DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CENTER FOR DRUG AND HEALTH PLAN CHOICE

DATE: January 14, 2009

TO: Part D Plan Sponsors

FROM: Anthony Culotta, Director
Medicare Enrollment and Appeals Group

SUBJECT: Updated Attestation Forms for Reporting Creditable Coverage

The purpose of this memorandum is to provide updated model attestation forms and related materials to be sent to beneficiaries to determine whether they had creditable coverage prior to enrolling in a Medicare prescription drug plan or during a subsequent break in prescription drug coverage. The updated materials, described further below, are the result of a series of in-depth interviews with beneficiaries. We believe that these materials will be better understood by beneficiaries and more likely to generate a timely, correct response to the questions posed in the attestation form.

As with previous versions, these are model materials that may be modified, subject to CMS review and approval. However, we again strongly urge plans to refrain from adding extraneous information to the documents, or from putting their own letterhead on the documents, except where indicated on the attestation form. Plans must begin using these new models with enrollments received on or after **April 1, 2009**, but may begin using them sooner and are, in fact, encouraged to do so. Neither the previous model nor previously-approved notices should be used after that date. We believe that using these new models will be in the best interests of both plans and beneficiaries, since timely completion of the form will reduce the burden associated with the reconsideration process on all parties involved.

Background

Organizations are required to mail an attestation form to solicit information about possible gaps in creditable coverage from beneficiaries who enroll in Medicare drug plans after they are first eligible, or who experience a break in such coverage of 63 or more consecutive days. (See our guidance at section 10.2 of Chapter 4: Creditable Coverage Period Determinations and the Late Enrollment Penalty (LEP)). Our experience has shown that the majority of requests for reconsideration of the LEP are from beneficiaries who had creditable coverage during the period in question, but failed to submit or complete the attestation form. In these cases, our independent review entity, Maximus, ultimately issues a favorable decision for those beneficiaries who can show that they had prior creditable coverage, but not until considerable time and resources have been expended on the part of the beneficiary, the plan, Maximus, and CMS.

In our previous memorandum, dated April 11, 2008, we outlined a number of steps we have taken to address this issue, including simplifying the current attestation form and creating a new model checklist designed to focus beneficiaries' attention on the form and emphasize the urgency of completing the attestation process. We recently had the opportunity to test our materials with Medicare beneficiaries, and, as a result, have reformatted the materials to include a beneficiary-specific cover letter, a set of frequently asked questions and answers about the penalty, and an updated attestation form. The finished product reflects the results of a series of in-depth interviews with Medicare beneficiaries in Baltimore, Chicago, and Seattle. We believe that these materials will be better understood by beneficiaries and more likely to generate a timely, correct response to the questions posed in the attestation form, thereby avoiding the administrative burden and potential confusion involved in the imposition of a penalty that is later overturned.

Separately, we have heard anecdotally that plans are receiving questions from beneficiaries about the terms of the penalty, why it is applicable, and what the term "creditable coverage" means. We have attempted to address these questions in the set of questions and answers provided and encourage plans to use this material to inform their own responses to beneficiary inquiries. We also note that we have used the phrase, "meets Medicare's minimum standards" instead of the term, "creditable coverage" because we consistently found during our interviews that beneficiaries did not understand the term "creditable coverage," and this lack of understanding appeared to be a barrier to their completing the form timely.

Summary of Revisions

Note: These new models replace current Exhibits 1A and 1B. Plans must begin using these new models for enrollments received on or after **April 1, 2009**.

1. NEW separate cover letter addressed to the beneficiary (Exhibits 1A and 1B)
    - This is a separate, one-page cover letter on Department of Health and Human Services/CMS letterhead that is addressed directly to the beneficiary.
    - The two versions, labeled "Exhibits 1A" and "Exhibits 1B," respectively, vary according to whether the beneficiary was previously enrolled but has since incurred a break in coverage or is enrolling in a Medicare prescription drug plan for the first time.
    - As with the previous model attestation form, plans must insert the following information into the letter:
        - Date
        - Beneficiary name and address
        - Dates of the gaps in creditable coverage
        - Plan address and contact information
        - Deadline for completion of the form

2. NEW set of frequently asked questions and answers about the LEP (Exhibit 1C)
   - This document is also on Department of Health and Human Services/CMS letterhead, because beneficiaries commented that such letterhead looked more official and that they were more likely to pay attention to the letter.
   - Plans must include the deadline for completion of the form in this letter, in addition to their address and contact information for beneficiaries with questions.

3. REVISED attestation form, now titled, "Declaration of Prior Prescription Drug Coverage" (Exhibit 1D)
   - Plans must insert their letterhead at the top of the form and their plan name in the declaration statement on the second page.
   - Beneficiaries are to complete the form with their name, address, and other information, and to check the boxes, which are displayed in similar fashion to the original form.

4. REVISED "Final Notice" Beneficiary Cover Letter (Exhibits 1E and 1F)
   - This is an optional notice that plans may use if they choose to follow up with their beneficiaries via written notice rather than telephonically.
   - As with the Beneficiary Cover Letter described above, these two versions vary according to whether the beneficiary was previously enrolled but has since incurred a break in coverage or is enrolling in a Medicare prescription drug plan for the first time.
   - Plans choosing to use this notice must include a deadline for returning the form that will allow for sufficient time to meet the reporting timeframes outlined in our April 11, 2008 memorandum.

Note: The marketing material code(s) for these models can be found in HPMS. Plans must use the appropriate marketing code(s) and can use these models as "file and use." The marketing material code(s) are:

- Code 8013 Exhibit 1A & 1B – Beneficiary Cover Letter for Individuals with Break in Coverage
- Code 8014 Exhibit 1C – Frequently Asked Questions and Answers
- Code 8015 Exhibit 1D – Declaration of Prior Prescription Drug Coverage
- Code 8016 Exhibit 1E & 1F—"Final Notice"

As previously stated, these new models replace current Exhibits 1A and 1B [HPMS Code 8001]. Therefore, HPMS Code 8001 is no longer available.

For questions about the information in this memorandum, please contact Rhonda GreeneBruce via e-mail at LEP@cms.hhs.gov or via telephone at (410) 786-7579.

Exhibit 1A – Beneficiary Cover Letter for Individuals With Break in Coverage--(HPMS Code 8013)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services

<Date of Notice>

<Insert Name of Enrollee>
<Insert Enrollee's Full Mailing Address>
<Insert Enrollee's ID Number>

<Insert Name of Enrollee>:

You recently enrolled in *<insert name of Plan>* prescription drug plan and Medicare's records show that you may owe a late enrollment penalty.

Prior to enrolling in the *<insert name of Plan>*, it appears that you had a break in prescription drug coverage from *<insert first day without creditable prescription drug coverage in month/day/year format>* to *<insert last day without creditable prescription drug coverage in month/day/year format>*. If you did not have prescription drug coverage during this time period that met Medicare's minimum standards, you will owe a penalty on your monthly premiums. If you did have prescription drug coverage during this time period, you may be able to avoid the penalty by returning the enclosed form.

Please complete the enclosed form and return it immediately to *<insert the name of plan and complete mailing address> [insert the following if you offer telephonic attestation:* or call us at *<insert plan's toll-free number and toll-free TTY number>* to provide us with the information] by *<insert the date that is 30 days from the date of this letter in month/day/year format>.*

If you don't contact *<insert name of plan>* by *<insert the date that is 30 days from the date of this letter in month/day/year format>*, we will assume the above information is correct and you will owe a late enrollment penalty.

Exhibit 1B – Beneficiary Cover Letter for Individuals Newly Enrolled in Medicare Drug Plan--(HPMS Code 8013)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services

<Date of Notice>

<Insert Name of Enrollee>
<Insert Enrollee's Full Mailing Address>
<Insert Enrollee's ID Number>

<Insert Name of Enrollee>:

Prior to enrolling in the *<insert name of Plan>*, it appears that you did not have prescription drug coverage that met Medicare's minimum standards. If your records show that you did have prescription drug coverage from *<insert first day without creditable prescription drug coverage in month/day/year format>* to *<insert last day without creditable prescription drug coverage in month/day/year format>,* you may be able to avoid paying the monthly penalty by returning the enclosed form.

Please complete the enclosed form and return it immediately to *<insert the name of plan and complete mailing address> [insert the following if you offer telephonic attestation:* or call us at *<insert plan's toll-free number and toll-free TTY number>* to provide us with the information] by *<insert the date that is 30 days from the date of this letter in month/day/year format>.*

If you don't contact *<insert name of plan>* by *<insert the date that is 30 days from the date of this letter in month/day/year format>*, we will assume the above information is correct and you will owe a late enrollment penalty.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services

Avoid a Penalty Related to Your Medicare Prescription Drug Plan Premium!

If you fail to respond to this notice by *<insert the return date located on the Beneficiary Cover Letter in name of month, day, and four digit year format>,* you will owe a penalty. You may be able to avoid a penalty by completing the attached "Declaration of Prior Prescription Drug Coverage" form or calling your Medicare drug plan directly to provide this information.

Why am I getting this letter?

<Insert name of plan> has sent you the attached form because it appears that you had a break in prescription drug coverage for 63 days or more and you may owe a penalty. We need you to complete the enclosed form or call us to give more information about your prior drug coverage. This information will help us determine if you had coverage that met Medicare's minimum standards and can avoid paying the late enrollment penalty.

What is the Part D late enrollment penalty?

The late enrollment penalty is an amount added to your monthly Medicare drug plan (Part D) premium for as long as you have Medicare prescription drug coverage. This penalty is required by law and is designed to encourage people to enroll in a Medicare drug plan when they are first eligible or keep other prescription drug coverage that meets Medicare's minimum standards.

You may owe a late enrollment penalty if you didn't join a Medicare drug plan when you were first eligible for Medicare Part A and/or Part B, and:

- You didn't have other prescription drug coverage that met Medicare's minimum standards; OR
- You had a break in coverage of at least 63 days.

How do I know if my prior prescription drug coverage met Medicare's minimum standards?

Most plans that offer prescription drug coverage, like plans from employers or unions, must send their members a notice explaining how their prescription drug coverage compares to Medicare prescription drug coverage. This notice tells you if the prescription drug coverage you had through your prior plan was "creditable prescription drug coverage," which means that it met Medicare's minimum standards. If you didn't get a separate written notice, your plan may have provided this information in its benefits handbook. If you don't know if the prescription drug coverage you had met this standard, you should contact your prior plan.

When do I need to respond?

You must respond by <*insert the return date located on the Beneficiary Cover Letter in name of month, day, and four digit year format*> to avoid the penalty.

Where do I return the form?

Option 1: <*Delete this heading if you do not offer telephonic attestation and do not include Option 2 below*>
Complete the "Declaration of Prior Prescription Drug Coverage" form attached to this sheet and mail it back to your Medicare drug plan at:

<*Insert name of plan*>

<*Insert complete mailing address*>

<*Insert "Option 2" as shown below, if you offer telephonic attestation*>

Option 2:
Instead of completing the enclosed form, you can call your Medicare drug plan to provide them with additional information they need.

<*Insert name of plan and plan's toll-free number and toll free TTY number*>

What if I have questions?

If you have questions about the information in this form or the late enrollment penalty [or would like to complete this form over the telephone], call your Medicare drug plan.

- *<Insert name of Plan, plan's toll-free number, and day and hours of operations>*
- *<Insert plan's TTY toll-free number>*

You may also contact Medicare:

- Visit www.medicare.gov on the web
- Call 1-800-MEDICARE (1-800-633-4227)
- TTY users call 1-877-486-2048.

<INSERT PLAN'S LETTERHEAD>

DECLARATION OF PRIOR PRESCRIPTION DRUG COVERAGE

Date: _____

Enrollee Name: _____

Address: _____

_____

Phone: _____

Medicare Health Insurance Claim #:
(from red, white and blue Medicare card)

_____

Name of Medicare Prescription Drug Plan:

_____

Please check all boxes that apply to you.	**Dates of Coverage (month/year)**
☐ I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP) Name: _____	From: _____ To: _____
☐ I had creditable* prescription drug coverage from Medicaid, State Pharmaceutical Assistance Program (SPAP), or another plan sponsored by my state Name of SPAP:_____ If you are in an SPAP, what state do you live in: _____	From: _____ To: _____
☐ I had prescription drug coverage through my VA benefits (veterans, survivor, or dependent benefits)	From: _____ To: _____

* "Creditable" means that your prior coverage met Medicare's minimum standards.

☐ I had prescription drug coverage through my TRICARE or other military coverage	From: _____ To: _____
☐ I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage	From: _____ To: _____
☐ I had prescription drug coverage through the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian organization (I/T/U)	From: _____ To: _____
☐ I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly)	From: _____ To: _____
☐ I had creditable* prescription drug coverage from a different source not listed above. Name of other source: _____	From: _____ To: _____
☐ I have/had extra help from Medicare to pay for my prescription drug coverage.	From: _____ To: _____
☐ I lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) and I joined a Medicare prescription drug plan before December 31, 2006. Name of Parish: _____	From: _____ To: _____
☐ I never had creditable* drug coverage	

Please complete this section: "To the best of my knowledge, the information on this form is true and correct. I understand that if I didn't have creditable coverage and/or don't give proof of creditable prescription drug coverage if asked, my premium may be higher.

I understand that my signature (or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides) on this document means that I have read and understand the contents of this declaration. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this enrollment and 2) documentation of this authority is available upon request by <*insert name of plan*> by Medicare."

Signature:_____

Date: *(month/day/year):* _____

If you are the representative, you must provide the following information:

Name:_____

Address:_____

City: _____ State: _____ Zip:_____

Phone Number: (_____) _____- _____

Relationship to Enrollee: _____

Exhibit 1E – "Final Notice" Beneficiary Cover Letter for Individuals With Break in Coverage--(HPMS Code 8016)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services

<Date of Notice>

<Insert Name of Enrollee>
<Insert Enrollee's Full Mailing Address>
<Insert Enrollee's ID Number>

FINAL NOTICE

<Insert Name of Enrollee>:

You recently enrolled in *<insert name of Plan>* prescription drug plan and Medicare's records show that you may owe a late enrollment penalty.

Prior to enrolling in the *<insert name of Plan>*, it appears that you had a break in prescription drug coverage from *<insert first day without creditable prescription drug coverage in month/day/year format>* to *<insert last day without creditable prescription drug coverage in month/day/year format>*. If you did not have prescription drug coverage during this time period that met Medicare's minimum standards, you will owe a penalty on your monthly premiums. If you did have prescription drug coverage during this time period, you may be able to avoid the penalty by returning the enclosed form.

Please complete the enclosed form and return it immediately to *<insert the name of plan and complete mailing address> [insert the following if you offer telephonic attestation:* or call us at *<insert plan's toll-free number and toll-free TTY number>* to provide us with the information] by *<insert the same return date that was inserted on the original Beneficiary Cover Letter mailed, in month/day/year format>.*

If you don't contact *<insert name of plan>* by *<insert the same return date that was inserted on the original Beneficiary Cover Letter mailed, in month/day/year format>,* we will assume the above information is correct and you will owe a late enrollment penalty.

Exhibit 1F – "Final Notice" Beneficiary Cover Letter for Individuals Newly Enrolled in Medicare Drug Plan--(HPMS Code 8016)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare and Medicaid Services

<Date of Notice>

<Insert Name of Enrollee>
<Insert Enrollee's Full Mailing Address>
<Insert Enrollee's ID Number>

FINAL NOTICE

<Insert Name of Enrollee>:

Prior to enrolling in the *<insert name of Plan>*, it appears that you did not have prescription drug coverage that met Medicare's minimum standards. If your records show that you did have prescription drug coverage from *<insert first day without creditable prescription drug coverage in month/day/year format>* to *<insert last day without creditable prescription drug coverage in month/day/year format>,* you may be able to avoid paying the monthly penalty by returning the enclosed form.

Please complete the enclosed form and return it immediately to *<insert the name of plan and complete mailing address> [insert the following if you offer telephonic attestation:* or call us at *<insert plan's toll-free number and toll-free TTY number>* to provide us with the information] by *<insert the same return date that was inserted on the original Beneficiary Cover Letter mailed, in month/day/year format>.*

If you don't contact *<insert name of plan>* by *<insert the same return date that was inserted on the original Beneficiary Cover Letter mailed, in month/day/year format>*, we will assume the above information is correct and you will owe a late enrollment penalty.