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MEDICARE PART D CREDITABLE COVERAGE DISCLOSURE TO CMS

December 2023

BACKGROUND

Each year, plan sponsors must disclose to the Centers for Medicare and Medicaid Services (CMS) the group health plan's creditable coverage status for prescription drug coverage. This information is used to help CMS determine when there might be other coverage creditable available to individuals who are eligible for Medicare.

WHO HAS TO REPORT

Any employer sponsoring a group health plan that provides prescription drug coverage is required to determine the plan's creditable status and report to CMS. There really are not any exceptions, even for small employers. This reporting is typically not done by the insurance carrier or the third-party administration (TPA), but instead must by handled by the employer. Note that this reporting requirement is separate and distinct from the Medicare Secondary Payer reporting requirements under Section 111 that are due to CMS on a quarterly basis and typically handled the insurance carrier or TPA.

WHEN TO REPORT

This reporting is due within 60 days of the beginning of each new plan year. For example, for calendar year plans, the due date will be March 1 (or February 29 if a leap year). In addition, disclosure must be made within 30 days after termination of the prescription drug plan, and within 30 days after any change to the creditable status of the prescription drug plan. This reporting is separate from the required Medicare Part D creditable/non- creditable coverage notice that is provided to participants upon initial eligibility and annually each year.

HOW TO REPORT

- CMS has provided detailed instructions that include screen shots. That document can be located here: *CredCovDisclosureCMSInstructionsScreenShots110410.pdf*.
- Start by navigating to the CMS *online portal* and follow the prompts.

INFORMATION YOU WILL NEED TO COMPLETE THE REPORTING

General employer information – Employers should report using the name and federal ID number (EIN) of the plan sponsor. If multiple employers within a controlled group are covered under the same plan, the EIN for the parent company (or other entity if it is the plan sponsor) may be used under a single filing. If each individual entity reports separately, each should report using its own EIN. The EIN of the insurance carrier or third-party administrator should not be used.

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Type of coverage – Most employers will choose "Group Health Plan: Employer Sponsored Plan," but there are also options for church plans and state and local government plans.

Plan option information – Employers must report the number of prescription drug options offered and the creditable or non-creditable coverage status for each (i.e., number of group health plan options offered with different prescription drug benefits).

DETERMINIG WHETHER AN EMPLOYER'S PERSCRIPTION DRUG COVERAGE IS CREDIBLE

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D. In other words, coverage is creditable if the expected amount of paid claims under the coverage is at least as much as the expected amount of paid claims under the standard Medicare Part D benefit. Often an insurance carrier or third-party administrator will provide information to a plan sponsor detailing whether a plan's drug coverage is creditable. But if a plan sponsor does not receive this information from the carrier or administrator, the plan sponsor (e.g., the employer) is responsible for making the determination, or hiring an actuary to help with the determination.

Some plans meeting the simplified determination method can assume their coverage is creditable. See the criteria for the simplified determination method here – *https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/CCSimplified091809.pdf*. If a plan does not meet the criteria under the simplified determination method, that does not automatically mean the plan is not creditable; but in that case, the plan must obtain an actuarial determination of whether the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D.

NOTE: For high deductible health plans (HDHPs), the prescription drug coverage will typically be integrated with the HDHP (i.e., shared deductible and maximum limits, if any), in which case the HDHP will not meet the simplified determination criteria for creditable coverage status because the annual deductible will always exceed $250. This does not mean that an HDHP can never qualify as creditable coverage. If the carrier or administrator does not advise as to the creditable status of the HDHP, it may require an actuarial determination to determine creditable status.

Estimated number of Medicare Part D individuals covered under each plan – CMS will accept a reasonable estimate of how many Medicare eligible individuals are expected to be covered under the plan. Remember that dependents can be Medicare eligible, and eligibility may be based on age, disability, end-stage renal disease, or ALS. The form also asks how many Medicare-eligible individuals are expected to be covered by a retiree plan.

- If the employer offers retiree coverage, the employer should indicate how many Medicare-eligible individuals are expected to be covered by the retiree coverage.
- If the employer does not offer retiree coverage, "0" should be entered.

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Date of creditable coverage notice distribution – The most recent date (MM/DD/YYYY) that the required annual creditable or non-creditable Medicare Part D Notice was distributed to participants.

FREQUENTLY ASKED QUESTIONS

Q. Is the disclosure to CMS tied to a group health plan's plan year, policy year, or fiscal year?
A. The disclosure to CMS should be tied to the ERISA plan year, which may be different than the plan's contract year with the carrier or the employer's fiscal year. Ideally, the ERISA plan year is set forth in plan documentation.

Q. After submitting the online disclosure, I realized that I had made a mistake. How can I correct that?
A. Fixing submission errors requires a new disclosure submission, which will override previous submissions.

Q. Due to turnover in HR, it appears the reporting was not done last year. Is there a way to find out if the disclosure was submitted to CMS for previous years?
A. We are not aware of any way to look up whether a plan has previously submitted this disclosure. However, there is no specific penalty for failing or being late to report to CMS for this disclosure requirement. The only specified penalty relates to a retiree plan attempting to receive the retiree drug subsidy...such a plan would be denied the subsidy if it had not complied with the required Medicare Part D notifications. As reporting is required it is our recommendation that you report now (late) and going forward on a timely basis.