Issued date: 09/03/24

2025 Part D Changes and Employer Sponsored Group Health Plans

Employers are required to notify participants and beneficiaries who are Medicare Part D eligible individuals and the Centers for Medicare and Medicaid Services ("CMS") of the creditable or non-creditable status of the group health plan prescription drug plan(s).

Prescription drug coverage is creditable when the coverage is as good as (or better than) Medicare Part D. Coverage that is not as good as Medicare Part D is considered non-creditable.

As previously reported, the Inflation Reduction Act of 2022 ("IRA") changed aspects of the Medicare Part D program to enhance and improve Medicare Part D coverage. The changes include:

- A newly defined standard Part D benefit design consisting of three phases: annual deductible, initial coverage, and catastrophic coverage;
- A lower annual out-of-pocket ("OOP") threshold of $2,000;
- The sunset of the Coverage Gap Discount Program ("CGDP") and establishment of the Manufacturer Discount Program ("Discount Program"); and
- Changes to the liability of enrollees, Part D sponsors, manufacturers, and CMS in the newly defined standard Part D benefit design.

As a result of these changes, some employer sponsored prescription drug coverage may no longer qualify as creditable for the 2025 plan year. This will likely happen with certain high deductible health plans ("HDHPs") (with or without a Health Savings Account ("HSA") component) that may have been creditable before, but due to the change no longer are. It should be noted that many of these plans have been non-creditable in the past and there is no change due to the IRA.

Employers will need to be aware of any change in the creditable status of their prescription drug coverage and provide timely notification to participants and CMS. The following Q&As, which focus on compliance issues related to employers sponsoring group health plan coverage for active employees (and not for retirees) are intended to help employers understand the changes and obligations and serve as a refresher to current requirements.

Why does this change matter to employers?

All group health plans that offer prescription drug coverage are required to notify Medicare Part D eligible individuals (and CMS) of the creditable status of their group health plan coverage. Nothing has changed with respect to group health plans being required to notify Medicare Part D eligible individuals and CMS of creditable status, but these changes may cause certain plan options offered by employer (e.g., some HDHPs) that were creditable in a prior year to no longer be creditable for the first plan year in 2025.

Do employers have to offer a creditable prescription drug program?

No, it's not required and there are no penalties on the employer for not offering one. However, it's important to note that Medicare Part D eligible individuals who delay Medicare Part D enrollment and go without creditable coverage for 63 days will face higher prescription drug premiums when they later enroll in a Medicare Part D prescription drug plan.

When do these changes take effect?

The changes to the Part D program take effect in 2025 and employers should review whether the prescription drug plans are creditable or non-creditable for plan years that begin on or after January 1, 2025. For non-calendar year plans, the redetermination occurs effective with the first plan year that begins in 2025 (e.g., June 1, 2025, for a June 1 – May 31 plan year).

If the creditable status of the prescription drug coverage is changing, it's important to promptly communicate this to plan participants. Even if there is no change in the creditable (or non-creditable) status of the prescription drug coverage, there are still notification requirements that must be met each year.

How do we know if the coverage is creditable?

For fully insured plans, the carrier will typically disclose whether coverage is creditable or non-creditable.

For self-funded plans (including level-funded plans), the TPA or PBM may provide this information or offer tools to help support this determination. Note that some may charge for this service and some TPAs and PBMs will not help.

It is important to note that a determination of creditable coverage must be made for each benefit option. For example, you may offer a PPO plan that has creditable coverage and a HDHP/HSA option that provides non-creditable coverage.

How is creditable coverage determined?

A health plan's prescription drug coverage is considered creditable if the average value of prescriptions paid by the plan meets or exceeds the average value of those paid under standard Medicare Part D prescription drug coverage. CMS rules provide two methods to determine creditable coverage: the simplified method and an actuarial determination.

<u>Simplified method</u>

- Some plans may use the simplified determination of creditable coverage status to annually determine whether coverage is creditable or not. However, an HDHP/HSA plan cannot use the simplified method. Additionally, employers who participate in the Retiree Drug Subsidy Program cannot use this method.

- The simplified method remains available for 2025; however, this will be reevaluated by CMS for 2026.

- Under the simplified method, a prescription drug plan is deemed to be creditable if:
    - It provides coverage for brand and generic prescriptions;
    - It provides reasonable access to retail providers;
    - The plan is designed to pay on average at least 60% of participants' prescription drug expenses; and
    - It satisfies at least one of the following:
    - The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000;
    - The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual; or
    - For entities that have *integrated health coverage*, the integrated health plan has:
        - No more than a $250 deductible per year,
        - No annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000, and
        - No less than a $1,000,000 lifetime combined benefit maximum.

    Integrated health coverage is any plan of benefits 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:

    - A combined plan year deductible for all benefits under the plan,
    - A combined annual benefit maximum for all benefits under the plan, and/or
    - A combined lifetime benefit maximum for all benefits under the plan.

Actuarial determination

Generally, this can be determined through an actuarial equivalency test, requiring an actuary to be hired (but an actuarial certification is not required). Prescription drug coverage is creditable if the actuarial value of the coverage equals or exceeds the actuarial value of standard Medicare Part D prescription drug coverage. In general, this is determined by measuring whether the expected total of paid claims under the employer's drug program is at least as much as what is expected under the standard Part D program.

Who do we need to notify of creditable status?

Employers need to notify both participants and CMS.

Participants

Employers that provide prescription drug benefits are required to notify Medicare Part D-eligible individuals annually as to whether the employer provided benefit is creditable or non-creditable so that these individuals can decide whether or not to delay enrollment in a Medicare Part D prescription drug plan. Since most employers won't know who is a Part D eligible individual, employers should provide the notice to all plan participants.

Medicare Part D eligible individuals who go without creditable coverage for 63 days will face higher prescription drug premiums when they later enroll in a Medicare Part D prescription drug plan.

CMS

At least annually, employers must notify CMS as to whether prescription drug coverage is creditable or non-creditable.

When do we provide the participant notice?

Group health plans must notify Medicare Part D eligible individuals at the following times:

- Prior to (but no more than 12 months before) October 15th each year (or next working day);
- Prior to (but no more than 12 months before) an individual's Initial Enrollment Period for Part D (three months before the month of the person's 65th birthday);
- Prior to (but no more than 12 months before) the effective date of coverage for any Medicare eligible individual under the plan;
- Whenever prescription drug coverage ends or changes so that it is no longer creditable, or it becomes creditable; and
- Upon a beneficiary's request.

If the disclosure notice is provided to all plan participants annually, CMS will consider the first two bullet points satisfied. Many employers provide the notice in connection with the annual group plan enrollment period or immediately following the start of the plan year.

To satisfy the third bullet point, employers should also provide the participant notice to new hires and newly eligible individuals under the group health plan.

How do we notify participants?

There is flexibility in the form and manner employers can provide notices to participants. An employer may provide a single disclosure notice to a participant and his or her family members covered under the plan; however, the employer is required to provide a separate disclosure notice if it is known that a spouse or dependent resides at an address different from the address where the participant's materials were provided.

Mail: Mail is the recommended method of delivery and the method CMS initially had in mind when issuing its guidance.

Electronic Delivery: The employer may provide the notice electronically to plan participants who have the ability to access the employer's electronic information system on a daily basis as part of their work duties (consistent with DOL electronic delivery requirements).

If this electronic method of disclosure is chosen, the plan sponsor must inform the plan participant that the participant is responsible for providing a copy of the electronic disclosure to their Medicare-eligible dependents covered under the group health plan.

In addition to having the disclosure notice sent electronically, the notice must be posted on the entity's website, if applicable, with a link to the creditable coverage disclosure notice.

It is important to note that sending notices electronically may not always work for COBRA qualified beneficiaries who may not have access to the employer's electronic information system on a daily basis. Mail is generally the recommended method of delivery in such instances.

Open enrollment materials: If an employer chooses to incorporate the Part D disclosure with other plan participant information, the disclosure must be prominent and conspicuous. This means that the disclosure portion of the document (or a reference to the section in the document being provided to the individual that contains the required statement) must be prominently referenced in at least 14-point font in a separate box, bolded or offset on the first page of the provided information. CMS provides model notice letters that can be used to disclose the creditable or non-creditable coverage status of the plan per the requirements. Such letters, including Spanish versions, can be found at:

https://www.cms.gov/medicare/employers-plan-sponsors/creditable-coverage/model-notice-letters

When do we provide notice to CMS?

Employers also need to electronically notify CMS as to the creditable status of the group health plan prescription drug coverage. This notice must be provided by the following deadlines:

- Within 60 days after the beginning date of the plan year (March 1, 2025, for a 2025 calendar-year plan);
- Within 30 days after the termination of the prescription drug plan; and
- Within 30 days after any change in the creditable coverage status (January 31, 2025, for a 2025 calendar year plan with a change in creditable status).

It is important to note that if there is a change in the creditable coverage status that applies to the coverage effective in the new plan year, the employer should provide CMS notice within 30 days (not 60 days). While there is no penalty for late notice, it appears that the 30-day deadline applies. A calendar year plan that changed from creditable to non-creditable coverage (or vice versa) should notify CMS by January 31, 2025.

How do we notify CMS?

Notice must be submitted electronically by completion of a form found at:
https://www.cms.gov/medicare/employers-plan-sponsors/creditable-coverage/disclosure-form

What happens if one of the plans we offer is creditable for 2024 but not for 2025?

For example, if an employer offers both a PPO plan and an HDHP/HSA plan and both prescription drug plans provide creditable coverage for the 2024 plan year, but the HDHP/HSA will not be creditable for the 2025 plan year and the PPO remains creditable, below are steps an employer should consider:

- Offer non-creditable coverage. Decide whether to offer the HDHP/HSA plan with non-creditable prescription drug coverage. There is no penalty for offering a non-creditable coverage. Employers may want to consider whether the arrangement could be made creditable and, if so, how much it would cost.

  Individuals who are enrolled in Medicare can no longer make contributions to their HSA account, so Medicare Part D eligible individuals may be more likely to elect a coverage option that is not an HDHP/HSA. Some individuals eligible for Medicare may be able to delay enrollment in Medicare (and therefore not a Part D eligible individual). These individuals would be allowed to enroll in HDHP coverage and to make HSA contributions. If the prescription coverage is not creditable, the individual would not necessarily face higher prescription drug premiums when they later enroll in Medicare Part D. However, this will generally not be an option for those who have begun receiving Social Security benefits since Medicare enrollment is automatic for those taking Social Security benefits (no delay available).

- Advance notice of the change. Provide advance notice that the HDHP/HSA plan will be considered non-creditable coverage for the 2025 plan year and what this may mean for Part D eligible individuals. This can be done in an email to plan participants or other form of communication.

- Required Participant Notification. Timely provide the required Medicare Part D participant notice for the PPO plan (creditable coverage) and the HDHP/HSA plan (non-creditable coverage). The notice should be provided to all plan participants, including COBRA qualified beneficiaries and can be provided with the 2025 open enrollment materials, or just after the start of the plan year. It must be provided annually before October 15 each year. Because the prescription drug coverage in the HDHP plan changed from creditable to non-creditable, the notice should be provided within 60 days of the change (if not earlier).

- Required CMS Notification. Timely notify CMS of the creditable status of prescription drug coverage for the 2025 plan year. Because the HDHP/HSA plan is changing from creditable to non-creditable, notice should be provided within 30 days of the change, or by January 31, 2025. You can also timely disclose the creditable status of the prescription drug coverage for the PPO plan at this time.