include employer or union Part D bids in the calculation of the Part D national average monthly bid amount or the low income premium benchmark amounts in 2006.

Design

Part D plan sponsors (both Part D plans and employer/union direct contractors) will submit Part D bids for employer or union retiree coverage in a manner similar to the flexible method offered to MA Organizations in the past. Under this approach, CMS will require group Part D plan sponsors to submit bids for employer or union-sponsored plans only for the standardized Part D coverage. They will not submit separate bids in 2006 for each employer/union benefit design variation. Any supplemental prescription drug coverage will be provided separately pursuant to a private agreement between the Part D plan sponsor and the employer/union, or in the case of a direct contract will be provided separately by the employer or union.

These private supplemental coverage arrangements cannot reduce the value of the basic standardized Part D benefit design. For example, supplemental coverage cannot impose a cap that would preclude group members 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 will require that the Part D plan sponsor that is submitting the Part D bid for the standard benefit design also provide an attestation that the total employer or union sponsored plan (including adjusting for any supplemental coverage) is providing at least the standard Part D coverage, including (for 2006) a deductible no higher than $250, full coverage between the deductible and the $2250 initial coverage limit (for which the standard Part D benefit pays 75% and the beneficiary pays 25%), and catastrophic coverage after the $3600 true out-of-pocket limit is met. (If the group plan sponsor avails itself of the waiver offered in the March 9, 2005 employer waiver guidance that permitted flexibility to offset increased cost sharing between the $250 deductible and initial coverage limit by other design changes that ensure the plan is at least actuarially equivalent to Part D, the attestation must reflect that modified design.)

Payment

CMS believes the above waivers are necessary to remove administrative burdens that would hinder the offering of employer and union-sponsored Part D plans, including the approval of such plans. As a condition of providing such waivers, however, risk corridor payments (which assist Part D plan sponsors entering a new market without any experience to mitigate any losses or gains by sharing these losses or gains with Medicare) will not apply to group Part D employer or union-sponsored plans.

In addition, CMS will modify the way catastrophic reinsurance is paid. CMS will not make a prospective payment for reinsurance but will include the group plans in the normal Part D reinsurance reconciliation at year end. Since no prospective payments will have been made during the year, the result of the year end process will be the full reinsurance payment due to the plan. We expect that most employers will be providing enhanced drug coverage through supplemental arrangements and these reinsurance payments will be small as a result of the application of True Out of Pocket Costs (TrOOP) rule. Low Income Subsidies (discussed below) will be paid through the normal

Part D process, which involves an estimate as part of the bid with a reconciliation at year

end. Thus, this payment method should provide administrative flexibility to both retiree plan sponsors and CMS.

Finally, the federal Part D direct subsidy risk adjusted payment will be based on the national benchmark rather than on the bid submitted by the employer or union plan sponsor.

Uniform Premium Requirements

In general, each Part D plan that provides coverage in the non-employer market must charge a uniform premium for each beneficiary enrolled in that plan. Further, the premium for each beneficiary in a defined standard Part D plan is determined by the difference between the plan's bid and the national benchmark. That amount (referred to here as the "standard Part D beneficiary premium") is established through the bidding process. The plan can also charge up to 100% of the value of any supplemental prescription drug coverage provided in conjunction with the Part D plan.

Under its waiver authority, CMS will allow the employer or union sponsoring a Part D plan to have flexibility to determine how much of a plan enrollee's Part D monthly beneficiary premium they will subsidize, subject to the following conditions. First, an employer or 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, business location, job category, and nature of compensation (e.g. salaried v. hourly). Different classes cannot be based on eligibility for the Low Income Subsidy described below. Second, the premium cannot vary for individuals within a given class of enrollees. Third, an enrollee cannot be charged more than the sum of his or her standard part D beneficiary premium and 100% of the premium for his or her supplemental prescription drug coverage (if any). Thus, direct subsidy payments from CMS to the Part D plan must be passed through to reduce the amount that the beneficiary pays. Part D sponsors that offer MA-PD or PDP plans to employers or unions will be required to obtain in writing from such employers or unions their agreement that they will satisfy the requirements of this waiver with respect to the premiums charged to their participants.

Low Income Subsidy

In general, the Low Income Subsidy (LIS) provisions of Subpart P of the final rule for the Medicare prescription drug benefit (423.771 et. seq.) apply to employer and union-sponsored Part D plans in the same manner as they apply to other Part D plans. For each beneficiary entitled to the LIS, CMS pays the beneficiary's premium (up to the low income premium subsidy amount) and cost sharing obligations minus the beneficiary's cost-sharing responsibilities under the LIS rules.

Premium

CMS will require that the LIS premium subsidy that CMS is paying on behalf of the LIS eligible retiree be passed through to that retiree under rules similar to those described above with respect to the uniform premium requirements. In other words, the monthly premium subsidy amount for a beneficiary eligible for the low-income subsidy must first be used to reduce the portion of the monthly beneficiary premium paid for by the beneficiary, with any remainder then used to reduce the employer's premium contribution. For example, if under the terms of the retiree plan, the beneficiary is responsible for paying $20 of a $40 monthly premium with the employer paying the remaining $20, a monthly low income premium subsidy amount of $35 would be used first to reduce the beneficiary's liability to $0, and then to reduce the employer's liability from $20 to $5. In the case of Part D sponsors that provide MA-PD or PDP plans to employer/union retiree plans, the Part D sponsors must obtain written agreements from such employers or unions indicating that they will satisfy these requirements with respect to the premium contributions collected from their retirees. Such Part D sponsors will also identify the LIS-eligible retirees for the employers/unions or their prescription drug providers, as necessary.

If the low income premium subsidy amount is less than the beneficiary premium contribution under the employer or union-sponsored part D plan (including any beneficiary premium contribution for supplemental benefits), employer and union plan sponsors should communicate with their LIS retirees the premium impact of remaining in the employer plan versus enrolling as an individual in another Part D plan.

Cost Sharing

Benefits provided in an employer or union-sponsored retiree-only Part D plan cannot be determined based on the retiree's LIS eligibility. In addition, for an LIS retiree in a retiree-only plan receiving a waiver, CMS will pay only the cost-sharing obligations imposed on the retiree under the plan. For this purpose, the employer/union plan must be designed to include supplemental coverage offered by the Part D sponsor to the employer or union, with the supplemental coverage primary to the LIS program.

For example, a Part D plan that provides benefits exclusively to employer X's retirees has a $100 deductible. For expenses incurred by a full subsidy eligible individual, CMS's 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 assumption the plan has a $250 deductible (as reflected in Part D standard prescription drug coverage).

Finally, the Part D sponsor of a retiree plan will be required (like other Part D plan sponsors) to submit as part of its bid an estimate of its LIS cost sharing, and submit at the end of the year information needed for a final reconciliation. The estimate must take into

account the aggregate effect on LIS payments of any supplemental coverage(s) not submitted as part of the bid to CMS.

Premium Withholding for Employer/Union Sponsored Group Plans

Under the MMA, Part D plans must permit their enrollees, at their option, to pay their Part D premium through deductions from their Social Security checks, Railroad Retirement checks, or Federal annuity. When employers also contribute to the beneficiary's Part D premium, in whole or in part, operationally for 2006 it will be extremely difficult for both plans and CMS to factor in the employer contribution and adjust the amount of the premium that should be deducted from the beneficiary's Social Security or other check. Thus, CMS will waive the requirement that the employer/union-sponsored Part D plan provide beneficiaries the option to pay their premium through Social Security withholding. Thus, the premium withhold option will not be available for enrollees in employer-union sponsored group plans. These plans will be required to bill the beneficiary and/or the employer directly (as Part C plans do today).

Non Calendar Year for Employer Only Part D Plans

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

CMS will use its waiver authority to permit employer or union-sponsored Part D plans to determine benefits (including deductibles, out-of-pocket limits, etc.) on a non-calendar year basis. However, bids and other submissions to CMS, along with CMS payments, will be determined on a calendar year basis, in a process similar to the process currently used for employer and union-sponsored MA plans. Under that process:

- Applications, formularies and bids for such plans must be submitted at the same time as calendar-year employer and union-sponsored Part D plans for the calendar year that follows the calendar year of submission.
- In a given month the standard Part D beneficiary premium (as discussed in the section above regarding uniform premiums) will be based on the difference between the plan's bid and the national average monthly bid amount benchmark for the calendar year in which that month falls.
- 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 benchmark for the calendar year for which the direct subsidy is being paid

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

Catastrophic reinsurance payments and (to the same extent as other employer or union-sponsored Part D plans) risk corridor payments will not be made available to such employer or union-sponsored Part D plans. 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.

For plan years that begin in 2005, the following special transition rules apply. CMS payments (direct subsidy and LIS) will apply for the period beginning January 1, 2006, based on applications, formularies and bids submitted in 2005 at the times described above and in other waiver guidance. Plans will be required to track deductibles and other beneficiary expenditures from the start of the plan year. Plan design and beneficiary premiums must meet the other standards applicable to Part D employer group plans starting January 1, 2006. Of course, another option for non-calendar year plans is to take the 28% subsidy for the partial year.

CMS will allow members of an employer or union Part D retiree plan that operates on a non-calendar year basis to leave such plan and enroll in another Part D plan through a special enrollment period (SEP) at the beginning of the month following the end of the employer/union plan year.

Group Enrollment

To the extent the employer or union is a beneficiary's authorized representation under applicable law, with the authority to act on behalf of the beneficiary for purposes of enrollment in a Part D plan, an employer or union may enroll the beneficiary into its Part D plan. If the employer or union is not a beneficiary's authorized representation, CMS will waive individual enrollment provisions under 423.32 to allow employer group plans to enroll their retirees under a special group enrollment process. In addition, the employer will also be required to provide CMS with any information it has on other insurance coverage for purposes of coordination of benefits.

As part of the group enrollment process, all beneficiaries must be advised that the employer intends to enroll them into the Part D plan that the employer or union is offering unless the beneficiary affirmatively opts out of such enrollment. This information must be provided at least 30 days prior to the effective date of a beneficiary's enrollment in the employer or union-sponsored Part D plan. The information must also include a summary of benefits offered under the employer or union-sponsored plan, an explanation of how to get more information on such plan, and an explanation of how to contact Medicare for information on other Part D plans that might be available to the beneficiaries. In addition, all information necessary to effectuate enrollment must be

submitted electronically consistent with instructions that CMS will provide at a future date.

For More Information

A significant amount of information regarding Part D plans (including applications, formulary information, a place to register for user group calls, and other implementation materials) can be found at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.