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MEDICARE PART D CREDITABILITY DETERMINATIONS AND DISCLOSURES: A GUIDE FOR EMPLOYERS

Employers of all sizes and plan funding types (fully insured and self-insured) that sponsor group health plans have two separate annual compliance obligations regarding the creditable status of the employer's prescription drug plan(s) relative to Medicare Part D, which is Medicare's standard prescription drug coverage. One obligation is to their employees and the other is to the Centers for Medicare and Medicaid Services (CMS).

Employers must notify employees and their family members regarding the creditable status of their prescription drug plan(s) by each October 14, prior to the October 15 start of the annual Medicare open enrollment period. They must also disclose the creditable status of the plan(s) to CMS within 60 days after the start of the medical plan year (policy year or contract year, regardless of the ERISA plan year). Additional disclosure requirements apply when there is a change to the creditable status of an employer's prescription drug plan.

Plan sponsors that offer prescription drug coverage must disclose the plan's Medicare Part D creditable status to Medicare eligible individuals and their families by each October 14, and to CMS within 60 days after the start of the medical plan year.

NFP Observation:	Employers need to be aware of the impending changes to Medicare Part D owing to the impact of the Inflation Reduction Act of 2022 (IRA) on the value of Medicare Part D effective for plan years beginning in 2025. Specifically, some group health plans that were creditable relative to Medicare Part D in prior years may not be creditable in the future. Although the compliance obligations regarding confirming a plan's creditable status and making Medicare Part D disclosures have not changed, it is increasingly important for employers to understand the concept of Part D creditability and comply with the employee notice and CMS disclosure requirements related to their prescription drug plans.

This publication provides an overview of Medicare Part D creditability determinations and disclosure requirements and describes the process for achieving compliance. It emphasizes the renewed importance of confirming a prescription drug plan's creditable status and providing timely employee communications if the status changes in a future plan year. The publication includes background information about **Medicare Part D Creditability Testing: 2024 and Beyond** (Appendix A) and **Sample Employee Communications** to accompany the annual distribution of the Medicare Part D Creditable/Non-Creditable Coverage Disclosure Notice (Appendix B). It also includes a **Chart of CMS Disclosure Due Dates** (Appendix C), which fluctuate based on the plan year start date.

The publication also includes a high-level overview of employer obligations under the Medicare Secondary Payer (MSP) Act, with emphasis on the importance of directing employees to contact CMS regarding any Medicare enrollment questions or concerns. Further, it explains how Medicare eligible employees may be subject to Medicare Part D late enrollment penalties if they are enrolled in a group health plan that does not provide creditable prescription coverage.

The topics addressed in the publication appear in the following order:

MEDICARE PART D CREDITABILITY DETERMINATIONS

Creditable Versus Non-Creditable Coverage

Entities that offer prescription drug coverage (including employer-provided group health plans) must disclose to Medicare Part D eligible individuals and to CMS whether the coverage is "creditable" or "non-creditable." Creditable coverage is prescription drug coverage that is actuarially valued at or above the value of standard Medicare Part D coverage. In other words, creditable coverage is expected to pay – on average – at least as much as a standard Medicare Part D plan. Conversely, non-creditable coverage is expected to pay – on average – less than a standard Medicare Part D plan.

NFP Observation:	Sponsors of group health plans are not required to provide prescription drug coverage that is creditable. However, many employers recognize that offering at least one creditable plan may improve their ability to attract and retain employees who are Medicare eligible or who may have Medicare eligible dependents.

Determining Part D Creditability

Under many circumstances, such as for most plans with a prescription drug copay schedule, the creditable status of a plan's drug coverage can be determined by meeting a non-actuarial test developed by CMS to simplify creditability testing. At a high level, the Simplified Determination test deems a prescription drug plan creditable if the plan provides coverage for both generic and brand-name prescriptions, offers reasonable access to retail providers, is designed to pay on average at least 60% of participants' prescription drug expenses, and satisfies at least one of three additional criteria that can generally be ascertained using a self-service tool without the help of an actuary. For details of the Simplified Determination test, see Appendix A, **Medicare Part D Creditability Testing: 2024 and Beyond**.

Where the Simplified Determination criteria cannot be met, such as for some high deductible health plans (HDHPs), an actuarial analysis may be required. The analysis is often performed by the insurer for fully insured plans and may need to be performed by the plan sponsor for self-insured plans.

NFP Observation:	For fully insured plans, including fully insured HDHPs, the creditable status of the prescription drug coverage is generally confirmed by the insurer, either directly in writing or by providing employers with a testing tool that allows the end user to enter relevant plan design variables. Note that employer contributions to health savings accounts do not affect the creditable status of prescription drug plans but health reimbursement arrangements are factored into the determination.

Impact of the Inflation Reduction Act of 2022 on Medicare Part D Creditability

The Inflation Reduction Act of 2022 (IRA) includes several provisions that will reduce out-of-pocket (OOP) costs for Medicare enrollees effective January 1, 2025. Importantly for plan sponsors, these provisions will improve the Medicare prescription drug benefits available under a standard Part D plan such that some group health plan designs that were previously creditable will become non-creditable for plan years beginning on and after January 1, 2025.

Specifically, effective January 1, 2025, the IRA reduces cost-sharing for Part D participants to a true out-of-pocket maximum of $2,000. In 2025, Part D participants will pay 100% of the cost of medications until they reach their deductible of $590, then 25% of the cost of additional medications until they reach their total OOP maximum of $2,000. This IRA provision eliminates the coverage gap feature of Part D plans (also referred to as the "donut hole") that affects all Part D plans through the end of 2024.

NFP Observation:	Actuaries expect that IRA-related Part D improvements, which increase the actuarial value of Part D, will affect the creditable status of some prescription drug coverage under group health plans for plan years beginning on and after January 1, 2025. Initial calculations raised concerns that many HDHPs would lose creditable status. However, final CMS guidance removed manufacturer discounts from the actuarial value calculation, resulting in less of an increase to the final actuarial valuation of Part D. Consequently, actuaries now estimate that fewer plans will lose creditable status in 2025 than originally projected.

Additional provisions of the IRA that take effect January 1, 2026, and in future years include a phased implementation of reduced pricing for high-cost drugs as negotiated directly between Medicare and the drug manufacturers. These provisions are designed to yield further cost savings for Part D participants and are therefore expected to have a further impact on the creditable status of prescription drug coverage under certain group health plans. See Appendix A for details of the IRA implementation timeline, including a list of the 10 medications for which Medicare's reduced pricing commences January 1, 2026.

COVERED EMPLOYERS

The requirement of plan sponsors to disclose the plan's Medicare Part D creditable status to Medicare eligible individuals and to CMS applies to all group health plans that offer prescription drug coverage to Medicare eligible individuals. For these purposes, "group health plans" encompass any employee welfare benefit plan that provides medical care and prescription drug coverage, including health reimbursement arrangements (HRAs), but excluding qualified retiree prescription drug plans, long-term care plans, health flexible spending accounts (FSAs), health savings accounts (HSAs), and Archer medical spending accounts (MSAs). HRAs are generally integrated with the major medical plan, and employers can issue a single, combined Medicare Part D disclosure notice covering both an HRA and another group health plan sponsored by that employer, provided the recipients are eligible to enroll in both the HRA and the major medical plan (as is usually the case).

NFP Observation:	Individual coverage health reimbursement arrangements (ICHRAs) are group health plans that allow employers to reimburse employees or directly pay the cost of an employee's individual health insurance policy, Medicare premium, and/or other qualified medical expenses on a tax-advantaged basis. ICHRAs that exclusively reimburse or pay premiums (but not medical expenses) are not subject to Medicare Part D disclosure requirements. However, ICHRAs that reimburse or pay qualified medical expenses must provide a Part D notice to Medicare eligible individuals and must disclose the plan's creditable coverage status to CMS. Because employers cannot reasonably know the creditable status of qualified medical expenses reimbursed to an ICHRA beneficiary, a conservative best practice is to assume the coverage is non-creditable and to notify employees and disclose to CMS accordingly. Employers should strongly encourage ICHRA beneficiaries to confirm the creditable status of their individual coverage with the issuer, such as by including a recommendation to this effect at the top of the Medicare Part D notice.

Unlike some compliance requirements, the requirement to disclose a plan's Medicare Part D creditable status to Medicare eligible individuals and to CMS pertains regardless of employer size, plan funding type (i.e., fully insured or self-insured), or whether the plan is primary or secondary to Medicare. The disclosure requirement also applies to church plans and federal, state, and local government plans. For entities that are part of a controlled group and participate in the same plan, the requirement applies to the plan sponsor, not necessarily to each participating entity. For further information about benefits compliance considerations related to an entity's controlled group status, see the NFP publication **Health Benefits Compliance Considerations in Mergers and Acquisitions: A Guide for Employers**.

DISCLOSURE TO MEDICARE PART D ELIGIBLE INDIVIDUALS

Plan sponsors must notify Medicare Part D eligible individuals regarding the creditable or non-creditable status of the sponsor's prescription drug plan(s) by each October 14, i.e., prior to the October 15 start of the annual Medicare open enrollment period. Notices must be sent to all individuals eligible to participate in the employer's plan(s), including active, disabled, COBRA, and retired individuals (employees or former employees and dependents). CMS provides Model Notice Letters in English and Spanish for this purpose. The notices are intended to help Part D eligible individuals make informed and timely decisions about whether to enroll in a Medicare Part D plan and to compare the employer's coverage options with a Part D plan.

NFP Observation:	Although there is no explicit guidance regarding whether employers can use a single Medicare Part D notice to inform employees about multiple prescription drug plans that share the same creditable status (i.e., all plans are creditable or all plans are non-creditable), it appears that this is permissible. However, employers that offer more than one plan, or that offer plans with different creditable statuses, may need to complete separate Medicare Part D notices if different employee groups are eligible for different plans or if some employee groups are eligible for both creditable and non-creditable plans. Employers with multiple prescription drug plans must be especially attentive to this detail if any of their plans that are currently creditable become non-creditable in a future year.

Importance of Medicare Part D Notices to Eligible Individuals

Medicare eligible individuals who go without creditable coverage for a continuous period of 63 or more days at any time after the end of their initial enrollment period will be subject to a late enrollment penalty when they subsequently enroll in Part D. Because of this, it is critically important for plan sponsors to timely notify employees and their dependents about the creditable or non-creditable status of the employer's prescription drug coverage.

The Part D late enrollment penalty is based on the number of months an individual was Medicare eligible but did not have creditable prescription drug coverage, as explained in greater detail in the Medicare Part D Late Enrollment Penalties section below.

NFP Observation:	The importance of notifying employees about the creditable or non-creditable status of the employer's prescription drug coverage cannot be overstated. Medicare eligible individuals rely on the accuracy and timeliness of the employer's Medicare Part D notice to make informed decisions regarding their enrollment in Part D, including how to avoid Part D late enrollment penalties.

Effective Date of Medicare Part D Notice

While the CMS model notices for informing Part D eligible individuals about the creditable or non-creditable status of the employer's prescription drug plan(s) refer to "your current prescription drug coverage," it is generally understood that the notices logically refer to the status of the coverage as of the following January 1. This is the case regardless of the renewal date of the employer's plan(s), as January 1 corresponds to the effective date of all Medicare elections made in connection with the annual Medicare open enrollment period.

NFP Observation:	The creditable or non-creditable status of an employer's prescription drug plan(s) as determined for the start of the plan year remains constant for the duration of the plan year, assuming the employer does not make midyear changes to the plan design(s).

Change in Creditable Status

Employers whose plan years begin in December or January face unique employee communications challenges if they have not yet determined the creditable status of their prescription drug plan(s) for the forthcoming plan year by the deadline for distributing the annual Medicare Part D notice. If a prescription drug plan's creditable status as of the following January 1 is unknown when the annual Medicare Part D notice is distributed, which may occur if the plan design details for the forthcoming plan year have not

yet been confirmed or if the creditable status of a prescription drug plan has not yet been determined, employers should disclose the status of the then-current plan on the assumption that the status will remain unchanged. If the plan's creditable coverage status subsequently changes, employers must distribute a new Medicare Part D notice that reflects the changed status.

While CMS does not specify a precise deadline to provide a new Medicare Part D notice when a plan's creditable coverage status changes, employers should distribute the new notice as soon as possible to keep Medicare eligible plan participants adequately informed of plan changes that may significantly impact their decision to enroll in the employer's group health plan or in Medicare. See Appendix B for **Sample Employee Communications** to accompany distribution of Medicare Part D notices.

NFP Observation:	Employers are required to notify employees whenever there is a change to the creditable status of their prescription drug coverage and should do so as soon as possible after the status change is confirmed. Preferably, the new Medicare Part D notice should be distributed before the end of the employer's open enrollment period for the following plan year. For plan years starting on January 1, the new notice should ideally be distributed before the December 7 end of the Medicare open enrollment period.

Note that if a non-calendar year plan loses its creditable coverage status on a mid-calendar year date that doesn't otherwise coincide with the Medicare open enrollment period, Medicare eligible participants will have a Medicare special enrollment period during which they can enroll in a Part D plan without penalty. This special enrollment period runs for two months following the latter of the date creditable coverage is lost or the date the participant is notified that their current coverage is no longer creditable.

NFP Observation:	Cafeteria plan rules do not specifically address whether enrollment in Medicare Part D constitutes a midyear election change event, as the rules were adopted relevant to Medicare Parts A and B but before the advent of Part D and were not later revised to incorporate a reference to Part D. As a practical matter, however, Medicare eligible employees must minimally enroll in Medicare Part A to enroll in Part D, and Medicare entitlement (becoming both eligible for and enrolled in Medicare Part A or B) is a permissible midyear election change event that would allow an employee to drop coverage under their employer's plan.

Identifying Medicare Part D Eligible Individuals

Individuals become eligible for Medicare due to age, end-stage renal disease, or disability. Because employers cannot rely exclusively on an employee's age to determine the Medicare eligibility of the employee or that of any of the employee's dependents, employers should distribute the Medicare Part D notice(s) to all individuals who are eligible to participate in the employer's plan(s), including COBRA participants and retirees, regardless of age and regardless of enrollment status in any of the employer's plans.

Importantly, the notice distribution should include a directive to share the notice with any dependents who are eligible for Medicare. Employers must distribute the notice separately to any Medicare eligible spouse or dependent who, to the best of their knowledge, resides at a different address from where the notice is otherwise sent. See Appendix B for **Sample Employee Communications** to accompany the distribution of the Medicare Part D notice(s).

When Must the Medicare Part D Notice be Delivered?

Plan sponsors must provide the Medicare Part D notice at each of the following times:

- Annually by October 14 (prior to the October 15 start date of the Medicare open enrollment period).
  - October 14 is a fixed date deadline that is not extended to the next business day even if it falls on a weekend or federal holiday.
- Prior to an individual's Medicare Part D initial enrollment period (this is satisfied if the notice is provided annually by October 14).
- Prior to the effective date of the individual's coverage under the group plan.
- Upon a change in the plan's creditable coverage status.
- Upon termination of the plan's prescription drug benefit.
- Upon an individual's request.

Delivery of the Medicare Part D Notice

The Medicare Part D notice may be combined with other informational materials, such as open enrollment information or summary plan descriptions, provided the notice is "conspicuous and prominently presented." This means that the Medicare Part D notice, or a reference to the section that includes the notice, must be prominently referenced in at least 14-point font in a separate box and must be bolded or offset on the first page of the plan participant information being provided. Employers whose summary annual report (SAR) distribution deadline is close to the October 14 deadline for distributing Medicare Part D notices may distribute both required notices at the same time, provided each notice is separately accompanied by the appropriate employee communication. For further information about SAR notice requirements, see the NFP publication **Summary Annual Report: A Guide for Employers**.

Employers may distribute the Medicare Part D notice by hand, by mail, or by electronic delivery (e.g., email) in a manner that complies with the DOL's electronic disclosure safe harbor. In general, employers must "use measures reasonably calculated to ensure actual receipt of the material by plan participants, beneficiaries and other specified individuals." The DOL's safe harbor rules allow for electronic distribution to employees who have computer access as an integral part of their job (e.g., work email address or regular access to laptop/phone or other device).

Employees without computer access as an integral part of their job must consent to electronic distribution of notices (usually using a personal email address). While electronic delivery can include posting to an employer's intranet or benefits portal or sending via email (among other electronic means), these measures alone do not satisfy the DOL's distribution requirements. The employer must also notify employees that the notice has been posted and must describe the significance of the notice and the employee's right to request a paper copy.

Importantly, employers should routinely document all methods of delivery used for each required notice and should retain these records in accordance with the employer's record retention policy. In general, records related to ERISA plans should be retained for eight years. For more detailed information about electronic distribution rules, including a **Sample Employee Communication** and a **Sample Employee Consent to Receive Plan Disclosures**, see the NFP publication **Electronic Distribution Rules: A Guide for Employers**.

Additionally, since individuals choosing to enroll in Part D coverage may need to show that the employer's coverage was creditable in prior years to avoid a late enrollment penalty, employers should be prepared to assist employees who request copies of Medicare Part D notices for prior plan years.

NFP Observation:	The employer, as plan administrator and fiduciary, must be able to demonstrate compliance with Part D disclosure requirements. Therefore, employers should maintain accurate and accessible records of their Part D notice distributions to individuals and their disclosures to CMS. This will also ensure they are well prepared to assist employees who request copies of Medicare Part D notices for current or prior plan years.

MEDICARE SECONDARY PAYER RULES

At a high level, Medicare Secondary Payer (MSP) rules govern the coordination of benefits for participants in group health plans who are also entitled to (i.e., both eligible for and enrolled in) Medicare. Under the MSP coordination of benefits rules, the employer's group health plan is generally the primary payer of claims for active employees, whereas Medicare is generally the primary payer of claims for COBRA participants and retirees. Special rules apply to individuals with disease-based Medicare and to employers with fewer than 20 employees.

For employers with 20 or more employees (where the employer's group health plan is generally the primary payer), the MSP rules prohibit employers from offering Medicare eligible individuals financial incentives or other benefits to waive coverage in (or to disenroll from) the employer's group health plan (i.e., actions that would cause Medicare to be the primary payer). So, for example, employers should not offer to reimburse Medicare premiums for active employees or their spouses or dependents who are eligible for Medicare. Additionally, employers should ensure that their employee communications, including with respect to Part D creditable/non-creditable coverage notices, do not appear to encourage eligible individuals to enroll in Medicare. (See Appendix B, **Sample Employee Communications**.)

NFP Observation:	Employers with 20 or more employees must keep in mind the MSP rules when communicating with employees regarding the creditable or non-creditable status of the prescription drug coverage under their group health plan(s). MSP rules prohibit such employers from incentivizing eligible employees or their dependents to enroll in Medicare.

MEDICARE PART D LATE ENROLLMENT PENALTIES

Individuals who are turning 65 have a Medicare initial enrollment period that generally lasts for seven months, starting three months before the individual turns 65 and ending three months after the month in which they turn 65. Employers should not advise employees regarding Medicare enrollment and should instead routinely direct them to contact Medicare or their State Health Insurance Assistance Program (SHIP) for information about their specific enrollment opportunities, including the risk or dollar amount of late enrollment penalties for any part of Medicare.

SHIP is a network of trained volunteer counselors who educate and assist people with questions about Medicare. SHIP is sponsored by CMS, and its volunteers are not affiliated with any insurance agent or company and will not sell or solicit for insurance. For more information on SHIP, see the State Health Insurance Assistance Program site. Of course, some employees may prefer to work with a Medicare agent who can help them navigate and better understand their health coverage options.

NFP Observation:	Separate from the initial enrollment period, Medicare eligible employees who are enrolled in an employer's group health plan will have a Medicare special enrollment period during which they can enroll in Part D without penalty if the employer's plan loses its creditable coverage status on a mid-calendar year date that doesn't otherwise coincide with the Medicare open enrollment period. This special enrollment period runs for two months following the latter of the date creditable coverage is lost or the date the participant is notified that their current coverage is no longer creditable. Remember that Medicare eligible employees must minimally enroll in Medicare Part A to enroll in Part D.

Delaying Enrollment in Medicare Part D

Medicare eligible individuals who are enrolled in creditable prescription drug coverage under a group health plan can delay enrollment in Medicare Part D beyond their initial enrollment period without penalty for the duration of their enrollment in any such creditable coverage. However, Medicare eligible individuals who forgo enrollment in Part D during their initial enrollment period and who then go without creditable coverage for a continuous period of 63 or more days prior to enrolling in a Part D plan will be subject to a Part D late enrollment penalty when they subsequently enroll in Part D.

The Part D late enrollment penalty is based on the number of calendar months that the individual was Medicare eligible and did not have creditable prescription drug coverage. The penalty applies once the individual enrolls in Medicare Part D, and it remains in perpetuity (unless the individual qualifies under the Extra Help Program, which provides low-income subsidies).

The Part D late enrollment penalty is calculated as 1% of the "national base beneficiary premium" (a value calculated per a statutory formula and adjusted annually) times the number of months after their initial enrollment period the individual was not covered by a creditable plan. (The first 63 days after an individual's initial enrollment period are not included in the number of months without creditable coverage.) The Part D late enrollment penalty is added to the monthly cost of whatever Part D premium the individual otherwise elects, regardless of whether the individual elects a Part D plan that is more expensive or less expensive than the national base beneficiary premium. The actual costs of Part D plans vary widely and change from year to year.

Sample Part D Late Enrollment Penalty Calculation

For example, a Medicare-eligible individual who was without creditable coverage for 20 months prior to enrolling in a Part D plan in 2023 would have a Part D late enrollment penalty of $6.55 per month added to their Part D monthly premium for all months they were enrolled in Part D during 2023 (see the calculation illustration in the chart below). Their penalty would increase to $6.90 per month for all months of 2024 and to $7.36 per month for all months of 2025. The same individual's Part D late enrollment penalty for 2026 and thereafter would continue to be added to their Part D monthly premium in perpetuity based on future annual adjustments to the national base beneficiary premium.

Although changes to future national base beneficiary premiums cannot be predicted with certainty, the premium stabilization provision of the Inflation Reduction Act caps annual growth of this variable at 6% from 2024 through 2029. Indeed, the national base beneficiary premiums announced for 2024 and 2025 reflect a 6% increase over the previous year. The following chart illustrates the year-over-year calculation of the Part D late enrollment penalty amount based on the example in the previous paragraph.

		CY2023	CY2024	CY2025
a	National base beneficiary premium per month (actual)	$32.74	$34.70	$36.78
b	Number of months without creditable coverage following initial enrollment period	20	20	20
c	Part D late enrollment penalty percentage (b x 1%)	20%	20%	20%
d	Part D late enrollment penalty amount per month (a x c, rounded to nearest $0.10)	$6.55	$6.90	$7.36

Additional Information for Medicare Eligible Individuals

For employees and their dependents who are Medicare eligible, the decision whether to obtain prescription drug coverage through Medicare Part D and/or an employer-sponsored group health plan can be complex. This is particularly true with the impact of the IRA on the value of Medicare Part D plans effective January 1, 2025. Employees will need to evaluate their individual and family needs for the full spectrum of healthcare benefits beyond just prescription drug coverage. There are numerous factors to consider, including the following:

- The creditable status of the available group health plan(s).
- The MSP coordination of benefits rules (i.e., whether Medicare or the employer's plan is the primary payer of claims).
- The application of the respective deductibles, coinsurance, and out-of-pocket maximums under the group coverage and Medicare.
- The relative scope and size of participating healthcare providers and pharmacy networks.
- The impact of Medicare enrollment on an employee's eligibility to make or receive contributions into an HSA.

NFP Observation:	While it is important for employers to recognize how the Medicare Part D creditable/non-creditable status of their plan's prescription drug coverage affects Medicare eligible employees (and enrolled dependents), MSP rules prohibit employers from incentivizing employees to drop employer-sponsored coverage. Importantly, employers should not advise individual employees regarding whether or when they should enroll in Medicare, including Part D. Employers should instead direct employees to contact CMS or their State Health Insurance Assistance Program (SHIP) about their specific circumstances, including the risk or dollar amount of late enrollment penalties for any part of Medicare.

DISCLOSURE TO CMS

In addition to notifying Medicare Part D eligible individuals of the creditable status of the prescription drug coverage under the group health plan(s), plan sponsors must disclose to CMS whether the prescription drug coverage offered through their group health plan(s) is creditable, non-creditable, or (if they sponsor more than one plan) includes both creditable and non-creditable coverage. The CMS disclosure is required regardless of whether the plan sponsor's prescription drug coverage is primary or secondary to Medicare.

As part of the CMS disclosure, plan sponsors must also report the number of Part D eligible individuals expected to be covered by the plan(s) at the start of the plan year for which the disclosure is being made. An estimate of this number, such as one based on the total number of covered individuals who were age 65 or older at the start of the plan year, may be used if the insurance carrier or third-party administrator cannot provide an exact headcount. The total should include Medicare eligible active, disabled, COBRA, and retired individuals (employees or former employees and dependents) covered under the employer's plan(s) at the start of the plan year.

The disclosure to CMS for each new medical plan year must be completed annually within 60 days following the start of that plan year. (See Appendix C, **Chart of CMS Disclosure Due Dates**.) Plan sponsors must also file a Disclosure to CMS Form within 30 days of any change to the creditable or non-creditable status of the then-current plan's prescription drug coverage, whether due to the plan sponsor's discretionary plan design changes or non-discretionary changes to the value of a standard Medicare Part D plan (such as changes that will take effect for plan years beginning on and after January 1, 2025, as part of the Inflation Reduction Act).

Plan sponsors must complete the Disclosure to CMS Form via the CMS website. The CMS disclosure must be signed (electronically) by an "entity's authorized individual," which is typically the Human Resources director or their designee. The signatory must be an employee of the plan sponsor or someone contracted by the plan sponsor to complete the disclosure on the plan sponsor's behalf.

For a full copy of the Creditable Coverage Notice to CMS Guidance, including details on which entities must provide the disclosure to CMS, see CMS's Disclosure to CMS Guidance and Instructions.

PENALTIES AND CORRECTIVE MEASURES

CMS does not currently have any specific enforcement measures or penalties for failing to complete the CMS disclosure or provide the Medicare Part D creditable/non-creditable coverage notices, except that employers that fail to complete both requirements will be unable to claim retiree drug plan subsidies.

Importantly, however, the DOL requires ERISA plan fiduciaries to administer their plans in accordance with federal laws. Thus, an employer's failure to accurately determine and disclose their plan's Part D creditable coverage status may be considered a fiduciary violation. A notice failure may also harm employee relations, particularly if the employer's coverage is not creditable and a covered individual is later assessed an unanticipated Part D late enrollment penalty. For further information about fiduciary duties of plan sponsors, see the NFP publication **ERISA Compliance Considerations for Health and Welfare Benefit Plans**.

NFP Observation:	A plan sponsor's fiduciary duties under ERISA include a responsibility to issue timely and accurate Medicare Part D notices of creditable/non-creditable coverage. A Medicare eligible individual who suffers a penalty in perpetuity for a delayed Part D enrollment could pursue an ERISA remedy if the employer neglected to provide a timely and accurate notice of the creditable/non-creditable status of the group health plan's prescription drug coverage.

Employers that previously failed to make either or both of the required Medicare Part D disclosures – the notice to Medicare eligible individuals or the disclosure to CMS – should make the most recently missed disclosure(s) as soon as possible and ensure that they make future disclosures in a timely manner going forward. Employers should consult with legal counsel regarding any prior compliance failures.

SUMMARY

Employers that sponsor group health plans that include prescription drug coverage should be closely attentive to the Medicare Part D disclosure rules that pertain respectively to Medicare eligible individuals and to CMS. To discuss your Medicare Part D compliance obligations and other aspects of your employee benefits program, or for copies of NFP publications, contact your NFP benefits consultant. For further information regarding NFP's full range of consulting services, see **NFP.com**.

RESOURCES

Creditable Coverage Guidance

Disclosure to CMS Guidance and Instructions

Disclosure to CMS Form

Model Notice Letters

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APPENDIX A

Medicare Part D Creditability Testing: 2024 and Beyond

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (also called the Medicare Modernization Act or MMA) requires entities that offer prescription drug coverage (including employer provided group health plans) to disclose to Medicare Part D eligible individuals and to CMS whether the coverage is "creditable" or "non-creditable." In the past, up through and including plan years beginning in 2024, most plans were considered creditable, either as determined under CMS's Simplified Determination criteria or as determined through actuarial analysis. Notable exceptions included plans that exclusively covered prescriptions for generic drugs (i.e., no coverage for brand name drugs) or certain high deductible health plans.

The Inflation Reduction Act of 2022 (IRA), which will continue to be implemented over the next several years, includes several provisions that will reduce out-of-pocket (OOP) costs for Medicare enrollees (herein "members"). These provisions are noted in the Inflation Reduction Act Medicare Part D Implementation Timeline section below. Importantly for plan sponsors, the specific IRA provisions that take effect January 1, 2025, will improve the Medicare prescription drug benefits available under a standard Part D plan such that some group health plan designs that were previously creditable will become non-creditable for plan years beginning on and after January 1, 2025.

CMS Simplified Testing

To make creditability testing easier, CMS developed a non-actuarial test known as the Simplified Determination. This testing deems a prescription drug plan creditable if the plan:

1. Provides coverage for brand and generic prescriptions.
2. Provides reasonable access to retail providers.
3. Is designed to pay on average at least 60% of participants' prescription drug expenses.
4. Satisfies at least one of the following (if a plan has an integrated deductible, the plan must satisfy Item C):
    A. The prescription drug coverage has no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000.
    B. The prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 per Part D eligible individual.
    C. For entities that have integrated health coverage (prescription drug coverage is combined with other coverage like medical), the integrated health plan has no more than a $250 deductible per year, has no annual benefit maximum or a maximum benefit payable by the plan of at least $25,000, and has no less than a $1,000,000 lifetime combined benefit maximum.

In its final guidance,[1] CMS has allowed for the Simplified Determination to be used for 2025 under the same guidelines as originally published in 2009. If the Simplified Determination continues beyond 2025, it is likely that it will be altered to account for the increase in the value of Medicare Part D. Specifically, the requirement for the value of the plan (Item 3 above) is likely to be increased above 60% since the value of Medicare Part D will increase.

1. Centers for Medicare and Medicaid Services. Final CY 2025 Part D Redesign Program Instructions, CMS.gov, 2024.

Inflation Reduction Act Medicare Part D Implementation Timeline

The IRA will continue to be implemented over the next several years. The timeline below lists in chronological order some of the material IRA changes to the standard Part D benefit, with special emphasis on the changes effective January 1, 2025. Note that the member cost-sharing reduction effective January 1, 2025, increases the value of Medicare Part D and therefore will have the greatest impact to date on creditability testing.

2023

- Requires drug companies to pay rebates to Medicare if a drug price increases more than inflation.
- Removes deductible for insulin products and limits cost-sharing for insulin to $35.
- Eliminates cost-sharing for adult vaccines.

2024

- Eliminates cost-sharing in the catastrophic coverage layer (i.e., after the OOP maximum is met).
  - Prior to 2024, members paid the greater of 5% or $4.15 for generic drugs and $10.35 for all other drugs.
  - In 2024, cost-sharing will be $0 once member hits the $8,000 OOP maximum.
- Expands eligibility for full benefits under the Extra Help Program.

2025

- Reduces cost-sharing for members to a true OOP maximum of $2,000.
  - Members will pay 100% of the cost of medications until they reach their deductible of $590, then members will pay 25% of the cost of medications until they reach their total OOP maximum of $2,000.

2026

- Requires implementation of negotiated prices for 10 high-cost drugs (see explanation below).
  - 15 more drugs will be added in 2027 and 2028, then 20 more in 2029 and 2030.

Which Medications Will Medicare Negotiate Pricing for Directly with the Manufacturer?

On August 29, 2023, HHS announced the first 10 medications for which Medicare will negotiate reduced pricing. These 10 medications cost Medicare Part D members $3.4 billion in OOP costs in 2022.[2] Negotiations for these medications will occur in 2023 and 2024, with the resulting negotiated pricing taking effect in 2026. The 10 medications are:

- Eliquis
- Jardiance
- Xarelto
- Januvia
- Farxiga
- Entresto
- Enbrel
- Imbruvia
- Stelara
- Fiasp; Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill

2. US Department of Health and Human Services. HHS Selects the First Drugs for Medicare Drug Price Negotiation, HHS.gov, 2023.

Guidance regarding how the negotiated pricing will impact creditability testing for 2026 has yet to be published. It is possible that this improvement to Medicare Part D will add some complexity for actuarial testing. Today, testing essentially asks whether the expected amount paid by the plan is greater than the expected amount paid by Medicare Part D. However, since Medicare will soon be able to negotiate prices for these particular drugs and could potentially receive preferential pricing compared to employer-based plans, the gross expected costs for members will be different under Medicare Part D and employer-sponsored plans. Accordingly, the industry is monitoring for additional guidance to address the effect of the pricing changes on 2026 creditability testing.

Planning for 2026 and Beyond

Prospectively, employers should determine their utilization of the medications that are subject to future price negotiation. The Part D creditability testing will likely be more complex for plans with higher utilization of those medications. However, CMS has not yet released specific guidance with respect to the 2026 creditable coverage determinations, so employers will need to monitor for further updates.

APPENDIX B

Sample Employee Communications

Appendix B includes two separate sample employee communications to facilitate distribution of the required Medicare Part D Creditable/Non-Creditable Coverage Disclosure Notice to Medicare eligible employees and their dependents.

- **Sample 1: Sample Employee Communication for Creditable Coverage**
- **Sample 2: Sample Employee Communication for Non-Creditable Coverage**

Sample 1: Sample Employee Communication for Creditable Coverage

The attached/enclosed Medicare Part D Creditable Coverage Disclosure Notice contains important information about our company's prescription drug coverage and your options under Medicare's prescription drug coverage (Medicare Part D) effective January 1, **[YYYY] [Insert the calendar year variable for the forthcoming calendar year.]**

We have confirmed that prescription drug coverage offered under our prescription drug plan(s) is, on average for all plan participants, expected to pay out at least as much as standard Medicare Part D coverage. Prescription drug coverage under our plan(s) is therefore considered **creditable coverage**.

> **IMPORTANT: Note that the status of our company's prescription drug coverage for the above-referenced year has changed from our prior Medicare Part D Notice. Medicare eligible individuals should review the Notice carefully. [Include this paragraph only if the company's prescription drug coverage changed from non-creditable to creditable coverage since the distribution of the most recent prior Notice.]**

You are responsible for providing a copy of the Medicare Part D Creditable/Non-Creditable Coverage Disclosure Notice, electronically or in hard copy, to any of your dependents who are eligible for Medicare.

Plan participants have a right to receive a paper version of the above-referenced document upon request. Where applicable, the plan sponsor reserves the right to charge a reasonable fee to cover the cost of furnishing the document. To request a paper copy of the document, or for any questions about the document, please contact **[HR Department or other employer information]**.

Please keep a copy of the attached notice for your records.

Sample 2: Sample Employee Communication for Non-Creditable Coverage

The attached/enclosed Medicare Part D Non-Creditable Coverage Disclosure Notice contains important information about our company's prescription drug coverage and your options under Medicare's prescription drug coverage (Medicare Part D) effective January 1, **[YYYY] [Insert the calendar year variable for the forthcoming calendar year.]**

We have confirmed that prescription drug coverage offered under our prescription drug plan(s) is, on average for all plan participants, NOT expected to pay out at least as much as standard Medicare Part D coverage. Prescription drug coverage under our plan(s) is therefore considered **non-creditable coverage**.

> **IMPORTANT: Note that the status of our company's prescription drug coverage for the above-referenced year has changed from our prior Medicare Part D Notice. Medicare eligible individuals should review the Notice carefully. [Include this paragraph only if the company's prescription drug coverage changed from creditable to non-creditable coverage since the distribution of the most recent prior Notice.]**

You are responsible for providing a copy of the Medicare Part D Creditable/Non-Creditable Coverage Disclosure Notice, electronically or in hard copy, to any of your dependents who are eligible for Medicare.

Plan participants have a right to receive a paper version of the above-referenced document upon request. Where applicable, the plan sponsor reserves the right to charge a reasonable fee to cover the cost of furnishing the document. To request a paper copy of the document, or for any questions about the document, please contact **[HR Department or other employer information]**.

Please keep a copy of the attached notice for your records.

APPENDIX C

Plan sponsors must submit a Disclosure to CMS Form annually "within 60 days after the beginning date of the Plan Year for which the entity is providing the Disclosure to CMS Form" (see Disclosure to CMS Guidance and Instructions).

The following chart shows the CMS disclosure due date that corresponds to each first of the calendar month plan year start date. Note that the due date is adjusted in leap years for plan years that start in January and February.

Chart of CMS Disclosure Due Dates

Plan Year Start Date	CMS Disclosure Due Date*
January 1	March 2 (March 1 in leap years)
February 1	April 2 (April 1 in leap years)
March 1	April 30
April 1	May 31
May 1	June 30
June 1	July 31
July 1	August 30
August 1	September 30
September 1	October 31
October 1	November 30
November 1	December 31
December 1	January 30

*When the due date falls on a weekend or federal holiday, the due date is extended to the next business day.