August 27, 2025

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 notice rule primarily applies to medical/Rx coverage and includes both self-insured and fully insured plans. This Alert is relevant to all employers offering prescription drug benefits.

Take action

In short, employers must notify Medicare eligible 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.

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, 2025.

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 Centers for Medicaid and Medicare Services (CMS) Model Disclosure Notices;
- Methods of delivery; and

Highlights

Overview

All employers offering group health plans with prescription drug coverage must provide the Medicare Part D Notice to Medicare eligible individuals *before* October 15, 2025.

- The Notice must indicate whether drug coverage offered under each plan option is "creditable" or "non-creditable."
- It is difficult to identify all Medicare eligible individuals, so we generally recommend distributing the Notice to all eligible individuals.

Employer Action

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

- 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.
- Given the changes to Medicare Part D, some plans may be at risk for losing creditable coverage status for 2025 and/or 2026.

Most plan sponsors should provide notice(s) no later than October 14th. If creditable coverage status will be lost for 2026, plans sponsors can send a follow-up Notice of the change in plan status.

- 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 it offers prescription drug coverage to its employees (including COBRA participants) and/or retirees, and these groups include any Medicare Part D eligible individuals (including dependents).

Although the Notice obligation belongs to the employer as plan sponsor, insurers and third party administrators (TPAs) may provide the Notice on their behalf. If the insurer/TPA will provide the Notice on the employer's behalf, the employer should ensure the Notice is sent to all eligible individuals and not just those enrolled. As a best practice, we generally 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, and retired employees, as well as 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 individuals eligible for coverage.

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?

The primary purpose of the Notice is to notify Medicare Part D eligible individuals whether 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), which helps them determine whether and when to enroll in Medicare Part D.

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

For fully insured coverage, the insurer should provide the plan's creditable or non-creditable coverage status upon request. For self-insured coverage, this may require actuarial analysis by the employer's broker and/or consulting firm. This frequently occurs at or near the beginning of the applicable plan year. Assuming there are no significant plan design changes, the plan can rely on the same determination for the annual report to CMS and the Notice requirement to eligible individuals.

Medicare eligible individuals enrolled in non-creditable prescription drug coverage may 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 this potential penalty.

2025 changes to Medicare prescription drug coverage may affect creditable coverage status

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

By contrast, the 2025 enhancements were significant and included a $2,000 limit on annual out-of-pocket prescription drug costs. As a result, some plans that were creditable for 2024 may not be creditable for 2025 and subsequent years without plan design changes. In general, the medical/Rx plans at most risk for losing creditable coverage status are those that qualified – or would have qualified – as creditable for 2024 by narrow margins. Marsh McLennan Agency determined that the 2025 changes would affect less than 10% of the group health plans in our book of business (including high deductible health plans or HDHPs).[1]

The limit on annual out-of-pocket prescription drug costs will rise to $2,100 for plan years beginning in 2026.

Creditable coverage simplified determination

CMS provides a simplified determination safe harbor to determine creditable coverage status, with 2026 serving as a transition year between prior and new approaches. The simplified determination safe harbor is an alternative to a more detailed actuarial analysis. We cover the prior and new approaches in detail in Appendix A.

Prior simplified determination approach: 2009 – 2026

CMS launched the prior approach in 2009. It provides two separate paths ("integrated" and "non-integrated"), which depend upon whether the prescription drug benefits coordinate with medical coverage.

CMS intended to retire the prior approach after 2024 because it no longer accurately measures creditable coverage status due to the recent changes to Medicare Part D prescription drug benefits. CMS agreed to allow most plan sponsors the option to continue to use it for plan years beginning in 2025 and 2026 after lobbying efforts by the health insurance industry. The caveat is that plan sponsors cannot rely upon it for plans participating in the Medicare retiree drug subsidy program. It is worth mentioning that HDHPs offering prescription drug benefits generally cannot qualify as creditable coverage under the prior simplified determination approach.

The prior approach is not available for any plan year beginning in or after 2027.

New simplified determination approach: 2026 and subsequent years

The new simplified approach to determine creditable coverage status accounts for the Inflation Reduction Act's recent changes to Medicare Part D prescription drug benefits. CMS also streamlined the approach into a single pathway that should make it easier for HDHPs to qualify as creditable coverage.

This approach is optional for plan years beginning in 2026, and it is the only simplified determination approach available for plan years beginning in or after 2027.

[1] Please see our Changes to Medicare Part D for 2025 Alert for more details about the 2025 changes to Medicare Part D.

Determining creditable coverage when there is an account-based plan

Health Reimbursement Accounts (HRAs)

Plan sponsors who offer HRAs – either 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. HRAs can help plans (usually HDHPs) offset higher plan limits for creditable coverage determination purposes.

  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.

[2] This can present certain ACA compliance issues if employees waiving or ineligible for 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

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, 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. If applicable, we recommend the plan provide a new change-in-status Notice as soon as it is practical to do so and within 30 days of the change in creditable coverage status, but please note that this is not a compliance safe harbor.

Change-in-status Notice for 2026 plan year: As discussed in our Changes to Medicare Part D for 2025 Alert, some plans may lose creditable coverage status as a result of the change to Medicare Part D's benefits. If an employer provides a creditable coverage Notice, the change-in-status rule requires the plan to provide a new non-creditable coverage Notice if the plan subsequently loses its creditable status for that plan year.

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 uses 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 under 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) within 60 days after the beginning *date* of the plan year[4] (or contract or 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.

[4] 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. This deadline is March 2, 2026, for a 2026 calendar year plan.

Indirect penalties may apply

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 program. 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.

For these reasons, it is generally recommended that employer plan sponsors meet both the participant and CMS disclosure obligations surrounding their prescription drug plan's creditable/non-creditable coverage status.

About the author

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Appendix A
Simplified Determination Method

Prior simplified determination approach: 2009 – 2026

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

CMS will allow most plan sponsors the option to continue using the prior approach for plan years beginning in 2025 and 2026, but plan sponsors cannot rely upon it for plans participating in the Medicare retiree drug subsidy program.

The prior approach is not available for any plan year beginning in or after 2027.

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 approach purposes.[5] Medical/Rx plans with separate deductibles for medical and prescription drug benefits are non-integrated. An integrated plan is creditable under the simplified determination approach 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;[6]
    b) The annual benefit maximum is at least $25,000; and
    c) The lifetime combined benefit maximum is at least $1,000,000.[7]

The deductible limitation effectively disqualifies all HDHPs that are integrated plans by default. To our knowledge, CMS never provided guidance addressing what constitutes "reasonable access" to retail providers.

[5] 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.

[6] 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.

[7] 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.

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 approach if it satisfies all of the following conditions:

1. It provides coverage for both brand and generic prescription drugs;
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;[8] 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 approach 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.

New simplified determination approach: 2026 and subsequent years

CMS published its new simplified determination approach in its Final CY 2026 Part D Redesign Program Instructions[9] (the "CY 2026 Instructions"). The new approach does away with the prior "integrated" and "non-integrated" paths and uses a single pathway that should make it easier for HDHPs to qualify.

This approach is optional for plan years beginning in 2026, and it is the only simplified determination approach available for plan years beginning in or after 2027.

Prescription drug coverage is creditable under the new simplified determination approach if it satisfies all of the following conditions:

1. It provides reasonable coverage for brand name and generic prescription drugs and biological products;
2. It provides reasonable access to retail pharmacies; and
3. It is designed to pay, on average, at least 72% of participants' prescription drug expenses.

The CY 2026 Instructions do not clarify when coverage or access are reasonable.

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

[9] See pages 27 and 28.