Department of Health & Human Services
Centers for Medicare & Medicaid Services
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Baltimore, MD 21244-1850

CENTER FOR BENEFICIARY CHOICES

MEMORANDUM

DATE: November 13, 2006

TO: All Prescription Drug Plan (PDP) Sponsors, Medicare Advantage Organizations and Section 1876 Cost Plan Sponsors Offering Employer/Union-Only Group Waiver Plans (EGWPs)

FROM: Abby L. Block, Director
Center for Beneficiary Choices

SUBJECT: 2008 Employer Group Waiver Policy – Elimination of the "Nexus" Test for PDPs, Non-Network PFFS and MSA MA plans and Service Area Extension for Certain MA Local Coordinated Care Plans

CMS has authority under 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 employment-based Medicare plans offered by employers and unions to their members.

For contract years 2006 and 2007, CMS employer group waiver policy requires PDP sponsors to offer plans to individual Medicare beneficiaries as a condition of being able to offer employer/union-only group waiver plans (i.e., "800 series" plans) associated with the same contract. Also, if individual coverage is offered in the service area where the most substantial portion of an employer's employees reside, PDP sponsors may extend coverage in "800 series" plans to the employer's retirees in other service areas. (This service area extension policy is commonly known as the "nexus test."). *See* April 6, 2005, Employer/Union-Only Group Waiver Guidance. These same standards were applied to non-network Private Fee-For-Service (PFFS) plans offered by Medicare Advantage Organizations (MAOs). *See* June 23, 2005 Employer/Union-Only Non-Network PFFS Service Area Guidance.

Elimination of the "Nexus" Test for PDPs, Non-Network PFFS Plans and MSA Plans

Beginning with the 2008 contract year, PDP sponsors offering prescription drug plans and MAOs offering non-network PFFS plans are not required to offer these plans to individual beneficiaries as a condition of offering associated "800 series" plans. This change includes the elimination of the "nexus" test. In addition, beginning with the 2008 contract year, standard "800 series" Medical Savings Account (MSA) plans will be treated the same as "800 series" demonstration MSA plans and will not be required to offer plans to individual beneficiaries.

The changes described above will apply to entities renewing "800 series" plan benefit packages in 2008, as well as to entities offering "800 series" plans for the first time in 2008. Further

details relating to the impact of the change on the application/renewal process will be outlined in the CMS 2008 contract year application and renewal instructions.

CMS believes that these changes will facilitate the offering of plans for employers and unions seeking to retain high quality coverage for their Medicare eligible retirees. Moreover, given the robust participation in the Part D program and our expectations for 2008 and beyond, a critical rationale for the requirement to offer individual plans – ensuring that individual Medicare beneficiaries have sufficient choice and access to high quality, low cost, prescription drug plans – will no longer be applicable.

Notwithstanding the changes, entities offering these plans will continue to have to meet all CMS requirements that are not otherwise waived or modified, including the requirement to be licensed as a risk bearing entity eligible to offer health insurance or health benefits. For entities that choose to only offer "800 series" plans for a particular PDP, MA PFFS or MA MSA contract, this requirement will be met if the entity is licensed in at least one state.

Service Area Extension for Certain MA Local Coordinated Care Plans

For contract year 2008 CMS will retain the current requirement that all other MAOs and Section 1876 Cost Plan Sponsors offer plans to individual beneficiaries as a condition of offering "800 series" plans. The design and operation of these plans differ appreciably from standalone PDPs, non-network MA PFFS plans and MA MSA plans. For example, MAOs must furnish Medicare Parts A and B health care services generally through local networks that they must establish and maintain and that are approved by CMS. We believe it is important to continue to provide incentives for these entities to offer these plans and promote greater choice and robust availability for Medicare beneficiaries.

However, to enable employers and unions to offer coordinated care plans to all their Medicare-eligible retirees wherever they reside, CMS will grant a waiver of service area requirements for the 2008 contract year to MAOs offering local coordinated care plans (e.g., local PPOs and HMOs) under certain circumstances. A MAO offering a coordinated care plan in a given service area (i.e., state) can extend coverage to an employer or union sponsor's beneficiaries residing outside of that service area when the MAO, either itself or through partnerships with other MAOs, is able to meet CMS provider network adequacy requirements and provide consistent benefits to those beneficiaries. This waiver of service area restrictions is generally available to all similarly situated entities meeting the terms of the waiver and will not need to be granted on an individual basis. Further details concerning the establishment of service areas in HPMS, bidding requirements and other operational requirements associated with this waiver will be outlined in future 2008 instructions.

If there are any questions about this policy, please contact Brenda Tranchida, Deputy Director, Employer Policy and Operations Group, via phone (410-786-2001) or via email at Brenda.Tranchida@cms.hhs.gov.