

MEDICARE PRESCRIPTION DRUG BENEFIT MANUAL

CHAPTER 4 Creditable Coverage Period Determinations and the Late Enrollment Penalty

This guidance update is effective with enrollment applications received on or after April 1, 2010. All enrollment applications received on or after April 1, 2010 must be processed in accordance with the revised guidance requirements, including new model forms and notices provided. Part D plan sponsors may, at their discretion, implement any aspect of this guidance (e.g. new model forms/notices) prior to the required implementation date.

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Introduction

Under §1860D-13(b) of the Social Security Act, and 42 CFR §423.46, 423.56(g), Medicare beneficiaries may incur a late enrollment penalty (LEP) if there is a continuous period of 63 days or more at any time after the end of the individual's Part D initial enrollment period during which the individual was eligible to enroll, but was not enrolled in a Medicare Part D plan and was not covered under any creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Creditable prescription drug coverage includes, but is not limited to: some employer-based prescription drug coverage, including the Federal Employees Health Benefits Program; qualified State Pharmaceutical Assistance Programs (SPAPs); military-related coverage (e.g., VA, TRICARE); and certain Medicare supplemental (Medigap) policies. (See 42 C.F.R. §423.56(b) for a complete list of types of prescription drug coverage that may be determined to be creditable. As outlined at 42 CFR 423.56(c) and (d), with the exception of Prescription Drug Plan (PDP) Sponsors, Medicare Advantage (MA) Organizations, §1876 Cost-Based Contractors, and PACE organizations offering prescription drug plans, entities that offer prescription drug coverage must make an annual determination of creditable coverage status and provide a disclosure notice to Medicare eligible individuals. Additional information related to creditable coverage requirements for employer and union-sponsored plans and all other entities that sponsor prescription drug coverage may be found at <http://www.cms.hhs.gov/CreditableCoverage/>.)

In general, Prescription Drug Plan (PDP) Sponsors, Medicare Advantage (MA) Organizations (including special needs plans (SNPs)), 1876 Cost-Based Contractors, and PACE organizations offering prescription drug plans (hereafter referred to as "Part D plan sponsors") are responsible for determining, at the time of enrollment, whether a beneficiary was previously enrolled in a Medicare prescription drug plan or had other creditable coverage prior to applying to enroll in their plan, and whether there were any lapses in coverage of 63 days or more. Part D plan sponsors inform CMS of these lapses in creditable coverage so that CMS can compute the LEP and inform the sponsor of the LEP amount. The sponsor then bills the beneficiary for the LEP as part of the premium. (For those in premium withhold status, the LEP is deducted (with the premium) from the individual's Social Security check.) With limited exceptions, as described in this chapter, the Part D LEP remains with the beneficiary for as long as he/she has Medicare prescription drug coverage.

This guidance describes the procedures that Part D plan sponsors are required to use in making creditable coverage period determinations, reporting them to CMS, and collecting the LEP.

10 - PROCESS FOR MAKING A CREDITABLE COVERAGE PERIOD DETERMINATION

The Part D plan sponsor shall make a creditable coverage period determination for their enrollees, unless otherwise noted in §10.3.

10.1 - Determine the Period in Question

The Part D plan sponsor shall determine, at the time of enrollment, whether a beneficiary who enrolls in Medicare drug plan will have or had a break in creditable prescription drug coverage for a continuous period of 63 days or more anytime after they were first eligible to enroll in a Medicare prescription drug plan. The Part D plan sponsor shall first determine the appropriate period in question: (1) following Part D/Retiree Drug Subsidy (RDS) disenrollment as described below; (2) the end of the Part D Initial Enrollment Period (IEP); or (3) end of the subsequent IEP.

10.1.1 - End of Prior Part D/RDS Enrollment

Where there is prior Part D or RDS plan coverage, the Part D plan sponsor does not have to look all the way back to the end of the member's initial enrollment period. Instead, the Part D plan sponsor shall determine whether the member has any period without creditable prescription drug coverage since the date he/she disenrolled from the prior Part D or RDS plan. The period in question begins on the effective date of the member's disenrollment from the prior Part D or RDS plan and ends on the day before the beneficiary's enrollment becomes effective with the current Part D plan sponsor. Plans shall only look at this period when determining if a beneficiary had or will have a continuous period of 63 days or more without creditable prescription drug coverage.

Example:

Mr. Jones enrolled in a Part D plan sponsor, Plan ABC, during his Part D IEP with an enrollment effective date of June 1, 2006. He disenrolled from Plan ABC effective December 31, 2007 and enrolled in another Part D plan, Plan XYZ, a year later, with coverage effective January 1, 2009. Plan XYZ will review the period of January 1, 2008 to December 31, 2008 to determine whether Mr. Jones went at least 63 continuous days without creditable prescription drug coverage

10.1.2 - End of the Part D Initial Enrollment Period

For individuals who did not have prior Part D plan or RDS enrollment and are not in their subsequent IEP, the period in question begins on the day following the

beneficiary's Part D IEP and ends on the day before the beneficiary's enrollment becomes effective with the Part D plan sponsor.

Unless otherwise informed by CMS, a Part D plan sponsor shall assume that the last day of a beneficiary's IEP is/was:

- May 15, 2006 for a beneficiary who was eligible for Medicare Part D in January 2006; or
- The last day of the 3rd month following the month of initial eligibility for Medicare Part D, for a beneficiary who became/becomes eligible for Part D after January 2006.

Example:

Mrs. Smith's 65th birthday is April 20, 2006. She is entitled to Medicare Part A and her Part B IEP begins January 1, 2006. Therefore, her IEP for Part D begins on January 1, 2006, and ends on July 31, 2006.

Note: Even if Mrs. Smith delayed enrolling in Part B, her IEP for Part D still ended on July 31, 2006 because the Part D IEP is based on entitlement to Medicare Part A and/or enrollment in Part B. As long as a beneficiary resides in a Part D plan service area, the month that he/she initially becomes eligible for Part D is generally the earlier of the first day of the month of entitlement to Medicare Part A and/or enrollment in Part B. These dates are on the beneficiary's enrollment request.

If CMS or its designee informs the Part D plan sponsor of a different IEP end date, the Part D plan sponsor shall use this new date in determining uncovered months and shall include documentation of the new IEP end date in the beneficiary's file.

Refer to the enrollment guidance appropriate to your plan type for more information about the Part D IEP.

10.1.3 - End of the Subsequent Part D IEP

An individual who is entitled to Medicare prior to turning age 65 (e.g., those who were entitled based on disability), will have a new or subsequent Part D IEP when they become entitled to Medicare based on age. If an enrollee attains age 65 while enrolled in a Part D plan and has been paying an LEP, his/her LEP will end on the day before his/her subsequent IEP begins, which is three months prior to the month s/he attains age 65.

The Part D plan sponsor shall have a process in place for identifying members who are attaining age 65 or who have recently attained age 65.

Example

Mrs. Brown was initially eligible for Medicare based on a disability, but never enrolled in a Part D plan. She will turn 65 on May 19 and her new (or subsequent) IEP will begin on February 1 and continue through August 30. If she enrolls in a Part D plan during this subsequent IEP, she will not be subject to an LEP.

Note: If, in this example above, Mrs. Brown was already enrolled in a Part D plan when she attained age 65, her current plan must take appropriate actions to have the LEP removed effective on the date that her IEP begins, which is February 1. See §30.4.3 for more information.

10.2 - Determining Whether There Has Been a Break in Creditable Prescription Drug Coverage

In general, the Part D plan sponsor shall follow the steps described below to determine whether there has been a qualifying break in creditable prescription drug coverage since the end of the Part D IEP, subsequent IEP, or Part D/RDS enrollment.

Step 1. Review the enrollment request and determine the period in question as described in §10.1. The Part D plan sponsor shall use the Beneficiary Eligibility Query (BEQ) or Common UI and other available information to determine whether there is a lapse in creditable prescription drug coverage of 63 continuous days or more since the end of his/her prior Part D/RDS enrollment, IEP, or subsequent IEP. Other information can be information that the Part D sponsor has indicating that the enrollee had creditable prescription drug coverage through another product it offers, e.g., employer coverage, individual coverage, or coverage offered by another plan benefit package (PBP). Also, this can be information that the beneficiary, on his/her own initiative, submitted to the Part D plan sponsor along with his/her enrollment application. (Refer to §20.1 for more information).

If this information shows that there has been no gap of 63 continuous days or more in which the individual did not have creditable prescription drug coverage since the end

of his/her prior Part D/RDS enrollment; or the beneficiary's IEP (or subsequent IEP) has not ended, the Part D plan sponsor shall determine that there is no break in creditable prescription drug coverage and shall determine that zero (0) is the appropriate number of uncovered months to report to CMS in accordance with §30 *Reporting Creditable Coverage Period Determinations to CMS*. In this case, the Part D plan sponsor shall not proceed to Step 2. That is, the Part D plan sponsor should not send the attestation documents to the member. Instead, the Part D plan sponsor shall include the appropriate documentation in the member's file and determine that zero (0) is the appropriate number to report to CMS. The Part D plan sponsor shall report zero uncovered months to CMS in accordance with §30 *Reporting Creditable Coverage Period Determinations to CMS*.

If a continuous period of 63 days or more have passed since the end of the enrollee's prior Medicare prescription drug plan enrollment, IEP, or subsequent IEP proceed to Step 2.

Step 2. If the BEQ or Common UI indicates that there is a gap of 63 continuous days or more in which the individual did not have creditable prescription drug coverage since the end of his/her prior Part D/RDS enrollment, IEP, or subsequent IEP, the Part D plan sponsor shall determine the number of months that the individual went without such creditable coverage. The Part D plan shall accomplish this by counting the number of full months (number of uncovered months) up to the month of enrollment in its plan. The Part D plan sponsor shall insert this information in the attestation documents (Exhibits 1A or 1B, 1C, and 1D) in accordance with §20, within 7 calendar days of receipt of the BEQ or Common UI response. The Part D plan sponsor shall instruct the beneficiary to return the form within 30 calendar days of the date on the form.

10.3 - Exceptions to Making Creditable Coverage Period Determinations

There are specific cases in which Part D plan sponsors shall not proceed with the creditable coverage period determination described in §10.2 above.

10.3.1 - Creditable Coverage Period Determinations for Disenrolled Members

In cases where a beneficiary submits a valid cancellation request to the Part D plan sponsor prior to his/her enrollment effective date the plan should not proceed with a creditable coverage period determination. (See the enrollment guidance appropriate to your plan type for information on valid cancellation requests),

However, if the member disenrolls after coverage is effective and the Part D sponsor has not had an opportunity to assess the LEP, the plan shall continue with a creditable

coverage period determination, report the number of uncovered months to CMS in accordance with §30.2 and, if applicable, notify the member of the LEP amount in accordance with §50 of this chapter.

It is important that the Part D plan sponsor proceeds with its determination because subsequent plans will not look back beyond the end of the beneficiary's enrollment in the previous plan as described in §10.1.1 Part D/RDS Enrollment) when determining the number of uncovered months.

10.3.2 - Creditable Coverage Period Determinations for Deceased Members

The Part D plan sponsor shall not initiate a determination or continue with a determination already in progress if the member dies before the plan has had an opportunity to report its determination to CMS.

10.3.3 - Creditable Coverage Period Determinations for Low-Income Subsidy (LIS) Eligibles

Pursuant to 42 CFR 423.46(a) and 42 CFR 423.780(e) Medicare beneficiaries who qualify for the low-income subsidy (LIS) may enroll in a Medicare prescription drug plan with no penalty. Therefore, Part D plan sponsors are not to make creditable coverage period determinations for any new enrollee who is LIS eligible at the time he/she makes the enrollment request or at the time the enrollment becomes effective. Additionally, should the enrollee lose his/her LIS status, but remain continuously enrolled in a Part D plan sponsor, the Part D plan sponsor shall not make a creditable coverage period determination following such loss for any period prior to their loss of LIS.

The Part D plan sponsor shall make a creditable coverage period determination, as described in §10.2, **only** if the individual loses his/her LIS-eligibility, disenrolls from a Part D plan sponsor, incurs a qualifying gap in creditable prescription drug coverage, and is not LIS-eligible at the time of reenrollment or at the time the enrollment is effective in a Medicare prescription drug plan.

10.3.4 - Enrollees in the Program of All-Inclusive Care for the Elderly (PACE)

As stated in the introduction to this Chapter, PACE organizations offering prescription drug plans also are required to make creditable coverage period determinations at the time of enrollment and report any lapses in coverage of 63 days or more to CMS. However, PACE enrollees who are dual-eligible members are not

subject to the LEP as long as they remain enrolled in Part D. Therefore, PACE organizations do not need to make creditable coverage period determinations for dual-eligible members. However, the organization is required to make the creditable coverage period determination in accordance with §10.2 for their Medicare-only enrollees.

In the event that a Medicare-only member becomes eligible for Medicaid while the PACE organization is conducting a creditable coverage period determination, the organization shall suspend its determination. If the organization has already submitted uncovered months to CMS, it shall submit a plan change transaction (73) in order to report zero uncovered months. (Refer to §30, for reporting requirements.)

10.3.5 - Individuals in the U.S. Territories

Beneficiaries in the U.S. territories who are dually eligible (e.g., those in Puerto Rico who are eligible for Medicare and Puerto Rico's Medicaid plan known as Reforma) are exempt from the LEP in the same manner as those who are LIS-eligible in the States.

20 - ATTESTATION OF CREDITABLE PRESCRIPTION DRUG COVERAGE

The Part D plan sponsor shall solicit information about creditable prescription drug coverage from beneficiaries (or organizations permitted to attest to such coverage on behalf of its beneficiary) where possible gaps in such coverage appear following a response from the BEQ or Common UI.

20.1 - Attestation Documents

As described in §10.2 above, if the BEQ or Common UI indicates that there is a gap of 63 continuous days or more in which the individual did not have creditable prescription drug coverage since the end of either his/her Part D/RDS enrollment, IEP, or subsequent IEP, the Part D plan sponsor shall send the attestation documents to the beneficiary so that the beneficiary can attest to whether he/she had creditable prescription drug coverage for the period in question. When soliciting prior creditable prescription drug, the Part D plan sponsor shall not request the beneficiary to provide proof of such coverage since the beneficiary's signature on the attestation form (or verbal attestation) affirms that the information he/she has provided is true and correct to the best of his/her knowledge. However, if the beneficiary, on his/her own initiative, provides proof of prior creditable prescription drug coverage, the Part D plan sponsor shall consider that information when determining whether the beneficiary had a qualifying gap in creditable coverage.

The attestation documents (Exhibits 1A, 1B, 1C, 1D, 1E, and 1F) are provided as models and may therefore be modified, subject to CMS review and approval. However, we 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 Exhibit 1D.

The marketing codes for these models can be found in HPMS and are located on the Exhibits at the end of this chapter. Plans must use the appropriate marketing codes and can use these models as "file and use."

20.1.1 - Initial Attestation Documents

The Part D plan sponsor shall fill-in the appropriate blank spaces as required on the following series of attestation documents and mail them within 7 calendar days of receipt of the BEQ or Common UI response as follows:

(1) Exhibit 1A—*Beneficiary Cover Letter* (HPMS Code 8013), Exhibit 1C—*Frequently Asked Questions and Answers* (HPMS Code 8014), and Exhibit 1D—*Declaration of Prior Prescription Drug Coverage*. The Part D plan sponsor shall mail

these exhibits collectively to those beneficiaries who had prior Part D or RDS coverage but incurred a break in creditable prescription drug coverage;

OR

(2) Exhibit 1B— *Beneficiary Cover Letter* (HPMS Code 8013), Exhibit 1C— *Frequently Asked Questions and Answers* (HPMS Code 8014), and Exhibit 1D— *Declaration of Prior Prescription Drug Coverage*. The Part D plan sponsor shall mail these exhibits collectively to those beneficiaries who have never enrolled in a Medicare prescription drug plan but may have incurred a break in creditable prescription drug coverage.

The Part D plan sponsor shall instruct beneficiaries to return the *Declaration of Prior Prescription Drug Coverage* form (also called the **attestation form**) within 30 calendar days of the date on the form.

When mailing the attestation documents, the Part D plan sponsor **shall not** include *Appendix 14—LEP Reconsideration Notice* and *Appendix 15—Reconsideration Request Form* (refer to §50 regarding issuance of these two documents). Likewise, the Part D plan sponsor shall not mail the attestation documents with an enrollment form, nor shall the Part D plan sponsor include any question(s) regarding the individual’s creditable prescription drug coverage on the enrollment form, as doing so may lead the beneficiary to believe that his/her enrollment in a Medicare prescription drug plan is contingent upon having prior creditable coverage. However, if the beneficiary, on his/her own initiative, includes creditable prescription drug coverage information and/or documentation with the enrollment form, the Part D plan sponsor shall take that information into account when determining whether there has been a gap in coverage. If the creditable coverage information provided coincides with the potential qualifying gap identified during the specific period in question, the Part D plan sponsor may not need to send the attestation documents.

In cases where a beneficiary provides creditable coverage information without an enrollment request, the Part D plan sponsor shall return the creditable coverage with a notice explaining why the information was returned. The Part D plan sponsor shall use the *Exhibit 8: Model Notice—Return of Creditable Coverage Information Received Without an Accompanying Enrollment Request* or create its own form using the requisite elements shown in the model, subject to CMS’ marketing review procedures.

20.1.2 - “Final Notice” Attestation Documents

Exhibits 1E and 1F are optional notices that the Part D plan sponsor may use to follow-up with beneficiaries to remind them that the 30-day deadline is approaching or has passed and no information has been provided. The Part D plan sponsor choosing to use these documents shall use the same return date that was inserted on

the initial attestation forms (See §20.1.1 above) when instructing the beneficiary of the return date deadline. However, the Part D plan sponsor must mail these “Final Notice” attestation documents with a deadline return date that will allow the plan enough time to meet the required timeframe for reporting to CMS. (See §30). Additionally, the Part D plan sponsor must mail one of the following sets of attestation documents outlined below:

(1) For beneficiaries who had prior Part D or RDS coverage but incurred a break in creditable prescription drug coverage --

- Exhibit 1E—*“Final Notice” Beneficiary Cover Letter* (HPMS Code 8013)
- Exhibit 1C—*Frequently Asked Questions and Answers* (HPMS Code 8014)
- Exhibit 1D—*Declaration of Prior Prescription Drug Coverage*.

OR

(2) For beneficiaries who have never enrolled in a Medicare prescription drug plan but may have incurred a break in creditable prescription drug coverage –

- Exhibit 1F— *“Final Notice” Beneficiary Cover Letter* (HPMS Code 8013),
- Exhibit 1C—*Frequently Asked Questions and Answers* (HPMS Code 8014)
- Exhibit 1D—*Declaration of Prior Prescription Drug Coverage*.

20.2 - Telephonic Attestation

Telephonic Attestation is a process that Part D plan sponsors can use to allow beneficiaries to provide creditable coverage information over the telephone rather than relying on the beneficiary to complete and return the form.

In all cases where the Part D plan sponsor provides this option, the Part D plan must still mail either Exhibits 1A or 1B along with 1C, and 1D as described in §20.1.1 above, and shall include on the attestation documents all of the information specific to telephonic attestations, as well as the Part D plan’s mailing information as shown in those exhibits. Part D plan sponsors may not use telephonic attestations in lieu of mailing the initial attestation documents.

When accepting an attestation via telephone, the Part D plan sponsor is not required to record the conversation but shall document the call and ensure that it captures all of the requisite elements of the attestation documents (as shown in Exhibits 1A/1B, 1C and 1D) and amend the beneficiary’s record.

20.3 - Attestations from Third Parties

Part D plan sponsors shall accept and retain creditable coverage information (including attestation documents) from all employer and union groups, as well as State Pharmaceutical Assistance Programs (SPAPs) that attest to their members’

creditable coverage history. The creditable coverage information or attestation documents can include the members' names and dates of creditable coverage.

CMS refrains from specifying the form and manner of the attestation of coverage and defers to arrangements made between the plan and the employer or union group and SPAP. For example, documentation can include individual attestations signed by one of the entities or one attestation supplemented by a list of affected members.

If an employer, union, or SPAP attests to creditable coverage on behalf of its members, but a member has also provided creditable coverage information (e.g., via a telephonic attestation, or via completed and returned *Declaration of Creditable Prescription Drug Coverage* form), the Part D plan sponsor shall use the information most favorable to the beneficiary. Thus, the information provided by the employer, union, or SPAP shall supersede the beneficiary's signed attestation only if it would eliminate or reduce the LEP.

30 - REPORTING CREDITABLE COVERAGE PERIOD DETERMINATIONS TO CMS

After the Part D plan sponsor makes its creditable coverage period determination in accordance with §10.2, it shall report its determination to CMS. Creditable coverage period determinations are reported to CMS in the form of full uncovered months, also referred to as a number of uncovered months (NUNCMO). The NUNCMO reflects the number of full calendar months that a beneficiary incurred during any continuous period of 63 calendar days or more after the end of his/her initial Part D IEP, subsequent Part D IEP, or prior RDS/Part D enrollment in which he/she did not have Medicare prescription drug coverage or other creditable prescription drug coverage.

In general, any period of time determined to be a period of uncovered months for the purposes of the Part D LEP always occurs outside a Part D plan enrollment period. Therefore, the effective date of the “number of uncovered months” data is always equal to a Part D plan enrollment effective date, with two exceptions: 1) when an individual becomes LIS eligible (see §30.4.B); and 2) when an individual has a second or subsequent Part D IEP (see §30.4.D).

30.1 - Reporting a Creditable Coverage Period Determination Using an Enrollment or Plan Change Transaction for New or Current Enrollees

Generally, the Part D plan sponsor may report a creditable coverage period determination to CMS in two ways: 1) on the enrollment transaction (transaction codes 60, 61, 62, and 71); or 2) on a plan change transaction (transaction code 73), provided that it meets the timeframes outlined in this chapter and in the appropriate enrollment guidance for the sponsor’s plan type. In accordance with CMS’ enrollment guidance (§30.3 of Chapter 2 of the Prescription Drug Manual and §40.3 of Chapter 3 of the Medicare Managed Care Manual), the sponsor must submit the enrollment transaction to CMS within 7 calendar days of receipt of a complete enrollment request. Therefore, it is often the case that the sponsor must submit the enrollment transaction before it can complete its creditable coverage period determination. In this situation, the sponsor shall submit an enrollment transaction that shows no uncovered months (in accordance with the process outlined in 30.1.1 below), and then, if necessary, submit a plan change transaction after it makes its determination to add the number of uncovered months, or indicate that there is a gap in coverage. (See §30.1.2 below.)

30.1.1 - Reporting Uncovered Months on the Enrollment Transaction

If the part D plan sponsor is not able to determine whether there is a break in creditable coverage before the deadline for submitting the enrollment transaction to CMS, the sponsor shall report to CMS the beneficiary had creditable coverage by taking the following actions:

- (1) Set the creditable coverage flag to “Y”;

- (2) Set “000” (zero) as the NUNCMO; and
- (3) Set the enrollment transaction date equal to the enrollment effective date in the plan.

30.1.2 - Submitting Uncovered Months Using a Plan Change (transaction code 73) Transaction

If the sponsor needs to change the number of uncovered months after submitting the enrollment transaction to CMS, Part D plan sponsor shall submit a plan change (73) transaction to reflect the new number of uncovered months as follows:

- 1) Set the creditable coverage flag to “N”;
- 2) Set the number value equal to the number of uncovered months; and
- 3) Set the effective date of the transaction equal to the effective date of enrollment in the plan.

Below is a description the creditable coverage flags “Y” and “N” along with how the Part D plan sponsor must notate the number of uncovered months it reports. Refer to Appendix 1: **Summary of MARx Transactions to Add, Change, or Remove the Number of Uncovered Months for an Enrolled Beneficiary* for a detailed listing of transactions used to report NUNCMOs to CMS.

Creditable Coverage Flag	Description	Number of Uncovered Months (NUNCMO)
“Y”	Use if sponsor has not yet completed determination, but enrollment transaction must be sent in order to meet the deadline. This transaction remains unchanged if your subsequent creditable coverage period determination is that the member had creditable prescription drug coverage for the entire period in question. That is, the determination is that there are no uncovered months for the period in question. In this case, you do not need to submit “Y” and “000” a second time via the plan change transaction code 73.	Report zero “000” (leading zeroes or right justified).
“N”	Use if member did not have creditable prescription drug coverage. That is, the determination is that there are uncovered months for the period in question.	Report a number equal to or greater than 1 (leading zeros, right justified; example “001”)

30.2 - Reporting Creditable Coverage Determinations for Disenrolled Members

The Part D plan sponsor shall report a creditable coverage period determination for a member who has since disenrolled from the Part D plan sponsor in cases that include, but are not limited to, the following:

- (1) The Part D plan sponsor did not make or adjust a creditable coverage period determination (see §10.3.1 and §30.4) prior to the effective date of the member's disenrollment from that plan;
- (2) CMS's Independent Review Entity (IRE) has made a reconsideration decision that requires an adjustment to the number of uncovered months previously reported by the Part D plan sponsor (see §30.4.F); or
- (3) The Part D plan sponsor realizes it made an error in making and/or reporting its creditable coverage determination to CMS while the member was enrolled in its plan.

Note: The Part D plan sponsor can make changes to the number of uncovered months for a disenrolled member for any time period up through the last day of the member's enrollment in the plan.

In order to report NUNCMO information for a member after the effective date of disenrollment, the Part D plan sponsor shall take the following steps:

- 1) Submit a plan change (73) transaction via a retroactive batch file.
The header date of the retroactive file must reflect a date that the member was enrolled in the Part D plan sponsor that is adjusting an existing or reporting a new creditable coverage determination and be in the month/year format (mm/yyyy). You must obtain approval from CMS to submit.
- 2) Contact the MMA Help Desk to obtain a ticket number to request the submission of a batch retroactive file to report these transactions. CMS Central Office staff will review each ticket and contact the requesting Part D plan sponsor regarding the request.

The Part D plan sponsor submitting the change to the uncovered months will receive a transaction reply code (TRC) on the transaction reply report (TRR) regarding the uncovered months and a recalculated LEP amount on the Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Report for members in direct bill status and the Monthly Premium Withholding Report/ Data file (MPWRD) for members in premium withhold status. Additionally, the disenrolled member's subsequent plan(s), including the member's current plan, will be impacted by this change to the uncovered months. Therefore, the member's subsequent plan(s) will receive information regarding changes to the uncovered months and recalculated LEP **only** on the Low Income Subsidy/Late

Enrollment Penalty (LIS/LEP) Report for members who are in direct bill status and the Monthly Premium Withholding Report/ Data file (MPWRD) for members in premium withhold status.

NOTE: The plan that submits the change to an individual's uncovered months will be the entity that receives a transaction reply on the TRR. The affected plans will see the change on the Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) for members in direct bill status and on the Monthly Premium Withholding Report/ Data file (MPWRD) for members in premium withhold status.

In cases where the former plan sponsor reports a creditable coverage determination (or an adjustment to a previous determination) that results in the imposition of or increase in the LEP amount, the former plan sponsor shall notify the member of the LEP amount in accordance with §50 of this chapter.

Example:

Mrs. Johnson enrolled in Plan KLM effective January 1, 2008. She disenrolled from Plan KLM with a coverage end date of February 28, 2008 and enrolled in Plan BCD effective March 1, 2008. Plan KLM completed its creditable coverage period determination on March 10, 2008, and determined that Mrs. Smith had 3 uncovered months. Plan KLM contacted the MMA Help Desk and asked to submit a batch retro file that contained a valid plan change (73) transaction changing the number of uncovered months from "000" to "003", setting the creditable coverage flag to "N," and using a header date of "012008" (January 2008) or "022008" (February 2008).

Plan KLM received authorization from CMS and submitted the change as directed and received a transaction reply code (TRC) from CMS showing that the change was accepted and another TRC from CMS showing that the LEP amount had changed.

Plan KLM then notified Mrs. Johnson that she owes an LEP. Since Mrs. Johnson is in premium withhold status, her current plan, Plan BCD, received this information on the MPWRD and then notified Mrs. Smith that her plan premium was increased accordingly, as a result of the LEP.

30.3 - Timeframes for Reporting Creditable Coverage Period Determinations to CMS

In all cases where the Part D plan sponsor has queried the BEQ or Common UI, it shall report its creditable coverage period determination to CMS in accordance with the reporting timeframes described in the below subsections. Additionally, in cases where the Part D plan sponsor has mailed the attestation form in accordance with §20, it shall follow up with its beneficiary (via telephone or in writing) to obtain the requested information if such information is not received or is received incomplete.

Beneficiary follow-up shall be done within a period of time that allows the Part D plan sponsor to meet the reporting timeframes as described below.

30.3.1 - Reporting Determinations Based on Information received from BEQ or Common UI

When the Part D plan sponsor queries the BEQ or Common UI and determines, in accordance with §20 *Attestation of Creditable Prescription Drug Coverage* of this chapter, that it does not need to send the attestation documents to the beneficiary, it shall report its creditable coverage period determination to CMS within 14 calendar days of receiving the information from the BEQ or Common UI in accordance with §§30.1 and 30.2.

30.3.2 - Reporting Determinations Based on Timely and Complete Attestations

If the Part D plan sponsor sends the attestation documents to a beneficiary as described in §20 of this chapter and receives the completed attestation form within the stated timeframe, the Part D plan sponsor shall report its creditable coverage period determination to CMS within 14 calendar days of receiving the creditable coverage information.

The Part D plan sponsor shall consider the attestation form complete if it contains:

- (1) The signature of the beneficiary, or the signature of the beneficiary's authorized representative (along with the authorized representative's name, address, phone number, and his/her relationship to the beneficiary; AND
- (2) A "✓" in one of the boxes indicating that he/she did or did not have prior creditable prescription drug coverage; and
- (3) Where the box is selected indicating that he/she did have creditable prescription drug coverage, the dates of such coverage is indicated on the corresponding lines.

NOTE: If the Part D plan sponsor receives a timely and complete attestation form (or the creditable coverage information is provided telephonically) after it has submitted an enrollment transaction to CMS on behalf of that beneficiary but before receiving confirmation of that beneficiary's enrollment from CMS, the Part D plan sponsor shall wait for CMS to confirm the beneficiary's enrollment before reporting its creditable coverage period determination to CMS. In this case, the Part D plan sponsor shall report its creditable coverage period determination within 14 calendar days of receiving confirmation of that beneficiary's enrollment.

30.3.3 - Reporting Determinations Based on a Timely, Incomplete Attestation Form

If the Part D plan sponsor receives an incomplete attestation form, the Part D plan sponsor shall follow-up with the beneficiary to obtain the missing information. The Part D plan sponsor shall follow up with the beneficiary via notice (e.g., it may send the “Final Notice” Exhibits 1E or 1F, and 1C, and 1D), telephone, **or** other method to obtain the missing information. However, it **must** follow-up with the beneficiary to obtain the missing information.

In the case of an unsigned attestation form, if the Part D plan sponsor chooses to use the telephonic method to follow-up with the beneficiary in order to obtain the missing information, the Part D plan sponsor can accept the beneficiary’s verbal attestation to the information he/she provides. The beneficiary does not need to provide a ‘wet signature’ in such case. Instead, as with all types of missing information, the Part D plan sponsor shall document the telephone call and amend the beneficiary’s record accordingly (see above §20.2 *Telephonic Attestation*).

The Part D plan sponsor shall report its creditable coverage determination to CMS within 28 calendar days of receipt of the incomplete form.

30.3.4 - Reporting Determinations Based on Missing Attestations

Where the beneficiary fails to return the attestation form (or fails to provide creditable coverage information via telephone) within 30 calendar days of the date on the initial attestation documents mailed to the beneficiary (refer to §20.1 et. al., *Attestation Documents*), the attestation form is considered “missing.” In such case, the Part D plan sponsor **shall** follow-up with the member to obtain the missing information or to obtain the actual attestation form.

The Part D plan sponsor may send a follow-up notice or contact the beneficiary via telephone to obtain the beneficiary’s prior creditable prescription drug coverage information. If the Part D plan sponsor receives information about the beneficiary’s prior creditable prescription drug coverage via telephone, it shall document that information in accordance with §20.2 of this chapter. If the Part D plan sponsor chooses to use the model language “Final Notices”—(Exhibits 1E or 1F, and 1C, and 1D)—it must do so in accordance with §20.1.2.

The Part D plan sponsor **shall** follow-up with the beneficiary within a timeframe that allows the plan to report its creditable coverage period determination within 14 calendar days after the stated deadline on the initial attestation documents. The Part D plan sponsor must report its creditable coverage period determination to CMS within this 14 calendar day timeframe even if it was unable to obtain the requested information from the beneficiary after performing the required follow-up.

30.4 - Reporting Adjustments to Creditable Coverage Period Determinations Previously Reported to CMS

There are circumstances in which a creditable coverage period determination has been made and reported to CMS, but later needs to be adjusted. The reasons for such adjustments include, but are not limited to, the following:

- A. Receipt of a beneficiary's late attestation of creditable coverage;
- B. Beneficiary becomes LIS-eligible;
- C. Beneficiary loses LIS eligibility;
- D. Incurring a subsequent Part D IEP;
- E. Corrections due to plan errors; or
- F. Decisions rendered by CMS's Independent Review Entity (IRE);

Where an adjustment to a member's previously submitted number of uncovered months needs to be made, unless otherwise noted in this Chapter or the enrollment chapters, the Part D plan sponsor shall report the adjustment as soon as it receives information that is the impetus for such change to the previously reported number of uncovered months.

A. Reporting Adjustments Based on Untimely Attestations

- (1) The Part D plan sponsor shall accept an attestation form (or permit plan members to provide information about their creditable coverage via telephone in accordance with §20.2, if the plan offers this option) if it is received no more than 60 days past the return deadline stated on the beneficiary's attestation form. If the plan sponsor has already reported its creditable coverage period determination to CMS, and must adjust the number of uncovered months previously reported, it shall take the following actions: Submit a plan change transaction (73) with the creditable coverage flag set to either:
 - a. (Y) if the late attestation indicates that there is no gap in creditable prescription drug coverage and set the number value to zero ("000");

OR

 - b. (N) if the late attestation indicates that there is still a gap in creditable prescription drug coverage and set the number value to a number greater than zero (e.g., "010" for 10 uncovered months)
- (2) Set the date of the transaction equal to the enrollment effective date in the plan.

In cases where the member has already requested a review of the LEP and CMS's independent review entity (Maximus) has notified the plan of a pending reconsideration request (i.e., Maximus has requested the case file from the plan), the plan must contact Maximus to alert them of the change and provide documentation of the such change. Plans should use the fax number noted on the LEP Reconsideration Case File Request Form to communicate this information to Maximus. If the change

results in the removal of the LEP (i.e., the NUNCMO = zero (0)), Maximus will then dismiss the case because there are no longer uncovered months in dispute. If, however, the change does not eliminate the LEP, Maximus will then proceed with its review of the LEP based on the new information that the plan used to adjust the member's uncovered months.

If the Part D plan sponsor receives an attestation more than 60 days after the return deadline stated on the member's attestation form, it **shall not** make any adjustments to the member's number of uncovered months it previously reported. Instead, the Part D plan sponsor shall inform the member via telephone or in writing (using the *Exhibit 10: Model Notice—Creditable Coverage Information Received After Deadline*) that the sponsor is not accepting the form (or verbal attestation) because more than 60 days have passed since the deadline. The Part D plan sponsor shall also inform the member that he/she will be notified in writing (*Exhibit 2: Model Notice--Beneficiary Notice of Late Enrollment Penalty*) of the amount of any LEP (if such notification has not been provided already) and, that information about requesting a review (using Appendices 14 and 15) of the plan's decision will be (or has already been) included with the letter.

NOTE: Exhibit 2 and Appendices 14 and 15 shall be mailed to the beneficiary in accordance with §50.1 of this chapter.

B. Reporting Adjustments Due to Low-Income Subsidy Eligibility

Pursuant to 42 CFR §§ 423.46(a) and 423.780(e), individuals who are LIS-eligible are exempt from being assessed an LEP. Therefore, if a beneficiary currently paying an LEP becomes LIS-eligible, the penalty is removed effective with the start of LIS eligibility. In such cases, the plan shall submit a plan change transaction to CMS that resets the NUNCMO to zero (0). Resetting the NUNCMO to zero (0) will also remove the LEP amount. To accomplish this, the Part D plan sponsor shall take the following actions:

- (1) Submit a plan change transaction (73) with the credible coverage flag set to "R";
- (2) Submit the number value zero "000"; and
- (3) Submit the effective date equal to the effective date of the individual's LIS eligibility.

NOTE: Using "R" means to "reset." The reset action will end an existing period of time subject to an LEP and begin a new period. This means that the NUNCMO (and corresponding LEP amount) will apply up until the reset date, and a new period will begin with zero NUNCMO (and zero LEP amount) effective with the reset date.

Part D plan sponsors are responsible for reviewing the appropriate CMS reports (see §40.2), including other updated information about its members' LIS status, in order to

ensure that the Part D plan sponsor accurately and timely resets the member's number of uncovered months.

The Part D plan sponsor shall notify the LIS-eligible member of the removal of the LEP and shall use either *Exhibit 5: Model Letter Informing Beneficiary of the Removal of the LEP Due to LIS Eligibility* or create its own form using the requisite elements shown in the model, subject to CMS's marketing review procedures. The Part D plan sponsor shall send this notice within 14 calendar days of receiving information about the member's LIS status from CMS (see §40.2). For members in direct bill status, the Part D plan sponsor shall issue a refund of any LEP amount paid since the member became LIS eligible in accordance with §60.3 of this chapter.

Example:

Mr. Johnson enrolled in Part D for the first time effective January 1, 2007. His Part D IEP ended on May 15, 2006, and, because he had no other creditable coverage prior to enrolling in Part D, he had 7 uncovered months, and was charged an LEP. He became eligible for LIS effective February 1, 2008, and his plan, Plan RST, was notified of this change through CMS plan reports released during the month of February. Plan RST must submit a plan change transaction (73) with the creditable coverage flag set to "R" and the number of uncovered months value set to "000" with the effective date of February 1, 2008 because this is the effective date of his LIS eligibility.

These actions will reset his NUNCMO to zero, thereby, resetting the LEP amount to zero as well. Therefore, he will no longer be assessed the LEP based on 7 uncovered months effective February 1, 2008.

NOTE: LIS-eligible members are responsible for any unpaid LEP amount owed prior to the effective date of their LIS eligibility; and the Part D plan sponsor shall bill and collect the owed amount in accordance with §40.3 of this chapter.

C. Reporting Adjustments Due to Loss of LIS-Eligibility

If a beneficiary loses his/her LIS-eligibility after enrolling in a Part D plan, the previous number of uncovered months that were reset to zero shall not be reapplied, even if the beneficiary later incurs a break of more than 63 days in creditable prescription drug coverage. Additionally, if the beneficiary disenrolls from the Part D plan, incurs a qualifying break in creditable prescription drug coverage and subsequently re-enrolls in a Part D plan, the previously reset number of uncovered months (i.e., the number of uncovered months that were reset to zero) shall not be counted towards any new number of uncovered months.

Continuing with the example described above, consider the following:

Mr. Johnson incurred an LEP because he enrolled after the end of his Part D IEP, and did not have other creditable prescription drug coverage for the period of May 15, 2006 to December 31, 2006 (a total of 7 uncovered months). Mr. Johnson's LEP

was removed effective February 1, 2008 because he was eligible for LIS as of that date. Assume Mr. Johnson then disenrolled from Plan RST. His last day of coverage with Plan RST was April 30, 2008. He later enrolled in Plan DEF effective January 1, 2009. Mr. Johnson was not LIS-eligible when he requested enrollment in Plan DEF, and did not have creditable prescription drug coverage for the period May 1, 2008 through December 31, 2008 (a total of 8 months). Accordingly, Plan DEF reported 8 uncovered months to CMS. CMS then reported to the plan the LEP amount for Mr. Johnson based on 8 uncovered months because none of the prior uncovered months (for the period of May 15, 2006 to December 31, 2006) were counted towards Mr. Johnson's new penalty.

D. Reporting Adjustments Based on Subsequent Part D IEPs

As explained in §10.1.3 of this Chapter, an individual who is eligible for Medicare prior to turning age 65, will have a new (subsequent) Part D IEP based on entitlement to Medicare due to attaining age 65. Any uncovered periods prior to the first day of their subsequent Part D IEP will not be counted towards any future number of uncovered months.

As noted in §10.1.3, The Part D plan sponsor shall have a process in place for identifying members who are attaining age 65 or who have recently attained age 65; and shall notify the member of the removal of the LEP and shall use *Exhibit 4: Model Notice—Removal of Late Enrollment Penalty Due to Subsequent IEP* or create its own form using the requisite elements shown in the model, subject to CMS's marketing review procedures. Additionally, for any LEP amount unpaid prior to the member's subsequent IEP, the Part D plan sponsor shall bill in accordance with §40.3 of this chapter.

Depending on the specific situation, the Part D plan sponsor shall take one of the actions described below to accurately report the NUNCMO to CMS when a beneficiary incurs a subsequent IEP.

1. Current Plan Members

For individuals who are currently enrolled in a Medicare prescription drug plan at the start of their subsequent Part D IEP, the LEP ends on the day before the second IEP begins, which is three months prior to the month the individual attains age 65.

Example:

Mrs. Smith is entitled to Medicare due to disability, but did not join a Medicare prescription drug plan when she was first eligible, and has been paying a LEP based on 9 uncovered months. Mrs. Smith turns age 65 on April 3, 2008. Her last day to be assessed an LEP is December 31, 2007, the day before her second or subsequent IEP begins on January 1, 2008.

The Part D plan sponsor shall take the following steps to reset the NUNCMO to zero (0):

- (1) Submit a plan change transaction (73) with the creditable coverage flag set to “R”;
- (2) Submit the number value zero “000”; and
- (3) Submit the effective date of the transaction equal to the effective date of the first month of the new Part D IEP.

2. New Members Enrolling During their Subsequent IEP

For individuals with prior Part D enrollment, who are currently not enrolled in a D plan, who have previous uncovered months greater than zero (0), and who are enrolling during their subsequent IEP, the Part D plan sponsor shall take the following steps to reset the number of uncovered months to zero (“0”):

- (1) Submit an enrollment transaction (60, 61, 62, or 71)—not a plan change transaction (73) — with the creditable coverage flag set to “R”;
- (2) Submit the number value zero “000”; and
- (3) Submit the effective date of the transaction equal to the effective date of the enrollment

Example:

Mrs. Johnson is currently not enrolled in a Part D plan, but had 12 uncovered months submitted by her previous Medicare prescription drug plan, Plan ABC. Mrs. Johnson was turning 65 on August 3, 2008. Her subsequent IEP was from May 1, 2008 through November 30, 2008. She decided to switch Medicare prescription drug plans during this period and enrolled in Plan XYZ in the month of July. Plan XYZ knew that Mrs. Smith was enrolling during her subsequent IEP and therefore submitted an enrollment transaction (61) with the creditable coverage flag set to “R” along with the number value 000 and the effective date August 1, 2008.

For individuals who are currently enrolled in a Part D plan, the current plan is responsible for resetting the number of uncovered months to zero as of the first day of the subsequent IEP. For this reason, if an enrollment request is received during the subsequent IEP, the plan receiving the new enrollment request should not have to take additional action to reset a prior number of uncovered months value.

3. Members Who Enrolled After Their Subsequent IEP

For individuals who did not enroll in a Medicare prescription drug plan by the end of their subsequent Part D IEP, who are currently not enrolled in a D plan and who have previous uncovered months greater than zero (0), the Part D plan sponsor shall take the steps outlined below to “reset” the first number of uncovered months value and

report any uncovered months incurred after the subsequent IEP so that a second LEP can be imposed:

- (1) Submit the appropriate enrollment transaction with the creditable coverage flag set to “Y” and the number of uncovered months value set to “000.”
- (2) Submit a plan change transaction (73) with the creditable coverage flag set to “R”; the number value equal to zero “000”; and the effective date of the transaction equal to the end date of the previous Medicare prescription drug plan enrollment; then
- (3) After acceptance of the last change transaction, submit an additional plan change (73) transaction with the creditable coverage flag set to “N”; the number value equal to the number of uncovered months; and the effective date of the transaction equal to the current enrollment effective date.

Example:

Mr. Smith was entitled to Medicare based on disability in 2004. He did not enroll in a Medicare prescription drug plan by May 15, 2006. Instead, he enrolled in a Medicare prescription drug plan (Plan QRS) with his enrollment effective January 1, 2007. Following the attestation process, Plan QRS reported 7 uncovered months to CMS. Mr. Smith disenrolled from Plan QRS effective January 1, 2008. Mr. Smith turned age 65 on June 15, 2008. Therefore, his subsequent Part D IEP began March 1, 2008 and ended September 30, 2008. Mr. Smith did not enroll in a plan during his subsequent IEP. He later enrolled in Plan TUV effective January 1, 2009.

Within seven days of receiving Mr. Smith’s enrollment application, plan TUV submitted an enrollment transaction with creditable coverage flag (Y), zero (000) uncovered months, and the effective date 01/01/2009. Following the attestation process, Plan TUV determined that Mr. Smith had 3 uncovered months since the end of his subsequent Part D IEP. Plan TUV submitted a plan change transaction (73) with the creditable coverage flag set to “R” to reset Mr. Smith’s prior uncovered months (7) submitted by Plan QRS and submitted the number value (000) with the effective date December 31, 2007. Plan TUV then submitted another plan change transaction (73), set the creditable coverage flag to “N,” and the number of uncovered months’ value of (003), with the enrollment effective date of January 1, 2009. The number of uncovered months now shows that Mr. Smith had 7 uncovered months from 01/01/2007 through 12/31/2007. As of 12/31/2007, this value was reset to 0. As of 01/01/2009, Mr. Smith has a number of uncovered months of 003. The LEP for Mr. Smith is 3% beginning 01/01/2009 and going forward.

E. Reporting Corrections to Creditable Coverage Period Determinations

In the event the Part D plan sponsor discovers it has reported an incorrect number of uncovered months to CMS, the Part D plan sponsor shall submit a plan change (73) transaction in accordance with §30.1.2. In all cases where a correction to the member’s uncovered months are made due to plan error as described in this subsection, the Part D plan sponsor that adjusted the number of uncovered months due to the error it made, shall advise the member of the adjustment within ten (10) calendar days of receiving confirmation from CMS that the transaction was accepted.

The Part D plan sponsor shall use the model notice *Exhibit 6: Model Notice Informing the Beneficiary of LEP Adjustment Due to Plan Error* or create its own form using the requisite elements shown in the model, subject to CMS's marketing review.

If the member is no longer enrolled in the plan that submitted the number of uncovered months that need to be corrected, the Part D plan sponsor shall follow the instructions for submitting a plan change (73) transaction in accordance with §30.2 of this chapter.

If the change to the number of uncovered months results in the imposition of or increase in the LEP (where the increase is due to reporting additional uncovered months except where the increase is due to a reconsideration), the plan must include the *Appendix 14--LEP Reconsideration Notice* and *Appendix 15—Reconsideration Request Form* with this notice. If, however, such a change results in the elimination or reduction of the LEP, the beneficiary is afforded no new reconsideration rights and the Part D plan sponsor shall not include the *Appendices 14 and 15*.

In cases where the member has already requested a review of the LEP and CMS's independent review entity (Maximus) has notified the plan of a pending reconsideration request (i.e., Maximus has requested the case file from the plan), the plan must contact Maximus to alert them of the change and provide documentation of the change. Plans should use the fax number noted on the LEP Reconsideration Case File Request Form to communicate this information to Maximus. If the correction results in the removal of the LEP (i.e., the NUNCMO = zero (0)), Maximus will then dismiss the case because there are no longer uncovered months in dispute. If, however, the correction does not eliminate the LEP, Maximus will then proceed with its review of the LEP based on the new information that the plan used to adjust the member's uncovered months.

Also, in limited, circumstances, there may be a change to the number of uncovered months because of a corresponding change in a member's enrollment effective date. In such cases, the Part D plan sponsor shall correct the previously reported number of uncovered months by submitting a plan change (73) transaction in accordance with §30.1.2 of this chapter.

F. Reporting Adjustments Due to Reconsideration Decisions

As noted in §60, the Part D plan sponsor shall refer to Chapter 18, §80.7.1 *Reconsideration of Late Enrollment Penalty Determinations* of this manual for a detailed explanation of the LEP Reconsideration process.

Reconsideration decisions may uphold, increase, decrease or eliminate the number of uncovered months previously submitted by a Part D plan sponsor. If the member is still enrolled in the Part D plan sponsor that imposed the number of uncovered

months to be adjusted, the Part D plan sponsor shall take the steps outlined below to remove or adjust the number of uncovered months previously reported:

- To remove the LEP, the Part D plan sponsor shall:
 - (1) Submit a plan change transaction (73) with the creditable coverage flag “Y”;
 - (2) Set the number value to zero (“000”); and
 - (3) Set the effective date of the transaction equal to the effective date of the member’s enrollment in the plan.
- To adjust the number of uncovered months to a number other than “0”, the Part D plan sponsor shall:
 - (1) Submit a plan change transaction (73) with the creditable coverage flag “N”;
 - (2) Set the number value equal to the number of uncovered months; and
 - (3) Set the effective date of the member’s enrollment in the plan.

The Part D plan sponsor shall take the appropriate action and report the revised number of uncovered months to CMS within 14 calendar days of receiving a reconsideration decision from CMS’s IRE.

If the member is no longer enrolled in the Medicare Part D plan sponsor that imposed the number of uncovered months to be adjusted, the Part D plan sponsor shall follow the steps in §30.2 of this chapter.

The Part D plan sponsor that imposed the number of uncovered months to be removed shall notify its member (or former member in cases where the member has disenrolled prior to the outcome of the reconsideration request) of any adjustment to his/her LEP as a result of a reconsideration decision by CMS’s IRE. The Part D plan sponsor shall use *Exhibit 7: Model Notice—Confirm Adjustment of Premium Based on Reconsideration of Late Enrollment Penalty* or create its own form using the requisite elements shown in the model, subject to CMS’s marketing review procedures. If the Part D plan sponsor that imposed the number of uncovered months collected an LEP based on the previous uncovered months, it shall issue a refund to the member in accordance with §60.3.

NOTE: In cases where the Part D plan sponsor that imposed the number of uncovered months to be removed receives notice of a partially or fully favorable LEP reconsideration on behalf of a deceased member, the Part D plan sponsor shall submit a plan change transaction and send the beneficiary’s estate notification in accordance with this chapter.

30.5 - Reporting Adjustments on Behalf of Current Members for Prior Periods

In general, a member’s current plan can submit changes to his/her number of uncovered months for any time period prior to the member’s enrollment in the plan,

and for any period during which s/he is currently enrolled in the Medicare prescription drug plan using the prospective regular batch file process.

The effective date of the plan change (73) transaction may be retroactive but cannot be prior to June 1, 2006. The effective date on the plan change (73) transaction can be prospective, but not beyond the current payment month plus two months (CPM+2).

When the member's current plan submits changes to the number of uncovered months, it will receive a transaction reply code (TRC) on the transaction reply report (TRR) regarding the adjustment and a recalculated LEP amount on the LIS/LEP Report for members in direct bill status and the MPWRD for members in premium withhold status. Additionally, when applicable, the member's previous plan(s) will be impacted by this change to the uncovered months. Therefore, prior plan(s) affected by this change will receive information regarding changes to the uncovered months and recalculated LEP **only** on the LIS/LEP Report for members who are in direct bill status and the MPWRD for members in premium withhold status.

NOTE: The plan that submits the change to an individual's uncovered months will be the entity that receives a transaction reply on the TRR. The affected plans will see the change on the Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) for members in direct bill status and on the Monthly Premium Withholding Report/ Data file (MPWRD) for members in premium withhold status.

There will be instances when a member will no longer be enrolled in the Medicare prescription drug plan that imposed the number of uncovered months to be adjusted as a result of a reconsideration decision rendered by CMS's IRE. In this situation, CMS's IRE will mail a copy of its reconsideration determination letter to the member's current Part D plan sponsor, as well as the prior plan that imposed the number of uncovered months to be adjusted. The member's current Medicare prescription drug plan may (but is not required to) adjust the number of uncovered months previously reported by the member's prior plan. If the plan does report an adjustment to the uncovered months, it must then notify the member, using *Exhibit 7: Model Notice—Confirm Adjustment of Premium Based on Reconsideration of Late Enrollment Penalty*—of the adjustment and refund any LEP amounts collected, in accordance with §60 of this chapter.

Example:

Mrs. Brown enrolled in Plan CDE effective January 1, 2008. Plan CDE determined that Mrs. Brown had five (5) uncovered months during which she was not enrolled in Part D and did not have other creditable coverage and reported this information to CMS. Plan CDE notified Mrs. Brown of the LEP, advised her of her right to request reconsideration, and collected the LEP owed since January 1, 2008, in accordance with CMS guidance. Mrs. Brown requested CMS's IRE to review her LEP in a timely

manner. While her request was pending with CMS's IRE, Mrs. Brown disenrolled from Plan CDE effective March 31, 2008, and enrolled in Plan DEF effective April 1, 2008. CMS's IRE found that Mrs. Brown did have creditable coverage during the 5 months in question, and issued a favorable decision for Mrs. Brown in April 2008. Plans CDE and DEF received a copy of the decision rendered by CMS's IRE.

Plan CDE must use the process described in §30.2 of this chapter to submit a batch retro file that contains a Plan Change (73) transaction changing the number of uncovered months from "005" to "000" and the creditable coverage flag from "N" to "Y" and using a header date of "012008" (January 2008), "022008" (February 2008), or "032008" (March 2008). Plan CDE submits the change as directed, and receives a transaction reply code showing that the change was accepted and another one showing that the LEP has also changed. Plan CDE notifies Mrs. Brown that the LEP was removed effective January 1, 2008, and refunds any LEP collected since that time.

Plan DEF receives the information regarding the change to Mrs. Brown's uncovered months and LEP on the Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) Report since she is in direct bill status. Plan DEF also notifies Mrs. Brown that her plan premium was reduced as a result of the reconsideration decision and refunds any LEP collected since her enrollment in Plan DEF was effective on April 1, 2008.

Although Plan DEF is not required to make the adjustment to Mrs. Brown's uncovered months (as Plan CDE is required to do so), Plan DEF could have submitted a Plan Change (73) transaction for the entire period in question – from January 1, 2008 up through the current payment month – through the regular batch file process, with the same results.

40 - CMS CALCULATING & REPORTING LEP TO PART D PLAN SPONSORS

40.1 - Calculating the LEP

CMS is the only entity authorized to calculate the beneficiary's LEP amount. Currently, the LEP is assessed as 1% of the national base beneficiary premium for the coverage year times the total number of uncovered months, regardless of the year(s) in which those months occurred. The LEP amount is rounded to the nearest ten cents.

Note: The national base beneficiary premium used in the calculation of the LEP is **not** the part D plan sponsor's premium. It is a national amount that is a function of the national average bid for the year in which the beneficiary is enrolled in a Part D plan sponsor. Therefore, even if there is no change in the number of uncovered months, the LEP may change each year because it is recalculated using the total number of uncovered months and the national base beneficiary premium for that particular year.

Example:

Mr. Jones enrolled in Plan XYZ effective January 1, 2009. Plan XYZ determined that Mr. Jones had a gap in creditable prescription drug coverage following the end of his Part D IEP. Therefore, Plan XYZ reported 5 uncovered months. Although Mr. Jones had uncovered months in 2008, CMS calculated the 5 uncovered months based on the 2009 national base beneficiary premium for the coverage year 2009 which is \$30.36 and arrived at the amount of \$1,518. CMS rounded this amount to the nearest ten cents and informed Plan XYZ that Mr. Jones' Part D LEP amount is \$1.50.

If the Part D plan sponsor receives a general inquiry about how the LEP is calculated, it shall inform the enrollee of the process by which CMS assesses the LEP, and if applicable, the number of uncovered months the Part D plan sponsor reported to CMS. However, the Part D plan sponsor shall not estimate the LEP and inform the beneficiary of that amount. The Part D plan sponsor shall wait for CMS to notify the Part D plan sponsor of the LEP amount and then inform the beneficiary of that amount using the appropriate notice as explained in §50.

If an inquiry is made about the likelihood of a beneficiary being assessed an LEP, but no enrollment request has been submitted on behalf of that beneficiary, the Part D plan sponsor shall exercise care when explaining the policy, since any explanation, (e.g., including hypothetical scenarios with beneficiary-specific information) may be interpreted by the beneficiary as official creditable coverage period determinations and an actual LEP amount.

40.2 - LEP Reports to Plans

According to §50, Part D plan sponsors are required to notify members, in writing, of the imposition of or adjustment to an LEP within 10 calendar days (or unless otherwise noted in this Chapter) of receiving notice of the LEP from CMS. Notification from CMS is in the form of several reports that are summarized in the table below. The 10-day reporting timeframe starts with the first report from CMS that contains the member-specific LEP.

For example, if information is first available in the LIS/LEP Report (for members in direct bill status) or the Monthly Premium Withholding Report Data File (for members in premium withhold status), the Part D plan sponsor has 10 calendar days from the receipt of these reports to notify the member of the LEP.

Name of Data File/Report	Availability
Weekly Transaction Reply Report (Weekly TRR) (only includes information about beneficiaries for whom a transaction was submitted during the prior week)	Weekly
Monthly Transaction Reply Report (Monthly TRR)	Monthly

(only includes information about beneficiaries for whom a transaction was submitted during the prior month)	
Low-Income Subsidy/Late Enrollment Penalty (LIS/LEP) (direct bill beneficiaries only)	Monthly
Monthly Premium Withholding Report Data File (MPWRD) (beneficiaries in premium withhold status only)	Monthly

The weekly/monthly TRR will show the LEP amount and number of uncovered months it submitted. However, to determine the members' total number of uncovered months, i.e., the number of uncovered months submitted by all Part D plan sponsors on which the total LEP amount is based, the Part D plan sponsor can review the Common UI M231—Beneficiary Detail Premium Screen, the M232—Beneficiary Eligibility Screen, and the BEQ Response File.

NOTE: The data files, reports, and information contained in the Common UI and BEQ Response File are described in detail in the Plan Communications Users Guide (PCUG). The Part D plan sponsor shall use the most recent PCUG or updated guidance from CMS to learn of any changes to the location of the LEP.

40.3 - Annual Changes in LEP Amounts

At the start of each calendar year, the LEP amount will change based on the change to the national base beneficiary premium. While there is no Transaction Reply Code (TRC) associated with this change, Part D plan sponsors will see the adjustment in the December LIS/LEP Report for January 1st plan payment and the January Monthly Premium Withhold Report for February 1st play payment. These reports will be released in accordance with the reports schedule contained in the Plan Communications User Guide.

Part D plan sponsors shall adjust their bills accordingly to reflect the new amount and include notification of this new amount in their premium bill or via a separate notice. If the Part D plan sponsor chooses to notify its member about this change to his/her LEP, it may use *Exhibit 9: Model Notice—Yearly Change to LEP Amount*, or create its own.

NOTE: The reconsideration process is not available for adjustments to the LEP based on a change to the national base beneficiary premium. Therefore, the Part D plan sponsor shall not include *Appendix 14—LEP Reconsideration Notice and Appendix 15—Reconsideration Request Form* with notice of the adjusted LEP.

50 - NOTIFICATION TO BENEFICIARIES OF THE LATE ENROLLMENT PENALTY

50.1 - Notification of LEP Based on a Creditable Coverage Period Determination

This subsection provides the notice requirements the Part D plan sponsor shall follow when a creditable coverage period determination is made in accordance with §10. The Part D plan sponsor shall follow the notice requirements outlined in §30.4 in cases where a creditable coverage period determination has been made and reported to CMS, but later needs to be adjusted.

The Part D plan sponsor that submitted the number of uncovered months which results in an imposition of or increase in the LEP (where the increase is due to reporting additional uncovered months) shall provide the beneficiary a written notice about the LEP within 10 calendar days of receiving notice of the LEP from CMS (as described in subsection §40.2.1 of this chapter) and information about how to request a review of the penalty. The Part D plan sponsor shall mail the member *Exhibit 2: Model Notice—Beneficiary Notice of Late Enrollment Penalty, as well as Appendix 14—LEP Reconsideration Notice and Appendix 15—Reconsideration Request Form*.

If the Part D plan sponsor creates its own notice, it must use the following requisite elements:

- 1) Beneficiary's name;
- 2) Monthly premium (in dollars and cents) for the current year, and provide what portion of that premium is the LEP;
- 3) Effective date of the penalty;
- 4) Basis for LEP in terms of the number of uncovered months reported to CMS; and
- 5) Information about the beneficiary's right to request reconsideration (review) of the LEP and the reconsideration filing deadline using the requisite elements described in *Appendix 14—LEP Reconsideration Notice and Appendix 15—Reconsideration Request Form* located in Chapter 18 of this manual.

Note: The Part D plan sponsor shall only include *Appendices 14 and 15* when there is an imposition of or increase to an LEP (where the increase is due to reporting additional uncovered months). The Part D plan sponsor **shall not** include *Appendix 14—LEP Reconsideration Notice and Appendix 15—Reconsideration Request Form* when notifying a beneficiary of an adjustment due to a reconsideration decision.

50.2 - Notification of LEP Imposed by Prior Part D Plan Sponsor

This subsection provides the notice requirements for Part D plan sponsors who have members with prior Part D enrollments and an LEP is imposed or adjusted by the member's prior plan after the member has disenrolled from that plan.

The LEP amount that a member is currently paying (or has previously paid) may change when a member's prior plan delays making a creditable coverage period determination (see §10.3.1 and §30.2) or adjusts a creditable coverage period determination it previously reported to CMS (see §30.4). As a result, the member's subsequent plan(s) will be impacted because this will result in a change to the LEP amount the subsequent plan(s) is billing, has billed, or needs to bill. When this occurs, the member's subsequent plan(s) shall notify the member that it either owes the member a refund or that the member owes the subsequent plan(s) additional payment as a result of adjustment. Unless otherwise noted in this chapter, the subsequent(s) plan shall notify the member of the imposition of or adjustment to the LEP using *Exhibit 11: Model Notice – Beneficiary Notification of LEP Adjustment Reported* within 10 calendar days of receiving notice from CMS about the beneficiary's LEP.

The subsequent plan(s) shall notify the member of the adjusted LEP in cases where the new or adjusted creditable coverage period determination removes, reduces, imposes, or increases the LEP. In all cases, however, the subsequent plan(s) **shall not** include *Appendix 14—LEP Reconsideration Notice and Appendix 15—Reconsideration Request Form*.

If the subsequent plan(s) creates its own notice, it must use the following requisite elements:

- 1) Beneficiary's name;
- 2) The full LEP amount to be refunded or owed (in dollars and cents). (If the member is currently in a plan affected by the change, it shall include the monthly premium amount and provide what portion of that premium is the LEP);
- 3) Effective date of the penalty owed or to be refunded;
- 4) Basis for LEP in terms of the number of uncovered months reported to CMS; and
- 5) A statement explaining that the plan was notified by CMS regarding the LEP.

The subsequent plan(s) shall bill or refund any LEP in accordance with §60 of this chapter.

50.3 - Notification of Existing LEP

In cases where the member's subsequent plan(s) is aware of an existing LEP at the time of enrollment, it **may** also use *Exhibit 3: Model Notice—Beneficiary Notice of Existing Late Enrollment Penalty* to remind the member that he/she has an existing LEP. However, the Part D plan sponsor **is not** required to provide additional information about an existing LEP. If the Part D plan sponsor opts to remind a member of an existing LEP using this form it **shall not** include *Appendix 14—LEP Reconsideration Notice and Appendix 15—Reconsideration Request Form* as this notification does not trigger the right to request a review of the LEP.

If the subsequent plan(s) creates its own notice, it must use the following requisite elements:

- 1) Beneficiary's name;
- 2) The full LEP amount to be refunded or owed (in dollars and cents). (If the member is currently in a plan affected by the change, it shall include the monthly premium amount and provide what portion of that premium is the LEP);
- 3) Effective date of the penalty owed or to be refunded;
- 4) Basis for LEP in terms of the number of uncovered months reported to CMS; and
- 5) A statement explaining that the plan was notified by CMS regarding the LEP.

50.4 - Notice of LEP When Employer/ Union Sponsors Pays the LEP

In cases where an employer or union sponsors prescription drug coverage for its members through the Part D plan sponsor, and the employer or union elects to pay the LEP on behalf of its members, the Part D plan sponsor shall inform the beneficiary that the employer or union has agreed to pay the LEP on his/her behalf. The Part D plan sponsor shall also inform the beneficiary that, if the coverage is terminated by him/her or by the employer or union sponsoring the Part D plan sponsor, the beneficiary will be responsible for paying the LEP if and when he/she enrolls into another Part D plan sponsor. *Exhibit 2: Model Notice—Beneficiary Notice of Late Enrollment Penalty* provides model paragraphs that Part D plan sponsors can use to convey this information.

60 - BILLING, COLLECTING, AND REFUNDING THE LEP

60.1 - Billing and Collecting the LEP from Members in Direct Bill Status

In accordance with 42 CFR §§423.286(d)(3) and 423.293(a)(1), the LEP is part of the Part D premium. Therefore, the Part D plan sponsor shall bill and collect it in the same manner it does the non-LEP portion of its member's premium once it receives information from CMS about the amount in accordance with §40.2 of this chapter. The same is also true for the Part D plan sponsor that has a zero (\$0) premium premium—members enrolled in such plans with LEPs must be billed and must be permitted to pay monthly—42 CFR 423.293(a)(2).

The Part D plan sponsor shall bill and make a reasonable attempt to collect any LEP amounts owed since the beneficiary's enrollment effective date but no earlier than January 1, 2007. The Part D plan sponsors shall also bill and make a reasonable attempt to collect any unpaid LEP from its former members.

For members that are billed directly for the Part D premium (i.e., members in direct bill status), the Part D plan sponsor shall bill such members for the LEP at the same time it bills for the Part D plan premium. The plan sponsor may choose to issue a separate invoice for the LEP and indicate that it is due at the same time as the non-LEP premium, or the plan sponsor may itemize the LEP amount on the same invoice as the non-LEP premium. Additionally, plans may establish a quarterly or annual billing cycle, but must always afford the member the option of monthly payment. The member must be permitted to actively choose among the various billing cycles a plan may provide.

Due to the time associated with the creditable coverage period determination process, in most cases, plans will initially have to bill members for LEP amounts retroactively. When this occurs, the Part D plan sponsor must bill and collect the retroactive LEP amount and may retroactively bill members for the past-due amount. Note that in all cases, even where the LEP is imposed or adjusted by a member's prior plan after the member has disenrolled from that plan, the Part D plan sponsor must bill and make a reasonable attempt to collect the LEP. (See §§10.3.1, 30.2, 30.4, and 50 of this chapter).

60.1.2 - Members in Premium Withhold Status

The Part D plan sponsor shall not bill members who are in premium withhold status, but shall notify the member of the LEP amount, in accordance with §50 of this chapter. The Social Security Administration (SSA) will take the necessary actions to collect the LEP amount from the member who has elected the SSA premium withhold

option. SSA accomplishes this by increasing the withhold amount by the amount of the LEP.

60.1.3 - Billing Employer or Union Sponsors

If an employer or union sponsors prescription drug coverage for its members through the Part D plan, the plan sponsor may bill the employer or union directly for any LEP if both parties agree.

60.1.4 - Billing the LEP During the Reconsideration Process

In cases where the member has filed a request for reconsideration, the Part D plan sponsor shall continue to bill (and SSA will continue to withhold) the LEP as part of the premium. The Part D plan sponsor shall not allow its member to forego paying his/her LEP until a decision is rendered by CMS's IRE.

Unless otherwise authorized by CMS, the Part D plan sponsor shall adjust the amount it bills the member only after the Part D plan sponsor has submitted a plan change (73) transaction to change the number of uncovered months based on the reconsideration decision **and** CMS has notified the Part D plan sponsor of the new LEP amount. In the event that the IRE determines that no LEP is owed, the sponsor shall promptly cease collection of the LEP and refund any LEP amount paid.

60.2 - Failure to Pay the LEP Portion of the Premium

If the Part D plan sponsor has opted to have a policy of involuntary disenrollment for failure to pay plan premiums (as explained in the enrollment guidance appropriate to your plan type), then it must also disenroll members who fail to pay the LEP portion of their premium. Plans may not selectively enforce this policy. However, the Part D plan sponsor can choose to set a threshold amount for non-payment of premiums before it disenrolls a member who fails to pay.

60.3 - Refunding the LEP

In accordance with §30.4 of this chapter, there are circumstances in which a creditable coverage period determination has been made and reported to CMS, but later needs to be adjusted. In cases where the adjustment reduces or removes the number of uncovered months previously reported, the Part D plan sponsor that imposed the number of uncovered months to be adjusted (as well as any subsequent Part D plan sponsor that billed the member a LEP based on the previously reported number of uncovered months to be adjusted), shall refund (or credit the member's future bill) any LEP amount paid by the member based on such uncovered months. If

the adjustment to the previously reported number of uncovered months results in a reduction rather than a removal of uncovered months, CMS will also provide the new number of uncovered months.

In cases where an individual has disenrolled from the Part D plan sponsor that imposed the number of uncovered months that was adjusted and is enrolled in another Medicare prescription drug plan, CMS will also notify the member's current plan of the refund amount and, if applicable, the new number of uncovered months.

Any Part D plan sponsor(s) that collected LEP payments based on the previously reported uncovered months shall notify the member of the LEP refund owed (see §50 of this chapter) and refund the LEP (or apply the amount to a future premium bill) promptly. If the beneficiary's premium was withheld from his/her Social Security benefits, CMS and SSA will take the necessary action to refund the LEP withheld as part of the premium.

The amount to refund the beneficiary can be found on the LIS/LEP and MPWRD Reports for members in direct bill and premium withhold statuses respectively.

70 - LEP RECONSIDERATION PROCESS

Part D plan sponsors shall refer to Chapter 18, §80.7.1 *Reconsideration of Late Enrollment Penalty Determinations* of this manual for a detailed explanation of the LEP Reconsideration Process.

80 - INFORMATION RETENTION REQUIREMENTS

In accordance with 42 CFR §423.46(d), Part D plan sponsors are required to retain **all** information collected concerning creditable coverage period determinations in the same manner as enrollment records. That is, the Part D plan sponsor shall retain creditable coverage period determinations for the current contract period and 10 (ten) prior periods. (See the appropriate CMS enrollment guidance for more information about these requirements). Similarly, the Part D plan sponsor shall also retain copies of any evidence of creditable coverage, including attestation forms, and any information regarding LEP reconsideration decisions.

Appendices

Appendix 1: Summary of MARx Transactions to Add, Change, or Remove the Number of Uncovered Months for an Enrolled Beneficiary

Action	Creditable Coverage Flag Value	Number of Uncovered Months Field Value	Effective Date on Transaction Code 73**
Submit a new number of uncovered months that is greater than 0	N	Number greater than 0	Equal to existing enrollment effective date <i>Note: This information may also be provided on an enrollment transaction (60/61/62/71),</i>
Change an existing number of uncovered months	N	Revised number greater than 0	Equal to existing enrollment effective date
	Y	0	Equal to existing enrollment effective date
Reset the existing number of uncovered months to 0 due to another IEP for Part D	R	0	Equal to the effective date of the 1 st month of the new IEP for Part D or as otherwise noted in this chapter.
Reset the existing number of uncovered months to 0 due to an individual becoming LIS eligible.	R	0	Equal to the effective date of the start of LIS eligibility.
Correct Erroneous Reset action already submitted	U	0	Effective date is equal to the date of the reset "R" transaction. (Page 5 of Fall Memo).
Submit a new number of uncovered months or change uncovered months for a former member	Insert the correct value as/per the directions above for the desired change	Insert the correct value as/per the directions above for the desired change	Equal to original enrollment effective date You must contact MMA Help Desk to obtain a ticket number to request the submission of a batch retro file to report these transactions.

*For more information about MARx transactions, please consult the October 9, 2007 HPMS Memo re: *Announcement of Fall Software Changes* and current CMS Plan Communications User Guide.

**For more information about the 73 Transaction, please consult the January 9, 2009 HPMS Memo re: *Announcement of Spring 2009 Software Release*.

Appendix 2: Creditable Coverage Period Determination/Late Enrollment Penalty Exhibits

Exhibit	Notice	Required?	Timeframe
1A (to be sent with 1C and 1D as attachments)	Beneficiary Cover Letter for Individuals with Break in Coverage	Yes – only for beneficiaries with prior RDS or Medicare Part D coverage	Within 7 calendar days of receipt of the Beneficiary Eligibility Query response
1B (to be sent with 1C and 1D as attachments)	Beneficiary Cover Letter for Individuals Newly Enrolled in Medicare Drug Plan	Yes – for beneficiaries new to Medicare Part D coverage	Within 7 calendar days of receipt of the Beneficiary Eligibility Query response
1C	Frequently Asked Questions and Answers	Yes	As attachment to 1A, 1B, 1E and 1F
1D	Declaration of Prior Prescription Drug Coverage	Yes	As attachment to 1A, 1B, 1E and 1F
1E (to be sent with 1C and 1D as attachments)	“Final Notice” Beneficiary Cover Letter for Individuals with Break in Coverage	No	Must be mailed with a deadline return date that will allow plans enough time to meet the plans reporting deadline to CMS
1F (to be sent with 1C and 1D as attachments)	“Final Notice” Beneficiary Cover Letter for Individuals Newly Enrolled in Medicare Drug Plan	No	Must be mailed with a deadline return date that will allow plans enough time to meet the plans reporting deadline to CMS
2 (to be sent with Appendices 14 and 15 as attachments)	Model Notice – Beneficiary Notice of Late Enrollment Penalty	Yes	Within 10 calendar days of receiving first notification from CMS regarding the beneficiary-specific LEP information
3	Model Notice - Beneficiary Notice of Existing Late Enrollment Penalty	No	N/A
4	Model Notice - Removal of Late Enrollment Penalty Due to Subsequent IEP	Yes	Within 10 calendar days of receiving first notification from CMS regarding the beneficiary-specific LEP information

5	Model Notice - Removal of the LEP Due to LIS Eligibility	Yes	Within 14 calendar days of receiving information about LIS status from CMS
6 (to be sent with Appendices 14 and 15 as attachments if error imposes or increases LEP due to reporting additional uncovered months).	Model Notice – LEP Adjustment Due to Plan Error	Yes	Within 10 calendar days of receiving confirmation from CMS that transaction was accepted
7	Model Notice - Confirm Adjustment of Premium After Reconsideration of Late Enrollment Penalty	Yes	Within 10 calendar days of receiving first notification from CMS regarding the beneficiary-specific LEP information
8	Model Notice - Return of Creditable Coverage Information Received Without an Accompanying Enrollment Request	Yes	Within 10 calendar days of the plan’s receipt of creditable coverage information from beneficiary
9	Model Notice - Yearly Change in LEP Amount	No	N/A
10	Model Notice - Creditable Coverage Information Received After Deadline	Yes, if attestation information is provided more than 60 days past attestation return deadline	Send no earlier than the 61st day following the deadline return date on beneficiary’s attestation form but no later than 10 calendar days following receipt of the late attestation form or creditable coverage information.
11	Model Notice – Beneficiary Notification of LEP Adjustment Reported	Yes	Within 10 calendar days of receiving notice of the LEP information from CMS
Appendix 14	Model Notice - Part D Late Enrollment Penalty Reconsideration Notice	Yes	As attachment to 2 and 6
Appendix 15	Model Notice - Part D Late Enrollment Penalty	Yes	As attachment to 2 and 6

	Reconsideration Request Form		
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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 codes are located at the top of each *Exhibit*.

EXHIBITS

Model Forms & Notices

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>.

<Contract#, Material ID#, CMS approval date (if applicable)>

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.

<Contract#, Material ID#, CMS approval date (if applicable)>

Exhibit 1C: Frequently Asked Questions and Answers (HPMS Code 8014)



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

<Contract#, Material ID#, CMS approval date (if applicable)>

- 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.

Exhibit 1D: Declaration of Prior Prescription Drug Coverage (HPMS Code 8015)

<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)
<input type="checkbox"/> I had creditable* prescription drug coverage from an Employer/Union, including the Federal Employees Health Benefits Program (FEHBP) Name: _____	From: _____ To: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> I had prescription drug coverage through my VA	From: _____

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

<Contract#, Material ID#, CMS approval date (if applicable)>

benefits (veterans, survivor, or dependent benefits)	To: _____
<input type="checkbox"/> I had prescription drug coverage through my TRICARE or other military coverage	From: _____ To: _____
<input type="checkbox"/> I had a Medigap (Medicare Supplemental) policy with creditable* prescription drug coverage	From: _____ To: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> I had prescription drug coverage through PACE (Program of All-Inclusive Care for the Elderly)	From: _____ To: _____
<input type="checkbox"/> I had creditable* prescription drug coverage from a different source not listed above. Name of other source: _____	From: _____ To: _____
<input type="checkbox"/> I have/had extra help from Medicare to pay for my prescription drug coverage.	From: _____ To: _____
<input type="checkbox"/> 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: _____
<input type="checkbox"/> 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>.

<Contract#, Material ID#, CMS approval date (if applicable)>

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.

<Contract#, Material ID#, CMS approval date (if applicable)>

Exhibit 2: Model Notice - Beneficiary Notice of Late Enrollment Penalty (HPMS Code 8003)

<Date>

Dear < Insert Name of Enrollee>:

We are writing to tell you that starting <effective date> your new premium will include a late enrollment penalty of <amount of new premium> per month. Your new premium amount includes an additional <LEP amount> each month because you didn't have Medicare prescription drug coverage or other drug coverage that met Medicare's minimum standards (creditable coverage).

[Insert the following if the beneficiary is enrolling in a Part D plan for the first time:]

According to Medicare's records, you did not have creditable coverage for <# of uncovered months> from < date > to < date > after you were first eligible to sign up for Medicare prescription drug coverage.

[OR insert the following if the beneficiary was previously enrolled in a Part D prescription drug plan:]

According to Medicare's records, you did not have creditable coverage for <# of uncovered months> from <effective date of disenrollment from previous plan> to <the month before the effective date in your plan> following your disenrollment effective date from your last Medicare prescription drug plan.

[Insert the following if the beneficiary's LEP amount has to be paid retroactively:]

Since you owe an LEP dating back to your effective date of enrollment, we will charge you a lump sum amount of <amount of lump sum owed retroactive to the date of their enrollment in the plan>. After this one time lump sum payment, you will be charged <amount of new premium> per month. *[For members in direct-bill status, insert the following language:]* Your premium bill will reflect this new premium amount. *[For members in premium withhold status, insert the following language:]* This lump sum amount will be deducted from your Social Security check. After this, your new

<Contract#, Material ID#, CMS approval date (if applicable)>

premium amount will also be deducted from your monthly Social Security check.

[Insert the following if employer, union, or State Pharmaceutical Assistance Program is paying the LEP amount on behalf of member:]
<Name of employer or union sponsoring the Plan> has agreed to pay <LEP amount>, the amount of your late enrollment penalty, on your behalf. If your coverage is terminated by you or <name of employer or union sponsoring the Plan>, or if <name of employer or union sponsoring the Plan> stops paying your late enrollment penalty, you will be responsible for paying that amount.

If you disagree with your late enrollment penalty, you can ask Medicare to reconsider (review) its decision if certain circumstances apply to you. (For example, you might disagree with the penalty if you had extra help from Medicare to pay for your prescription drug coverage; or if you did not receive notice that clearly explained whether you had creditable coverage). A notice explaining your right to a reconsideration of the late enrollment penalty is included with this letter along with a reconsideration request form. You must submit your reconsideration request within 60 days of the date of this letter to the address listed on the enclosed *Part D Late Enrollment Penalty Reconsideration Request Form*, or Medicare may not consider your request.

If you have questions about the information in this letter, or if you would like more information about the late enrollment penalty, call <Plan Name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 3: Model Notice - Beneficiary Notice of Existing Late Enrollment Penalty (HPMS Code 8008)

<Date>

Dear < Insert Name of Enrollee >:

We are writing to tell you that starting <effective date>, your premium will be <amount of premium> per month. This amount is based on an existing late enrollment penalty that you were charged by your previous plan(s) because you did not have Medicare prescription drug coverage or other drug coverage that met Medicare's minimum standards (creditable coverage) for a total of <insert total # of uncovered months that resulted in the existing LEP> months.

[Insert the following if the beneficiary's LEP amount has to be paid retroactively:]

Since you owe a late enrollment penalty dating back to your effective date of enrollment, we will charge you a lump sum amount of <amount of lump sum owed retroactive to the date of their enrollment in the plan>. After this one time lump sum payment, you will be charged <amount of premium> per month. *[For members in direct-bill status, insert the following language:]* Your premium bill will reflect this new premium amount. *[For members in premium withhold status, insert the following language:]* This lump sum amount will be deducted from your Social Security check. After this, your new premium amount will also be deducted from your monthly Social Security check.

[Insert the following if employer, union, or State Pharmaceutical Assistance Program is paying the LEP amount on behalf of member:] <Name of employer or union sponsoring the Plan> has agreed to pay <LEP amount>, the amount of your late enrollment penalty, on your behalf. If your coverage is terminated by you or <name of employer or union sponsoring the Plan>, or if <name of employer or union sponsoring the Plan> stops paying your late enrollment penalty, you will be responsible for paying that amount.

If you have questions about the information in this letter, or if you would like more information about the late enrollment penalty, call

<Plan Name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 4: Model Notice - Removal of Late Enrollment Penalty Due to Subsequent IEP (HPMS Code 8009)

<Date>

Dear < Insert Name of Enrollee >:

We are writing to inform you that beginning *<effective date of new IEP>* you will no longer be charged a late enrollment penalty. This means that your monthly premium will be reduced by *<insert amount of LEP>*. Your new monthly premium will be *<insert amount of premium minus LEP>*.

You *<will no longer>/ no longer* owe a late enrollment penalty because this penalty is removed whenever a beneficiary enters a new Initial Enrollment Period for Part D (Part D IEP). In your case, Medicare's records show that you *<will have>/<had>* a new Part D IEP based on turning age 65 that begins/began *<insert first month of new IEP>* and ends/ended *<insert last month of new IEP>*. As long as you have Medicare prescription drug coverage or other drug coverage that meets Medicare's minimum standards (creditable coverage) after the end of this Part D IEP, you will not be charged a late enrollment penalty.

If you have questions about the information in this letter, or if you would like more information about the late enrollment penalty, call *<Plan Name>* at *<toll-free number>* *<days and hours of operation>*. TTY users should call *<toll-free TTY number>*. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 5: Model Letter - Informing Beneficiary of the Removal of the LEP Due to LIS Eligibility (HPMS Code 8010)

<Date>

Dear < Insert Name of Enrollee >:

We are writing to inform you that your monthly premium will no longer include a late enrollment penalty amount that you were being charged.

You will no longer be charged a late enrollment penalty because Medicare's records show that effective <effective date of LIS eligibility> you were receiving extra help from Medicare to pay for your prescription drug coverage. This means that your monthly premium will be reduced by <insert amount of LEP>. Therefore, your new premium amount will be <new premium amount>.

[For members in direct-bill status, insert the following language:]
This also means any late enrollment penalty amount that you've paid since <effective date of LIS eligibility> *[Select method of LEP refund:] will be refunded back to you as soon as possible OR will be applied to reduce your next bill. We will [Select method of LEP refund:] refund you /reduce your next bill by <total LEP amount since the effective date of LIS eligibility>. However, if you owe a late enrollment penalty prior to <effective date of LIS eligibility> you are responsible for paying that amount.*

[OR insert the following for members in premium-withhold status:]
This also means that any late enrollment penalty amount that you've paid since <effective date of LIS eligibility> will be refunded to you by the Social Security Administration. The Social Security Administration will refund you <total LEP amount since the effective date of LIS eligibility> as soon as possible. However, if you owe a late enrollment penalty prior to <effective date of LIS eligibility> you are responsible for paying that amount.

If you have questions about the information in this letter or if you would like more information about the late enrollment penalty, call <Plan Name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You can also get

<Contract#, Material ID#, CMS approval date (if applicable)>

information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 6: Model Notice - Informing Beneficiary of LEP Adjustment Due To Plan Error (HPMS Code 8011)

<Date>

Dear < Insert Name of Enrollee >:

We are writing to tell you that starting <effective date>, your new premium will be <amount of new premium> per month. This new amount is due to <insert the reason, e.g., erroneous calculation of number of uncovered months or error in transmitting that information to CMS>.

[Insert the following if the error imposes or increases the amount of the LEP amount:] As a result of this error, the above monthly premium includes a new late enrollment penalty of <new LEP amount>. *[Insert the following if the error causes a beneficiary to owe a retroactive amount due to the error:]* This also means that you now owe a past due late enrollment penalty of <amount of retroactive LEP amount owed as a result of error>.

[Insert the following if the beneficiary's LEP amount has to be paid retroactively:]

Since you owe a late enrollment penalty dating back to your effective date of enrollment, we will charge you a lump sum amount of <amount of lump sum owed retroactive to the date of their enrollment in the plan>. After this one time lump sum payment, you will be charged <amount of new premium> per month. *[For members in direct-bill status, insert the following language:]* Your premium bill will reflect this new premium amount. *[For members in premium withhold status, insert the following language:]* This lump sum amount will be deducted from your Social Security check. After this, your new premium amount will also be deducted from your monthly Social Security check.

[OR insert the following if the error reduces the LEP amount:]

Because of this error, your new late enrollment penalty amount has been reduced. Your new late enrollment penalty amount is <new LEP amount>. *[For members in direct bill status, insert the following language:]* This also means that any late enrollment penalty amount

<Contract#, Material ID#, CMS approval date (if applicable)>

that you've paid as a result of this error [*Select method of LEP refund:*] will be refunded back to you as soon as possible OR will be applied to reduce your next bill. We will [*Select method of LEP refund:*] refund you /reduce your next bill by <total LEP amount owed to the beneficiary>. [*For members in premium-withhold status, insert the following language:*] This also means that any late enrollment penalty amount that you've paid as a result of this error will be refunded to you by the Social Security Administration. The Social Security Administration will refund you <total LEP amount owed to the beneficiary> as soon as possible.

[Insert the following only if the error resulted in the imposition of or increase in LEP, except where the increase is due to a reconsideration:] If you disagree with your late enrollment penalty, you can ask Medicare to reconsider (review) its decision if certain circumstances apply to you. (For example, you might disagree with the penalty if you got/get extra help from Medicare to pay for your prescription drug coverage or if you did not receive notice that explained whether you had other prescription drug coverage that met Medicare's minimum standards (creditable coverage). A notice explaining your right to a reconsideration of the late enrollment penalty is included with this letter. You must submit your reconsideration request to the address listed on the enclosed *Part D Late Enrollment Penalty Reconsideration Request Form* within 60 days of the date of this letter, or Medicare may not consider your request.

If you have questions about the information in this letter or if you would like more information about the late enrollment penalty, call <Plan Name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 7: Model Notice - Confirming Adjustment of Late Enrollment Penalty After LEP Reconsideration (HPMS Code 8004)

<Date>

Dear <Name of Member>:

Your Part D late enrollment penalty has changed based on Medicare's reconsideration (review) of your circumstances, as explained in the decision letter you received from Medicare's Appeals Contractor dated <insert date>.

[Insert the following if the beneficiary still owes an LEP; i.e., the LEP reconsideration decision was either PARTIALLY FAVORABLE or UNFAVORABLE:] [For current members:] As a result of Medicare's reconsideration decision, your premium still includes a late enrollment penalty. Your premium amount is <premium amount> per month effective <effective date>. *[For prior members:]* As a result of Medicare's reconsideration decision you still owe a penalty of <penalty amount> per month, effective <effective date>.

*[For **current and prior members**, insert the following if the beneficiary's LEP amount has to be paid retroactively:]* Since you owe a late enrollment penalty dating back to your effective date of enrollment, we will charge you a lump sum amount of <amount of lump sum owed retroactive to effective date of enrollment>. *[For **current and prior members** in premium withhold status, insert the following language:]* This lump sum amount will be deducted from your Social Security check. *[For **current members** in premium withhold status only, insert the following language:]* After this one time lump sum payment, your new premium amount of <amount of new premium> will be deducted from your monthly Social Security check. *[For **current members** in direct bill status only, insert the following language:]* After this one time lump sum payment, your premium bill will reflect this premium amount of <amount of new premium> per month.

*[OR for **current and prior members** who no longer owe an LEP; i.e., the LEP reconsideration*

<Contract#, Material ID#, CMS approval date (if applicable)>

*decision was FULLY FAVORABLE, insert the following:] Medicare decided you are not required to pay a late enrollment penalty. Any late enrollment penalty you have already paid [Select method of LEP refund:] will be refunded to you as soon as possible OR [for current members:] will be applied to reduce your next bill. [For **prior and current members** in direct bill status, insert the following language:] We will refund you <total LEP amount owed to the beneficiary> OR [for **current members only** select alternative method of LEP refund:] We will apply <total LEP amount owed to the beneficiary> to reduce your next bill. [For prior and current members in premium-withhold status, insert the following language:] This means that any late enrollment penalty amount that you've paid as a result of this error will be refunded to you by the Social Security Administration. The Social Security Administration will refund you <total LEP amount owed to the beneficiary> as soon as possible.*

If you have questions about the information in this letter or if you would like more information about the late enrollment penalty, call <Plan Name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 8: Model Notice - Return of Creditable Coverage Information Received Without an Accompanying Enrollment Request (HPMS Code 8005)

<Date>

Dear < Insert Name of Enrollee >:

We received information from you that showed you had other prescription drug coverage that met Medicare's minimum standards (creditable coverage), but our records don't show that you have applied to join <Plan Name>. Since we don't have an application from you to join our plan, we are returning your creditable coverage information to you. If you want to join <Plan Name>, please call us at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>.

Once we receive your application, we will let you know if we will let you know if we think you need to tell us whether you had creditable coverage prior to joining <Plan Name>. Remember, if you don't keep Medicare prescription drug coverage or other creditable coverage after you are eligible to join a Medicare prescription drug plan, you may have to pay a late enrollment penalty for each month you were eligible to join but didn't. You will then have to pay the penalty as long as you have Medicare prescription drug coverage.

If you have questions about the information in this letter or if you would like more information about the late enrollment penalty, call <Plan Name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 9: Model Notice - Yearly Change to LEP Amount (HPMS Code 8012)

<Date>

Dear < Insert Name of Enrollee >:

We are writing to tell you that starting <January 1, yyyy>, your new premium will be <amount of new premium> per month.

This new amount is a change to your current late enrollment penalty amount based on the annual change to the National Base Beneficiary Premium. This means that each year that the National Base Beneficiary Premium changes, so will the amount of your late enrollment penalty.

If you have questions about the information in this letter or if you would like more information about the how the national base beneficiary premium affects the late enrollment penalty, call <Plan Name> at <toll-free number> <days and hours of operation>. TTY users should call <toll-free TTY number>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.

Exhibit 10: Model Notice - Creditable Coverage Information Received After Deadline (HPMS Code 2055)

< Date >

Dear < Insert Name of Enrollee >

On <insert the date located on the Beneficiary Cover Letter for Individuals with Break in Coverage (HPMS Code 8013)>, we sent a letter asking you to complete a form that would tell us about any prescription drug coverage you had that met Medicare's minimum standards. We sent this request to you because Medicare records show that you have a break in prescription drug coverage from <insert first day without creditable prescription drug coverage in month/day/year format> to <insert the day before enrollment in your plan in month/day/year format>. That letter told you that the deadline for providing us with any information about creditable coverage you had during this period was <insert return date from final notice>.

[If the beneficiary returned the attestation form, include the following sentence: On <insert date plan received attestation form>, we received your attestation form.] [Or, if you offer telephonic attestation and the beneficiary attempted to provide telephonic attestation, insert the following sentence: On <insert date the beneficiary provided (or attempted to provide) telephonic attestation> you attempted to provide this information over the telephone.] However, we received this information more than 60 days after the deadline that we gave you to respond to our request. Therefore, we did not consider this information when we reported to Medicare the number of months you went without creditable coverage.

We <insert one of the following: [have already sent] [will send]> a letter to you explaining the amount of your late enrollment penalty and a notice of your right to ask Medicare to reconsider (review) its penalty decision if certain circumstances apply to you. If you ask Medicare to review its decision, follow the instructions in the notice entitled **“YOUR RIGHT TO ASK MEDICARE TO REVIEW YOUR MEDICARE PART D LATE ENROLLMENT PENALTY.”** <If the plan is returning the late creditable prescription drug coverage information,

<Contract#, Material ID#, CMS approval date (if applicable)>

include the following sentence>: If you ask Medicare's Appeals Contractor to review your case, you should include a copy of the information we are returning to you.

If you have any questions, please call <*insert name of plan*> at <*insert plan's toll-free number*> <*days and hours of operation*>. TTY users should call <*toll-free TTY number*>. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Exhibit 11: Model Notice - Beneficiary Notice of Late Enrollment Penalty Adjustment Reported (HPMS Code 2056)

<Date>

Dear < Insert Name of Enrollee>:

[Insert the following paragraph if the reporting of uncovered months imposes or increases an LEP and the member is currently enrolled in your plan]:

We are writing to tell you that Medicare informed us that your previous plan reported that you did not have prescription drug coverage that met Medicare's minimum standards for at least 63 days. As a result of this, starting <effective date of enrollment>, your new premium will be <amount of new premium> per month. Your new premium amount includes an additional <LEP amount>. *[Insert the following if the new LEP causes a beneficiary to owe a retroactive amount in your plan:]* This also means that you owe a previous late enrollment penalty dating back to your effective date of enrollment. *[Insert the following if the member is in direct bill status]:* Therefore, we will charge you a lump sum amount of <amount of lump sum owed retroactive to the date of their enrollment in the plan>. *[Insert the following if the member is in premium withhold status]:* This lump sum amount will be deducted from your Social Security check.

[OR insert the following paragraph if the reporting of uncovered months imposes or increases an LEP and the member is no longer enrolled in your plan]:

We are writing to tell you that Medicare informed us that your previous plan reported that you did not have prescription drug coverage that met Medicare's minimum standards for at least 63 days. As a result of this, we should have charged you *[Insert the appropriate language]:* a/an additional late enrollment penalty amount of <total LEP amount owed. *[Insert the following if the individual is in direct bill status]:* Please send your payment to following address:

<Insert Name of Plan and full mailing address where plan should remit payment>

<Contract#, Material ID#, CMS approval date (if applicable)>

[Insert the following if the individual is in premium withhold status]:
This amount will be deducted from your Social Security check.

[Or insert the following paragraph if the reporting of uncovered months reduces or removes an LEP and the member is currently enrolled in your plan]:

We are writing to tell you that your late enrollment penalty has been *[Insert the appropriate language]: reduced OR removed* based on a change to what your former plan reported to Medicare. Your new premium amount is *<insert total premium amount>*. This amount *[Insert the appropriate language] no longer includes a late enrollment penalty OR includes a reduced late enrollment penalty amount of <new LEP amount>*. *[For members in direct bill status, insert the following language:]* This also means that any late enrollment penalty amount that you paid, while in our plan, *[Select method of LEP refund:] will be refunded back to you as soon as possible OR will be applied to reduce your next bill*. We will *[Select method of LEP refund:] refund you /reduce your next bill by <total LEP amount owed to the beneficiary>*. *[For members in premium-withhold status, insert the following language:]* This also means that any late enrollment penalty amount that you paid, while in our plan, will be refunded to you by the Social Security Administration. The Social Security Administration will refund you *<total LEP amount owed to the beneficiary>* as soon as possible.

[Or insert the following paragraph if the reporting of uncovered months reduces or removes an LEP and the member is no longer enrolled in your plan]:

We are writing to tell you that Medicare informed us that *[Insert the appropriate language]: you should not have been assessed a late enrollment penalty OR you should have paid a reduced late enrollment penalty while you were enrolled in our plan*. This decision was based on information reported to Medicare by your previous plan. *[For members in direct bill status, insert the following language:]* Therefore, we will refund you *<total LEP amount owed to the beneficiary>* as soon as possible *[For members in premium-withhold status, insert the following language:]* Therefore, this means that the Social Security Administration will refund you *<total LEP amount owed to the beneficiary>* as soon as possible.

[Include the below paragraph with the appropriate paragraph you selected above]:

We did not make this decision. Therefore, if you have questions about what your previous plan reported to Medicare, you should contact your previous plan. If you have questions about other information contained in this letter, or would like more information about the late enrollment penalty, you can call *<Plan Name>* at *<toll-free number>* *<days and hours of operation>*. TTY users should call *<toll-free TTY number>*. You can also get information by visiting www.medicare.gov on the web or by calling 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Thank you.