Employer/Union-Only Group Waiver Plans and Prescription Drug Event Data

The following guidance applies to employer/unions that directly contract with Medicare to become prescription drug plans (PDPs) and to MA-PDs, PDPs and section 1876 cost plans that offer employer/union-only group plans. These plans are authorized under §1857(i) and §1860D-22(b) of the Social Security Act which provides that CMS may waive or modify requirements that "hinder the design of, the offering of, or the enrollment in" such employer sponsored plans. CMS refers to employer or union-sponsored plans in these arrangements as employer/union-only group waiver plans (EGWPs) and to the subset of directly contracted plans as Direct EGWPs. These instructions apply to both types of EGWPs and are applicable to these plans pursuant to CMS' waiver authority and to the executed Part D contractual agreements between CMS and these entities. This guidance will be included as part of the existing Prescription Drug Event (PDE) Data Instructions, and may be appended to the existing instructions upon issuance.

Section 16. Special Instructions for Employer/Union-Only Group Waiver Plans

Section 16.1 Background

Employers and unions that offer retiree medical coverage that includes prescription drug benefits have several options under the Medicare Modernization Act (MMA) beginning in the 2006 coverage year. As referenced above, under CMS statutory waiver authority, these options include becoming Part D plans through direct contracting with CMS or obtaining customized coverage for their retirees through special arrangements with Part D plan sponsors.

All EGWPs must report PDE data according to the requirements in the PDE Instructions. These plans remain subject to the requirements of 42 CFR §423.104(d) and (e) to provide standard coverage or a benefit that has the same gross value, and these plans may also offer an enhanced package with a value above the standard benefit. Due to unique payment provisions and waivers for EGWPs, we are providing clarification of the rules for data submission by these plans. Note that all PDE submission rules apply unless plans are instructed otherwise.

Note: Employers and unions also have the option to elect to receive a 28 percent federal subsidy to apply towards their non-Part D retiree drug coverage. We refer to these plans as Retiree Drug Subsidy (RDS) plans. RDS plans will not submit data to CMS at the PDE level and should follow separate guidance from CMS for their cost submission requirements.

Section 16.2 Plan types

For purposes of this Instruction only, all EGWPs will be considered enhanced alternative plans as defined and described in Section 7. They will use the same instructions provided in Section 7.2 to report supplemental drugs for exclusion from payment. They will report

enhanced alternative cost sharing benefits in accordance with the instructions in Section 7.3 for mapping to the defined standard benefit. The mapping enables CMS to distinguish standard from enhanced cost sharing benefits for payment purposes.

Section 16.3 Tracking TrOOP and Gross Covered Drug Costs

EGWPs are responsible for tracking their enrollees' true out-of-pocket costs (TrOOP) and gross covered drug costs (GDCA and GDCB). Like all Part D plans, EGWPs must track enrollee balances in these two categories because they are required to transfer these amounts to a new plan if a beneficiary changes enrollment during the year. The beneficiary's accumulated TrOOP costs determines when they would reach catastrophic coverage in the new plan, and the beneficiary's accumulated gross covered drug costs determine what phase of the new plan's PBP they are placed into. The balances must be tracked on a calendar year basis even if the EGWP operates on a non-calendar year basis, because the Part D benefit is paid and administered on a calendar year basis.

Section 16.4 Reinsurance

EGWPs are only eligible for the federal reinsurance subsidy if they operate on a calendar year basis. Those that administer benefits on a calendar year basis are subject to all reporting and payment provisions in Section 12 except that they will not receive prospective reinsurance payments during the year. Instead, CMS will make retrospective payment in reconciliation after the end of the year, based on allowable costs reported on PDEs.

EGWPs that operate on a non-calendar year basis are not eligible for reinsurance. However, they are still required to administer all catastrophic coverage provisions prescribed by the MMA, in regulation, and in these Instructions. Specifically, once the beneficiary reaches the OOP threshold by accumulating $3,600 in TrOOP costs (see Section 8), beneficiary cost sharing is limited to the statutory amount or an alternative amount that was approved by CMS in the plan's bid. Also, above the OOP threshold, non-calendar year EGWPs must report gross covered drug costs above the threshold (GDCA) and must populate the Catastrophic Coverage Code field with "A" or "C" as appropriate.

Section 16.5 Risk sharing

EGWPs are not subject to risk sharing. Therefore, the payment and reconciliation calculations in Section 13 do not apply to these plans. However, EGWPs must still report covered plan-paid amounts (CPP) to CMS as described in Section 7, to distinguish covered and non-covered benefits.