2025 Changes - Medicare Part D Creditable Coverage

August 2024

Employers sponsoring any size group health plan that provides prescription drug coverage are not required to offer creditable coverage, but they are required to determine whether the prescription drug coverage is creditable and then must communicate creditable or non-creditable coverage status annually to eligible employees and their family members and to the Centers for Medicare & Medicaid Services (CMS).

Medicare Part D prescription drug coverage will expand in 2025 as required under the Inflation Reduction Act (IRA), which could impact whether an employer's group health plan provides creditable prescription drug coverage. The IRA legislation requires a phased approach aimed at lowering prescription drug costs for Medicare. Beginning in 2025, amongst other changes, out-of-pocket drug spending for Medicare Part D coverage will be capped at $2,000. This will increase the actuarial value of the coverage available via Medicare Part D. For this reason, plans that met creditable coverage status previously may no longer be creditable beginning in 2025, especially high deductible health plans (HDHPs). However, the simplified method will remain available for 2025, which may allow many plans to maintain creditable status in spite of the changes to Medicare Part D coverage.

Employers who offer prescription drug coverage need to be aware of the Medicare Part D changes, take the required steps to understand the creditable status of their prescription drug plan(s) for 2025, and then clearly communicate status to eligible employees and report status to CMS. If the creditable status of an employer's prescription drug coverage will change for the 2025 plan year, employers may want to communicate and educate in addition to what is set forth in the CMS model notice (e.g., perhaps a cover letter explaining who should care (Medicare Part D eligible individuals) and why creditable status matters).

Creditable Status – Why It Matters

Individuals become eligible for Medicare Part D (prescription drug coverage) upon enrolling in Medicare Part A, Medicare Part B, or both. Individuals who are merely eligible for Medicare, but not yet enrolled in Part A or B are not eligible for Medicare Part D. Individuals who are eligible for Medicare Part D can delay enrollment if they are enrolled in other creditable prescription drug coverage (e.g., through an employer-sponsored group health plan). However, an individual who delays Medicare Part D enrollment and goes 63 days or more without creditable prescription drug coverage may then face late enrollment penalties when the individual eventually chooses to enroll in Medicare Part D.

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TIP: Coordination of Benefits

Except for group health plan coverage sponsored by small employers (e.g., <20 employees for age-based Medicare), the employer's group health plan is the primary payer to Medicare for active plan participants (not for retirees or COBRA participants). Individuals could potentially have dual coverage under an employer's group health plan and Medicare, and might want to enroll in Medicare Part D in 2025 due to the richer coverage available, but because the employer's group health plan would be the primary payer, the individual may not receive the expected level of coverage from Medicare Part D. For this reason, especially if the employer's coverage is no longer creditable, individuals may be better off dropping the employer's group health plan coverage upon moving to Medicare Part D (and Part B if not already enrolled).

Employers are not required to offer creditable prescription drug coverage, but employers are required to determine and communicate creditable (or non-creditable) status to eligible individuals. The information assists Medicare Part D eligible individuals in making an informed decision about whether to enroll in Medicare Part D. In addition, reporting the information to CMS is required to help CMS determine when there might be other creditable coverage available to individuals who are eligible for Medicare.

When the employer's prescription drug coverage changes from creditable to non-creditable, the employer is required to notify eligible individuals (i.e., send a notice of non-creditable coverage). Upon the change in creditable status, a special enrollment right is triggered for Medicare Part D; individuals have 2 months from the loss of creditable status or notification of the change in creditable status, whichever is later. https://www.medicare.gov/basics/get-started-with-medicare/get-more-coverage/joining-a-plan/special-enrollment-periods

Determining Whether an Employer's Prescription Drug Coverage Is Creditable

Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard prescription drug coverage under Medicare Part D. In other words, coverage is creditable if the expected amount of paid claims for prescription drugs under the coverage is at least as much as the expected amount of paid claims under the standard Medicare Part D benefit.

TIP: Timing of Creditable Status Determinations

For employer-sponsored prescription drug coverage, creditable status determinations must be made upon plan renewal. For example, for an August – July plan year, creditable status based on the 2025 Medicare Part D changes must be determined for the plan that goes into effect in August 2025. Creditable status for the August 2024 – July 2025 plan year is tied to the 2024 Medicare Part D plan design.

Often an insurance carrier or third-party administrator (TPA) will provide information to a plan sponsor detailing whether a plan's drug coverage is creditable. But if a plan sponsor does not receive this information from the

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carrier or TPA, the plan sponsor (e.g., the employer) is responsible for making the determination, or for hiring an actuary to help with the determination.

If a plan sponsor is not applying for the retiree drug subsidy available to sponsors of a qualified retiree prescription drug plan, the sponsor can use a "simplified method" for determining whether the prescription drug coverage is creditable. If a plan does not meet the criteria under the simplified determination method, the employer could assume the plan is non-creditable. Alternatively, the employer could obtain an actuarial determination to confirm. Our understanding is that many carriers, TPAs and employers rely on the simplified method versus obtaining a formal actuarial determination. CMS has confirmed that the simplified method will continue to be available in 2025.

Simplified Method for Determining Creditable Status

To qualify for the simplified determination and be deemed creditable, the plan must meet the following criteria:

1. Cover brand-name and generic prescription drugs;
2. Provide reasonable access to retail providers;
3. Pay on average at least 60% of participants' prescription drug expenses; and
4. Depending upon whether the plan is integrated (i.e., the prescription drug benefit is combined with other coverage with a combined deductible and annual/lifetime maximums):
    - A non-integrated drug plan must satisfy at least one of the following standards:
        - Have either no annual benefit maximum or a minimum annual benefit of $25,000; OR
        - Have an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare-eligible individual.
    - An integrated plan must:
        - Have a maximum annual deductible of $250;
        - Have either no annual benefit maximum or a minimum annual benefit of $25,000; AND
        - Have a lifetime combined benefit maximum of at least $1 million.

See the simplified method description here – https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/CCSimplified091809.pdf.

CMS guidance indicates that the simplified method will continue to be available for 2025, but that it may be changed or no longer available beginning in 2026. See final Part D redesign program instructions here - https://www.cms.gov/files/document/final-cy-2025-part-d-redesign-program-instructions.pdf.

Analysis of the Simplified Method Requirements:

- Requirements #1 and #2 above are met by most employer's prescription drug plans.
- It is less clear whether Requirement #3 is met for most plans, especially HDHPs where participants may have to cover a significant portion of the drug cost prior to meeting the plan's deductible. The

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employer may need help determining whether the plan design will cover on average at least 60% of prescription drug coverage.

- For Requirement #4, there is an argument that most plans are NOT integrated, in which case most plans would meet this requirement due to not having a minimum or maximum annual benefit.
    - An integrated plan is any plan where the prescription drug benefits are combined with other coverage offered by the employer (e.g., medical, dental, vision) and the plan contains all of the following provisions: (a) a combined plan-year deductible for all benefits under the plan; (b) a combined annual benefit maximum for all benefits under the plan; and (c) a combined lifetime benefit maximum for all benefits under the plan.
    - Many plans have separate deductibles and benefit maximums in place for different benefits, in which case they would not meet this definition of integrated. In addition, for those plans with no annual or lifetime limits at all, it is unclear whether they would satisfy items (b) and (c), in which case the plan may not meet this definition of integrated.

Required Disclosure of Creditable Status to Eligible Participants

Detailed guidance from CMS on these disclosures can be found here - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/Updated_Guidance_09_18_09.pdf

Content of the Disclosure

Disclosures of creditable (or non-creditable) coverage must address the following:

- That the employer has determined that the prescription drug coverage is creditable (or non-creditable);
- The meaning of creditable coverage;
- That an individual generally may only enroll in a Part D plan from October 15 through December 7 of each year; and
- Why creditable coverage is important and that the individual could be subject to payment of higher Part D premiums if there is a break in creditable coverage of 63 days or longer before enrolling in a Part D plan.

CMS makes model notices available in both English and Spanish for purposes of the disclosure requirement. The model notices can be found on CMS' page here – https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Model-Notice-Letters.html

Guidance on completing the Notice of Creditable Coverage can also be found on our resources page here – https://www.benefitcomply.com/resources/wp-content/uploads/2022/09/MedicarePartDCreditableCoverage_ModelNotice_Sept2022.docx

Timing of the Disclosure

The notice is required to be provided to Medicare Part D eligible individuals at the following times:

1. Prior to commencement of the annual enrollment period for Medicare Part D (Oct. 15);

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2. Prior to an individual's initial enrollment period (IEP) for Medicare Part D;
3. Prior to the effective date of coverage for any Medicare Part D eligible individual who enrolls in the plan sponsor's prescription drug coverage;
4. Whenever the employer no longer offers prescription drug coverage or changes it so that it is no longer creditable or becomes creditable; and
5. Upon request by a Medicare Part D eligible individual.

TIP: Distribution Timing

The first three occasions use the term "prior to," which according to CMS means within the last 12 months, so the employer can meet the first three timing requirements by providing the notice at the following times:

- Each year during the employer's open enrollment period, or in late September/early October to coincide with the Medicare Part D open enrollment period; and
- When individuals are first eligible for the prescription drug coverage (e.g., new hires).

We recommend providing it during open enrollment each year for the upcoming plan year because creditable status needs to be determined annually when the plan renews, and such timing also avoids confusion for the employer and eligible individuals about which plan year is being labeled as creditable.

Who Is Entitled to Receive the Disclosure

The notice must be provided to Medicare Part D eligible individuals who are eligible to enroll in the plan sponsor's prescription drug plan. This includes employees, COBRA participants, and retirees, as well as their spouses and dependents. Individuals are eligible for Medicare Part D if they are enrolled in either Medicare Part A or Medicare Part B and live in the service area of a Medicare Part D plan. In other words, if somebody is both Medicare Part D eligible AND eligible to enroll in the plan sponsor's prescription drug plan, a notice is required. Since it may be difficult for a plan sponsor to identify which individuals are eligible for Medicare Part D (e.g., spouses or disabled dependents), many plan sponsors choose to provide the disclosure notice to everyone who is eligible to enroll in their prescription drug plan.

Method of Delivery for the Disclosure

When providing the notices, CMS prefers using paper documents because Medicare Part D eligible individuals are more likely to receive and understand them, and because it is easier to ensure that paper documents have been received by both employees and eligible spouses and dependents. However, the notices may be sent electronically in accordance with the Department of Labor's (DOL's) electronic delivery safe harbor for required ERISA disclosures (i.e., to those who have access to the employer's electronic system as an integral part of their daily duties at their regular workplace, and to those who provide consent to an electronic distribution). CMS has indicated that a plan sponsor providing a disclosure notice may generally provide a single notice to both the eligible individual and all his or her eligible dependents. However, a separate disclosure notice must be provided if the plan sponsor knows that any eligible spouse or dependent resides at a different address from the participant.

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If the notice is incorporated with other information or notices (such as a benefits booklet or enrollment packet), it is recommended that the disclosure be on its own page. In addition, CMS guidance suggests including a 14-point font prominent reference on the first page of the materials or guide listing the notice's specific page number.

Required Reporting of Creditable Status to CMS

In addition to the disclosure requirements to eligible individuals, plan sponsors of prescription drug plans are also required to report to CMS annually, within 60 days after the beginning of the plan year. For example, for a 2025 calendar year plan, the employer should report by early March 2025 on whether the coverage offered for 2025 is creditable or non-creditable. Note that this reporting requirement is also separate and distinct from the Medicare Secondary Payer reporting requirements under Section 111 that are due to CMS on a quarterly basis and typically handled by the insurance carrier or administrator. Reporting to CMS on the creditable status of the prescription drug coverage is generally not done by the insurance carrier or third-party administrator (TPA), but instead must be done by the employer. This reporting is done electronically. The instructions and online form for reporting creditable status to CMS can be found here - https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/CCDisclosure

How to Report

- CMS has provided detailed instructions that include screen shots. That document can be located here: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/Downloads/CreditableCoverageDisclosureUserManual05292012.pdf
- The electronic report can be found here - https://surveys.cms.gov/jfe/form/SV_6ilHtZUoAtl92n4

Information Needed to Complete the Reporting

General employer information – Employers should report using the name and federal ID number (EIN) of the plan sponsor. If multiple employers within a controlled group are covered under the same plan, the EIN for the parent company (or other entity if it is the plan sponsor) may be used under a single filing. If each individual entity reports separately, each should report using its own EIN. The EIN of the insurance carrier or third-party administrator should not be used.

Type of coverage – Most employers will choose "Group Health Plan: Employer Sponsored Plan," but there are also options for church plans and state and local government plans.

Plan option information – Employers must report the number of prescription drug options offered and the creditable or non-creditable coverage status for each (i.e., number of group health plan options offered with different prescription drug benefits).

Estimated number of Medicare Part D individuals covered under each plan – CMS will accept a reasonable estimate of how many Medicare-eligible individuals are expected to be covered under the plan. Remember that dependents can be Medicare-eligible, and eligibility may be based on age, disability, end-stage renal disease (ESRD), or amyotrophic lateral sclerosis (ALS). The form also asks how many Medicare-eligible individuals are expected to be covered by a retiree plan.

- If the employer offers retiree coverage, the employer should indicate how many Medicare-eligible individuals are expected to be covered by the retiree coverage.

- If the employer does not offer retiree coverage, “0” should be entered.

Date of creditable coverage notice distribution – The most recent date (MM/DD/YYYY) that the required annual creditable or non-creditable Medicare Part D Notice was distributed to participants.

Frequently Asked Questions for Reporting Creditable Coverage to CMS

Q. Is the disclosure to CMS tied to a group health plan’s plan year, policy year, or fiscal year?

A. The disclosure to CMS should be tied to the ERISA plan year, which may be different than the plan’s contract year with the carrier or the employer’s fiscal year. Ideally, the ERISA plan year is set forth in plan documentation.

Q. After submitting the online disclosure, I realized that I made a mistake. How can I correct that?

A. Fixing submission errors requires a new disclosure submission, which will override previous submissions.

Q. Due to turnover in HR, it appears the reporting was not done last year. Is there a way to find out if the disclosure was submitted to CMS for previous years?

A. We are not aware of any way to look up whether a plan has previously submitted this disclosure. A failure to report as required could result in a retiree plan attempting to receive the retiree drug subsidy being denied of the subsidy, but otherwise, there is no specific penalty for failing to report or being late to report to CMS. That being the case, as reporting is required, the recommendation is to report now (late) and going forward on a timely basis.

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