

Medicare Managed Care Manual

Chapter 9 – Employer/Union-Sponsored Group Health Plans

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(Rev. 91, 7-13-12)

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10 – Introduction

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

A list of waivers or modifications approved for MAOs offering employer/union-sponsored group health plans is set forth in this chapter. As noted in §10.1, as a condition of CMS granting the particular waiver or modification, MAOs must demonstrate that they meet the criteria established by CMS as outlined in the specific waiver. For each waiver, CMS has noted whether the waiver/modification applies to “800 Series” MA plans, Direct Contract MA plans, or employer/union-sponsored group health plan enrollments in individual MA plans. Each of these waivers/modifications will automatically apply to those MAOs approved to offer EGWPs or individual plans that satisfy the applicable criteria; thus, they do not need to be granted on an individual basis. However, some waivers may be restricted to particular kinds of entities and/or a particular set of circumstances as noted. A complete list of currently-approved waivers can be found in Appendix II.

10.1 – Application of CMS Employer Group Waiver Authority

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

CMS has the statutory authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in, employer/union-sponsored Medicare Advantage (MA) plans. This statutory authority, set forth in section 1857(i) of the Social Security Act (the Act), provides:

[Medicare Advantage] Program Compatibility with Employer or Union Group Health Plans –

(1) **CONTRACTS WITH MA ORGANIZATIONS** - To facilitate the offering of MA plans under contracts between Medicare Advantage organizations (MAOs) and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity’s employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans.

(2) **EMPLOYER SPONSORED MA PLANS** - To facilitate the offering of MA plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements that hinder the design of, the offering of, or the enrollment in such MA plans. Notwithstanding §1851(g), an MA plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

Under this specific statutory authority, in order to facilitate the offering of MA plans to employer/union group health plan sponsors, CMS may grant waivers and/or modifications to MAOs. When exercising its discretion to grant these waivers or modifications, each waiver or modification will be conditioned upon the MAO meeting a set of defined circumstances and

complying with a set of conditions. MAOs offering employer group plans must comply with all MA and/or Part D requirements unless those requirements have been specifically waived or modified.

Waivers/modifications may be granted to MAOs offering “individual” MA plans or MAOs offering customized employer group MA plans offered exclusively to employer/union group health plan sponsors. Individual MA plans are open to both individual Medicare beneficiaries and employer/union-sponsored group health plans’ MA eligible beneficiaries. Customized employer group MA plans offered exclusively to employer/union group health plan sponsors include: (1) plans offered by MAOs to employers/unions (these plans are hereinafter referred to as “employer-only” plans because their plan benefit packages are enumerated in the CMS Health Plan Management System (HPMS) with identifiers in the 800s to distinguish them from individual plans offered by MAOs); and (2) plans offered by employers/unions that directly contract with CMS (hereinafter referred to as “Direct Contract” plans). These “800 series” and Direct Contract MAOs are referred to collectively as employer/union-only group waiver plans (“EGWPs”).

Note that CMS’ employer group waiver authority only applies to the Part D portion of the coverage provided by Cost contracts, not Parts A and B.¹ Thus Cost contracts may only use the Part D waiver authority to offer Part D EGWPs as an optional supplemental benefit. Although the MA employer group waiver authority does not apply, a Cost contract may negotiate with employer/union group health plan sponsors to offer extra benefits in addition to Medicare Part A and Part B benefits (including allowing the employer/union group to buy-down cost sharing for Medicare Part A and B benefits). These benefits are not supplemental benefits and are not subject to CMS review or approval.

10.2 – Employer/Union Group Health Plan Sponsorship of Individual MA Plans

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As stated in §10.1, in addition to EGWPs, employer/union group health plan sponsors may choose to enroll their Medicare beneficiaries in individual MA plans. These MA plans do not qualify for the entire employer/union group health plan waivers outlined below in this chapter (and also in Appendix II). Those waivers that apply to employer/union group sponsorship of individual MA plans are specifically identified in §20 (e.g., actuarial benefit swapping, group enrollment/disenrollment process, special enrollment periods (SEPs), and the annual open enrollment period waiver).

10.3 – Private Reinsurance Arrangements with Employer/Union Group Health Plan Sponsors

¹ For further detail on 1876 and 1833 (HCPP) Cost benefit requirements, please see Medicare Managed Care Manual, Chapter 17 (Cost Based Payment).

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MA organizations must meet State licensure and financial solvency requirements under 42 CFR 422, Subpart I. With regard to these requirements, all MAOs are permitted to obtain reinsurance or make other arrangements for the cost of coverage provided to any enrollee (including arrangements with employers/unions) to the extent that the MAO is at risk for providing the coverage. (See 42 CFR 423.401(b).) Similarly, Medicare requirements do not prohibit MAOs offering “800 series” or individual MA plans to employer and union group health plan sponsors from entering into these kinds of reinsurance arrangements with self-insured (i.e., self-funded) employers/unions.² Notwithstanding these arrangements, the MAO retains the responsibility for meeting all Medicare requirements.

10.4 – EGWP Application Procedures

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

Entities that seek to offer an MA or MA-PD EGWP must enter into a contract with CMS. An applicant must meet certain requirements before CMS can consider entering into a contract with the entity. In addition, an applicant must have an acceptable bid before it may enter into a contract to offer an MA or MA-PD plan. Information on the application process can be found at: <http://www.cms.gov/MedicareAdvantageApps/>.

10.5 – Employer/Union-Only Group Waiver Plans and COBRA

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires employer group health plans with at least 20 employees to offer continuation coverage to plan enrollees who experience a COBRA qualifying event such as termination of employment, death of the participant or a divorce. COBRA requirements apply to active employee plans and retiree plans. Employer/union-sponsored group Medicare plans that meet the definition of “group health plan,” as that term is defined at section 5000(b)(1) of the Internal Revenue Code, may be subject to COBRA requirements.

The basic Part A and Part B benefits and any other benefits financed by Medicare through rebate dollars are not subject to COBRA continuation of coverage requirements. Employer/Union sponsors, however, may be required by COBRA to offer continuation of coverage for supplemental benefits that are financed outside of Medicare to beneficiaries enrolled in their plans that experience a COBRA qualifying event. For example, if an employer offered a vision benefit that was integrated into a customized EGWP (Direct Contract or “800 series” plan) but was solely paid for by employer premiums, the employer/union sponsor may be required to offer continuation of coverage only for the vision benefit when a beneficiary enrolled in the plan experiences a

² Employer group plans may enter into administrative services only (ASO) arrangements with MAOs whereby the entity provides certain administrative services to a self-funded employer group plan, such as claims adjudication and enrollment services.

COBRA qualifying event.

However, nothing in either the Medicare law or the COBRA law prohibits an employer/union sponsor from electing to provide continuation coverage for the entire employer sponsored group health plan (the Medicare benefits along with the non-Medicare supplemental benefits). In doing so, however, an employer/union sponsor must adhere to Medicare requirements. These include the following requirements:

- 1) When an MAO offering an employer/union-sponsored group plan receives notification that an individual is no longer eligible for the employer/union group sponsored plan because a COBRA qualifying event has occurred, it must follow the termination procedures documented in the Medicare Managed Care Manual, Chapter 2, §50.7, which only allows prospective termination. Terminations can be effective only at the end of a calendar month; and
- 2) Although COBRA permits a group health plan to charge up to 102% of the applicable premium for continuation of coverage, an employer/union sponsor that offers COBRA coverage can charge no more than 100% of the premium for the Medicare portion of the benefits offered (Medicare will continue to pay its portion of the cost). If an employer/union sponsor can segregate the premium for the non-Medicare supplemental benefits offered, it can charge up to 102% of the portion of the premium that is attributable to the non-Medicare supplemental benefits.

Since in some instances, employer/union sponsors have up to 44 days after a qualifying event to provide notice to an enrollee of a right to elect continuation of coverage, and an enrollee has up to 60 days after receiving the notice to elect continuation of coverage, an enrollee may elect to continue this coverage after the effective date of termination. Under COBRA law, an enrollee who elects continuation of coverage is entitled to have coverage reinstated retroactively back to the date of the termination of coverage. For employer/union sponsors that wish to reinstate beneficiaries who elect continuation of coverage back to the effective date of termination, MAOs offering such plans should submit such reinstatements using Transaction Code 61.

10.6 - Submission of Part C EGWP Bids

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

MAOs have the option of preparing Part C bids by either using the expected composite benefit plan (a composite of all of the actual expected benefit designs offered to different employer/union groups), or by basing the bid on the Medicare fee-for-service benefit provisions.

For MAOs that have a monthly beneficiary rebate amount described in 42 CFR 422.266:

- The MAO may vary the form of rebate for a particular plan benefit package so that the total monthly rebate amount may be allocated differently for each employer/union group to whom the MAO offers the plan benefit package.
 - However, MA bids submitted by MAOs cannot reflect an allocation of A/B rebates to buy down Part D basic premium or Part D supplemental premium. Even though this kind of specific allocation is prohibited in the bid submission, MAOs still

retain the flexibility to allocate rebates to buy down Part D basic premium or Part D supplemental premium on an individual employer/union basis for each PBP.

- The MAO must:
 - Ensure Part B premium reductions are the same for all enrollees in a particular “800 series” plan benefit package. MAOs may not offer particular employer/union groups enrolled in the same “800 series” plan benefit package (e.g., “801”) different Part B premium reductions from that established by their MA bids and also cannot offer to separately refund Part B premiums outside of the CMS established bidding and rebate allocation process;
 - Ensure that the total monthly rebate amount per enrollee is uniform across all employer/union groups in a particular “800 series” plan benefit package. All employer/union groups in a particular “800 series” plan benefit package must receive supplemental benefits equal to the amount of the A/B rebate allocation.
 - However, supplemental benefits provided to each employer/union group may be customized;
 - Ensure that all rebates are accounted for and used only for the purposes provided in the Act; and
 - Retain documentation that supports the use of all of the rebates on a detailed basis for each employer/union group in a particular “800 series” plan benefit package and provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements of 42 CFR 422.503(d) and 422.504(d) and (e).

10.7 - CMS EGWP Part C Payment

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

MAOs offering EGWPs will be paid in the same manner as they are paid for their non-group MA plans. Note that Part C Regional PPO EGWP bids are included in the calculation of the MA regional benchmark calculations.

20 - Benefit Design Requirement Waivers

(Rev. 91, Issued: [Date], Effective: [Date], Implementation: [Date])

MAOs are permitted to modify the cost sharing, benefit level and/or premium offered only to employers/unions from the levels of cost sharing, benefits and premiums offered to individual enrollees as long as the minimum required Medicare coverage levels (i.e., benefits and coverage equivalent to Fee-For-Service (FFS) Medicare)³ are met and as long as the modification does not

³ Sections 1852(a)(1)(A) and 1852(b) of the Act; 42 CFR 422.101

violate applicable CMS cost sharing limits for discriminatory cost sharing and mandatory maximum out-of-pocket (MOOP) limit requirements. These requirements can be found in the Medicare Managed Care Manual, Chapter 4 (Benefits and Beneficiary Protections), §50.1. Also, to the extent that there are specific MA requirements concerning cost sharing or benefit coverage requirements, these requirements apply equally to EGWPs unless explicitly waived or modified.

20.1 - Actuarial Equivalence of Part C Benefits

(Rev. 91, Issued: [Date], Effective: [Date], Implementation: [Date])

MAOs offering plans for individual enrollment (i.e., not employer-only plans) have the flexibility when negotiating with employers/unions to raise cost sharing (coinsurance, copayments and/or deductibles) for plan benefits by providing a higher benefit level and/or a modified premium compared to what is offered for non-employer/union group members.

Example: An MAO might offer a plan to individual beneficiaries with a \$10 copayment for all physician office visits (primary care and specialist). The MAO might want to offer employers/unions an MA plan that includes a \$5 copayment for primary care physician visits and a \$20 copayment for specialist physician visits.

An MAO may take advantage of this flexibility by informing CMS of its intentions when it submits its bid proposals and providing supporting documentation for the MA plans it intends to offer to employer/union sponsors. In its supporting documentation to CMS, the MAO must identify the following:

- The cost sharing amounts the MAO intends to change and the MA plan containing the cost sharing;
- Any modification to the premium charged; and
- Any improvement in the benefit related to the changed cost sharing.

An MAO is permitted to modify the cost sharing, benefit level and/or premium offered only to employers/unions from the levels of cost sharing, benefits and premiums offered to individual enrollees as long as the minimum required Medicare coverage levels are met and the modification does not have the effect of denying or discouraging access to covered medically-necessary health care items and services. Unlike the actuarial swapping flexibility outlined below in §20.2, this customization can apply to Medicare-covered benefits and non-Medicare-covered benefits. Please note this waiver/modification applies only to employer/union group sponsorship of individual MA plans.

20.2 - Actuarial Swapping of Part C Benefits Not Covered By Original Medicare

(Rev. 91, Issued: [Date], Effective: [Date], Implementation: [Date])

MAOs may swap different types of Part C supplemental benefits not covered under Original

Medicare that are of equal actuarial value for employer/union group plan sponsors. The swaps may be used if an employer/union prefers to offer a different benefit package to its members than the MAO offers to individual beneficiaries under the MA plan.

Example: An employer may prefer to offer a vision benefit to its employees rather than the dental benefit the MAO offers to individual beneficiaries. The MAO may design a vision benefit for the employer that has equal actuarial value to the dental benefit and swap these benefits in the plan it offers to the employer.

MAOs do not need to obtain specific, advance approval from CMS in order to take advantage of actuarial swapping for particular employer/union group plan sponsors.

20.3 - Mid-Year Benefit Customization/Enhancements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

The EGWP program is designed explicitly to allow flexibility for MAOs to negotiate different customized plans with particular employer/union groups throughout the year. This design also takes into account that employers/unions offering group health plans may operate on different bidding and negotiation timelines. Therefore, MAOs are allowed to offer “800 series” customized plans at any time during the contract year (i.e., MAOs are implicitly allowed to offer enhanced benefits throughout the year to individual employers/unions that differ from the benefits reflected in their bid). Also, when utilizing individual MA plans open to general enrollment for their members, employer/union sponsors are also free to enhance benefits mid-year for the part of the package that is a “wrap-around” or enhancement to the MA plan. See 422 CFR 106.

20.4 - Part C Premium Requirements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

20.4.1 – Waiver of Uniform Premium Requirement

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

The uniform premium requirement (see 42 CFR 422.100(d)(2)) has been waived for entities offering “800 series” plans under certain circumstances. Under this waiver of the uniform premium requirement, entities offering “800 series” plans serving multiple counties, regions or the nation will be allowed to vary premium and cost sharing between defined market areas within the same employer/union-sponsored group plan. This waiver is contingent on the requirement that the market areas (geographic areas) within the employer-sponsored group plan with premium variation are based on objective market information demonstrating verifiable differences in medical costs between these market areas. The MAO must have documentation validating the medical cost variation in these market areas comprising the plan. The MAOs will be required to retain all of these documents and must provide access to this documentation for inspection or audit by CMS (or its designee) in accordance with the requirements at 42 CFR §422.503(d) and §422.504(d) and (e). Entities offering “800 series” plans that serve multiple counties, which do not represent separate market areas in terms of medical costs, may not utilize this waiver. However, these entities may consider using the plan segmentation rules at §422.262(c)(2) to vary premium

between an “800 series” plan’s payment areas (i.e. counties).

20.4.2 - Premium Subsidization by Employer/Union Group Health Plan Sponsors

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

Under its waiver authority, CMS allows the employer/union sponsoring the MA plan flexibility in determining how much of the enrollee’s Part C beneficiary premium the plan can subsidize, subject to the conditions set forth below. Further information on requirements allowing Employer/Union Group Health Plan’s to subsidize the enrollee’s Part D monthly beneficiary premium can be found in the Prescription Drug Benefit Manual, Chapter 12 (Employer/Union-Sponsored Group Health Plans).

An employer/union sponsor can subsidize different amounts for different classes of enrollees in a plan, provided: 1) such classes are reasonable and based on objective business criteria, such as years of service, date of retirement, business location, job category, and nature of compensation (e.g., salaried vs. hourly); 2) the premium cannot vary for individuals within a given class of enrollees; and 3) the employer/union must pass through any direct subsidy payments received from CMS to reduce the amount that the beneficiary pays (or in those instances where the subscriber to or participant in the employer/union-only plan pays premiums on behalf of a Medicare-eligible spouse or dependent, the amount the subscriber or participant pays).

As a condition of CMS providing these particular waivers, MAOs that offer “800 series” MA plans to employers/unions must obtain in writing from such employers/unions their agreement that they will satisfy the requirements of this waiver with respect to the premiums charged to their participants. Also, MAOs must retain these agreements with employers/unions and provide access to these written agreements to CMS (or its designees) in accordance with 42 CFR §422.503(d) and §422.504(d) and (e).

20.4.3 - Charging Different Premiums to Different Employer/Union Group Health Plan Sponsors

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

In addition to the flexibilities outlined above for employers/unions to subsidize different amounts of an enrollee’s premium contribution, “800 series” MAOs have the flexibility to negotiate with and vary the premium charged to particular employer/union group health plan sponsors. This includes the ability to “experience rate” “800 series” employer/union group health plan sponsors in determining these premiums.

20.5 - Premium Withhold

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

MAOs are required to allow their enrollees, at their option, to pay their premium through deductions from their Social Security checks, Railroad Retirement checks, or Federal annuity. However, when employers/unions also contribute to the beneficiary’s premium, in whole or in

part, it is not feasible for both MAOs and CMS to factor in the employer/union sponsor's contribution and adjust the amount of the premium that should be deducted from the beneficiary's Social Security or other check.

Therefore, in consideration of this operational obstacle, as a condition of sponsoring an EGWP, CMS has waived the requirement that MAOs offering "800 series" and Direct Contract EGWPs provide beneficiaries the option to pay their premium through withholding. Thus, the premium withhold option will not be available for enrollees in EGWPs; MAOs offering these plans will bill the beneficiary and/or the employer/union directly. This waiver is not applicable to employer-sponsored enrollments in individual MA plans. Employer-sponsored group beneficiaries enrolled in these MA plans will have the option to pay premiums through withholding.

30 - Enrollment Requirement Waivers

(Rev. 90, Issued: 11-07-08, Effective: 11-07-08, Implementation: 11-07-08)

MAOs are permitted to modify certain enrollment requirements that hinder enrollment into employer/union-sponsored Medicare Advantage (MA) plans. Where there are specific MA requirements concerning enrollment, these requirements apply equally to EGWPs unless explicitly waived or modified. Further information on enrollment requirements can be found in the Medicare Managed Care Manual, Chapter 2 (Medicare Advantage Enrollment and Disenrollment).

30.1 - Enrollment Eligibility

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

Restricted Enrollment Requirement: In general, MAOs have to accept all Medicare-eligible beneficiaries who reside in their service area as set forth in 42 CFR §422.60(a). EGWPs are not subject to this requirement. Instead, under the CMS eligibility rules for these kinds of plans, EGWPs must restrict enrollment solely to those Medicare eligible individuals who are also eligible for the employer/union sponsor's employment-based health coverage. See section 1857(i) of the Act. Note that, aside from having Medicare eligibility, the employer/union sponsor's eligibility rules exclusively govern a beneficiary's enrollment entitlement in these plans. Under the employer/union sponsor's eligibility requirements, for example, Medicare eligible spouses and dependents of participants in the employer/union sponsor's plan may be permitted to enroll in these EGWPs based on the employer/union sponsor's eligibility rules regardless of whether or not the participant is Medicare eligible.

"Employment-Based" Group Health Plan Requirement: Employer/union group health plan enrollment in EGWPs and individual MA plans is only available to Medicare beneficiaries who are members 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 either entered into a contractual arrangement with an MAO to provide coverage or has contracted

directly with CMS to provide coverage for its Medicare beneficiaries.⁴ Membership in a State Pharmaceutical Assistance Program (SPAP) would not make an individual eligible for enrollment into these types of plans. Similarly, coverage obtained through a professional or other type of group association would not make a beneficiary eligible for these kinds of plans, except to the extent that the coverage obtained through the association can properly be characterized as “employment-based” group health plan coverage.

In defining an employer-sponsored group MA plan, employment-based retiree health coverage, and a group health plan we have not precluded professional or other types of group associations from enrolling Medicare beneficiaries in EGWPs and individual MA plans. However, CMS has made clear that a beneficiary’s enrollment in one of these MA plans is based on his/her receipt of employment-based health coverage from an employer/union group health plan sponsor. To the extent that membership in an association is based on employment, that association could meet the definition of employment-based retiree coverage. For example, an association may elect to provide coverage via an EGWP or individual MA plan to retirees who were formerly employed by the association. We also clarify that we believe that employers, such as school districts, could form an association for the purpose of purchasing employer coverage on behalf of retirees from the school districts and that this would be acceptable because, independently, each school district would be eligible to enroll its retirees in an EGWP or individual MA plan. Therefore, for example, two or more school districts could combine to form an association for the purpose of purchasing retirement coverage for their retired employees. However, an association of farm bureaus would not meet this test if membership in a farm bureau were not exclusively based on former employment by these farm bureaus. (See §422.106(d)(4) through (6)).

Active Employees and Retirees Eligible for Enrollment: Under section 1857(i) of the Act, MAOs may offer employer/union-only group plans to both retirees and current (i.e., active) employees of a particular employer/union group plan sponsor who are Medicare eligible. However, when enrolling active employees into these employer/union group-sponsored MA plans, MAOs must comply with all applicable Medicare program requirements, including the Medicare Secondary Payer (MSP) requirements. MAOs must ensure that employers do not enroll retirees/active employees in an MA plan offered by the MAO in a manner contrary to MSP rules. See the Medicare Managed Care Manual, Chapter 4 (Benefits and Beneficiary Protections), §130, for more information. For active employees receiving benefits from a group health plan of an employer that employs at least 20 employees, the MSP rules establish that the non-Medicare group health plan is the primary payer and Medicare is the secondary payer. If the enrollee or enrollee's spouse is an active employee, the enrollee must be enrolled in the employer/union-sponsored and/or contributed-to non-Medicare group health plan in order to also be enrolled in the employer/union-sponsored MA plan. In other words, active employees cannot be enrolled in an employer/union-sponsored MA plan unless they also retain their employer/union-sponsored primary coverage. In these situations, Medicare payments to MAOs for these active employees are adjusted accordingly to account for the presence of the primary group health plan payer. More detailed information on MSP requirements is available at 42 CFR §411.100 and 42 CFR §422.108 or in the Medicare Secondary Payer Manual on the CMS website at:

⁴ See 42 CFR §422.106.

<http://www.cms.hhs.gov/Manuals/IOM/list.asp>.

30.2 - Minimum Enrollment Requirements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

In general, MAOs must meet minimum enrollment standards as set forth in 42 CFR §422.514(a), but such standards do not apply to EGWPs.

30.3 - Enrollment of End Stage Renal Disease (ESRD) Members

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

CMS has granted an additional waiver of 42 CFR 422.50(a) (2) to allow employer/union group members who have ESRD to enroll in employer/union-sponsored MA plans, under certain circumstances.

The MA organizations may choose to accept enrollees with ESRD who are enrolling in an MA plan through an employer or union group under any one of four scenarios described in Medicare Managed Care Manual Chapter 2 (Medicare Advantage). As a condition, the MA organizations that choose to apply this waiver must agree to apply it consistently; MAOs must consistently allow enrollment of employer/union group ESRD beneficiaries in all plan benefit packages offered by the MAO under a particular MA contract. Each year, MA organizations may choose whether or not to apply this waiver at the time of their renewal. For further information, refer to Medicare Managed Care Manual, Chapter 2 (Medicare Advantage Enrollment and Disenrollment), §20.2.3.

30.4 - Enrollment of Part B-Only Members

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

Certain State and local employers do not deduct Federal Insurance Contributions Act (FICA) taxes and as a result their employees may not be entitled to premium free Medicare/Part A. Employers sometimes would like to offer enrollment in an MA plan for their Part B-only beneficiaries. MAOs may develop plans for Part B-only Medicare beneficiaries who are members of employer/union groups. In permitting such plans, CMS is waiving the existing regulations that prohibit individuals only eligible for Part B from enrolling in MA plans. See 42 CFR 422.50(a) (1). In order to enroll new Part B-only employer/union group members in an MA plan, the MAO must create a separate Part B-only employer/union-only “800 series” plan in accordance with CMS requirements. See Medicare Managed Care Manual, Chapter 2 (Medicare Advantage Enrollment and Disenrollment) for more on enrollment of Part B-only individuals.

30.5 - Annual Open Enrollment Periods

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

CMS has waived the requirement to comply with the Medicare annual coordinated election period described in 42 CFR 422.62(a)(2)(iii) for employer/union group health plan-sponsored enrollments in EGWPs or individual MA plans. Thus, employer/union group-sponsored enrollments in EGWPs or individual MA plans may have different annual open enrollment periods. However, such plans must accept valid requests for disenrollment at any time.

30.6 - Group Enrollment/Disenrollment

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

All MAOs may enroll/disenroll employer/union-sponsored group health plan Medicare beneficiaries as a group. This waiver applies to both EGWPs and individual MA plans offered to employer/union group health plan Medicare beneficiaries. The group enrollment and disenrollment procedures are outlined in the Medicare Managed Care Manual, Chapter 2 (Medicare Advantage Enrollment and Disenrollment).

Additionally, employer/union members enrolled in EGWPs and individual MA plans are eligible for special election periods (SEPs). These SEPs apply to employer-sponsored enrollments in an individual MA plan or an EGWP. While the SEP for employer/union group members exists year-round, the employer/union sponsor's eligibility rules determine when the SEP may be used. These SEP procedures are outlined in the Medicare Managed Care Manual, Chapter 2 (Medicare Advantage Enrollment and Disenrollment).

30.7 - Beneficiary Enrollment Notification Requirements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

In general, the notice requirements contained in Appendix 1 (Summary of Notice Requirements) of the Medicare Managed Care Manual, Chapter 2 (Medicare Advantage Enrollment and Disenrollment) apply to all employer/union group health plan-sponsored enrollments in individual MA plans or EGWPs, with the following clarification that employer/union-sponsored group health plans can be customize each model beneficiary notice, which is applicable, to the extent the modifications will more clearly and accurately reflect the employer group plan.

Certain notices contained in the Medicare Managed Care Manual, Chapter 2 (Medicare Advantage Enrollment and Disenrollment), Appendix 1, are not applicable to employer/union group health plan-sponsored enrollments in individual MA plans or EGWPs, as identified below:

- Exhibit 27: MA Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in MA-PD Plan;
- Exhibit 27a: MA-PFFS Model Notice to Inform Full-Benefit Dual Eligible Member of Auto-Enrollment in PDP;
- Exhibit 28: MA Model Notice to Inform Member of Facilitated Enrollment into MA-PD plan; q
- Exhibit 28a: MA Model Notice to Inform Member of Facilitated Enrollment into PDP; and
- Exhibit 29: Acknowledgement of Request to Opt Out of Auto/Facilitated Enrollment.

30.8 - Simultaneous Enrollment in an MA Local or Regional Coordinated Care Plan and a Stand-Alone PDP

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

Members of 800-series regional PPO EGWPs and local coordinated care plan EGWP enrollees 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.

40 - Service Area Requirement Waivers

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

CMS has waived certain service area requirements that hinder the design of, the offering of, or the enrollment in, employer/union-sponsored Medicare Advantage (MA) plans. Further information is provided in this section describing when these waivers are applicable.

40.1 - Coverage throughout the State

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

If an MAO provides coverage to individuals in any part of a State, CMS is waiving the requirement that the Individual Employer Group Health Plans and EGWPs have the same service area. Accordingly, under this waiver, an MAO offering an individual MA plan in a state can offer an EGWP (of the same plan type) in any area within that State or throughout the entire State (provided the EGWP service area is properly requested and defined in HPMS). For Part C benefits, the MAO is responsible for ensuring that CMS provider network adequacy requirements are met and that consistent benefits are provided to the employer/union group plan sponsor's enrollees.

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

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

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. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) prohibits non-network employer PFFS plans beginning in CY 2011; therefore, this waiver is no longer available.

Section 162(a)(2) of MIPPA amended section 1852(d) of the Act by adding a new requirement for employer/union-sponsored PFFS plans. For plan year 2011 and subsequent plan years, MIPPA requires that all employer/union-sponsored PFFS plans under section 1857(i) of the Act meet the access standards described in section 1852(d)(4) of the Act only through entering into written contracts or agreements in accordance with section 1852(d)(4)(B) of the Act, and not, in whole or in part, through establishing payment rates meeting the requirements under section 1852(d)(4)(A) of the Act. 42 CFR 422.114(a)(4) describes this requirement. Further detail on requirements

related to PFFS plans can be found in Medicare Managed Care Manual Chapter 16a (Private Fee-for-Service (PFFS) Plans).

40.3 - Service Area Extension and Network Adequacy for MA Local Coordinated Care Plans

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

To enable employers/unions to offer coordinated care plans to all their Medicare-eligible members wherever they reside, CMS has expanded the waiver of service area requirements for MAOs offering local coordinated care plans (e.g., local PPOs and HMOs) as described in this section. An MAO offering a coordinated care plan in a given service area (i.e., State) can extend coverage to an employer/union sponsor's beneficiaries residing outside of that service area when the MAO, either itself or through partnerships (i.e., arrangements) with other MAOs, is able to meet CMS provider network adequacy requirements and provide consistent benefits to those beneficiaries. This waiver is made available in recognition that an MAO offering a local coordinated care "800 series" plan has limited flexibility in designing an expanded service area outside a State in which it is unable to secure contracts with an adequate number of network providers to satisfy CMS' MA coordinated care network adequacy requirements that would otherwise apply. MAOs offering "800 series" local coordinated care plans that desire to offer expanded service areas (e.g., national service areas) must request an expanded "800 series" service area in accordance with CMS requirements and meet the following conditions:

- (1) The MAO must be able to meet CMS' MA coordinated care network adequacy requirements for at 51% of a particular employer or union group's beneficiaries enrolled in the "800 series" coordinated care plan. In those instances where the MAO cannot meet this requirement for a particular employer or union group's beneficiaries, CMS will require information, including MA network adequacy information for the particular employer or union group, to be submitted for review and approval by CMS;
- (2) All of an employer or union group's beneficiaries, including those beneficiaries that do not have access to contracted MA network providers, must receive the same covered benefits at the preferred in-network cost sharing for all covered benefits offered by the coordinated care plan;
- (3) The MAO must provide payment to non-contract providers in accordance with the requirements of "The Act" (i.e., the MAO must provide "payment in an amount so that – (i) the sum of such payment amount and any cost sharing provided under the plan is equal to at least (ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing under such parts [emphasis added])"). Note that, unlike private fee-for-service MA plans, MAOs offering local coordinated care plans may pay more than the required above-mentioned statutory amounts to any particular non-contract provider. Please

note that hospitals and other institutional providers with Original Medicare fee-for-service provider agreements that place certain restrictions on treating any Medicare beneficiaries may be subject to having those agreements terminated by CMS. (See also 42 CFR 422.214; and 42 CFR 489.53(a)(2).)

- (4) The MAO must take whatever steps are necessary to ensure that beneficiaries residing in areas where the MAO is unable to secure contracts with an adequate number of a specific type of provider(s) to satisfy CMS' MA network adequacy requirements will have access to providers. This may include providing assistance to these beneficiaries in locating providers and/or utilizing its ability, as outlined above, to pay non-contract providers more than the statutory minimum required in section 1852(a)(2)(A) of the Social Security Act;
- (5) In addition to assisting enrollees residing in non-network areas of the local coordinated care plan (i.e., areas in which the MAO is unable to satisfy CMS' network adequacy requirements) in finding providers who will furnish services, the MAO must also establish a program to specifically assist these enrollees in the coordination of their health care services. Areas that should be addressed in its coordination plan for its non-network enrollees are discussed in Chapter 4 of this manual;
- (6) In order to minimize any adverse effects on beneficiaries residing in areas where the MAO is unable to satisfy CMS' MA network adequacy requirements, the MAO also must have in place an effective communication plan with employer groups prior to transitioning these employer group beneficiaries to the local coordinated care plan. This must include the following key communications:
 - (a) Ensure employer sponsors and their beneficiaries understand how the plan will work for those enrollees residing in areas where MA network providers are not available, including that non-contract providers are generally not required to accept the plan and furnish services;
 - (b) Ensure the MAO has a targeted communication strategy and provides information and assistance to beneficiaries affected by lack of access to network providers (e.g., whom to contact if they have difficulties locating a provider that will furnish services, etc);
 - (c) Conduct targeted education and outreach to the current providers of beneficiaries affected by lack of access to network providers prior to transitioning the group to the local coordinated care plan. This may include explaining how the local coordinated care employer group product works, how claims are submitted, etc.; and

(d) Assure all non-contract providers that they will receive prompt and accurate payment.

- (7) In addition, MAOs offering “800” series local coordinated care plans that desire expanded services areas (e.g., a national service area) must request an expanded service area in accordance with CMS requirements to ensure their service area is properly defined in HPMS and must bid accordingly.

50 - Marketing Requirement Waivers

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

MAOs are permitted to modify certain Marketing requirements including those listed in this section. Where there are specific MA requirements concerning Marketing, these requirements apply equally to EGWPs unless explicitly waived or modified. These requirements can be found in the Medicare Managed Care Manual, Chapter 3 (Medicare Marketing Guidelines).

50.1 - Prior Review and Approval of Marketing Materials and Election Forms

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

50.1.1 - Rules for Direct Contract and “800 series” Plans

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

CMS has waived the prior review and approval requirements for marketing materials and election forms contained in 42 CFR 422.2262 for all EGWPs. These waivers apply to “800 series” and Direct Contract plans.

As a result of this waiver, Direct Contract plans and MAOs offering “800 series” EGWPs or employer-sponsored individual MA plans are not subject to the annual restriction on communications directed to Medicare eligible beneficiaries prior to October 1st. Rather, CMS strongly encourages employer/union sponsors and entities offering these plans to employers/unions to communicate to beneficiaries early in the process and to continue to communicate about their benefits frequently prior to their annual open enrollment period (which may differ from Medicare’s annual coordinated election period. Employers/unions and/or entities that offer employer-sponsored “800 series” or individual plans to employers/unions should direct beneficiaries to available resources and explain their coverage and how it coordinates with Medicare.

50.1.2 – Rules for Employer/Union Group Plan-Sponsored Individual MA Plans

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

The waiver of prior review and approval requirements for marketing materials and election forms

contained in 42 CFR 422.2262 similarly applies to an MAO that elects to use the waiver outlined in §50.3, which allows MAOs to customize disclosure materials. This waiver applies to those MAOs that elect to customize disclosure materials for a particular employer/union group health plan sponsor that offers coverage to its Medicare beneficiaries using an individual MA plan (e.g., individual MA plan paired with non-Medicare supplemental coverage designed to “wrap around” or enhance the individual MA plan).

50.2 – Customizing Medicare Disclosure Materials and Election Forms

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

In order to meet the requirements of 42 CFR 422.111(a)(2), which require an MA plan to disclose information about the plan in a clear, accurate and standardized form, MAOs should provide customized disclosure materials to “800 series” and Direct Contract MA plan enrollees to reflect the modified/supplemental benefits being provided to that particular employer/union group health plan enrollees, if any. More specifically, CMS has waived any rules that would otherwise prohibit these entities from offering customized disclosure materials to the extent those customized materials will more clearly and accurately describe the benefits available to employer/union group Medicare beneficiaries (for example, when the supplemental coverage is taken into account). This waiver also allows customization of disclosure materials for employer-sponsored enrollments in individual MA plans (e.g., where an employer/union group health plan sponsors coverage to its members using an individual MA plan and a non-Medicare supplemental plan designed to “wrap around” or enhance the individual MA plan).

Premium amounts are required to be accurately reflected on any customized beneficiary disclosure material. MAOs should ensure these materials accurately reflect the actual premium amount the beneficiary pays when the supplemental coverage, if any, and any corresponding employer/union premium subsidization (or subsidization by CMS in the case of low-income premium subsidy eligible beneficiaries) is taken into account. Alternatively, if accurate premium information concerning the amount the beneficiary actually pays is not available to the MAO, the MAO may substitute language in lieu of providing actual premium amounts. Such language may include, for example, “For information concerning the actual premiums you will pay, please contact [insert employer/union group health plan sponsor name] or your employer group benefits plan administrator.”

50.3 – Timing for Issuance of Employer/Union-Sponsored Group Plan Medicare Disclosure Materials

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

Employer-sponsored “800 series” plans, Direct Contract plans or individual MA plans that are subject to Medicare marketing and disclosure requirements are also subject to any applicable timing requirements for issuance of these materials. However, CMS has waived or modified applicable timing requirements in certain circumstances. These include those circumstances where a particular employer/union sponsor has an open enrollment period that differs from Medicare’s Annual Coordinated Election Period (AEP). In this situation, the timing for issuance of any disclosure materials that are based on the AEP should be based instead on the employer/union

sponsor's open enrollment period. Further information is provided in the Medicare Managed Care Manual, Chapter 3 (Medicare Marketing Guidelines).

50.4 - Disclosure Requirements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

CMS has waived the specific disclosure requirements at 42 CFR 422.111 for employer/union group health plan beneficiaries when the employer/union sponsor is subject to alternative disclosure requirements (e.g., those required by the Employee Retirement Income Security Act of 1974 ("ERISA")), and the employer/union sponsor complies with such alternative requirements. However, these alternative disclosure materials (including summary plan descriptions and all other beneficiary communications that provide descriptions of the Medicare benefit offerings) must be provided by the Direct Contract MAO, or the MAO offering the "800 series" plan or employer-sponsored individual MA plan to beneficiaries on a timely basis.

Similarly, for an employer/union sponsor plan eligible for the alternative disclosure standards waiver, an MAO that offers "800 series" plans to these employer/union sponsors may provide copies of the alternative disclosure materials or, alternatively, information that would be necessary to satisfy its reporting and disclosure obligations under 42 CFR 422.516(d). 42 CFR 422.516(d) states that entities must furnish, upon request, the information that any employees' health benefits plan needs to fulfill its reporting and disclosure obligations under ERISA. As a condition of CMS providing these particular waivers or modifications, CMS reserves the right to request and review these materials in the event of beneficiary complaints, or for any other reason it determines to ensure the information accurately and adequately informs Medicare beneficiaries about their rights and obligations under the plan. MAOs are also required to retain these dissemination materials and provide access to these written materials to CMS (or its designees) in accordance with 42 CFR 422.503(d) and 422.504(d) and (e).

50.5 - Identification (ID) Card Requirements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

Direct Contract MAOs and MAOs that offer "800 series" plans may provide enrollees with one combination member Identification (ID) card which incorporates medical, Part D, and employer-sponsored non-Medicare supplemental medical and/or drug benefits. However, entities must comply with all other CMS ID card requirements, including the requirements contained in the Medicare Marketing Guidelines. Note that this same waiver applies when an MAO elects to use the waiver outlined in §50.2 to customize disclosure materials for a particular employer/union sponsor that offers coverage to its members using an individual Medicare plan paired with a non-Medicare supplemental plan designed to "wrap around" or enhance the individual Medicare plan. Note that it is also permissible to include the name and/or logo of the employer/union sponsor on the ID card. This activity is not considered "co-branding."

50.6 - Agent and Broker Licensure and Training Requirements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

Unless otherwise noted, all requirements listed in the Medicare Managed Care Manual, Chapter 3 (Medicare Marketing Guidelines), §120 do apply. All agents and brokers (employed and contracted) selling “800 series” plans to employer/union group plan sponsors on behalf of an MAO must be licensed to sell these products as required by State law. However, representatives of an MAO or representatives of employer/union group plan sponsors or others acting on their behalf (e.g., their employees, benefit consultants, third party administrators) who conduct educational, enrollment or informational events for retirees of employer/union sponsors are not required to be licensed for these purposes, as these activities do not constitute marketing or sales activities. Consequently, the broker/agent testing requirements, as described in the Medicare Managed Care Manual, Chapter 3 (Medicare Marketing Guidelines), do not apply under these circumstances.

50.7 - Providing Information to CMS about the MA Program

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

CMS has waived the requirements contained in 42 CFR 422.64 for all EGWPs. These regulatory provisions require plans to report certain information annually to CMS to enable us to provide current and potential beneficiaries the information they need to make informed decisions concerning their available choices for Medicare coverage. This includes information to be included in the CMS “Medicare and You” publications and on the CMS website (e.g., “Medicare Plan Finder”). Since these plans are not available for general enrollment, these requirements do not apply and are waived.

50.8 - Requirement for MA Organization to Provide Specific Information via an Internet Website

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

To the extent an MAO has a website or provides information through the Internet, 42 CFR 422.111(f)(12) requires MAOs to post copies of the plan’s Evidence of Coverage, Summary of Benefits, and information on the network of contracted providers on the website. CMS has waived both the requirements of 42 CFR 422.111(f)(12) and 42 CFR 422.111h(2) for all “800 series” plans. MAOs will not be required to provide any information concerning these EGWPs on the MAO’s website. Since these kinds of employer-sponsored MA plans are not available for general enrollment, these requirements do not apply and are therefore waived.

50.9 - Beneficiary Customer Service Call Center Requirements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

CMS has granted a waiver of the beneficiary customer service call center hour requirements for all Direct Contract and “800 series” EGWPs offered by MAOs. These entities will be allowed to operate beneficiary customer service call center hours for their employer/union group health plan only enrollees that differ from the requirements for plans offered to individual beneficiaries listed in 42 CFR 422.111h(1). These entities must ensure that a sufficient mechanism is available to respond to beneficiary inquiries and must provide customer service call center services to Medicare beneficiaries during normal business hours. However, CMS may review the adequacy

of these call center hours and potentially require expanded beneficiary customer service call center hours in the event of beneficiary complaints or for other reasons in order to ensure that the entity's customer service call center hours are sufficient to meet the needs of its enrollees.

60 - Waivers Only Applicable to Direct Contract EGWPs

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

A list of waivers or modifications approved specifically for Direct Contract EGWPs can be found in this section.

60.1 - State Licensure

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

In general, an MAO must be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers coverage. However, an employer/union applying to become an MAO solely for purposes of providing coverage to its members will not have to meet the State licensing requirements set forth at 42 CFR 422.400(a) and 42 CFR 422.503(b)(2) as a condition of being an MAO.

60.2 - Financial Solvency

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

An MAO generally must be licensed as a risk-bearing entity eligible to offer health insurance or health benefits coverage under State law. (See 42 CFR 422.400(a).) CMS waived the licensure requirement for employer/union direct contract MAOs that provide coverage to their own members pursuant to its waiver authority. However, as a condition of this waiver, CMS requires that these entities meet certain financial solvency standards. CMS requires that the entity demonstrate that its fiscal soundness is commensurate with its financial risk, and that through other means, the entity can assure that claims for benefits paid for by CMS and beneficiaries will be covered.

60.3 - Bonding and Insurance

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

An employer/union directly contracting with CMS as an MAO must meet the bonding and insurance standards described at 42 CFR 422.503(b)(4)(iv)-(v). However, CMS may, on a case-by-case basis, provide flexibility to an employer/union directly contracting with CMS as an MAO by waiving these requirements upon a demonstration that different Federal or State legal standards (such as the Employee Retirement Income Security Act (ERISA) bonding requirements) are satisfied.

60.4 - Management and Operations

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

In general, an entity seeking to contract with CMS as an MAO must have administrative and management arrangements that demonstrate the following pursuant to 42 CFR

422.503 (b)(4)(i)-(iii):

- Policy-making bodies exercising oversight and control to ensure that management actions are in the best interest of the organization and its enrollees;
- A quality improvement program and external quality review;
- Administration and management; and
- An executive manager whose appointment and removal are under the control of the policy-making body.

An employer/union directly contracting with CMS as an MAO may be subject to other potentially different standards governing its management and operations, such as fiduciary requirements under the “ERISA” State law standards, and certain oversight standards created under the Sarbanes-Oxley Act. To reflect these issues and avoid imposing additional (and potentially conflicting) government oversight that may hinder employers/unions from considering MA direct contracts with CMS, the requirements at 42 CFR 422.503(b)(4)(i)(iii), as noted above, are waived if the employer/union (or to the extent applicable, the business associate with which it contracts for benefit services) is subject to ERISA fiduciary requirements or similar State or Federal law standards. However, such entities (or their business associates) are not relieved from the record retention standards applicable to other MAOs set forth at 42 CFR 422.504(d).

60.5 - Reporting Requirements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

In general, MAOs must report certain information to CMS, to their enrollees, and to the general public (such as the cost of their operations and financial statements) under 42 CFR 422.516(a). To avoid imposing additional and possibly conflicting public disclosure obligations that would hinder the offering of employer/union-sponsored group plans, CMS will modify these reporting requirements for Direct Contract EGWPs to allow information be reported to enrollees and to the general public to the extent required by other law (including ERISA or securities laws), or by contract.

APPENDIX 1

Instructions for MA Organizations and PDP Sponsors Requesting Additional Waiver/Modification of Requirements

(Rev. 91, Issued: 7-13-12, Effective: 7-13-12, Implementation: 7-13-12)

MAOs may submit individual waiver/modification requests to CMS at any time. The MAO should submit these additional waiver/modification requests to their respective Account Manager.

These requests must be identified as requests for additional waivers/modifications and must fully address the following items:

- Specific provisions of existing statutory, regulatory, and/or CMS policy requirement(s) the entity is requesting to be waived/modified (please identify the specific requirement (e.g., “42 CFR 422.66,” or appropriate section in the Medicare Managed Care Manual and whether you are requesting a waiver or a modification of specific requirements);
- A description of how the particular requirements hinder the design of, the offering of, or the enrollment in, the employer-sponsored group plan;
- A detailed description of the waiver/modification requested, including how the waiver/modification will remedy the impediment (i.e., hindrance) to the design of, the offering of, or the enrollment in, the employer-sponsored group plan;
- Other details specific to the particular waiver/modification that would assist CMS in the evaluation of the request; and
- Contact information (contract number, name, position, phone, fax and email address) of the person available to answer inquiries about the waiver/modification request.