DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
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CENTER FOR BENEFICIARY CHOICES

TO: All Part D Sponsors

FROM: Cynthia Tudor, Ph.D., Director, Medicare Drug Benefit Group

RE: Update on the 2008 TrOOP Balance Transfer Process and Model Explanation of Benefits

DATE: September 25, 2007

In the CMS 2008 call letter, and elsewhere previously, CMS announced our plans to automate the required transfer of true out-of-pocket (TrOOP) costs and gross covered drug spending balances when a beneficiary changes Part D plan sponsors during the coverage year. To that end, CMS has worked with the industry and the National Council for Prescription Drug Programs (NCPDP) to develop an NCPDP Financial Information Reporting (FIR) transaction to support the on-line, real-time transfer of the TrOOP-related data between plan sponsors.

Implementation of the automated process will require that Part D plan sponsors develop the capacity to receive and respond in real-time (or batch) to the FIR transactions that will be used to request TrOOP-related data for disenrolling Part D beneficiaries from the prior plan(s), and to report these data for newly enrolling Part D beneficiaries transferring from another plan mid-year to the subsequent plan(s) of record. Part D plan sponsors will also need to develop the capacity to integrate data received via these electronic transactions into those systems that track and apply beneficiary-level TrOOP and gross covered drug costs. As the automated process is developed, CMS will be requesting that plan sponsors participate in its testing and implementation.

We anticipate that the FIR transaction standard will be approved by the NCPDP Board in early November 2007. To allow adequate time for plan sponsors to program and test the capacity to receive and respond to FIR transactions and to integrate the reported data into their systems, CMS expects to implement the automated balance transfer process on July 1, 2008.

On a parallel track for implementation will be the new model explanation of benefits (EOB). Part D plan sponsors are required to issue an EOB to those enrollees who had activity under the Part D program during the prior month. In May of this year, we issued in draft a new model EOB for industry review and comment. We have revised that model based on the comments received (Please see the attached note highlighting the significant changes which have been incorporated into the final model). We believe the new model will be a clearer, more effective communication for beneficiaries.

Given the programming that will be required for plan sponsors to reflect the changes associated with the new EOB model, we are delaying its implementation to be consistent with the implementation of the FIR transactions. We therefore expect Part D plan sponsors to implement use of the new model on July 1, 2008. Since we expect mid-year implementation of the new model EOB, we will provide a model cover letter sponsors can use to familiarize their enrollees with the new EOB format. This cover letter will need to be attached only to the first EOB sent to enrollees after July 1, 2008. We will make the model cover letter available to plans well before the July 1, 2008 implementation date.

If you have any questions concerning this memorandum, please contact Deborah Larwood via email at Deborah.Larwood@cms.hhs.gov or by phone at 410-786-9500.

Attachment

Significant Changes Incorporated into the Final New Model Explanation of Benefits

The draft model EOB was issued in May 2007 for public review and comment. We received several hundred comments from plan sponsors, pharmacy benefit managers, and industry trade associations, with many offering suggestions for improving the model's clarity and effectiveness. We revised the model based on these comments. The significant changes are highlighted below:

Page 1— Cover Page

- Added an instructions that plans should only include sections 1 or 4 when applicable, renumbering the remaining sections as appropriate.
- Added an instruction that plans must provide an EOB within 15 days of the end-of-the-month in which there was activity.
- Moved the customer service information from the first page to the last page.

Page 2— Summary of Year-to-Date Medicare Prescription Drug Costs

- Added an instruction that Part D plan sponsors may modify the summary chart based on their benefit package and use their discretion regarding how to highlight where the beneficiary is in the benefit.

Page 3—Definitions

- Removed the definition of "Premium."

Page 4—Summary of Prescription Claims Processed

- Changed the summary of claims processed information to a table format.
- Removed the proposed "Price of Generic Equivalent" field.
- Added the word "Prescription" in front of claim number.
- Added an instruction to use an asterisk to identify claims for prescriptions filled at an out-of-network-pharmacy.

Page 4— Updates to Drug List (formulary)

- Changed the "Updates to Drug List" to a table format.
- Added an instruction that the drug list updates table will only be populated for enrollees affected by a negative change.
- Added an instruction so that plans can inform affected enrollees of the appropriate effective date for the negative formulary changes listed in the "Updates to Drug List" table.

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Page 6— Beneficiary Instructions

- Added customer contact information.
- Added a sentence that encourages members to first contact the plan with any questions or concerns about their EOB before instructing them of their right to file a grievance.