September 19, 2023

Annual Reminder: Medicare Part D (Creditable Coverage) Notices Due to Individuals

Plans must send notices *before* October 15th

Employer group health plans that include prescription drug coverage must provide a Medicare Part D creditable and/or non-creditable coverage notice (“Notice”), as applicable, each year to all Medicare-eligible employees and dependents *before* the annual October 15th Medicare Part D enrollment period. The rule usually only applies to medical/Rx coverage, and self-insured or fully insured plan status does not matter.

In short, prescription drug coverage is creditable if it provides benefits that are at least as generous as Medicare Part D prescription drug coverage.

Take action

Employers should review their prescription drug coverage for each benefit option offered to determine creditable and/or non-creditable coverage status and distribute the appropriate Notice by or before October 14, 2023. Although, this year’s deadline falls on a weekend, there is no automatic extension to the next business day.

Contents of this Alert

In order to assist with Medicare Part D Notice requirements, the remainder of this Alert provides additional information on:

- Which plans and sponsors are subject to the Notice requirements;
- Who should receive the Notice;
- Determining whether coverage is creditable or non-creditable (including coverage with accompanying account-based health plans);
- Notice deadlines;
- Form & content requirements, along with recommended CMS Model Disclosure Notices;
- Methods of delivery; and

Highlights

Overview

Employers offering group health plans with prescription drug coverage must provide the Medicare Part D Notice to Medicare eligible individuals *before* October 15, 2023.

- It is difficult to know for certain who all of the Medicare eligible individuals are, so we generally recommend distributing the notice to everyone eligible for coverage.
- The Notice must indicate whether drug coverage offered under each plan option is “creditable” or “non-creditable”

Employer Action

Employers offering group health plans with prescription drug coverage should confirm the creditable/non-creditable coverage status of their prescription drug coverage.

- For fully insured coverage, the insurer should provide this information upon request.
- For self-insured coverage, this may require a review with the employer’s broker and/or consulting firm and require actuarial analysis.

Unless already provided during 2023, send a separate stand-alone notice no later than October 14th.

We recommend employers use the CMS model notices.

- Whether any penalties apply for failure to distribute the Notice.

We will also discuss the separate requirement to report the plan's creditable coverage status to CMS.

Plan sponsors subject to Medicare Part D notice requirements

A plan sponsor – the employer for a single employer plan – is subject to the Notice requirements if they offer prescription drug coverage to its employees (including COBRA participants) and/or retirees, and these groups include any Medicare Part D eligible individuals (including dependents). As a best practice, we recommend all employers sponsoring coverage providing prescription drug benefits assume responsibility for providing the Notice and for notifying CMS, as discussed below.

Medicare Part D eligible individuals

All Medicare Part D eligible individuals who are enrolling in, or are covered by, the employer's prescription drug plan must receive the Notice. A "Medicare Part D eligible individual" is a person who:

1. Is enrolled in Medicare Part A or B as of the effective date of coverage under a Medicare Part D plan (active employees may have Medicare coverage); and

2. Resides in a "service area" of a Medicare Part D plan. A "service area" is a location that meets certain pharmacy access standards. Most individuals live in a service area (particularly with mail-order and online pharmacy options).

Medicare Part D eligible individuals may include active employees, employees who are disabled or on COBRA, retired employees, and their covered spouses and dependents. Since employers may not know the Medicare eligibility status for some of these individuals, we recommend employers conservatively provide the Notice to all covered individuals.

Example

A 48-year-old employee has an eligible dependent child who is 23 and eligible for Medicare due to disability. Assume the employee and child are eligible for medical coverage through the employer's medical plan. Based on the information available to the employer, the dependent may not appear to be Medicare eligible, but the employer has a Notice obligation to the dependent.

Please see *Method of Delivery* below for best practices when delivering to multiple eligible individuals living at the same address.

Creditable or non-creditable coverage?

Generally, prescription drug coverage is creditable if (a) it constitutes an authorized type of coverage; and (b) the actuarial value of the coverage equals or exceeds the actuarial value of Medicare Part D prescription drug coverage. In other words, creditable coverage means prescription drug coverage that, on average, pays benefits at least equal to the standard coverage available through a Medicare prescription drug plan.

For fully insured coverage, the insurer should provide this information upon request. For self-insured coverage, this may require a review with the employer's broker and/or consulting firm and require actuarial analysis. This likely occurred at the beginning of the current plan year. Assuming there are no significant plan design changes, the plan

Current plan year: The Notice applies to the current plan year and not the next plan year, even for calendar year plans distributing the Notice close to or during annual enrollment for the following year.

can rely on the same determination for the annual report to the Centers for Medicaid and Medicare Services and the Notice requirement to eligible individuals.

The primary purpose of the Notice is to notify Medicare Part D eligible individuals if their employer's prescription drug coverage is at least as generous as Medicare Part D prescription drug coverage (i.e., creditable) or not (i.e., non-creditable) and helps them determine whether and when to enroll in Medicare Part D.

Medicare eligible individuals enrolled in non-creditable prescription drug coverage may later incur a late enrollment penalty for failing to timely enroll in Medicare Part D. An individual with non-creditable coverage should generally enroll in Medicare Part D when initially eligible to avoid a potential penalty. An individual who loses creditable coverage has 63 days from the loss of coverage to enroll in Medicare Part D to avoid a potential penalty.

Creditable coverage simplified determination

CMS provides a simplified determination safe harbor to determine creditable coverage.

Integrated health coverage

Most employers combine medical and prescription drug benefits into the same plan/plan option (the rules refer to this as "integrated" coverage). Under the simplified determination standard for integrated health coverage, prescription drug benefits are automatically creditable if:

1. The plan provides coverage for both brand and generic prescriptions;
2. The plan provides reasonable access to retail providers;
3. By design, the plan pays on average at least 60% of participants' prescription drug expenses;
4. The plan's deductible is not greater than $250 per year;
5. The plan has an annual benefit maximum limit of at least $25,000 (or no limit); and
6. The plan has a lifetime combined benefit maximum limit of at least $1 million.[1]

HDHPs: The deductible limitation in #4 prevents high deductible health plans from qualifying for the creditable coverage simplified determination.

Stand-alone prescription drug benefits

Stand-alone prescription drug benefits (i.e., offered as separate coverage or "non-integrated" coverage) are automatically creditable if:

1. The plan provides coverage for both brand and generic prescriptions;
2. The plan provides reasonable access to retail providers;
3. By design, the plan pays on average at least 60% of participants' prescription drug expenses; and
4. The plan satisfies one of the following:

[1] The Affordable Care Act's prohibition on annual and lifetime dollar limits makes #5 and #6 moot.

a. The prescription drug coverage has no annual benefit maximum benefit or a maximum annual benefit payable by the plan of at least $25,000, or

b. The prescription drug coverage has an actuarial expectation that the plan will pay at least $2,000 annually per Medicare eligible individual.

Determining creditable coverage when there is an account-based plan

Health Reimbursement Accounts (HRAs)

Plan sponsors who offer HRAs in conjunction with a major medical plan or on a stand-alone basis must take the HRA into account for Medicare Part D creditable coverage purposes if the HRA can be used to reimburse participants for the cost of prescription drugs.

- **Participation in Medical Plan + HRA:** If an individual participates in both the HRA and the major medical plan, the plan determines creditability by increasing the expected prescription drug claims payable from the major medical plan by the amounts credited to the HRA.

  For HRAs that pay for both prescription drug costs and other medical claims, the plan may allocate a reasonable portion of the year's HRA contribution to prescription drug coverage. If an HRA is limited to reimbursement for prescription drugs, the plan should allocate the entire HRA contribution to prescription drug coverage.

  Example 1

  A medical plan has an annual deductible of $1,000. The employer makes an annual HRA contribution of $500. If the HRA can reimburse participants for both prescription drugs and other medical expenses, the plan should only allocate a reasonable portion of the $500 to the prescription drug coverage for creditability determination purposes. The plan can base this amount on average reimbursement data and/or other facts and circumstances.

  Example 2

  A medical plan has an annual deductible of $1,000. The employer makes an annual HRA contribution of $500. If the HRA can only reimburse participants for prescription drug expenses, the plan provides prescription drug coverage with a $500 annual deductible.

- **Stand-alone HRA:** If the employer offers an HRA on a stand-alone basis without requiring participation in a medical plan,[2] the plan determines creditability as if the HRA were a medical plan with no deductible and an annual limit equal to the amount of the credit for that year.[3]

Health Flexible Spending Accounts (Health FSAs)

Health FSAs do not count when determining the creditable coverage status of an underlying medical plan and are not independently subject to the Notice requirement.

Health Savings Accounts (HSAs)

HSAs do not count when determining the creditable coverage status of an underlying HDHP and are not independently subject to the Notice requirement.

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[2] This can present certain ACA compliance issues if employees waiving the employer's medical coverage do not have to attest to having other employer-provided medical coverage elsewhere.

[3] CMS, "*Treatment of Account-Based Health Arrangements under the Medicare Modernization Act,*" last updated December 29, 2005: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/EmployerRetireeDrugSubsid/Downloads/AccountBasedPlansGuidanceRev1.pdf.

Notice deadlines, form and contents, and delivery

Deadlines

Although October 14th is the due date most associated with the Medicare Part D Notice, there are other situations when the Notice must be given to Medicare Part D eligible individuals:

- Prior to an individual's initial enrollment period for Medicare Part D;
- Prior to the effective date of coverage for any Medicare-eligible individual that joins the employer's plan;
- Within a reasonable amount of time whenever prescription drug coverage ends or changes so that it is no longer creditable or becomes creditable; and
- Within a reasonable amount of time after an individual requests a copy.

The employer's standard delivery of the Notice before October 15th each year can satisfy the first two situations.

Form and content requirements

Although not required, we recommend using CMS's Model Disclosure Notices. These model notices do require some customization, but will satisfy the content requirements.

The CMS model creditable and non-creditable coverage disclosure Notices are posted on its website along with additional guidance. While the templates state, "For use on or after April 2011," these are the most current versions. CMS has made no changes to the standard language since that time.

An employer may include multiple plan options in the same Notice, so long as the plans have the same creditable (or non-creditable) status. Otherwise, employers should complete a separate Notice for each plan option.

Method of delivery

The Notice may be hand-delivered, mailed (first-class), or sent electronically. For paper delivery, the employer can provide a single Notice to a family of multiple Medicare-eligible individuals living at the same address. Employers wishing to provide the Notice electronically may do so, as long as the Department of Labor (DOL) electronic delivery safe harbor conditions are satisfied. Essentially, the DOL does not require obtaining participant consent for electronic delivery of the Notice if:

- The employee has work-related computer access and use the computer as an integral part of their job;
- The employee can access the documents in electronic format at their work site;
- Appropriate measures are taken to ensure actual receipt by participants; and
- The employer notifies participants in writing or electronically of their right to receive a paper copy of the Notice free of charge.

If an employee does not use a computer as an integral part of their job, or the employer cannot satisfy all of the above conditions, an employer may rely on electronic delivery if the employee provides advance consent.

In addition, if an employer provides the Notice electronically, it must also notify participants that they are individually responsible for providing a copy of the disclosure to their Medicare-eligible dependents covered by the group health plan.

Special form and content rules apply when providing Notice in a notices packet or benefits guide

Plans may provide the Notice with other member information materials (including new hire and open enrollment materials) or in a separate mailing. It is arguably more beneficial for a Medicare eligible individual to receive the notice closer to the October 14th deadline, which marks the start of Medicare's annual open enrollment.

> **Note:** Employers who hold their annual open enrollment after October 14th should not rely on including the Part D notice solely in their enrollment materials to satisfy the delivery requirement. Providing a separate notice may be more appropriate in this case. While employers must provide the notice at least once per year, there is no rule against providing the notice more than once per year.

If the Notice is included in a separate packet of legal notices or in a benefits enrollment guide, one of the following must occur:

1. The Notice must appear on the first page (we interpret this to mean it is sufficient if it appears after the table of contents); or

2. A call-out box must appear on the first page of the packet, indicating that the Notice appears later. The language in the call-out box must include a cross-reference to the page where the Notice may be found. The delivery guidance provides the following sample call-out box:

> **If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see page [XX] for more details.**

When including the Notice with other materials, the delivery guidance indicates the initial disclosure portion of the Notice or the call-out box must appear in 14-point font.

Creditable coverage reporting to CMS

A separate and frequently overlooked requirement for employers/plan sponsors is the obligation to determine and report the creditable coverage status of its prescription drug plan(s) to CMS. The Online Disclosure to CMS Form should be completed: (i) annually no later than 60 days from the beginning of a plan year (contract year, renewal year), (ii) within 30 days after termination of a prescription drug plan, and (iii) within 30 days after any change in creditable coverage status.

Indirect penalties may apply

There is no penalty for failing to provide creditable prescription drug coverage. There are also no automatic penalties for failing to distribute the required Notice or failing to report to CMS, although both are likely plan administration failures for ERISA fiduciary purposes. If the employer's medical/Rx plan is subject to ERISA, a failure to provide a copy of the Notice to a participant within 30 days upon request could result in a potential $110/day late penalty (this requires a dispute to get to federal court and is at the court's discretion).

A failure to provide an appropriate Notice is also likely to result in employee "noise" from disgruntled Medicare-eligible employees, spouses and/or dependents who incur late enrollment penalties under the assumption that a plan's prescription drug coverage is creditable when it is not.

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