

**We Provide Prescription Drug Coverage to Retirees Through a Part D Plan. Do We Have to Provide Disclosures for Such Plans?** No. Entities that contract with Medicare directly as a Part D plan or that contract with a Part D plan to provide qualified retiree prescription drug coverage are exempt from the disclosure requirement. Sending notice of creditable status is superfluous since, as Part D plans, the creditable status is automatic.\* Thus, an employer that provides prescription drug coverage to retirees through a Part D plan is exempt from the disclosure requirement,† as is coverage provided by PDPs, MA-PD plans, PACE plans, or cost-based HMO or CMP plans.‡

\* Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193, 4227 (Jan. 28, 2005).

† *Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance*, available at [http://www.cms.hhs.gov/CreditableCoverage/Downloads/Updated\\_Guidance\\_01\\_01\\_09.pdf](http://www.cms.hhs.gov/CreditableCoverage/Downloads/Updated_Guidance_01_01_09.pdf) (as visited Jan. 16, 2009), reproduced behind Appendix Tab 8.

‡ SSA §§ 1860D-13(b)(4) and (b)(5); 42 U.S.C. §§ 1395w-113(b)(4) and (b)(5), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR § 423.56(c).

## F. What Is a “Group Health Plan” for Purposes of the Disclosure Requirement?

As described in subsection E, entities providing prescription drug coverage through group health plans must disclose to Part D eligible individuals and to CMS whether coverage is creditable or non-creditable.<sup>94</sup> This requirement applies to employers sponsoring prescription drug coverage through group health plans, regardless of whether the employers are eligible for, or elect to apply for, the retiree drug subsidy.<sup>95</sup> Effectively, the disclosure requirement imposes a mandate on private-sector, employer-sponsored health plans providing drug coverage to Medicare beneficiaries who are retired or active workers.<sup>96</sup>

For disclosure purposes, group health plans generally include coverage provided to employees or retirees by the following entities: employers sponsoring group health plans under ERISA § 607(1); certain account-based medical plans; MEWAs; unions, churches, and federal, state, and local governments providing health coverage for employees or retirees; the Department of Veterans Affairs with respect to group health plans sponsored for employees or retirees; military coverage, including TRICARE; and qualified retiree prescription drug plans.<sup>97</sup> These health plans are described below.

### 1. Employers Offering Prescription Drug Coverage Through Group Health Plans Under ERISA § 607(1)

#### a. Employee Welfare Benefit Plans Providing Medical Care

For purposes of the disclosure requirement, the term “group health plans” includes plans as defined in ERISA § 607(1) (known as the COBRA definition),<sup>98</sup> which provides as follows:

The term “group health plan” means an employee welfare benefit plan providing medical care (as defined in section 213(d) of the [Code]) to participants or beneficiaries directly or through insurance, reimbursement, or otherwise. Such term shall not include any plan substantially all of the coverage under which is for qualified long-term care services (as defined in section 7702B(c) of such Code).

<sup>94</sup> SSA § 1860D-13(b)(6); 42 U.S.C. § 1395w-113(b)(6), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR §§ 423.56(c) and (e).

<sup>95</sup> See Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193, 4227 (Jan. 28, 2005). See also *Medicare Modernization Act Entities Required to Provide Disclosure to All Medicare Eligible Individual [sic]*, available at <http://www.cms.hhs.gov/CreditableCoverage/Downloads/entitiesrequiredtoprovidedisclosure.pdf> (as visited Jan. 16, 2009).

<sup>96</sup> Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193, 4456 (Jan. 28, 2005).

<sup>97</sup> SSA §§ 1860D-13(b)(4), (b)(5) and (b)(6); 42 U.S.C. §§ 1395w-113(b)(4), (b)(5) and (b)(6), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); 42 CFR §§ 423.4, 423.56(a), (b) and (c), and § 423.882. The preamble also notes that since the definition of group health plan in SSA § 1860D-22(c) includes ERISA plans, this “may include an FSA, MSA and, in limited circumstances, an HSA.” Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193, 4242 (Jan. 28, 2005). However, in subsequent guidance, CMS confirmed that health FSAs, MSAs, and HSAs do not need to send disclosure notices—see subsection F. See also *Medicare Modernization Act Entities Required to Provide Disclosure to All Medicare Eligible Individual [sic]*, available at <http://www.cms.hhs.gov/CreditableCoverage/Downloads/entitiesrequiredtoprovidedisclosure.pdf> (as visited Jan. 16, 2009) and *Treatment of Account-Based Health Arrangements Under the Medicare Modernization Act*, reproduced behind Appendix Tab 8.

<sup>98</sup> SSA § 1860D-13(b)(4)(C); 42 U.S.C. § 1395w-113(b)(4)(C), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR §§ 423.4 and 423.882.

An employee welfare benefit plan, in turn, is:

any plan, fund or program...established or maintained by an employer...to the extent that such plan...was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise...medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability [or other enumerated benefits].<sup>99</sup>

Thus, for purposes of the ERISA § 607(1) definition, group health plans are a subset of ERISA welfare plans. The ERISA definition has three elements: (1) a plan, fund, or program (2) established or maintained by an employer (3) for the purpose of providing medical care. If an employer's prescription drug plan meets that definition, then that arrangement will be treated as a group health plan even if the plan isn't otherwise subject to ERISA or COBRA.<sup>100</sup> Both insured and self-insured plans may qualify.

**Is a Plan That Qualifies for an Exception Under ERISA or COBRA Exempt From the Disclosure Requirement?** No, not if the plan otherwise meets the ERISA § 607(1) definition. As described in the rest of this subsection F, disclosure notices must be provided by governmental and church plans (even though they would ordinarily be exempt under ERISA) and there is no small employer exception (unlike under COBRA).

#### **b. Examples of Prescription Drug Coverages That May Qualify as Group Health Plans**

There are many types of group health plans under ERISA § 607(1), but only those that offer prescription drug coverage are subject to the disclosure requirement.

**What Drugs Can Be Included in Determining Whether an Employer's Prescription Drug Coverage Is Actuarially Equivalent to the Part D Benefit?** CMS staff members have informally indicated that the employer can only include drugs that are covered by Part D\* in determining actuarial equivalence. Foreign drugs, over-the-counter (OTC) drugs, and experimental drugs can't be included in the calculation.<sup>†</sup>

\* 42 CFR § 423.464(f)(2). "Covered Part D drugs" are Part D drugs that are included in a Part D plan's formulary. Both "covered Part D drugs" and "Part D drugs" are defined in 42 CFR § 423.100.

† *American Bar Association, Technical Session Between the Centers for Medicare and Medicaid Services and the Joint Committee on Employee Benefits, Q/A-4* (May 16, 2005), available at <http://www.abanet.org/jceb/2005/qa05cms.pdf> (as visited June 26, 2007).

The following are examples of health coverages that may qualify as group health plans under ERISA § 607(1) and may also provide prescription drug coverage—as discussed above, all such plans must be established or maintained by an employer and be for the purpose of providing medical care.

- *Health Insurance Plans, HMOs, and Self-Funded Health Plans.* If an employer provides health benefits through a group insurance policy, a health maintenance organization (HMO), or a self-funded plan, the plan can be a group health plan under ERISA § 607(1), even if employees pay 100% of the premium.<sup>101</sup>
- *Prescription Drug Plans.* Amounts paid for prescription drugs constitute "medical care" under Code § 213(d); thus, employer-maintained prescription drug plans are group health plans under ERISA § 607(1).
- *Dental and Vision Plans.* Such plans, if maintained by the employer, provide health care and therefore are group health plans. However, even if these plans provide prescription drug coverage (many don't), the coverage often won't meet the actuarial equivalence standard—see the text box at the end of this subsection F.1.
- *Cancer Policies.* Some cancer policies may be group health plans within ERISA § 607(1), but many aren't. For example, policies providing only a predetermined benefit without regard to the care provided or expenses incurred wouldn't be providing medical care; policies offered as part of a voluntary employee-pay-all program may not meet the "maintained" requirement.

<sup>99</sup> ERISA § 3(1).

<sup>100</sup> Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193, 4402 (Jan. 28, 2005).

<sup>101</sup> Treas. Reg. § 54.4980B-2, Q/A-1(a).

- *Individual Health Insurance Policies.* The types of medical insurance coverage discussed in the previous four bullets could be group health plans within the COBRA definition even if they are provided as individual (not group) policies.<sup>102</sup>
- *Health Reimbursement Arrangements (HRAs), Health FSAs, Health Savings Accounts (HSAs), and Medical Savings Accounts (Archer MSAs).* CMS has adopted special rules for these account-based medical plans. See subsection F.2.
- *Employee Assistance Plans (EAPs).* EAPs providing only referrals to employees needing medical treatment and that are staffed by untrained counselors probably won't be group health plans. But if the EAP is staffed by trained counselors who provide some medical care (including prescription drugs), then it may be a group health plan providing prescription drug coverage<sup>103</sup> subject to the disclosure requirement.

For more information about whether the above and other arrangements would meet the ERISA § 607(1) definition, see *COBRA: The Developing Law* (EBIA, 1990-present, updated quarterly) and *ERISA Compliance for Health & Welfare Plans* (EBIA, 1992-present, updated quarterly).

**Prescription Drug Coverage May Be Subject to the Disclosure Requirement (but Still Not Be Creditable).** Many of the above plans won't be creditable. Coverage is only creditable if it (1) is authorized in the statute and regulations (e.g., a group health plan under ERISA § 607(1)); and (2) has an actuarial value that equals or exceeds the actuarial value of "defined standard Part D prescription coverage"\* (the actuarial equivalence requirement). Some group health plans offering prescription drug coverage won't meet this requirement, because coverage is inadequate—for example, coverage less comprehensive than full pharmacy benefits (such as for specific disease-only drugs) likely wouldn't meet the actuarial equivalence test.† (See subsection I.) Sponsors of plans failing the test will have to provide non-creditable coverage disclosure notices.

\* SSA §§ 1860D-13(b)(4) and (b)(5); 42 U.S.C. §§ 1395w-113(b)(4) and (b)(5), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR §§ 423.56(a) and (b).

† Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193, 4226 (Jan. 28, 2005).

## 2. Account-Based Medical Plans and High-Deductible Health Plans (HDHPs) Offering Prescription Drug Coverage

**Bottom Line on Disclosure Notices.** HRAs generally have to provide disclosure notices; health FSAs, HSAs, and Archer MSAs don't have to provide them.\*

\* *Treatment of Account-Based Health Arrangements Under the Medicare Modernization Act* (Updated 12/29/05), reproduced behind Appendix Tab 8.

Under the regulations, the term "group health plans" for purposes of the disclosure requirement specifically includes "account-based medical plans."<sup>104</sup> The latter includes HRAs, health FSAs, HSAs, and Archer MSAs, to the extent that they are ERISA employee welfare benefit plans providing medical care (or would be subject to ERISA but for the ERISA § 4(b) exclusion for governmental or church plans).<sup>105</sup> HRAs

<sup>102</sup> Arrangements for individual medical insurance coverage that include employer contributions for any portion of premium payments or other employer involvement (such as making a cafeteria plan available for individual policies or participation by the employer in ongoing administration) may be group health plans for COBRA purposes. This may be so even if the arrangement covers one employee and even if the employer makes no contribution toward premiums. For more information, see *COBRA: The Developing Law* (EBIA, 1990-present, updated quarterly) and *ERISA Compliance for Health & Welfare Plans* (EBIA, 1992-present, updated quarterly).

<sup>103</sup> See DOL Advisory Opinion 88-04A (Mar. 11, 1988) (DOL concluded that an EAP provided medical benefits and was an ERISA welfare benefit plan). See also DOL Advisory Opinion 83-35A (June 27, 1983); and *In re General Motors Corp.*, 3 F.3d 980, 17 EBC 1001 (6th Cir. 1993) (EAP funded by employer, providing "counseling and related services for employees with problems such as those stemming from drug and alcohol abuse," and staffed by employer and union representatives was an ERISA welfare benefit plan).

<sup>104</sup> 42 CFR §§ 423.4, 423.56(b), and 423.882.

<sup>105</sup> SSA § 1860D-13(b)(4)(C); 42 U.S.C. § 1395w-113(b)(4)(C), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR § 423.4, 423.100 and 423.882. See also *Treatment of Account-Based Health Arrangements Under the Medicare Modernization Act* (Updated 12/29/05), reproduced behind Appendix Tab 8.

and health FSAs are usually treated as health plans by ERISA employers—HSAs and Archer MSAs generally aren't ERISA plans, unless they are treated as part of an ERISA group health plan.<sup>106</sup>

**a. Account-Based Medical Plans May Be Offered in Conjunction With HDHPs**

Account-based medical plans are often provided in conjunction with other health coverage that has high deductibles (high-deductible health plans or HDHPs). Participants can use funds from the accounts to pay for all or part of the expenses not covered by the HDHP. Regardless of whether an account standing alone is a group health plan, the HDHP associated with that account can qualify as a group health plan if it is contributed to or otherwise established or maintained by an employer.<sup>107</sup> Any HDHP that an employer provides in connection with HSAs and Archer MSAs is a group health plan.<sup>108</sup> Although account-based medical plans are often group health plans for disclosure purposes, they raise challenging questions with respect to the actuarial equivalence determination.<sup>109</sup> See subsection I regarding how to determine actuarial equivalence for HRAs.

**b. HRAs Can Be Creditable Coverage—Disclosure Notices Required**

HRAs can be creditable coverage on either a stand-alone basis or in conjunction with an HDHP. Consequently, HRA sponsors must provide notices to Part D eligible individuals advising whether the coverage provided through the HRA, either on a stand-alone basis or combined with an HDHP, is creditable.<sup>110</sup> Of course, the HRA would have to be a group health plan that offers prescription drug coverage—see subsection F. For information about how to determine whether HRA coverage is creditable, see subsection I.

**Participation in HRA and Another Group Health Plan.** CMS officials have informally stated that plan sponsors can issue a single, combined disclosure notice covering both an HRA and another group health plan offered by the same employer, if (1) the non-HRA plan is a non-account plan (such as an HDHP or a major medical plan); and (2) the Part D eligible individual participates in both the non-account plan and the HRA.\*

\* ABA Joint Committee on Employee Benefits, meeting with CMS officials, Q/A-5 (May 7, 2007), available at <http://www.abanet.org/jceb/2007/2007cms.pdf> (as visited June 30, 2008).

**c. Health FSAs Aren't Taken Into Account for Creditable Coverage—No Disclosure Notices Required**

Health FSAs aren't to be taken into account when determining whether coverage is creditable, since it is extremely difficult to make an actuarial determination of whether they provide creditable coverage. Consequently, employers won't have to send disclosure notices for them. However, disclosure notices would be required for HDHPs and other non-account benefits available to participants with health FSAs.<sup>111</sup>

**d. HSAs Aren't Taken Into Account for Creditable Coverage—No Disclosure Notices Required**

Under CMS guidance, HSAs aren't to be taken into account when determining whether coverage is creditable. Consequently, employers won't have to send disclosure notices for them. However, notices would be required for HDHPs and other non-account benefits available to participants with HSAs.<sup>112</sup>

<sup>106</sup> For information about HRAs, HSAs and Archer MSAs, see *Consumer-Driven Health Care* (EBIA, 2004-present, updated quarterly). For information about health FSAs, see *Cafeteria Plans* (EBIA, 1991-present, updated quarterly).

<sup>107</sup> *Treatment of Account-Based Health Arrangements Under the Medicare Modernization Act* (Updated 12/29/05), reproduced behind Appendix Tab 8.

<sup>108</sup> Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193, 4402 (Jan. 28, 2005). This assumes, of course, that the HDHP meets the ERISA § 607(1) definition of group health plan, which most HDHPs would.

<sup>109</sup> Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193, 4402 (Jan. 28, 2005).

<sup>110</sup> *Treatment of Account-Based Health Arrangements Under the Medicare Modernization Act* (Updated 12/29/05), reproduced behind Appendix Tab 8. For more information about HRAs and HDHPs, see *Consumer-Driven Health Care* (EBIA, 2004-present, updated quarterly).

<sup>111</sup> *Treatment of Account-Based Health Arrangements Under the Medicare Modernization Act* (Updated 12/29/05), reproduced behind Appendix Tab 8. Participants typically elect whether and how much to contribute in a year, resulting in a wide range of coverage levels. The actuarial value of a health FSA can't be determined prospectively, since an employer won't know in advance how much the Part D eligible individual will contribute and what portion will be spent on prescription drugs. For more information about health FSAs, see *Cafeteria Plans* (EBIA, 1991-present, updated quarterly).

<sup>112</sup> See *Treatment of Account-Based Health Arrangements Under the Medicare Modernization Act* (Updated 12/29/05), reproduced behind Appendix Tab 8. For more information about HSAs, see *Consumer-Driven Health Care* (EBIA, 2004-present, updated quarterly).

**Does Enrollment in Medicare Part D Affect HSA Eligibility?** Yes. An individual who is enrolled in Medicare Part D (or in any other Medicare benefit) is not an HSA-eligible individual in any month during which the individual is enrolled in Medicare. Similarly, an individual who is eligible for benefits under Medicare and is also enrolled to receive benefits under Medicare is not an HSA-eligible individual in any month in which those conditions occur. For more information about HSA-eligibility and Medicare, see *Consumer-Driven Health Care* (EBIA, 2004-present, updated quarterly).\*

\* Code § 223(b)(7); and IRS Notice 2008-59, Q/As-5 and -6.

**e. Archer MSAs Aren't Taken Into Account for Creditable Coverage—No Disclosure Notices Required**

Archer MSAs aren't to be taken into account when determining whether coverage is creditable. Consequently, employers won't have to send disclosure notices for them. However, notices would be required for HDHPs and other non-account benefits available to participants with Archer MSAs.<sup>113</sup>

**f. HDHPs Can Be Creditable Coverage—Disclosure Notices Required**

Under CMS guidance, although employers don't have to send disclosure notices to Part D eligible individuals with health FSAs, HSAs, and Archer MSAs, such notices would be required for HDHPs and other non-account benefits available to participants with these accounts, assuming they are group health plans that offer prescription drug coverage. (See subsection F.1 for details.) Because no contributions can be made to HSAs or Archer MSAs once the retiree becomes entitled to Medicare, HSAs and Archer MSAs can't be taken into account in determining whether an HDHP qualifies as creditable coverage.<sup>114</sup>

**3. Multiple Employer Welfare Arrangements (MEWAs) Offering Prescription Drug Coverage**

MEWAs that offer prescription drug coverage through group health plans for employees or retirees are subject to the disclosure requirement.<sup>115</sup>

**4. Collectively Bargained Plans Offering Prescription Drug Coverage**

Collectively bargained plans are group health plans for purposes of the disclosure requirement. These are plans providing medical care that are established or maintained under one or more collective bargaining agreements.<sup>116</sup> The disclosure requirement applies to unions that sponsor retiree coverage, regardless of whether they are eligible for or apply for the retiree drug subsidy.<sup>117</sup>

**5. Church Plans Offering Prescription Drug Coverage**

For purposes of the disclosure requirement, group health plans also include church plans. These are plans that provide medical care and that are established and maintained for employees or their beneficiaries by a church or by a convention or association of churches exempt from tax under Code § 501.<sup>118</sup>

**6. Federal, State, County, and Local Governmental Plans Offering Prescription Drug Coverage**

Group health plans include federal, state, county, and local governmental plans offering prescription drug coverage for employees or retirees. Such plans provide medical care and are established or maintained for employees by the U.S. government, the government of a state or political subdivision (e.g., counties), or by agencies such as the Federal Employees Health Benefits Plan (FEHBP).<sup>119</sup>

<sup>113</sup> See *Treatment of Account-Based Health Arrangements Under the Medicare Modernization Act* (Updated 12/29/05), reproduced behind Appendix Tab 8. For more information about Archer MSAs, see *Consumer-Driven Health Care* (EBIA, 2004-present, updated quarterly).

<sup>114</sup> *Treatment of Account-Based Health Arrangements Under the Medicare Modernization Act* (Updated 12/29/05), reproduced behind Appendix Tab 8. For more information about HDHPs, see *Consumer-Driven Health Care* (EBIA, 2004-present, updated quarterly).

<sup>115</sup> *Medicare Modernization Act Entities Required to Provide Disclosure to All Medicare Eligible Individual [sic]*, available at <http://www.cms.hhs.gov/CreditableCoverage/Downloads/entitiesrequiredtoprovidedisclosure.pdf> (as visited June 30, 2008).

<sup>116</sup> SSA § 1860D-13(b)(4)(C); 42 U.S.C. § 1395w-113(b)(4)(C), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR §§ 423.4 and 423.882.

<sup>117</sup> Preamble to Medicare Part D Regulations, 70 Fed. Reg. 4193, 4227 (Jan. 28, 2005). See also *Medicare Modernization Act Entities Required to Provide Disclosure to All Medicare Eligible Individual [sic]*, available at <http://www.cms.hhs.gov/CreditableCoverage/Downloads/entitiesrequiredtoprovidedisclosure.pdf> (as visited June 30, 2008).

<sup>118</sup> SSA § 1860D-13(b)(4)(C); 42 U.S.C. § 1395w-113(b)(4)(C), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR § 423.4 and 423.882. See also *Medicare Modernization Act Entities Required to Provide Disclosure to All Medicare Eligible Individual [sic]*, available at <http://www.cms.hhs.gov/CreditableCoverage/Downloads/entitiesrequiredtoprovidedisclosure.pdf> (as visited June 30, 2008).

<sup>119</sup> SSA § 1860D-13(b)(4)(C); 42 U.S.C. § 1395w-113(b)(4)(C), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); 42 CFR §§ 423.4 and 423.882. See also *Medicare Modernization Act Entities Required to Provide Disclosure to All Medicare Eligible Individual [sic]*, available at <http://www.cms.hhs.gov/CreditableCoverage/Downloads/entitiesrequiredtoprovidedisclosure.pdf> (as visited June 30, 2008).

### **7. Department of Veterans Affairs Offering Prescription Drug Coverage**

The disclosure requirement applies to Department of Veterans Affairs-sponsored group health plans that offer prescription drug coverage to Medicare eligible veterans, survivors, and dependents.<sup>120</sup>

### **8. Military Coverage, Including TRICARE, Offering Prescription Drug Coverage**

The disclosure requirement applies to military coverage, including TRICARE, that is sponsored through group health plans for active and retired Medicare eligible individuals.<sup>121</sup> See Section XXVII.

### **9. Certain Types of Group Health Plans Are Exempt From the Disclosure Requirement**

#### **a. Qualified Retiree Prescription Drug Plans (Coverage Offered by Part D Plans)**

Group health plans also include “qualified retiree prescription drug plans.”<sup>122</sup> Such plans offer “employment-based retiree health coverage” meeting certain requirements for Part D eligible individuals who are retired participants (or the spouses or dependents of such participants).<sup>123</sup> Employers contracting with Medicare directly as a Part D plan or contracting with a Part D plan to provide qualified retiree prescription drug coverage are exempt from the disclosure requirement.<sup>124</sup> See subsection E.3.

#### **b. Long-Term Care Plans**

The ERISA § 607(1) definition of “group health plans” excludes “any plan substantially all of the coverage of which is for qualified long-term care services (as defined in section 7702B(c))” of the Code.<sup>125</sup>

#### **c. Health FSAs, HSAs, and Archer MSAs**

As discussed in subsection F.2, health FSAs, HSAs, and Archer MSAs aren’t taken into account when determining whether coverage is creditable for the disclosure requirement.

## **G. Who Are the Part D Eligible Individuals Entitled to Disclosure Notices?**

Group health plans offering prescription drug coverage must disclose to all Part D eligible individuals enrolled in or seeking to enroll in the coverage and to CMS whether the prescription drug coverage is creditable.<sup>126</sup> A Part D eligible individual is an individual who (1) is entitled to benefits under Medicare Part A or is enrolled in Medicare Part B; and (2) lives in the service area of a Part D plan.<sup>127</sup> Both requirements are discussed in the following paragraphs.

<sup>120</sup> *Medicare Modernization Act Entities Required to Provide Disclosure to All Medicare Eligible Individual [sic]*, available at <http://www.cms.hhs.gov/CreditableCoverage/Downloads/entitiesrequiredtoprovidedisclosure.pdf> (as visited Jan. 16, 2009).

<sup>121</sup> *Medicare Modernization Act Entities Required to Provide Disclosure to All Medicare Eligible Individual [sic]*, available at <http://www.cms.hhs.gov/CreditableCoverage/Downloads/entitiesrequiredtoprovidedisclosure.pdf> (as visited Jan. 16, 2009).

<sup>122</sup> SSA § 1860D-13(b)(4)(C); 42 U.S.C. § 1395w-113(b)(4)(C), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR §§ 423.4 and 423.882.

<sup>123</sup> SSA § 1860D-22(a)(2); 42 U.S.C. § 1395w-122(a)(2), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); and 42 CFR § 423.882. “Employment-based retiree health coverage” means health insurance or other coverage of health care costs (whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation) for Part D eligible individuals (or for such individuals and their spouses and dependents) under a group health plan based on their status as retired participants in such plan. SSA § 1860D-22(c)(1); 42 U.S.C. § 1395w-122(c)(1), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); 42 CFR § 423.882.

<sup>124</sup> *Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance*, available at [http://www.cms.hhs.gov/CreditableCoverage/Downloads/Updated\\_Guidance\\_01\\_01\\_09.pdf](http://www.cms.hhs.gov/CreditableCoverage/Downloads/Updated_Guidance_01_01_09.pdf) (as visited Jan. 16, 2009), reproduced behind Appendix Tab 8; 42 CFR §§ 423.56(c) and (e).

<sup>125</sup> SSA § 1860D-13(b)(4)(C); 42 U.S.C. § 1395w-113(b)(4)(C), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); 42 CFR §§ 423.4 and 423.882.

<sup>126</sup> SSA § 1860D-13(b)(6); 42 U.S.C. § 1395w-113(b)(6), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); 42 CFR § 423.56.

<sup>127</sup> SSA §§ 1860D-1(a)(3) and 1860D-41(a)(4); 42 U.S.C. §§ 1395w-101(a)(3) and 1395w-141(a)(4), as added by Section 101 of the MMA, Pub. L. No. 108-173 (2003); 42 CFR §§ 423.4 and 423.30(a).