August 21, 2024

Changes to Medicare Part D for 2025 May Affect Creditable Coverage Status

At a high level, Medicare Part D is a prescription drug benefit within the overall Medicare program available to Medicare-eligible individuals. Employers must notify these individuals whether their employer-provided prescription drug benefits are at least as good as the benefits available through Medicare Part D, known as creditable coverage.

The Inflation Reduction Act of 2022 (the "Act") included delayed enhancements to the Medicare Part D prescription drug benefits for 2024 and 2025. The 2024 enhancements were minor, and the 2024 Medicare Part D parameters (the "2024 parameters") did not generally affect employers sponsoring prescription drug coverage.

By contrast, the enhancements to the 2025 Medicare Part D parameters (the "2025 parameters") are significant and include a $2,000 limit on annual out-of-pocket prescription drug costs. The 2025 parameters may affect the creditable coverage status for some employer-provided plans. The Centers for Medicare and Medicaid Services (CMS) published corresponding guidance on April 1, 2024 (the Final CY 2025 Part D Redesign Program Instructions).

This Alert is relevant for all employers offering coverage for prescription drug benefits and will address:

- A refresher on Medicare creditable coverage status and its notice and disclosure requirements;
- The potential issues caused by the 2025 changes to Medicare Part D (including a number of examples and potential solutions); and
- Employer action items.

Highlights

Overview

Changes to Medicare Part D for 2025 may affect the creditable coverage status for some employer-provided plans for plan years beginning in 2025. The 2025 changes do not affect the creditable coverage status for plan years that begin in 2024 and end in 2025.

This Alert is relevant for all employers offering prescription drug benefits, including both fully insured and self-insured coverage.

Key Provisions

A loss of creditable coverage status can affect:

- Participant notices and CMS disclosure requirements,
- Medicare enrollment, and
- Contribution limits for health savings accounts for individuals that enroll in Medicare.

Employer Action Items

Employers should address the following action items:

- Determine creditable status for plan years beginning in 2025 as soon as it is feasible to do so.
- Develop a communication plan if creditable coverage status will be lost.
- Be prepared to address questions related to the change in creditable coverage status.

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A brief refresher

Let's start with some basics about Medicare Part D creditable coverage and certain disclosure requirements.

Creditable coverage in a nutshell

Coverage is creditable if the prescription drug benefits provided under a group health plan are at least as good as the prescription drug benefits available through Medicare Part D. There is no requirement to provide creditable coverage or employer penalties for failing to do so, although creditable coverage is mandatory to qualify for the Medicare retiree drug subsidy (RDS) program.

There are two methods to determine creditable coverage status:

1. The simplified determination method (remains available for 2025);[1] and

[1] The existing simplified determination approach may not be available after 2025. See page 3 of the Final CY 2025 Part D Redesign Program Instructions. This approach is not available for plans participating in the Medicare RDS program.

2. The actuarial equivalence method.

The simplified determination method is not available for many medical plans that share combined deductible and out-of-pocket limits for medical and prescription drug benefits (referred to as "integrated" plans) because their deductibles are too high. Please see Appendix A for more information about the simplified determination method. We will generally refer to medical plans that include prescription drug benefits as medical/Rx plans for the remainder of this Alert.

Existing regulatory and other CMS guidance[2] address the permitted methodology under the actuarial equivalence method, but a detailed discussion of this approach is outside the scope of this Alert. Among other requirements, the method only allows the plan to take prescription drugs covered by Medicare Part D into account when determining actuarial equivalence.

Insurers/TPAs: Insurers typically determine creditable coverage status for their fully insured plans, and we believe insurers/third party administrators (TPAs) generally do this for most level-funded coverage. TPAs may determine or assist with the determination of creditable coverage status for self-insured clients using their standard plan designs.

Timing and duration of creditable coverage determinations

If a plan qualifies as creditable coverage under the Medicare Part D parameters in effect as of the first day of the plan year, the plan generally remains creditable through the end of that plan year. The applicable regulation states (bolded text ours for emphasis):

> *Creditable prescription drug coverage means any of the following types of coverage listed in paragraph (b) of this section only if the actuarial value of the coverage* ***equals or exceeds the actuarial value of defined standard prescription drug coverage under Part D in effect at the start of such plan year****…*[3]

There is a change-in-status rule, but a plan's creditable coverage status remains measured against the Medicare Part D parameters that were in effect as of the first day of the plan year. For non-calendar year plans, this means the 2024 parameters apply to the 2024 – 2025 plan year, and the 2025 parameters do not take effect until the plan year beginning in 2025.

Example 1

ABC Company offers a calendar year medical/Rx plan and determines the plan is creditable for the January 1, 2025 – December 31, 2025, plan year under the 2025 parameters. Assuming ABC Company makes no changes to its plan design that affect the plan's creditable coverage status, the plan will remain creditable through December 31, 2025.

Example 2

ABC Company offers a medical/Rx plan with a July 1 – June 30 plan year and determined the plan was creditable for the July 1, 2024 – June 30, 2025, plan year under the 2024 parameters. Assuming ABC Company makes no changes to its plan design that affect the plan's creditable coverage status, the plan will remain creditable through June 30, 2025.

[2] 42 CFR §423.56, et. al. and Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance (July 1, 2009).

[3] 42 CFR §423.56(a).

If ABC Company makes a change to the plan design during the 2024 – 2025 plan year, any effect on creditable coverage status is measured against the 2024 parameters. The 2025 parameters do not apply until the July 1, 2025 – June 30, 2026, plan year.

Beware of short plan years: The use of a short plan year causes a new creditable coverage determination for the start of the next plan year.

Medicare Part D notice to participants

Employer group health plans that include prescription drug coverage must provide a Medicare Part D creditable or non-creditable coverage notice to Medicare Part D eligible individuals,[4] as applicable:

1. Each year *before* the annual October 15th Medicare Part D enrollment period to all Medicare-eligible employees and dependents;
2. Prior to an individual's Medicare Part D initial enrollment period;
3. Prior to the effective date of coverage for any Medicare-eligible individual that joins the employer's plan;
4. When an employer ceases offering prescription drug coverage or coverage changes so that it is no longer creditable or becomes creditable (a "change-in-status"); and
5. Within a reasonable amount of time after an individual requests a copy.

An employer can generally satisfy the first three requirements at the same time through standard delivery of the notice before October 15th each year. The notice rule applies to both self-insured and fully insured coverage. The notice obligation generally belongs to the employer as plan sponsor, although insurers/TPAs may provide the notice on their behalf.

Disclosure to CMS

A separate 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:

1. Annually, no later than 60 days after the beginning date of the plan year (contract year, renewal year);
2. Within 30 days after termination of a prescription drug plan; and
3. Within 30 days after any change in creditable coverage status.

Note: Please see our annual Medicare Part D Notice Reminder and CMS Medicare Part D Disclosure alerts for a more detailed discussion of these notice and disclosure requirements.

[4] Medicare eligible individuals include spouse and dependents. As a practical matter, employers typically provide this notice to all participants given the difficulty in identifying every Medicare eligible individual.

2025 Medicare Part D creditable coverage issues

The Act made minor changes to Medicare Part D's 2024 parameters and had no implications for most employers. By contrast, the changes to the 2025 parameters are significant and include a $2,000 limit on annual out-of-pocket prescription drug costs. The 2025 parameters go into effect for plan years beginning on or after **January 1, 2025**.

Affected group health coverage

The 2025 parameters raise the bar for plans to qualify as creditable coverage and jeopardize those plan designs: (i) that qualified or would have qualified as creditable for 2024 by relatively small margins; and/or (ii) that utilize very high plan limits (see *High deductible health plans* (HDHPs) below).

Marsh McLennan Agency (MMA) does not believe the 2025 parameters will affect the creditable coverage status for most plan designs that qualified or would have qualified as creditable in 2024 by more comfortable margins and that do not utilize very high plan limits.

Similarly, we expect many standard plan designs offered by employers through insurers and TPAs will remain creditable "as is" or will adjust to remain so. Insurers will likely amend their standard plan designs for fully insured coverage as necessary without employer involvement. Employers sponsoring self-insured coverage can expect to receive recommendations and/or encouragement from their TPAs to make any necessary corresponding changes.[5]

Small impact expected: MMA's actuarial team expects the 2025 parameters will affect the creditable coverage status of less than 10% of the group health plans in our book of business (including HDHPs). This does not include plans that are or would already be non-creditable under the 2024 parameters.

High deductible health plans

We are aware that a number of third parties are reporting that many or most HDHPs will fail to qualify as creditable coverage once the 2025 parameters go into effect. This is primarily because the HDHP statutory minimum annual deductible for family coverage is already greater than the $2,000 limit on annual out-of-pocket prescription drug costs.[6]

After discussions with our senior actuarial team and a review of the permitted actuarial equivalence methodology, we disagree. The regulatory and interpretive guidance for the actuarial equivalence method indicate the determination process matches the first part of the actuarial equivalence test (the "gross test") applicable when an employer applies for the Medicare RDS.

> *This determination is identical to the first prong of the actuarial equivalence test (gross test) that is applied in 42 CFR §423.884 when an employer or union applies for the retiree drug subsidy under that section. It does not take into account whether or to what degree the coverage is financed by the individual or entity.*[7]

This is significant, because the RDS gross test and its interpretive guidance allow integrated medical/Rx plans to determine actuarial equivalence by allocating a reasonable portion of medical and prescription drug expenses toward the plan's cost sharing provisions based upon either actual or projected future claims.[8] In other words, there

[5] It is in the insurer's/TPA's self-interests to standardize plan design and administration across their books of business as much as possible.

[6] For HDHP plans years beginning in 2025, the statutory minimum annual deductibles are $1,650 for self-only and $3,300 for family coverage.

[7] 42 CFR §423.56(a), as interpreted under *Creditable Coverage Definition and Determination,* Disclosure of Creditable Coverage to Medicare Part D Eligible Individuals Guidance, page 5 (July 1, 2009).

[8] 42 CFR §423.884(d), as interpreted under *Integrated Health and Drug Situations*, CMS Retiree Drug Subsidy Program Guidance: Actuarial Equivalence Standard, page 4 (May 30, 2008).

is no required assumption or bias to treat all or most of the first $2,000 in expenses as prescription drug expenses toward a plan's deductible or out-of-pocket maximum limit when determining actuarial equivalence. In addition, the CMS instructions for the 2025 parameters indicate that discounts paid by manufacturers can be ignored for creditable coverage determination purposes.[9]

While we agree that greater scrutiny should be given to HDHP creditable coverage determinations for 2025 and beyond, we believe many HDHPs and other medical/Rx plans with higher deductibles should still be able to qualify as creditable. As indicated earlier, plans (including HDHPs) in jeopardy of losing creditable coverage status are those plan designs that qualified or would have qualified as creditable for 2024 by relatively small margins and/or that utilize very high plan limits. Plans using very high plan limits were likely non-creditable already.

Example

For 2025, ABC Company will offer a medical/Rx plan with annual deductibles of $2,500 self-only/$5,000 family, out-of-pocket maximum limits of $6,000 self-only/$12,000 family, and 20% member coinsurance (in-network). If it is reasonable to project prescription drug expenses will make up 30% of the plan's cost for 2025, it is entirely possible this plan will be creditable for the 2025 plan year. Please note that creditable coverage status depends upon a variety of factors and requires careful analysis. This example should not be read to mean that all plan designs with these parameters will qualify as creditable coverage.

Very high plan limits: By "very high plan limits," we are generally referring to plan designs with deductibles that are multiples of the HDHP statutory minimum annual deductibles and have out-of-pocket maximum limits at or near the annual statutory limit. Further discussion is best left to your available actuarial support.

Health reimbursement arrangement (HRA) as an offset

As a reminder, HRAs integrated with medical coverage that can reimburse prescription drug expenses help offset plan limits for creditable coverage determination purposes. By contrast, health flexible spending accounts and health savings accounts do not.

New participant notice due to change-in-status for 2025 plan year

If an employer provides a creditable coverage notice for a plan year beginning in 2025, the Medicare Part D notice change-in-status rule requires the plan to provide a new non-creditable coverage notice if the plan loses creditable coverage status for 2025.[10]

Remember, the 2025 parameters apply to plan years beginning on or after January 1, 2025, so the loss of creditable coverage status in this situation can occur solely because of the changes to Medicare Part D, even if there are no changes to plan design. In the alternative, you can think of this as correcting the prior notice that indicated the plan was creditable for 2025.

Example 1

ABC Company offers a calendar year medical/Rx plan and provides a notice of creditable coverage on October 10, 2024. The plan (or its replacement) will not be creditable as of January 1, 2025, requiring delivery of a new non-creditable coverage notice.

[9] See page 19 of the Final CY 2025 Part D Redesign Program Instructions.

[10] 42 CFR §423.56(f)(2).

Example 2

ABC Company offers a medical/Rx plan with a July 1 – June 30 plan year and provided a creditable coverage notice in June 2024 during annual enrollment based on the 2024 parameters. Assuming there are no changes to the plan design or plan year, the plan will remain creditable through June 30, 2025. The 2025 parameters will not apply until the plan year beginning July 1, 2025.

Delivery approaches

If necessary, we believe an employer (or a third party acting on the employer's behalf) can provide creditable and non-creditable coverage notices at the same time. For example: (i) a creditable coverage notice effective through December 31, 2024; and (ii) a non-creditable coverage notice effective as of January 1, 2025. This requires advance knowledge that creditable coverage status will be lost, which may not be possible for this delivery option to work.

The alternative is to provide the second notice once it is clear the coverage will be non-creditable (see *Delivery timing* below).

Note: There is no need to provide a new notice for coverage that remains creditable.

Delivery timing

The rule and available guidance are unclear about the timing for a new notice required due to a change-in-status. The rule states:

> *Notices must be provided, at minimum, at the following times…upon any change that affects whether the coverage is creditable prescription drug coverage.*

This arguably requires notification by the date of the status change (e.g., January 1, 2025, for a calendar year plan losing creditable coverage status due to the 2025 parameters), but there do not appear to be any penalties for providing later notification.

Ideally, the employer (or a third party acting on the employer's behalf) will provide the notice by or before the date of the status change, but this may not be feasible. We recommend the plan provide the notice as soon as it is reasonably practical to do so and within 30 days of the loss of creditable coverage status, but please note that this is not a compliance safe harbor. The notice timing does affect Medicare special enrollment for Medicare-eligible participants.

If the loss of creditable coverage status is due solely to the 2025 enhancements and not because of any change in the plan's design or terms, the following two notification requirements and their timing rules do not apply since there hasn't been any change to actual plan design or benefits offered under the plan:

1. ERISA's summary of material modification or summary of material reduction notification requirements for summary plan descriptions; and

2. The material modification notice rule for summaries of benefits and coverage (SBC). This notice also only applies to changes affecting the SBC that occur mid-plan year.

CMS disclosure and change-in-status for 2025 plan year

The annual disclosure to CMS is due within 60 days after the beginning *date* of the plan year,[11] which is March 2, 2025, for a 2025 calendar year plan. This timing requirement means employers will know their plan designs in

[11] While many start counting on the first day of the plan year, this wording means the 60-day count actually begins on the second day.

advance of the disclosure deadline, allowing more time to account for the 2025 parameters when reporting creditable and non-creditable coverage status.

The disclosure requirement has a change-in-status rule that requires a new disclosure within 30 days after any change in creditable coverage status, but it only applies if the reported status from the annual disclosure changes.

There are no penalties for failing to complete the CMS disclosure, although eligibility for the Medicare RDS depends upon a valid attestation of creditable coverage. We recommend complying with the disclosure requirement.

Medicare special enrollment

The initial enrollment period (IEP) for Medicare Part D due to age is the same as for Medicare Parts A and B,[12] beginning three months before and ending three months after the individual's birth month in which they turn age 65.[13]

Individuals who do not enroll during their IEP must generally wait for permitted enrollment periods to enroll later, such as the annual Medicare open enrollment period (October 15 – December 7) or during a special enrollment period. A loss of Medicare Part D creditable coverage triggers a two-month special enrollment period that begins on the later to occur of:

1. The first day of the following month after creditable coverage ends; or
2. The first day of the following month after notification of the loss of creditable coverage.[14]

An individual must have Medicare Part A or B to enroll in Part D. Individuals can enroll in Medicare Parts A and B during their IEP, the annual Medicare open enrollment period, or at other permitted times such as during a special enrollment period.

Late enrollment penalties

A Medicare Part D late enrollment penalty applies if an individual does not have creditable coverage for at least 63 continuous days, measured from the later of:

1. The end of the individual's IEP; or
2. The individual's loss of creditable coverage.[15]

The penalty is a permanent increase in the Medicare Part D premium each year by 1% of that year's applicable national base beneficiary premium ($36.78 in 2025) for every month the individual did not have Medicare Part D or creditable coverage. As a reminder, the date creditable coverage is considered lost can be affected by delayed notification of the loss of creditable coverage. There is a mechanism for individuals to appeal Medicare Part D late enrollment penalties caused by delayed notifications for losses of creditable coverage.[16]

As discussed above, an individual must have Medicare Part A or B to enroll in Part D. An individual can temporarily avoid the Part D late enrollment penalty by delaying enrollment in Parts A or B, but the 63-day gap in coverage is still measured from the later of the end of the individual's IEP or their loss of creditable coverage, and delayed enrollment will likely increase the penalties further.[17]

[12] 42 CFR §423.38.

[13] 42 CFR §407.14.

[14] 42 CFR §423.38(c)(1), 42 CFR §423.56(g), and Special Enrollment Periods from Medicare.gov.

[15] 42 CFR §423.46(a) and Preamble to Medicare Program; Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194, 4217 (January 28, 2005).

[16] 42 CFR §423.56(g), 42 CFR §423.46(c), and Late Enrollment Penalty (LEP) Appeals.

[17] 42 CFR §423.46(a), and CMS confirmed this interpretation for us.

Example 1

ABC Company offered a calendar year medical/Rx plan that was creditable for 2024 and provided a notice in December 2024 that the plan would not be creditable as of January 1, 2025. Assume Chris turned 65 in early 2024, which means the measurement of a 63-day gap in creditable coverage begins on January 1, 2025.

In February 2025, Chris enrolls in Medicare Part A online, receives his Medicare ID number electronically, and enrolls in Medicare Part D. Chris's Medicare Part D coverage will be effective as of March 1, 2025. Chris's gap in creditable coverage is less than 63 days and he will not owe any Medicare Part D late enrollment penalties.

Note: An individual must enroll in Medicare Part A or B and have a Medicare ID number to enroll in Part D. If applying online, the process to receive a Medicare ID number usually only takes a few days, but individuals should not wait until the end of their special enrollment periods to act.

Example 2

ABC Company offered a calendar year medical/Rx plan that was creditable for 2024. The plan lost creditable coverage status as of January 1, 2025, but ABC Company did not provide a notice of non-creditable coverage until February 17, 2025. Assume Chris turned 65 in early 2024, which means the measurement of a 63-day gap in creditable coverage begins on March 1, 2025 (the first day of the following month after notification).

Chris must enroll in Medicare Part D or other creditable coverage with an effective date by or before May 2, 2025, to avoid potential late enrollment penalties.

Example 3

ABC Company offered a calendar year medical/Rx plan that was creditable for 2024 and provided a notice in December 2024 that the plan will not be creditable as of January 1, 2025. Assume Chris turned 65 in early 2024, which means the measurement of a 63-day gap in creditable coverage begins on January 1, 2025.

Chris terminates from employment in 2025, loses eligibility for ABC Company's coverage, and enrolls in Medicare (including Parts A, B, and D) during his special enrollment period with an effective date of October 1, 2025 for Medicare Part D. Chris has a gap in creditable coverage of at least 63 days and went 9 months without creditable coverage. Chris will owe the following late enrollment penalty for Medicare Part D for the remainder of 2025:

- 9% × $36.78 = $3.31
- $3.31 rounded to the nearest $0.10 = $3.30 per month

Chris will continue to owe late enrollment penalties in subsequent years based on each year's applicable national base beneficiary premium.

HDHPs and HSA eligibility

Since enrollment in Medicare Part D is conditioned on enrollment in Parts A or B, there is a separate HDHP issue worth attention. Employees who delayed signing up for Part A should be aware that the effective date of their Medicare Part A coverage is retroactive up to six months from the month they enroll, but no earlier than the month they turned age 65. This also retroactively affects their annual HSA contribution limit (potentially to $0), and affected individuals will need to take corrective distributions for any excess contributions to avoid penalties.

An employee enrolled in Medicare loses the ability to make or receive further HSA contributions but does not lose access to existing HSA funds. Once an HSA account holder turns 65, distributions for non-qualifying medical expenses remain taxable, but they are no longer subject to the 20% penalty.

Example

Todd turns 65 on March 5, 2025, but he delays enrollment in Social Security and Medicare because he is still working. ABC Company offers an HDHP with a July 1 – June 30 plan year. The HDHP was creditable for the July 1, 2024 – June 30, 2025, plan year, but it is not creditable for the plan year beginning on July 1, 2025.

Todd was enrolled in family coverage under the HDHP for the 2024 – 2025 plan year. He waives coverage for the 2025 – 2026 plan year and applies for Social Security and Medicare Parts A, B, and D in June 2025. His Medicare Part A coverage will be effective March 1, 2025,[18] retroactively pro-rating his 2025 HSA contribution limit to $1,592.

(2025 family limit + catch-up contribution) × (2 months ÷ 12 months) = Pro-rated limit

($8,550 + $1,000) × (2 ÷ 12) = $1,592

Qualifying life event

A qualifying life event (QLE) is necessary to make pre-tax election changes through an Internal Revenue Code §125 cafeteria plan during a plan year in progress. Enrolling in Medicare is a permitted QLE allowing employees who enroll in Medicare to change their pre-tax elections during the plan year to drop medical coverage, and the overwhelming majority of cafeteria plans allow this event.

A significant change in plan design during the plan year is also a permitted QLE, and it is a basis to permit certain corresponding mid-year election changes, such as changing plan options, enrolling in another employer's coverage, or simply dropping coverage. A loss of creditable coverage status due solely to the 2025 parameters without a change in plan design is not a QLE. It will also occur as of the beginning of the plan year and not during the plan year. Strictly speaking, a delayed notice that the plan lost creditable coverage status as of the beginning of the plan year is not a QLE either. We understand some employers may want to consider allowing exceptions under this circumstance, and we recommend discussing this with legal counsel.

The loss of creditable coverage still results in a Medicare special enrollment period, and the act of enrolling in Medicare remains a QLE.

Employer action items

As a reminder, there is no requirement to provide creditable coverage or any employer penalties for failing to do so, although creditable coverage is mandatory to qualify for the Medicare RDS program.

We recommend employers sponsoring group health plans that provide prescription drug benefits seek the assistance of appropriate advisors for the action items described below, which may include their insurance broker and/or consulting firm (including actuarial support) and legal counsel.

1. **Determine creditable status for plan years beginning in 2025 –** Employers should determine whether their coverage will be creditable for plan years beginning in 2025 as soon as it is possible to do so.

   Insurers typically determine creditable coverage status for their fully insured plans, and we believe the insurers/TPAs generally do this for most level-funded coverage. The insurers/TPAs may provide this automatically or upon request. Employers may need assistance determining the creditable coverage status for many self-insured plans.

2. **Develop a communication plan –** In the event that one or more of its plan options will lose creditable coverage status for 2025, the employer should determine how and when it will communicate this change to its eligible employees. Employers may wish to consider providing additional information about Medicare enrollment.

[18] Todd's Medicare Parts B and D should be effective July 1, 2025.

3. **Be prepared to address questions –** Employers, with the assistance of their advisors, should be prepared to address questions related to the issues discussed in this Alert.

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Appendix A
Simplified Determination Method

CMS published its existing simplified determination method in 2009, which differentiates between integrated and non-integrated group health coverage providing prescription drug benefits.

Integrated plans

An integrated plan means a group health plan that includes both prescription drug benefits and other group health coverage that share the following:

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

Many medical/Rx plans are integrated plans for simplified determination method purposes.[19] Medical/Rx plans with separate deductibles for medical and prescription drug benefits are non-integrated. An integrated plan is creditable under the simplified determination method if it satisfies all of the following conditions:

1. It provides coverage for both brand and generic prescriptions;
2. It provides reasonable access to retail providers (i.e., a network of retail pharmacies);
3. It is designed to pay, on average, at least 60% of participants' prescription drug expenses; and
4. The plan design meets the following requirements:
    a) The annual deductible does not exceed $250;[20]
    b) The annual benefit maximum is at least $25,000; and
    c) The lifetime combined benefit maximum is at least $1,000,000.[21]

The deductible limitation effectively disqualifies all HDHPs that are integrated plans by default.

Non-integrated plans

A non-integrated plan is either: (i) a standalone prescription drug benefits program; or (ii) a group health plan that provides prescription drug coverage but does not share combined plan limits for all covered benefits. For example, a medical/Rx plan with separate deductibles and/or out-of-pocket maximum limits for medical and prescription drug benefits is a non-integrated plan.

A non-integrated plan is creditable under the simplified determination method if it satisfies all of the following conditions:

[19] While most integrated plans only cover medical and prescription drug benefits, the requirement to share combined limits also applies when the plan covers vision and/or dental benefits.

[20] This $250 deductible limit is not subject to CMS's indexed deductible limit for Medicare prescription drug plans. The indexed deductible limit does affect the actuarial equivalence method.

[21] The Affordable Care Act (ACA) does not allow annual or lifetime limits for medical and prescription drug benefits that are *essential health benefits*. If a plan provides for annual or lifetime limits for any covered non-essential health benefits, it is not an integrated plan.

1. It provides coverage for both brand and generic prescriptions;
2. It provides reasonable access to retail providers (i.e., a network of retail pharmacies);
3. It is designed to pay, on average, at least 60% of participants' prescription drug expenses; and
4. The plan satisfies at least one of the following:
    a) The annual benefit maximum must be at least $25,000;[22] or
    b) The plan is actuarially expected to pay at least $2,000 in annual prescription drug benefits per Medicare eligible plan participant.

MMA's actuarial team indicates it is still mathematically possible for a non-integrated HDHP to qualify as creditable under this standard, but this is unusual and unlikely to remain possible long-term. HDHPs will generally have to rely on the actuarial equivalence method to qualify as creditable.

Mail order: In 2005, CMS's simplified determination guidance included a reference to optional mail order coverage in relation to providing reasonable access to retail providers. The mail order reference did not appear in the 2009 guidance. Plans can obviously continue to provide the option to receive prescription drugs by mail, but this cannot replace reasonable access to retail providers.

[22] The ACA's prohibition on annual limits for essential health benefits effectively makes this provision moot.