Medicare Part D Creditable Coverage

In 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) added a voluntary prescription drug benefit to the Medicare program. The benefit, known as Medicare Part D or "Part D" is an optional program for Medicare beneficiaries to access covered prescription drugs at a lower cost. In 2022, the Inflation Reduction Act was signed, and set into motion changes to Part D benefits, with additional impact on employers in 2024 and 2025.

Group plan sponsors that provide prescription drug coverage to individuals who are eligible for coverage under Part D have reporting and disclosure requirements under the MMA. Part D eligible individuals are those eligible for Medicare A or B and include COBRA participants, retirees, covered spouses and dependents, and employees. Because the list of Medicare eligible individuals is broad, many employers choose to provide all participants with a Part D notice.

The reporting requirements apply to large and small plans and to self-funded and fully insured plans regardless of whether the plan pays primary or secondary to Medicare. There are no exceptions for church plans or government plans.

Employers with fully insured plans should review their contract to determine if the insurance carrier has chosen to take on the disclosure requirements through the contract. If they have not, the burden is on the employer, despite the plan's fully insured design.

Plans with reporting requirements include:

- Major medical plans, including HMO plans and self-funded plans, regardless of who pays the premium
- Prescription drug plans
- Dental and vision plans if they provide prescription drug coverage
- Cancer policies or specified illness policies if they are a group health plan under ERISA
- EAPs that provide prescription drugs in the course of medical care
- A Health Reimbursement Arrangement (HRA) that is paired with another plan, unless the non-HRA plan is a plan (such as an HDHP) and the Part D eligible individual participates in the HRA and non-account plan.

The two main reporting requirements that must be completed annually are:

- Annual written notices to all Medicare eligible individuals who are covered under the prescription drug plan, and
- Disclosure to the Centers for Medicare and Medicaid Services (CMS) whether the coverage is "creditable prescription drug coverage" through the CMS Creditable Disclosure webpage.

Disclosure to CMS

The disclosure to CMS form must be provided at the following times:

- Within 60 days after the beginning of the plan year for which the disclosure is provided;
- Within 30 days after the termination of the prescription drug coverage provided by the Plan; and
- Within 30 days after any change in the creditable coverage status of the prescription drug coverage provided by the Plan.

Notices to Medicare Eligible Individuals

Employers can use the model notices provided by CMS for participant notices. CMS has samples for both creditable and non-creditable coverage. There are five times that creditable coverage determinations must be provided to Part D eligible beneficiaries:

1. Prior to the Medicare Part D Annual Coordinated Election Period October 15 – December 7 of each year;
2. Prior to an individual's Initial Enrollment Period for Part D;
3. Prior to the effective date of coverage for any Medicare eligible individual who 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 request by the individual.

If the creditable coverage disclosure notice is provided to all plan participants annually prior to October 15 of each year, CMS will consider items 1 and 2 to be met. For example, if a calendar year plan distributes the Medicare Part D notice to plan participants as part of its open enrollment materials and to new hires throughout the year, it does not need to re-distribute the notice in September or October of the same year in which the notice applies.

What is Creditable Coverage?

Creditable coverage is coverage that provides "coverage of the cost of prescription drugs the actuarial value of which…to the individual exceeds the actuarial value of standard prescription drug coverage." In simplified terms, employer coverage is creditable if it is as good or better than what Medicare Part D would provide. Non-creditable coverage is not as rich as Part D coverage. Employers are not required to offer creditable coverage, but many wish to do so.

In 2022, President Biden signed the **Inflation Reduction Act** (IRA), which included provisions that impact drug prices for individuals enrolled in Medicare, as well as reducing what the federal government spends on prescription drugs. The IRA had bipartisan support. Components of the IRA cap certain out-of-pocket spending for Part D enrollees beginning in 2024, and limit cost sharing for insulin to $35, among other things.

Because of the IRA, Part D prescription drug benefits became richer to enrollees in 2024.

STANDARD MEDICARE BENEFIT COMPARISON

The impact of the IRA can be seen when you compare the 2023 standard Medicare benefit to the 2024 standard Medicare benefit:

STANDARD BENEFIT	2023	2024
Deductible	$505	$545
Initial Coverage Limit	$4,660	$5,030
Out-of-Pocket Threshold	$7,400	$8,000
Total Covered Part D Spending at OOP Threshold for non-applicable beneficiaries	$10,516.25	$11,477.39
Estimated Total Covered Part D Spending for Applicable Beneficiaries (2)(6)	$11,206.28	$12,447.11
Minimum Cost Sharing in Catastrophic Coverage Portion of the Benefit Generic/Preferred Multi-Source Drug	$4.15	Not applicable
Minimum Cost Sharing in Catastrophic Coverage Portion of the Benefit Other	$10.35	Not applicable

Table Source: Alera Group

Plans that are unable to determine their creditability with the safe harbor method must utilize an actuary to provide a determination.

For employer plans, coverage can be determined creditable through either a design-based safe harbor or through an actuarial equivalence determination provided by an actuary.

Many, but not all, insurance carriers, HMOs and TPAs for self-funded plans will perform the calculations to determine if a plan is creditable or not.

Under the design-based safe harbors, to be considered creditable, the plan must meet the following standards:

1. Coverage for brand-name and generic prescriptions;
2. Reasonable access to retail providers;
3. Designed to pay on average at least 60% of participants' prescription drug expenses; and
4. At least one of the following standards:
    a. Prescription drug coverage either has no annual benefit maximum or has a maximum annual benefit of at least $25,000;
    b. 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
    c. Integrated plans only, an integrated health plan:
        i. Has no more than a $250 deductible per year;
        ii. Either has no annual benefit maximum or has a maximum annual benefit payable by the plan of at least $25,000; and
        iii. Has a lifetime combined benefit maximum limit of at least $1 million.

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. Combined plan year deductible for all benefits under the plan,
2. Combined annual benefit maximum for all benefits under the plan, and
3. 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 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).

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Additional Changes Beginning in 2025

The IRA also outlined additional changes that will dramatically impact Medicare Part D benefits effective beginning in 2025. On April 1, 2024, CMS released Final Redesign Program Instructions for the Medicare Part D program that will be effective starting January 1, 2025.

The 2025 updates include:

- The lower annual out-of-pocket (OOP) threshold from $8,000 to $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, sponsors, manufacturers and CMS in the new standard Part D benefit design.

The new Medicare Part D benefits will change the creditable coverage determinations for plans starting in 2025. Employers should confer with their carriers/TPAs to know whether their coverage will remain creditability status when they renew in 2025. If the carrier/TPA is unable to make this determination for the plan and the plan does not meet the safe harbor requirements, our Alera Group Actuarial team can help make the determination for a fee.

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*STATISTICS ACCURATE AS OF MARCH 31, 2024.

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