



October X, 2008

Dear Employer:

Since 2006, Medicare beneficiaries have been eligible to receive prescription drug coverage through Medicare's Part D program, enacted as part of the Medicare Modernization Act of 2003 (MMA). Authoritative information for Medicare beneficiaries is available from the Centers for Medicare & Medicaid Services (CMS).

If your group health plan offers a prescription drug plan to Medicare-eligible individuals, CMS requires that you take the following actions each year:

- 1. You must determine if your prescription drug plan provides coverage that is considered 'creditable' to Medicare Part D (below).**
- 2. You must communicate your plan's creditable status to Part D-eligible individuals covered under the plan by November 15, 2008. This date is the start of the annual Part D individual enrollment period. CMS requires that you disclose your plan's status whether or not your plan is considered creditable or non-creditable.**
- 3. You must disclose to CMS whether or not your prescription drug plan is creditable to Part D (Refer to page 8 in this document).**

Detailed descriptions of each of these requirements can be found in the following sections. Also, creditable coverage information is available on CMS' website at <http://www.cms.hhs.gov/CreditableCoverage/>. For more details on your plan's benefits, consult your pharmacy plan documents. **Please note that some of the plans that failed the Gross Value test last year are now considered to be creditable.**

1. Determine if your prescription drug plan is "creditable".

Coverage is considered creditable if the actuarial value of the coverage is equal to or exceeds the actuarial value of standard Medicare Part D prescription drug coverage, when using generally accepted actuarial principles in accordance with the CMS actuarial guidelines. This actuarial determination shows whether the expected amount of paid claims under the employer's prescription drug coverage is at least as much as the expected amount of paid claims under the standard Medicare prescription drug benefit.

If your plan satisfies the requirements as creditable and you make the plan available throughout 2008, your Medicare-eligible active members and retirees are able to stay with their current plan and, in the future, be able to enroll in a Medicare prescription drug plan without a late enrollment penalty. **Please note that group health plans with multiple benefit options must apply the actuarial creditable coverage test separately for each benefit option.**

Following are two different tests you can use to determine whether or not your prescription drug plan is considered creditable:

CMS Simplified Creditable Coverage Test

CMS has created the following simplified test for determining if a prescription drug plan is creditable to Medicare Part D.

A prescription drug plan is considered creditable if it meets the following four criteria:

- 1) Provides coverage for brand and generic prescriptions;
- 2) Provides reasonable access to retail providers and, optionally, for mail order coverage;
- 3) Is designed to pay on average at least 60 percent of participants' prescription drug expenses; and
- 4) Satisfies at least one of the following:
 - a) The prescription drug coverage has no annual maximum benefit or a maximum annual benefit payable by the plan of at least \$25,000; or
 - b) The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least \$2,000 per Medicare eligible individual.
 - c) For employers or entities that have integrated health coverage, the integrated health plan has no more than a \$250 deductible per year, has no annual benefit maximum or a maximum annual benefit payable by the plan of at least \$25,000 and has no less than a \$1,000,000 lifetime combined benefit maximum.

Integrated Plan - An integrated plan is any plan of benefits that is offered to a Medicare eligible individual where the prescription drug benefit is combined with other coverage offered by the entity (i.e., medical, dental, vision, etc.) and the plan has all of the following plan provisions:

- 1) a combined plan year deductible for all benefits under the plan,
- 2) a combined annual benefit maximum for all benefits under the plan, and
- 3) a combined lifetime benefit maximum for all benefits under the plan.

A prescription drug plan that meets the above parameters is considered an integrated plan for the purpose of using the simplified method and would have to meet steps 1, 2, 3 and 4(c) of the simplified method. If it does not meet all of the criteria, then it is not considered to be an integrated plan and would have to meet steps 1, 2, 3 and either 4(a) or 4(b).

Gross Value Test

Under the CMS Simplified Test, a plan would pay at least 60 percent of the member's total prescription drug costs. The member would pay the remaining 40 percent. However, CMS also allows you to use the gross value test to determine if your coverage is creditable. Under the gross value test, the expected amount of paid claims for your coverage must be at least equal to the expected amount of paid claims under the standard Medicare Part D benefit. When using the gross value test, our estimates indicate that the value of the Part D benefit is 54 percent of the drug costs. Therefore, any plan that is expected to pay at least 54 percent of the total drug costs would be considered creditable.

Although the final determination of whether or not your plan is creditable remains your responsibility as an employer, we have analyzed many of our Blue Cross and Blue Shield prescription drug plans using the gross value test to help you evaluate the creditability of the Blue Cross and Blue Shield plan you have purchased.

The following tables can be used instead of the Simplified Determination method to determine creditable coverage status. If your plan is not shown on the following tables, you can use the CMS simplified test above to determine if your plan is creditable using that criteria.

2. Communicate your plan's creditable coverage status to Part-D eligible individuals

Employers must give written notice to Part D eligible individuals enrolled in the group plan of the creditable status of the group's drug coverage, whether or not the coverage is creditable. CMS has created model creditable and non-creditable notices, updated for use after June 15, 2008, which can be found on CMS' website at www.cms.hhs.gov/CreditableCoverage/.

When must the notice be provided?

- 1) In 2008, notice must be provided prior to the beginning of the Medicare Part D Annual Coordinated Election Period (ACEP), which runs from November 15 through December 31, 2008.
- 2) Notice must also be given
 - a) Prior to an individual's initial enrollment period (IEP) for Medicare Part D.
The Part D IEP runs concurrently with the Medicare Part B IEP. This seven-month period begins three months before the month an individual meets the eligibility requirements for Part B and ends three months after the month of eligibility. For example, an individual is eligible for Medicare Part B on July 1, 2009. His or her seven-month IEP runs from April 1, 2009 through October 31, 2009; or
 - b) Prior to the effective date of coverage for any Medicare-eligible individual who joins the plan; or
 - c) Whenever the employer no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable, or
 - d) Upon a beneficiary's request.

If the creditable coverage disclosure notice is provided to all plan participants annually, CMS will consider items 1 and 2 (above) to be met. "Prior to" means the beneficiary must have been provided the disclosure notice within the past 12 months.

The following decisions are up to the employer group and not the carrier and should also be disclosed to your Part D eligible individuals:

- 1) Are you collecting the Retiree Drug Subsidy?
 - a) If yes, suggest putting the impact, if any, on the retirees coverage if they enroll in Medicare Part D.
 - b) If no, do you allow your Part D eligible individuals to enroll in Medicare Part D?
- 2) Do you allow the Part D eligible individual and their dependents to drop coverage and then come back on later.

3. Disclose to CMS whether or not your prescription drug plan is creditable to Part D

When must disclosure be made to CMS?

According to CMS' January 10, 2006 instructions, at a minimum, disclosure to CMS must be made by the following deadlines:

- For plan years ending in 2007 and beyond, disclosure must be provided within 60 days after the beginning of the plan year for which the entity is providing the disclosure
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status of the prescription drug plan.

Who must make the disclosure to CMS?

- Sponsors of group health plans, including employers, unions, churches, Federal, State and local governments, among others, that provide prescription drug coverage to Medicare Part D-eligible individuals must disclose creditability status to CMS.
- Though the disclosure requirement applies to prescription drug coverage provided to Medicare Part D-eligible individuals, group health plan sponsors may want to consider providing the disclosure to CMS even if they're not aware of Part D-eligible members in their group health plan. This is because of the difficulty in determining whether employees' spouses or dependents are Medicare-eligible.
- Plan sponsors that have applied for and anticipate receiving payment for the retiree drug subsidy (RDS) are not required to make this disclosure to CMS.

How is the disclosure made?

Disclosure must be made electronically via the Disclosure Notice form on the CMS Creditable Coverage webpage at www.cms.hhs.gov/creditablecoverage/45-CCDisclosureForm.asp.

Using the BCBS plan tables

To determine if your BCBS plan is creditable you will need to do the following:

- 1) Determine if your prescription drug plan is a copay plan (Table 1) or a coinsurance plan design (Table 2) or an integrated Rx and medical plan (Table 3).
- 2) Determine if your plan has one, two or three tiers of copays or coinsurance levels.
- 3) Find the mail order level, if any, (one, two or three times the retail copay) that corresponds to your plan.
- 4) Find the lowest deductible level applicable to your plan, if any.
- 5) If the copays or coinsurance amounts and the benefits of your BCBS plan are at or below those shown in the table, then your plan is creditable.
- 6) If the copays, coinsurance or deductible amounts of your BCBS plan are greater than those shown in the tables, then your plan may not be creditable. You can use the CMS simplified test above to determine if your plan would be creditable using that criteria.

Example 1:

If you have a three tier copay plan with mail order at two times the retail copay and no deductible, then, if the plan copays are not greater than \$25 generic, \$50 preferred brand and \$77 non-preferred brand, the plan is creditable. See bold area on Table 1.

Example 2:

If you have a two-tier copay plan with mail order at two times retail and \$100 deductible, and the plan copays are not greater than \$25 generic and \$42 brand, then the plan is creditable. See bold area on Table 1.

Example 3:

If you have an integrated drug and medical plan with 70% coinsurance, a \$2,500 deductible and \$3,000 out-of-pocket limit for medical/drug coverage, then the drug coverage will pass. However, if a plan has 90% coinsurance rate for drug and medical with a \$10,000 deductible and \$2,500 out-of-pocket limit for medical/drug coverage, then the drug coverage will fail. See bold area on Table 3.

If you have questions about your plan, contact your sales or account representative or producer.

ESTIMATES OF CREDITABLE COVERAGE FOR STANDARD DRUG BENEFIT

NOTE: UNDER THE GROSS VALUE TEST AS SET OUT IN TABLES 1 – 3

Copay Plans

Table 1

One Tier Plans

Copay	Mail Order Copay	Deductible
\$0 - \$55	1X retail copay	\$0
\$0 - \$44	2X retail copay	\$0
\$0 - \$38	3X retail copay	\$0
\$0 - \$43	1X retail copay	\$1 - \$295
\$0 - \$35	2X retail copay	\$1 - \$295
\$0 - \$30	3X retail copay	\$1 - \$295

Two Tier Plans

Generic Copay	Brand Copay	Mail Order Copay	Deductible
\$0 - \$25	\$0 - \$73	1X retail copay	\$0
\$0 - \$25	\$0 - \$56	2X retail copay	\$0
\$0 - \$25	\$0 - \$45	3X retail copay	\$0
\$0 - \$25	\$0 - \$55	1X retail copay	\$1 - \$295
Ex. 2 \$0 - \$25	\$0 - \$42	2X retail copay	\$1 - \$295
\$0 - \$25	\$0 - \$34	3X retail copay	\$1 - \$295
\$0 - \$20	\$0 - \$38	3X retail copay	\$1 - \$295

Three Tier Plans

	Generic Copay	Preferred Brand Copay	Non-Preferred Brand Copay	Mail Order Copay	Deductible
	\$0 - \$25	\$0 - \$68	\$0 - \$92	1X retail copay	\$0
Ex. 1	\$0 - \$25	\$0 - \$50	\$0 - \$77	2X retail copay	\$0
	\$0 - \$20	\$0 - \$51	\$0 - \$105	2X retail copay	\$0
	\$0 - \$25	\$0 - \$41	\$0 - \$64	3X retail copay	\$0
	\$0 - \$25	\$0 - \$46	\$0 - \$89	1X retail copay	\$1 - \$295
	\$0 - \$25	\$0 - \$37	\$0 - \$60	2X retail copay	\$1 - \$295
	\$0 - \$25	\$0 - \$30	\$0 - \$49	3X retail copay	\$1 - \$295
	\$0 - \$20	\$0 - \$37	\$0 - \$60	2.5X retail copay	\$1 - \$295

The purpose of the above analysis of standard Blue Cross and Blue Shield drug benefit plans is to help employer plan sponsors decide whether to inform their covered retirees that current coverage is creditable or non-creditable, and is not for the purposes of the retiree drug subsidy or other uses.

Please note: Our analysis is based on a gross value test explained in creditable coverage guidance from CMS. Under that gross value test, the expected amount of paid claims for current coverage must be at least equal to the expected amount of paid claims under the standard Medicare Part D benefit. Our estimates indicate that the value of the standard Part D benefit is 54% of the total covered drug costs (the remainder is the beneficiary's share) and that a plan is therefore "creditable" if it pays at least 54% of the expected amount of total drug costs.

All estimates are based on the above benefits and limitations and assume a standard Medicare eligible population. This information should not be construed as legal or actuarial advice. You are urged to consult your own independent legal, actuarial and other advisors.

**ESTIMATES OF CREDITABLE COVERAGE FOR STANDARD DRUG BENEFIT
Coinsurance Plans
Table 2**

<u>One Tier Plans</u>		
Coinsurance %	Minimum cost per Rx	Deductible
0% - 45%	\$0	\$0
0% - 41%	\$1 - \$15	\$0
0% - 37%	\$0	\$1 - \$295

Two Tier Plans

Generic Coinsurance %	Brand Coinsurance %	Minimum cost per Rx	Deductible
0% - 33%	0% - 50%	\$0	\$0
0% - 30%	0% - 44%	\$1 - \$15	\$0
0% - 30%	0% - 39%	\$0	\$1 - \$295

Three Tier Plans

Generic Coinsurance %	Preferred Brand Coinsurance %	Non Preferred Brand Coinsurance %	Minimum cost per Rx	Deductible	Mail Order Coinsurance %
0% - 35%	0% - 45%	0% - 65%	\$0	\$0	1X retail copay
0% - 30%	0% - 40%	0% - 58%	\$1 - \$15	\$0	1X retail copay
0% - 30%	0% - 35%	0% - 57%	\$0	\$1 - \$295	1X retail copay
\$1 - \$15	0% - 40%	0% - 60%	\$0	\$0	2X retail copay

Drug Plans Integrated with Medical

The following information on creditable plans with integrated drugs and medical (Chart 3) may be used for your creditable coverage notification requirements under Medicare D. Large deductibles and out of pocket amounts still qualify as creditable because much of the cost sharing is taken up by the medical benefits.

For a particular drug coinsurance level, a table is shown with deductible across the top and out-of-pocket limit down the side and whether the combination will pass or fail. For example, if a plan has 70% drug coinsurance with a \$2,500 deductible and \$3,000 out-of-pocket limit for medical coverage, then the drug coverage will pass. However, if a plan has 90% drug coinsurance with a \$10,000 deductible and \$2,500 out-of-pocket limit for medical coverage, then the drug coverage will fail.

These scenarios assume that the medical and drug coinsurance are the same. Especially in a case where the plan is on the borderline of passing, it is possible that the result could be different if the drug coinsurance is greater than the medical coinsurance.

Also, if a plan's out-of-network coverage fails, it is possible that the plan is still creditable if the plan's in-network coverage is well within the range of passing.

ESTIMATES OF CREDITABLE COVERAGE FOR STANDARD DRUG BENEFIT

**Integrated Drug/Medical Plans
Table 3**

**100% Rx
coinsurance**

OPX Limit	Deductible									
	500	1000	1500	2000	2500	3000	4000	5000	7500	10000
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
4000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
5000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
7500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail
10000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail

**90% Rx
coinsurance**

OPX Limit	Deductible									
	500	1000	1500	2000	2500	3000	4000	5000	7500	10000
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
4000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
5000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
7500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
10000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail

**80% Rx
coinsurance**

OPX Limit	Deductible									
	500	1000	1500	2000	2500	3000	4000	5000	7500	10000
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
4000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
5000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
7500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
10000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail

**70% Rx
coinsurance**

OPX Limit	Deductible									
	500	1000	1500	2000	2500	3000	4000	5000	7500	10000
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail	Fail
4000	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail	Fail	Fail
5000	Pass	Pass	Pass	Pass	*	*	Fail	Fail	Fail	Fail
7500	Pass	Pass	Pass	Pass	*	*	Fail	Fail	Fail	Fail
10000	Pass	Pass	Pass	Pass	*	*	Fail	Fail	Fail	Fail

**60% Rx
coinsurance**

OPX Limit	Deductible									
	500	1000	1500	2000	2500	3000	4000	5000	7500	10000
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail	Fail
4000	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail	Fail	Fail
5000	Pass	Pass	Pass	*	*	Fail	Fail	Fail	Fail	Fail
7500	*	*	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail
10000	*	*	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail

**50% Rx
coinsurance**

OPX Limit	Deductible									
	500	1000	1500	2000	2500	3000	4000	5000	7500	10000
500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
1500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Pass	Fail	Fail
2000	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
2500	Pass	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail
3000	Pass	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail	Fail
4000	Pass	Pass	Pass	Pass	Pass	*	Fail	Fail	Fail	Fail
5000	Pass	Pass	Pass	*	*	Fail	Fail	Fail	Fail	Fail
7500	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail
10000	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail	Fail

* These are borderline pass situations. An independent analysis is advisable.

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Please note: Our analysis is based on a gross value test explained in creditable coverage guidance from CMS. Under that gross value test, the expected amount of paid claims for current coverage must be at least equal to the expected amount of paid claims under the standard Medicare Part D benefit. Our estimates indicate that the value of the standard Part D benefit is 54% of the total covered drug costs (the remainder is the beneficiary's share) and that a plan is therefore "creditable" if it pays at least 54% of the expected amount of total drug costs.

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