Department of Health & Human Services
Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850

CENTER FOR BENEFICIARY CHOICES

DATE: October 11, 2006

TO: All Prescription Drug Plans, Medicare Advantage Organizations, and 1876 Cost Plan Sponsors Offering Employer/Union-Only Group Waiver Plans

FROM: Brenda Tranchida
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SUBJECT: Enrollment and Marketing/Dissemination Materials - REMINDERS

This memorandum provides several important reminders and/or clarifications for entities that offer employer/union-only group waiver plans (EGWPs). EGWPs include employer-only group plans (i.e., "800 series") offered by Prescription Drug Plan (PDP) Sponsors, MA Organizations and Cost Plan Sponsors[1] to employers or unions and plans offered by employers or unions that directly contract with CMS to become a Medicare plan exclusively for their members (i.e., "Direct Contract plans").

ENROLLMENT:

(1) "Employment-Based Coverage" Requirement -

As a reminder, enrollment in an "800 series" or Direct Contract plan is only available to beneficiaries who are members of an employer or union group. Thus, a beneficiary's enrollment must be based on receiving "employment-based" coverage from an employer or union

- that has entered into an arrangement with a Medicare plan to provide coverage, or
- contracted directly with CMS to provide coverage for its members.

For example, membership in a State Pharmaceutical Assistance Program (SPAP) would not, in and of itself, make an individual eligible for enrollment into these types of plans, unless the enrollment appropriately meets the "employment-based" coverage requirement. Similarly, coverage obtained through a professional or other type of association would not make a beneficiary eligible for these kinds of plans, except to the extent the coverage obtained through the association can properly be characterized as "employment-based" coverage.

[1] . For Section 1876 Cost Plans, Part D coverage may be offered to employer-only group members as an optional supplemental benefit; CMS' employer-only group waiver authority applies only to Part D, *not* to Parts A or B of a Cost Plan.

(2) Employer-Only Group PDPs – May Not Include Active Employees -

As a reminder, under the waiver authority contained in Section 1860D-22(b) of the Social Security Act (SSA), "800 series" and Direct Contract standalone PDPs may only be offered to an employer or union group's *retirees* who are Medicare eligible beneficiaries. These PDP Sponsors may not enroll active employees in these employer-only group Part D plans.

Medicare Advantage Organizations are subject to a different statutory waiver authority, Section 1857(i) of the SSA. This authority allows MA Organizations to enroll *active* employees of an employer or union group in "800 series" or Direct Contract plans. Please note, however, when enrolling active employees into these employer-only group plans, MA Organizations must ensure that all other applicable Medicare program requirements, including the Medicare Secondary Payer (MSP) requirements, are met.

(3) Transitioning Employer or Union Groups From the Retiree Drug Subsidy (RDS) To Part D Plans ("TR 127" Procedures) -

We have been asked to clarify how a Part D Plan that enrolls an employer or union's members into a Part D plan should implement the beneficiary notification procedures contained in Section 10.4 of the CMS PDP Enrollment Guidance (Eligibility, Enrollment and Disenrollment), and Section 40.2.5 of Chapter 2 of the Medicare Managed Care Manual (for MA Organizations) in circumstances where the employer/union is currently participating in the Retiree Drug Subsidy (RDS) program but is changing its benefit program to include Part D benefits. In particular, we have been asked whether each beneficiary must receive a letter or other contact confirming an intent to enroll in Part D (as required under Section 10.4) if the Part D Plan receives a transaction reply ("TR") 127 indicating current RDS coverage for substantially all of these retirees.

In this specific case, where the Part D Plan is working directly with an employer or union to implement the Part D enrollment as a replacement for the RDS plan, the notification procedures identified above are not needed to protect beneficiaries from possible loss of that employer/union's coverage. Accordingly, the Part D Plan in this situation is not required to provide each retiree with the notification letter or other contact specified in CMS enrollment guidance. If a TR 127 is received for these retirees, the plan must resubmit the enrollment with the proper employer subsidy override flag. Part D Plans should maintain records to support the use of this alternate process for these individuals.

Please note that in some rare instances the employer group member may have other drug coverage through another RDS employer plan sponsor (i.e., as a spouse or dependent of a retired participant). In these instances, the employer group member may potentially lose this other coverage upon enrollment in Part D. CMS strongly recommends that the Part D plan work closely with employer/union sponsors to communicate about this possibility, identify affected members (if possible) prior to enrollment into the Part D plan, and

communicate with all members about their opt-out rights under CMS group enrollment notification procedures.

MARKETING/DISSEMINATION MATERIALS:

As a reminder, PDP Sponsors, MA Organizations and 1876 Cost Plan Sponsors generally may provide customized marketing/dissemination materials to "800 series" and Direct Contract plan enrollees to reflect the modified/supplemental benefits being provided to that particular employer or union group. In addition, this memorandum clarifies that CMS has waived any rules that would otherwise prohibit these entities from offering customized dissemination materials to the extent those customized materials will more accurately describe the benefits available to employer group members when the supplemental coverage is taken into account. These customized materials are not required to be submitted for review and approval by CMS prior to use. However, they must be submitted to CMS as informational copies at the time of use in accordance with the procedures outlined in Chapter 13 of the Medicare Marketing Guidelines. CMS reserves the right to 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.

In addition, please note that for non-calendar year "800 series" and Direct Contract employer-only group plans, the timing for issuance of marketing/dissemination materials should be appropriately based on the employer/union sponsor's plan year. For example, if an employer or union sponsor's plan year begins on July 1, 2007 and ends on June 30, 2008, the Annual Notice of Change (ANOC) must be issued no later than April 30, 2007 (two months before the beginning of the plan year).

If you have any questions regarding this memorandum, please contact Brenda Tranchida at 410-786-2001 or at Brenda.Tranchida@cms.hhs.gov.