BlueCross BlueShield of North Carolina

An independent licensee of the Blue Cross and Blue Shield Association

August 22, 2022

RE: Creditable Coverage Testing Results for Plans Offered Starting January 1, 2023

Dear Group Administrator:

Medicare Part D Requirements for Groups

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a new prescription drug program to Medicare, referred to as "Part D." Prescription drug coverage under Medicare became available starting January 1, 2006. **The MMA created an ongoing notification requirement for groups, which applies to your group if any subscribers or dependents are eligible for Medicare, even if you don't offer retiree drug coverage.**

The requirement means groups that currently provide prescription drug coverage to Medicare beneficiaries must disclose whether the entity's coverage is "creditable prescription drug coverage" (Disclosure Notice). Generally, prescription drug coverage is creditable if, on average, it is at least as generous as Medicare prescription drug coverage. For more information on what it means for coverage to be "creditable," please see the Centers for Medicare & Medicaid Services (CMS) website referenced below.

If a Medicare beneficiary chooses not to enroll before the end of the initial enrollment period for Part D, and they do not have other coverage that is "creditable", they will pay a penalty (in the form of a higher premium) if they later enroll in Part D. Therefore, the notice of whether their coverage is creditable or not creditable is very important for someone deciding whether to sign up for a Medicare Prescription Drug Plan or to stay with their current coverage.

Disclosure Notice Responsibility

Employers that offer prescription drug coverage on a group basis are responsible for providing this Disclosure Notice to Medicare beneficiaries who are active employees and those who are retired, as well as Medicare beneficiaries who are covered as spouses under active or retiree coverage. Employers are also responsible for determining which of their members must receive this communication, as BCBSNC does not track which members are Medicare Eligible. The group may choose to satisfy this requirement by providing a notice to all employees.

When to provide:

Timing of Creditable Coverage Disclosure from Entity to Beneficiaries

The regulation specifies the times when creditable coverage disclosures must be made to Part D eligible individuals. At a minimum, disclosure must be made at the following times:

1. Prior to the Medicare Part D Annual Enrollment Period (AEP) – beginning October 15th through December 7th of each year;
2. Prior to an individual's Initial Enrollment Period (IEP) for Part D, as described under 423.38(a)
3. Prior to the effective date of coverage for any Medicare eligible individual that joins the plan;
4. Whenever the entity no longer offers prescription drug coverage or changes the coverage offered so that it is no longer creditable or becomes creditable; and
5. 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 to be met.

This guidance clarifies that "prior to" means that the beneficiary must have been provided the Disclosure Notice within the past twelve months.

Your group will continue to have an obligation to provide notification in subsequent years. Furthermore, the group must also provide a disclosure to CMS on an annual basis.

Steps to take:

1. Determine if your plan is creditable.
2. Communicate the status to eligible individuals at the appropriate times (if providing annual notice, this is prior to October 15 each year). Follow the guidelines found in the CMS Creditable Coverage Guidance. Note that you should *not* direct your members to call BCBSNC with questions about your Creditable Coverage notice.
3. Provide a disclosure to CMS on an annual basis

Included in this packet, you will find:

1. List of BCBSNC standard prescription drug plans and estimates of whether their status is Creditable, Non-Creditable, or Inconclusive
2. List of BCBSNC standard High Deductible Health Plans with integrated prescription drug benefit and estimates of whether their status is Creditable, Non-Creditable, or Inconclusive

We also recommend consulting the CMS website at http://www.cms.hhs.gov/CreditableCoverage/, for the following documents:

1. CMS Creditable Coverage Simplified Determination (updated guidance effective September 18, 2009)
2. CMS model letters for Creditable and Non-Creditable Coverage (a personalized model letter is available on the CMS website)
3. Disclosure to CMS Guidance and Instructions for Creditable Coverage (updated June 29, 2009)

Plans Evaluated and Methodology

Below, you will find details for BCBSNC's standard prescription drug plans and High Deductible Health Plans with integrated pharmacy benefits. A national actuarial consulting firm has reviewed the benefit plan designs, on behalf of BCBSNC.

A critical actuarial assumption in our consultant's analysis for plans that have an integrated medical and pharmacy benefit is that the employer plan is primary and Medicare is secondary. If the employer plan is secondary, then the benefit plans are less likely to constitute creditable coverage.

The evaluation of the creditability of BCBSNC's coverage is being provided by BCBSNC as a courtesy to our group customers. ***It is ultimately the employer group's responsibility to determine whether coverage under its plan(s) is creditable and to communicate this to Medicare eligible group members at the appropriate times***. You may wish to consult with benefits counsel or an actuarial firm to assist you further. You can find instructions for making this determination in the Creditable Coverage Simplified Determination document from CMS in the section titled *Benefit Designs for Simplified Determination of Creditable Coverage Status*. Neither BCBSNC nor our consultant is responsible for any loss or liability associated with your reliance on this evaluation of the creditability of your group's prescription drug coverage.

Creditable Coverage Determinations

Below we have provided a summary of our determination of BCBSNC plans that appear to meet Creditable Coverage. This is to be used as a general guidance, with the employer group taking responsibility of final determination, if a specific design cannot be found in the more detailed lists provided in the appendix to this letter.

ACA Qualified Health Plans:

Creditable coverage test results for all ACA Qualified Health Plans available to Individuals and Small Groups in 2023 can be found in Exhibits D1 through D2 in the Appendix.

Individual Non-ACA Plans:

All individual non-ACA plans except for our Value C/D product failed. See Exhibits A and D3 in the Appendix for more details on these plans.

Small Group Grandfathered and Transitional Plans:

All Small Group Grandfathered and Transitional plans passed. See Exhibit D4 in the Appendix for more details on these plans.

4 Tier Copay Plans (drugs subject to non-integrated deductible) (Exhibit B):

Any plan offered with tier 1 copayments at or below $10
AND tier 2 copayments at or below $45
AND tier 3 copayments at or below $60
AND tier 4 (specialty) coinsurance levels at or below 25% (member liability) subject to a $100 cap or less
AND drug deductibles at or below $300

--OR--

Any plan offered with tier 1 copayments at or below $15
AND tier 2 copayments at or below $40
AND tier 3 copayments at or below $80
AND tier 4 (specialty) copayments at or below $160
AND no drug deductibles

--OR--

Any plan offered with tier 1 copayments at or below $25
AND tier 2 copayments at or below $75
AND tier 3 copayments at or below $100
AND tier 4 (specialty) coinsurance levels at or below 50% (member liability) subject to a $200 cap or less
AND no drug deductibles

5 Tier Copay Plans (drugs subject to non-integrated deductible) (Exhibit B):

Any plan offered with tier 1 copayments at or below $10
AND tier 2 copayments at or below $25
AND tier 3 copayments at or below $40
AND tier 4 copayments at or below $80
AND tier 5 (specialty) coinsurance levels at or below 25% (member liability) subject to a $200 cap or less
AND drug deductibles at or below $300

--OR--

Any plan offered with tier 1 copayments at or below $10
AND tier 2 copayments at or below $25
AND tier 3 copayments at or below $45
AND tier 4 copayments at or below $60
AND tier 5 (specialty) coinsurance levels at or below 25% (member liability) subject to a $100 cap or less
AND drug deductibles at or below $300

--OR—

Any plan offered with tier 1 copayments at or below $15
AND tier 2 copayments at or below $45
AND tier 3 copayments at or below $85
AND tier 4 copayments at or below $105
AND tier 5 (specialty) coinsurance levels at or below 25% (member liability) subject to a $200 cap or less
AND no drug deductibles

--OR—

Any plan offered with tier 1 copayments at or below $20
AND tier 2 copayments at or below $35
AND tier 3 copayments at or below $45
AND tier 4 copayments at or below $90
AND tier 5 (specialty) coinsurance levels at or below 25% (member liability) subject to a $200 cap or less
AND no drug deductibles

--OR—

Any plan offered with tier 1 copayments at or below $25
AND tier 2 copayments at or below $50
AND tier 3 copayments at or below $75
AND tier 4 copayments at or below $100
AND tier 5 (specialty) coinsurance levels at or below 50% (member liability) subject to a $200 cap or less
AND no drug deductibles

--OR—

Any plan offered with tier 1 copayments at or below $10
AND tier 2 copayments at or below $30
AND tier 3 coinsurance levels at or below 75% (member liability) subject to a $100 cap or less
AND tier 4 coinsurance levels at or below 100% (member liability) subject to a $100 cap or less
AND tier 5 (specialty) coinsurance levels at or below 100% (member liability) subject to a $100 cap or less
AND no drug deductibles

--OR--

Any plan offered with tier 1 copayments at or below $25
AND tier 2 copayments at or below $75
AND tier 3 copayments at or below $100
AND tier 4 coinsurance levels at or below 25% (member liability) subject to a $100 cap or less
AND tier 5 (specialty) coinsurance levels at or below 25% (member liability) subject to a $100 cap or less
AND no drug deductibles

4 Tier $10 / % Coinsurance Plans (Exhibit B):

Any plan offered with tier 1 copayments at or below $10
AND subject to a per script limit (at any member coinsurance level) of $200 or less for tiers 2, 3, and 4
AND no drug deductibles

5 Tier $10 / % Coinsurance Plans (Exhibit B):

Any plan offered with tier 1 copayments at or below $10
AND subject to a per script limit (at any member coinsurance level) of $200 or less for tiers 2 and 3
AND subject to a per script limit (at any member coinsurance level) of $200 or less for tiers 4 and 5
AND no drug deductibles

--OR--

Any plan offered with tier 1 copayments at or below $10
AND subject to a per script limit (at any member coinsurance level) of $150 or less for tiers 2 and 3
AND subject to a per script limit (at any member coinsurance level) of $300 or less for tiers 4 and 5
AND no drug deductibles

High Deductible Health Plans (integrated drug plans) with Aggregate Deductibles (Exhibit C):

Any aggregate deductible plans with the following combination of individual and family out of pocket maximums, including any plan whose maximums are below one or both of any values of the listed combination:

Individual Out of Pocket Maximum	Family Out of Pocket Maximum
$1,500	$3,000
$2,000	$4,000
$2,500	$5,000
$2,700	$5,450
$2,750	$5,500
$3,000	$6,000
$4,000	$8,000
$5,000	$10,000
$5,500	$11,000
$6,000	$12,000

High Deductible Health Plans (integrated drug plans) with Embedded Deductibles (Exhibit C):

Any embedded deductible plans paired with deductible & coinsurance (with or without preventive generic covered) Rx plans that are *AT* the following INN member coinsurance *AND* also have deductible *AND* out of pocket maximums at or below the listed deductible/OOP values:

INN Member Coinsurance		Deductible	Out of Pocket Maximum
0%		$7,500	$7,500
10%		$6,000	$7,500
20%		$6,000	$7,500
30%		$6,000	$7,500
40%		$6,000	$7,500
50%		$6,000	$7,500

Any embedded deductible plans paired with 4-tier $10/100%/100%/100% (per Rx max of $100) Rx plans that are *AT* the following INN member coinsurance *AND* also have deductible *AND* out of pocket maximums at or below the listed deductible/OOP values:

INN Member Coinsurance		Deductible	Out of Pocket Maximum
0%		$7,500	$7,500
10%		$6,000	$7,500
20%		$6,000	$7,500
30%		$6,000	$7,500
40%		$6,000	$7,500
50%		$6,000	$7,500

Any embedded deductible plans paired with 5-tier $10/100%/100%/100%/100% (Tier 2/3 max of $100 and Tier 4/5 max of $250) Rx plans that are *AT* the following INN member coinsurance *AND* also have deductible *AND* out of pocket maximums at or below the listed deductible/OOP values:

INN Member Coinsurance		Deductible	Out of Pocket Maximum
0%		$7,500	$7,500
10%		$6,000	$7,500
20%		$6,000	$7,500
30%		$6,000	$7,500
40%		$6,000	$7,500
50%		$6,000	$7,500

Appendix: Creditable Coverage Testing Detail

Please see file "2023 Plans Group Creditable Coverage Letter Send to Sales Appendix.pdf"

Please note that this is not a comprehensive list of plans. The guidance provided above is recommended for all other plans not found in the Appendix.

While most of the plans at the levels described above passed the Creditable Coverage testing by a large margin, some may have passed at a fairly narrow margin. Our consultant has deemed these plans to pass for this plan year, but this determination could change in future plan years. All assessments of creditable coverage are based on several different factors and the assumptions used in this analysis. The employer group is responsible for making the final determination for their prescription drug benefits.

Coverage is considered to be "creditable" if the ratio of Blue Cross NC plan benefits to Medicare defined standard plan benefits is at least 100%. The majority of our plans passed at above 105%. Plans with an asterisk passed the Creditable Coverage testing by a narrower margin (of between 100% and 105%). Our consultant has deemed these plans to pass for both single and family contracts for this plan year, but this determination could change in future plan years. All assessments of creditable coverage are based on several different factors and the assumptions used in this analysis. The employer group is responsible for making the final determination for their prescription drug benefits.

HRA paired with an HDHP: If your group offers an HRA in conjunction with an HDHP, the amounts credited to the HRA in any given year will increase the expected amount of prescription drug claims payable. This means that an HRA contribution may favorably change the status of a plan. Please consult your benefits counsel to determine whether this impacts your group.

We appreciate your business and the opportunity to serve your group.

Sincerely,

Blue Cross and Blue Shield of North Carolina