Department of Health & Human Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244-1850

CENTER FOR BENEFICIARY CHOICES

DATE: December 18, 2006

TO: All Entities Offering Employer/Union Sponsored Group Plans

FROM: Brenda Tranchida, Deputy Director
Employer Policy and Operations Group

SUBJECT: Contract Year 2007 Determinations - Requests for Additional Waivers of Requirements from Entities Offering, Sponsoring or Administering Employer/Union Sponsored Group Plans

Attached are CMS final determinations on requests for additional waivers of requirements received from entities offering, sponsoring or administering employer/union sponsored group plans. These determinations apply for contract year 2007.

If you have any questions regarding this memorandum, please contact Brenda Tranchida at 410-786-2001 or brenda.tranchida@cms.hhs.gov.

Attachment

CONTRACT YEAR 2007 DETERMINATIONS:
REQUESTS FOR ADDITIONAL WAIVERS OF REQUIREMENTS
FROM ENTITIES OFFERING, SPONSORING OR ADMINISTERING
EMPLOYER/UNION SPONSORED GROUP PLANS
(DECEMBER 18, 2006)

Background

The Medicare Modernization Act (MMA) provides employers and unions with a number of options for providing Medicare prescription drug coverage ("Part D") to their Medicare-eligibles. Under the MMA, those options include making arrangements with Medicare Advantage (MA) Organizations and Section 1876 Cost Plans to purchase benefits, including drug benefits; purchasing benefits from sponsors of prescription drug-only plans (PDPs); and contracting directly with CMS to themselves sponsor a Medicare plan. Under Sections 1857(i) and 1860D-22(b) of the Social Security Act (SSA), CMS may waive or modify requirements when these requirements "hinder the design of, the offering of, or the enrollment in" employer or union-sponsored group plans.

For contract year 2006, CMS issued specific guidance waiving or modifying a number of Part D requirements for MA Organizations, PDP sponsors and Section 1876 Cost Plan Sponsors[1] that offer, sponsor or administer certain types of employer sponsored group plans -- employer/union-only group waiver plans (hereinafter referred to as "EGWPs" or "800 series plans") and employers/unions that directly contract with CMS to become a Medicare Part D plan exclusively for their retirees (hereinafter referred to as "Direct Contract EGWPs"). CMS waiver guidance is located at: http://www.cms.hhs.gov/EmpGrpWaivers.

In addition to these existing waivers, 42 CFR 423.458(c) allows any entity seeking to offer, sponsor, or administer an employer-sponsored group prescription drug plan to request, in writing, a waiver or modification of additional requirements under Part D that hinder the design of, the offering of, or the enrollment in, such plans. Waivers or modifications approved by CMS automatically apply to any similarly situated entity seeking to offer, sponsor, or administer an employer-sponsored group prescription drug plan that meets the conditions of the waiver or modification.[2]

During the 2007 Part D application process, applicants submitted requests for additional waivers and modifications. CMS has completed its review and consideration of these additional waiver requests. Below are the CMS final determinations on each of these requests. The approved waiver requests will be applicable for the 2007 contract year. Please direct any questions concerning these determinations to Brenda Tranchida, Deputy Director, Employer Policy and Operations Group, at (410) 786-2001 or via email at: Brenda.Tranchida@cms.hhs.gov.

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[1] Section 1876 Cost Plan Sponsors may only offer Part D coverage as an optional supplemental benefit. CMS' employer group waiver authority applies only to Part D, *not* to Parts A or B of the Cost Plan.

[2] Similarly, 42 CFR 422.106(d) allows sponsors of MA plans (including MA-PD plans) to submit requests to waive or modify additional Part C or Part D requirements.

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Approved Waiver Requests

WAIVER OF ENROLLMENT RESTRICTIONS FOR BENEFICIARIES WITH END-STAGE RENAL DISEASE:

Section 1851(a)(3)(B) of the Social Security Act, 42 CFR 422.50(a)(2), Medicare Managed Care Manual (MMCM), Section 20.3.2, September 8, 2006

A MA Organization requested a modification of previously issued employer group waiver guidance concerning the enrollment of end-stage renal disease (ESRD) beneficiaries. Under 42 CFR 422.50(a)(2), an individual Medicare beneficiary determined to have ESRD may not enroll into a Medicare Advantage (MA) plan unless he/she meets one of three unique exceptions (the beneficiary developed ESRD while enrolled in a health plan offered by the MA Organization and is converting to Medicare Parts A and B, the plan the beneficiary with ESRD is enrolled in terminates or discontinues, or the beneficiary elects to enroll in a MA special needs plan that specifically permits ESRD enrollees). Individuals already enrolled in an MA plan who develop ESRD may remain enrolled in that plan and may elect other MA plans offered by that MA Organization; however, he or she generally may not elect an MA plan offered by a different MA Organization or a plan offered by the same MA Organization in a different State.

In 2003, CMS granted a modification of the ESRD enrollment restrictions contained in 42 CFR 422.50(a)(2) for certain employer group beneficiaries. CMS allowed ESRD employer group beneficiaries to enroll in any employer sponsored group plan (i.e., either an "800 series" plan or an individual plan offered to employer group members) when: (1) the employer offers a MA plan as a new option to its members; (2) the employer consolidates its coverage options by dropping an option and the member is enrolled in one of the dropped options; and (3) an ESRD beneficiary permanently relocates to an area in which the employer has contracted with another MA Organization. *See* Medicare Managed Care Manual (MMCM), Section 20.2.3 ("Optional Employer Group Waiver for ESRD Enrollees").

The MA Organization requested that CMS consider extending its waiver authority to allow the enrollment of newly eligible Medicare beneficiaries with ESRD into MA plans. The requestor states that granting the waiver will facilitate employer group coverage because employers typically expect the plan will be able to be offered to all of their employer group members. This is especially important in cases where there is a single MA plan offered to all employer group members.

CMS has granted a modification of the existing employer group waiver guidance contained in Section 20.2.3 of Chapter 2 of the MMCM to allow employer or union group beneficiaries with ESRD who age into Medicare to be enrolled in MA plans

sponsored by employers or unions regardless of prior commercial coverage affiliation. Please note that, as with the employer group waiver issued in 2003, this waiver will apply to enrollment of employer and union group beneficiaries in both "800 series" plans and in plans open to general enrollment (i.e., those plans offered to individual Medicare beneficiaries). MA Organizations that choose to apply one of the ESRD enrollment waivers must agree to apply it consistently in accordance with the requirements contained in Section 20.2.3 of Chapter 2 of the MMCM (i.e., the MA Organization must consistently allow enrollment of employer group ESRD beneficiaries in all plan benefit packages offered by the MA Organization under a particular MA contract).

WAIVER OF SERVICE AREA RESTRICTIONS FOR LOCAL MA-PDs:

Section 1851(b)(1)(a) of the Social Security Act, 42 CFR 422.50(a)(3)

A MA Organization requested a limited waiver of the service area requirements for local MA-PDs on behalf of Voluntary Employee Beneficiary Association ("VEBA") trusts established in their service area to preserve employer benefits for individuals losing such benefits due to the economic failure of their employers. Under CMS guidance, local MA plans that provide coverage to individuals in any part of a State can offer "800 series" employer only group plans in any area within that State or throughout the entire State. The MA Organization requested a waiver of these service area requirements to extend coverage to employer only group beneficiaries residing primarily in contiguous counties outside of the State when: (1) the individuals are beneficiaries of a VEBA that is headquartered in a state in which the MA Organization offers an MA-PD plan to individuals; (2) the MA Organization meets MA-PD network access standards in the areas in which they would be allowed to enroll the VEBA beneficiaries; and (3) the state allows the MA Organization to provide coverage when the individuals are members of an employer or union plan that has contracted with the MA Organization in a state in which it is licensed as a risk bearing entity.

The MA Organization stated that the waiver allows the employer group and the MA Organization to administer coordinated care benefits for these VEBA beneficiaries in a consistent manner and to offer uniform, comprehensive and affordable coverage to all of these beneficiaries, many of whom are economically disadvantaged. The particular area of the country in which the MA Organization offers coverage has a unique geography where several states are located in close proximity to its service area and thereby form a local community with local patterns of care which encompass these neighboring states. The MA Organization states that it currently serves commercial groups in these contiguous states and thus has sufficient numbers and types of providers in the counties of these contiguous states where beneficiaries reside to meet CMS network access requirements.

CMS has granted the waiver of the service area restrictions for MA Organizations offering "800 series" employer only group plans under the circumstances provided in the waiver request. Thus, it is available to MA Organizations when (1) the individuals are beneficiaries of a VEBA that is headquartered in a state in which the MA Organization offers an MA-PD plan to individuals; (2) the MA Organization meets network access standards in the areas outside of their defined service area where these VEBA beneficiaries reside; and (3) the state allows the MA Organization to provide coverage to individuals in that state when the individuals are members of an employer or union plan contracted with the MA Organization in a state in which it is licensed as a risk bearing entity.

Existing service area requirements will continue to apply for all other local MA Organizations that do not meet the requirements of this specific waiver.

WAIVER OF REQUIREMENTS FOR PART D PLANS TO OPERATE BENEFICIARY CUSTOMER SERVICE CALL CENTER HOURS DURING CERTAIN PERIODS:

**PDP Instructions for 2007 Contract Year ("Call Letter"), April 4, 2006
Medicare Marketing Guidance, Addendum 2, Revised July 25, 2006**

A PDP sponsor requested a waiver of the Part D beneficiary customer service call center hour requirements.[3] The PDP sponsor stated that these requirements should not apply to its "800 series" employer only group plans. The PDP sponsor is requesting that the requirements be revised to allow customer call center hours for these kinds of plans to differ based on the existing call center hours for its employer only group business. The PDP sponsor also stated that these requirements should be modified because employer group members do not require the same level of support as individual beneficiaries and because employer group open enrollment periods do not necessarily coincide with the open enrollment period for Medicare plans offered to individual beneficiaries.
The PDP sponsor also stated that the extended call center hour requirements are more costly and hinders its ability to provide effective customer service to its employer group beneficiaries, particularly those beneficiaries for whom the employer is also providing medical coverage, because the PDP sponsor must separate any medical calls from the

[3] These requirements mandate that all Part D sponsors have beneficiary customer service call centers that are staffed appropriately in order to be available to beneficiaries from 8 a.m. to 8 p.m., seven days a week, during the annual open enrollment period (November 15 – December 31) through 60 days past the beginning of calendar year (CY) 2007 (i.e., January 1, 2007 to March 1, 2007). From March 2, 2007 until the following annual open enrollment period PDP sponsors are permitted to use alternative technologies to meet the customer service call center requirements for Saturday, Sunday and holidays.

pharmacy calls to meet the Part D requirement, leading to potential confusion and disruption in existing member levels of service.

Another entity (which is both a PDP sponsor and an MA Organization) requested a waiver of the Part D beneficiary customer service call center hour requirements and the corresponding performance standards for "800 series" employer only group plans. The PDP sponsor stated that employer groups generally have dedicated call centers with employer-specific servicing agreements containing customer service center and performance requirements that are uniform for all of the employer's members (i.e., active and retired Medicare eligibles and non-Medicare eligibles) and for all benefits offered (e.g., medical services and drug benefits) and these requirements typically differ from CMS requirements. The PDP sponsor also stated that requiring the extended hours would lead to additional costs for these employer groups.

A Direct Contract EGWP requested a waiver of the Part D beneficiary call center hour requirements. The Direct Contract EGWP stated employers that directly contract with CMS have national service areas to cover retirees wherever they reside; therefore, this requirement essentially requires them to operate a beneficiary call center 24 hours of day, despite the fact that most of its retirees reside in one time zone. The Direct Contract EGWP also stated that these requirements do not directly benefit its enrollees because its annual enrollment period does not coincide with the Medicare annual open enrollment period. The requestor also provided that in order to meet CMS requirements it would have to hire more employees and incur substantial additional expense to provide expanded customer service to only approximately 2% of its enrollees.

CMS has granted a waiver of the Part D beneficiary customer service call center hour requirements for all Direct Contract EGWPs and "800 series" Part D employer only group plans offered by PDP sponsors, MA Organizations and Cost Plans sponsors. These entities will be allowed to operate beneficiary customer service call center hours for their employer group only enrollees that differ from the Part D requirements for plans offered to individual beneficiaries. These entities must ensure a sufficient mechanism is available to respond to beneficiary inquiries and must provide customer service call center services to these members 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 enrollee population. Also, CMS has granted a waiver of the Part D call center performance requirements for all Direct EGWPs and "800 series" Part D employer only group plans offered by PDP sponsors, MA Organizations and Cost Plans sponsors.

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Disapproved Waiver Requests

The requests to waive/modify additional requirements set forth below were disapproved for one or more of the following reasons: the requirement did not hinder the design of, the offering of, or the enrollment in employer-sponsored group plans; certain beneficiary protections outweighed any alleged hindrance presented by the requirement; and/or the operational complexities associated with the implementation of the waiver could not be overcome.

WAIVER OF REQUIREMENT TO OFFER INDIVIDUAL PLANS IN ORDER TO OFFER EMPLOYER/UNION-ONLY GROUP WAIVER PLANS:

April 6, 2005 Part D Waiver Guidance for Employer/Union Retiree Coverage

A PDP sponsor requested a waiver to allow an entity to offer "800 series" employer only group plans under a contract with CMS without fulfilling the requirement to offer individual plans under that same contract. In addition, a MA Organization requested a waiver under certain circumstances to allow an entity to offer "800 series" employer only group plans under a contract with CMS without fulfilling the requirement to offer individual plans under that same contract. The requestor asked to be allowed to be deemed to meet this requirement for a local PPO contract by offering individual plans under a different local HMO/POS contract. More specifically, the requestor asked CMS to allow the entity to offer only "800 series" local PPO plans under a particular PPO contract when the entity also offers HMO/POS plans to individual beneficiaries in the same service area under a separate contract. The requestor alleged that employer groups prefer a wider array of products than necessary for individual beneficiaries and that granting the request will reduce confusion for individual beneficiaries because the HMO/POS and PPO products are very similar.

Please note that although this policy remains in effect for 2007, for the 2008 contract year, CMS has eliminated this requirement for the following: PDPs, MA Non-Network Private Fee-For-Service Plans, and MA MSA plans. *See* 2008 Employer Group Waiver Policy – Elimination of the "Nexus" Test, November 13, 2006.

WAIVER OF MEDICARE APPEALS AND COVERAGE DETERMINATIONS:

Sections 1860D-4(f), (g) and (h) of the Social Security Act, 42 CFR, Subpart M (Grievances, Coverage Determinations and Appeals)

A PDP sponsor requested a waiver to allow employers and unions that sponsor plans covered by the Employee Retirement Income Security Act of 1974 ("ERISA") to follow ERISA requirements for appeals and coverage determinations as opposed to the Medicare procedures. The requestor stated that absent a waiver of Medicare appeals rules, two

separate, often conflicting sets of rules would have to be followed by an employer sponsor (one for Medicare eligible retirees and one for non-Medicare eligible members). The requestor stated that granting this waiver would minimize costs and disruption by alleviating the requirement to design and implement two different appeals processes, especially when these employer/union groups are already accustomed to complying with ERISA appeals and grievance procedures. Also, the requestor stated the waiver would minimize the potential for beneficiary confusion caused by the existence of two different appeals procedures for pre-Medicare and post-Medicare eligible participants.

WAIVER OF PART D TRANSITION PROCESS REQUIREMENTS:

42 CFR 423.120(b)(3), 2007 Transition Process Requirements for Part D Sponsors, April 2006

A PDP sponsor requested a waiver of the 2007 transition process requirements (which provides for temporary fills for non-formulary drugs) for its "800 series" employer only group plans. The requestor stated that employer only group plans are existing prescription benefit plans with relatively static formularies, plan designs and membership. The PDP sponsor provided that beneficiaries in these plans are already using the existing plan design and formulary and therefore do not need a transitional fill process to make changes to their prescriptions. The PDP sponsor also stated the transitional fill requirements would add unnecessary administration and costs for employer only group plans.

WAIVER/MODIFICATION OF EXPLANATION OF BENEFITS (EOB) REPORTING REQUIREMENTS:

Sections 1860D-4(a)(4) and 1806(a) of the Social Security Act, 42 CFR 423.128(e)

A PDP sponsor requested a waiver of the requirement to provide Part D beneficiaries enrolled in "800 series" employer only group plans with a monthly Explanation of Benefits (EOB) for enrollees with employer sponsored, full wrap around Part D coverage ("first dollar coverage" and thus no TrOOP expenditures to report) as the information may be confusing to these enrollees and may lead to the need for increased customer support volume. The requestor stated it would provide an EOB if requested by a member that showed pharmacy costs accrued during the year in print or through its web site. The PDP sponsor stated it would also be able to provide information on deductibles, TrOOP and other pharmacy expenditure information via phone as necessary. The PDP sponsor stated that if the waiver is not granted, employer groups will incur additional, unnecessary costs and providing EOBs may lead to confusion and misunderstandings from enrollees.

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A Direct Contract EGWP requested a waiver/modification of the requirement to provide monthly EOBs. The Direct Contract EGWP stated that none of its enrollees pay any premiums, there are low maximum out of pocket maximums, thereby making it impossible or remote that any enrollee would reach the TrOOP amount. Monthly EOBs are costly, time consuming, will strain a small employer benefits staff responding to calls from enrollees concerned about the monthly notices, are unnecessary given the plan design and have little to no value to enrollees. Instead of monthly, the Direct Contract EGWP is asking to be permitted to issue quarterly EOBs which will substantially reduce costs and will clearly state on these EOBs that enrollees may obtain an EOB summary at any time upon request.

Please note that beginning with the 2006 contract year, CMS granted a waiver of EOB requirements to Direct Contract EGWPs, and MA Organizations, PDPs or Cost Plans offering "800 series" employer only group plans in certain limited circumstances. In accordance with this previous waiver guidance, the disclosure requirements set forth in 42 CFR 423.128 (which include explanation of benefits) will not apply when the employer/union is subject to alternative disclosure requirements (e.g., the Employee Retirement Income Security Act of 1974 ("ERISA")) and fully complies with such alternative requirements. *See* Beneficiary/Marketing Communication waiver contained in the CMS March 9, 2005 Part D Employer Group Waiver Guidance. The Part D EOB requirements will continue to apply to all entities that do not meet the conditions of this above-mentioned waiver.