

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



CENTER FOR MEDICARE

DATE: February 23, 2011

TO: Medicare Advantage and Prescription Drug Plan Employer/Union-Sponsored Group Health Plans

FROM: Danielle R. Moon, M.P.A., J.D., Director, Medicare Drug & Health Plan Contract Administration Group

Cynthia G. Tudor, Ph.D., Director, Medicare Drug Benefit and C&D Data Group

SUBJECT: Update to Parts C and D Employer Group Waiver Plan (EGWP) Waivers -- REVISED

This memorandum supersedes our memorandum of November 15, 2010 regarding employer group waiver plan (EGWP) waiver activity and policies. We are maintaining the policy changes reflected in the November 15, 2010 memo with the exception that we are continuing the waiver of the prohibition simultaneous enrollment in an MA Coordinated Care Plans and 800 series stand-alone prescription drug plan (PDPs).

New EGWP Waivers

Consistent with our authority at sections 1857(i) and 1860D-22(b) of the Social Security Act to waive or modify requirements that hinder the design of, the offering of, or the enrollment in, employer/union sponsored MA and MA-PD plans and prescription drug plans (PDPs), CMS has approved two new waivers. Any similarly situated MA organization or PDP sponsor of EGWPs may take advantage of these waivers as long as they meet the conditions of the waiver.

Allow Offering of 800-series Network Private Fee-For-Service (PFFS) Plans Exclusive to Employers

In 2006, CMS granted a waiver of the “nexus” test (that requires that an MAO offering an 800-series EGWP also offer an individual market MA plan under the same contract) for non-network private-fee-for service plans (PFFS) effective CY 2008 (refer to Chapter 9, section 20.2.1.2, of the Medicare Managed Care Manual). Given the prohibition on non-network employer PFFS plans beginning in CY 2011, as provided under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), this waiver is no longer available as of CY 2011. However, in response to a waiver request from an MA organization exclusively serving the employer market,

CMS has agreed to create a new waiver for those MAOs that in 2010 are offering a non-network PFFS plan exclusively to the employer market and are converting from a non-network to a network PFFS 800-series plan in 2011. Since the purpose of this waiver is to facilitate the transition of those organizations exclusively serving the employer market, the waiver is time-limited. Therefore, the waiver of the requirement that MA organizations offer an individual market MA plan under the same contract as an 800-series EGWP is only applicable to MA organizations that in 2010 are offering a non-network 800 series PFFS plan exclusively to employers but will offer a network-based PFFS plan exclusively to employers in CY 2011. This waiver will expire at the end of CY 2011, or in 2012 in the case of a non-calendar year plan. As previously noted, after this waiver ends in the 2011-2012 time frame, in order to offer an employer PFFS or coordinated care MA plan (i.e., HMO, PPO, RPPO) an organization will also have to offer an MA plan of the same type for individual (i.e., non-employer) Medicare enrollment. However, as described in Chapter 9, section 20.2.1.2. of the Medicare Managed Care Manual, organizations will still be able to offer Medicare medical savings account (MSA) plans exclusively to employers.

Conditional Approval of Waivers of Enrollment Sanction

CMS has conditionally approved a waiver allowing an MAO or PDP under marketing and enrollment sanctions to continue to serve its existing employer contracts by permitting its employer plans to enroll eligible or newly eligible employees (i.e., age-ins) in their employer contracts. However, we note that approval of this waiver is conditional and will only be granted to other organizations on a case-by-case basis if CMS determines it to be warranted given the basis of the sanction and other relevant facts specific to the MA organization or PDP sponsor under sanction.

Revisions to Existing EGWP Waivers

Revised EGWP Waiver of Bid Submission Requirements

As required of individual market PDPs, the value of supplemental benefits provided under a Part D enhanced benefit plan must be calculated prior to the application of the Medicare manufacturer coverage gap discount. This requirement also applies to Part D benefits provided by sponsors of employer group health and waiver plans (EGWPs). In our most recent guidance on the coverage gap discount, we detail how EGWP sponsors must apply supplemental coverage in the coverage gap (see http://www.cms.gov/PrescriptionDrugCovContra/Downloads/MemoCoverageGapAdditionalGuidance_09.10.10.pdf). This guidance provides information regarding the application of the discount for those sponsors with EGWPs that do not have an initial coverage limit (ICL), and explains further the application of the coverage gap discount for non-calendar year plans.

Since EGWP sponsors do not submit bids for their Part D EGWP benefit packages (because they are paid the national Part D bid amount), CMS does not require sponsors of EGWPs to submit Part D benefit information, including Part D supplemental (enhanced) benefit information. Absent the supplemental information collection, CMS cannot validate that the application of the

coverage gap discount has been calculated correctly by the Part D sponsor. Therefore, beginning in 2011, a Part D sponsor of EGWPs will be required to attest, as part of its contract with CMS, that if the sponsor provides supplemental coverage via any of its enhanced benefit plans, it will apply the manufacturer coverage gap discount only after the plan's supplemental benefits have been applied.

We note that if EGWP benefits are restructured to provide commercial (non-Part D) wrap-around coverage that supplements a basic Part D benefit package, sponsors would be permitted to apply the manufacturer coverage gap discount **before** any coverage or financial assistance is provided by the other commercial payer (see §1860D-14A(c)(1)(A)(v) of the Act).

Extending Waiver of Prohibition on Simultaneous Enrollment in an MA Coordinated Care Plan and a Stand-Alone PDP

Effective June 1, 2010, members of 800-series regional PPO EGWPs may enroll in 800-series stand-alone PDPs, provided that separate medical and prescription drug vendors work closely together with the employer/union sponsor to provide coordinated care and disease management services between the MA and the PDP portion of the benefit. Prior to extending this waiver to regional coordinated care EGWPs, simultaneous enrollment in MA plans and PDPs was limited to local coordinated care plan enrollees (see Chapter 9, section 20.1.10, of the Medicare Managed Care Manual).

After reviewing trends in enrollment data for the first month of CY 2011, and speaking with our partners in the industry, CMS concluded that sunsetting this waiver which currently allows beneficiaries in MA coordinated care plans to enroll in 800 series stand-alone PDPs would likely have a negative impact on beneficiary access to prescription drug coverage. Therefore, CMS will extend this waiver indefinitely. Continuing the waiver to permit beneficiaries who enroll in MA-only coordinated care plans (both local and regional) to enroll in the stand-alone 800 series PDPs (instead of as part of a MA coordinated care plan benefit) allows the beneficiary to keep the prescription drug coverage previously received from the employer and also enroll in an MA plan in place of original Medicare benefits.

Continuation of Waiver of Service Area Extension

Section 3207 of the Affordable Care Act extended the waiver described in Chapter 9, section 20.2.1.4. of the Medicare Managed Care Manual ("Waiver of Service Area Extension for Certain MA Local Coordinated Care Plans") to direct contracting (described at section 1857(i)(2) of the Act) PFFS EGWPs that had enrollment as of October 1, 2009. This waiver sets conditions under which direct contracting (i.e., network based) PFFS EGWPs can serve an employer if the plan has a direct contracting network available to at least 51% of an employer group's retirees.

Declined Waiver Requests

Retraction of Waiver Allowing Coordinated Care Plans not to Provide Qualified Prescription Drug Coverage

On March 2, 2010, at the request of a direct contract EGWP, CMS granted a waiver that would have allowed employer direct coordinated care plans to operate a local PPO plan without having to offer qualified prescription drug coverage under Part D for one year. The waiver would have allowed the local PPO (and other similarly situated entities) to continue to provide drug coverage via the Retiree Drug Subsidy. CMS is retracting this waiver, and EGWPs that are employer direct coordinated care plans must offer qualified prescription drug coverage under Part D as required.

Requests to Waive the MA Maximum Out-of-Pocket (MOOP) and Cost Sharing Limits

CMS has received requests that it use its waiver authority under section 1857(i) of the Act to exempt EGWPs from the MOOP and cost sharing limits (see 42 CFR 422.100(f)(4) and (5)). While requestors have argued that applying a MOOP to all employer plans introduces a new feature that some employers are not familiar with, they have not convincingly made the case that the existence of a MOOP is a significant barrier to employer contracting. As stated in the preamble to our final regulation published on April 15, 2010 (75 FR 19712) both the MOOP and the cost sharing limits for Parts A and B services are important new beneficiary protections. We believe that beneficiaries enrolled in employer plans are no less deserving of these protections than enrollees in individual MA plans. Therefore, we decline to waive this requirement for EGWPs.

EGWP Policy Updates

Associations as Employers

As stated in Chapter 9, sections 10.2 and 20.1.1, of the Medicare Managed Care Manual, employer/union group health plan enrollment in EGWPs and individual MA plans is only available to beneficiaries who are Medicare eligible and part of an employer/union sponsored group health plan. Thus, a beneficiary's enrollment in one of these MA plans must be based on receiving "employment-based" health coverage from an employer/union group health plan sponsor that has entered into a contractual arrangement with an MA organization to provide coverage or that has contracted directly with CMS to provide coverage for its Medicare eligible members.

Chapter 9, section 20.1.1, of the Medicare Managed Care Manual clarifies that coverage obtained through a professional or other type of group association would not make a beneficiary eligible for enrollment into EGWPs, except to the extent that the coverage obtained through the association can properly be characterized as "employment-based group health plan coverage." That is, the individuals are direct employees of the association. Since CMS policy regarding what is "employment-based group health plan coverage" is not clear, organizations' interpretation of this term has not been applied consistently across the program, especially when the health plan coverage is obtained through associations. CMS intends to clarify in regulation what constitutes employment-based group health plan coverage for MA organizations. Such a clarification would be effective no earlier than for CY 2012.

Future Waivers Requests

We remind MA organizations and Part D sponsors that waiver requests should be submitted to their regional office account manager. Requests for waivers of Parts C and D requirements must be consistent with our authority at sections 1857(i) and 1860D-22(b) of the Social Security Act to waive or modify requirements that hinder the design of, the offering of, or the enrollment in, employer/union sponsored MA and MA-PD plans and PDPs. The waiver authority cannot be used by CMS to permit restriction of Parts C and D benefits, to circumvent Medicare-required beneficiary protections, or expand the definition of an employer/union group.

If you have further questions regarding the memorandum, please contact:

Marty Abeln (Part C-related issues) at (410)786-1032 or marty.abeln@cms.hhs.gov; or,
Christine Hinds (Part D-related issues) at (410)786-4578 or christine.hinds@cms.hhs.gov