Brown & Brown

EMPLOYEE BENEFITS

Changes to Medicare Part D Benefit Payment Parameters as of January 1, 2025

August 2024

Background

Employer group health plans are required to disclose to Medicare-eligible individuals whether the prescription drug plan (if applicable) provides creditable or non-creditable coverage typically by October 15 of each calendar year (in addition to other applicable times during the year). Employers must also report to CMS whether the prescription coverage offered under the group health plan is considered creditable or non-creditable within 60 days following the beginning of the plan year.

An employer's prescription drug plan is considered creditable when the actuarial value (the measurement of how robust a plan is in providing coverage) of the prescription drug plan is the same as, or greater than, the actuarial value of Medicare Part D prescription drug coverage. Non-creditable means an employer's prescription drug plan's actuarial value does not meet or exceed the actuarial value of Medicare Part D prescription drug coverage.

Typically, a Medicare-eligible individual who does not enroll in Medicare Part D or creditable coverage shortly after becoming eligible for Medicare (typically for a period of 63 days or more from the date of Medicare eligibility) will be subject to late enrollment penalties under Medicare.

Creditable Coverage Determination

The actuarial value of an employer's prescription drug plan varies from health plan to health plan. Whether a prescription drug plan is creditable may require an annual "actuarial determination" to determine the creditable/non-creditable status of the plan. Qualifying prescription drug plans may also utilize an alternative to the actuarial determination methodology, referred to as the Simplified Determination methodology[1], which provides a more straightforward process for determining whether a prescription drug plan is creditable. The following describes the Creditable Coverage Simplified Determination methodology (also referred to as the Simplified Determination methodology) under the CMS rules.

Creditable Coverage Simplified Determination

Employers/union health plans that do not apply for the retiree drug subsidy (RDS) may use the Simplified Determination methodology to assess whether their prescription drug plan is creditable under the rules. If the prescription drug plan meets the standards set forth for an integrated or non-integrated plan, the plan would be considered creditable.

[1] *https://www.cms.gov/Medicare/Prescription-Drug-Coverage/CreditableCoverage/downloads/CCSimplified091809.pdf*

Integrated vs. Non-Integrated Plan

The criteria to determine if a plan is creditable or non-creditable under the Simplified Determination methodology differs depending on whether the plan is considered integrated or non-integrated. Therefore, the first analysis under the Simplified Determination methodology is to determine whether the plan is **integrated** or **non-integrated**. Once a prescription drug plan determines whether it is integrated or non-integrated, the next step is to carefully compare the applicable criteria to the employer's prescription drug plan offerings to determine if the plan qualifies as creditable coverage under the Simplified Determination methodology.

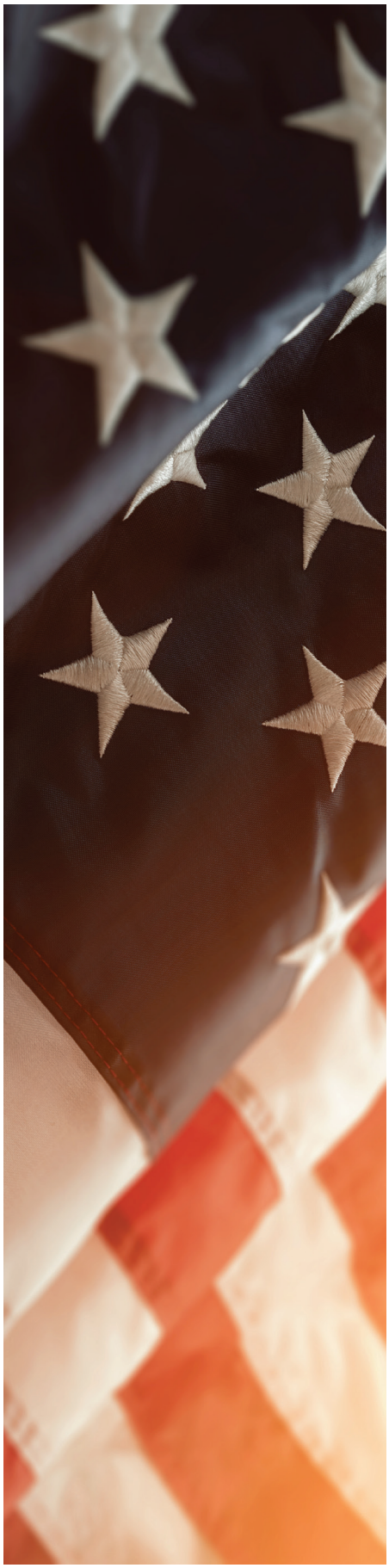
Integrated Plan

A plan is considered integrated if:

- All benefits under the plan have a combined plan year deductible
- All benefits under the plan have a combined annual maximum dollar amount, and
- All benefits under the plan have a combined lifetime maximum dollar amount

Note: The CMS Creditable Coverage Simplified Determination methodology was created before the ACA's prohibition on health plan annual/lifetime dollar maximums for Essential Health Benefits (EHBs). There is some ambiguity as to whether a plan's lack of any annual/lifetime dollar maximum means that the plan has a "combined" annual/lifetime maximum (because a plan could pay an infinite amount towards an individual's medical expenses) and therefore would be considered integrated. Or, in the alternative, it is possible that plans that have no lifetime and annual dollar maximums have no annual/lifetime maximums to "combine" under the plan. The latter interpretation would mean that such plans would be considered non-integrated. Plan sponsors should seek guidance from legal counsel to determine whether their specific plan is considered integrated or non-integrated. Further guidance from CMS on the Simplified Determination methodology post-ACA would be welcome.

In contrast, if a plan has an annual and/or lifetime dollar maximum on a non-EHB, which is allowed under the ACA, the plan should not be considered an integrated plan because the annual/lifetime maximum dollar amount is not combined for all benefits under the plan.



If the plan is **integrated**, then it is considered creditable if:

- Brand name and generic prescriptions are covered under the plan
- There is "reasonable access" to retail providers
- The prescription plan pays, on average, at least 60% of all participants' prescription drug expenses
- The plan (i.e., medical and prescription drug plan) has **no more than a $250 deductible per year**
- The plan has either no annual benefit maximum or a maximum annual benefit of at least $25,000, and
- The annual lifetime combined benefit is no less than $1,000,000

Non-Integrated Prescription Drug Plan

If a prescription drug plan is considered non-integrated under the CMS rules, the prescription drug plan will be considered creditable if it meets the following requirements:

- Brand name and generic prescriptions are covered under the plan
- There is "reasonable access" to retail providers
- The prescription plan pays, on average, at least 60% of all participants' prescription drug expenses; and
- Either one of the two criteria are satisfied:
  - » Prescription drug coverage has either no annual benefit maximum or a maximum annual benefit of at least $25,000, or
  - » There is an actuarial expectation that the amount paid under the prescription drug coverage for each Medicare-eligible individual will be at least $2,000 annually.

Actuarial Determination Methodology

Even when a plan is not creditable under the Simplified Determination methodology, the actuarial determination methodology could still be used to demonstrate that a plan is creditable. This requires using actuarial models to determine the estimated Part D base plan's gross and net costs (or the Gross Costs less the member cost sharing). The net-to-gross cost ratio is the Part D actuarial value. This number is compared to the actuarial value of the employer's plan you are testing. For it to be creditable, the actuarial value of the employer's plan must be equal to, or higher than, the actuarial value of the Part D plan design.

Changes to Medicare Part D in 2024 and January 1, 2025

Beginning in 2024, the primary change to Medicare Part D plans impacting the creditable coverage testing is the removal of the 5%-member coinsurance for catastrophic coverage. This will cap a member's cost at about $3,300 if they are utilizing brand-name drugs (member cost exposure was previously uncapped). After the initial member deductible, the 25%-member coinsurance will remain in place up to the catastrophic phase for all drugs (see 2023 Brand Drug Design, compared to 2024 Brand Drug Design at the end of this article). The shift of the 5% coinsurance from the member to the Part D Plan increases the actuarial value of the base Part D plan design, increasing the threshold to pass as creditable coverage.

Beginning January 1, 2025, the changes to Medicare Part D will dramatically impact the actuarial value more than the 2024 changes. The coverage gap phase is being eliminated, and an out-of-pocket spending cap of $2,000 is being placed on the initial coverage phase (see 2025 Brand Drug Design at the end of this article). This cost shift from the member cost share to the Part D plans further increases the actuarial value and will make it even more difficult for plans to pass creditable coverage testing.

The changes for 2024 and 2025 have caused the Medicare Part D plan's actuarial value to increase from about 68% in 2023 to nearly 74% in 2025. This meaningful difference could cause many existing employer-sponsored plans that were considered creditable in 2023 or 2024 to no longer meet minimum requirements in 2025 subject to an actuarial review.

Simplified Determination Methodology beginning January 1, 2025 and Beyond

CMS recently released guidance[2] that may eliminate the Simplified Determination methodology after the calendar year 2025. At this time, prescription drug plans that are **not** Employer Group Waiver Plans (EGWPs) and have **not** applied for retiree drug subsidies may continue to utilize the Simplified Determination methodology until December 31, 2025 to analyze whether a prescription drug plan is creditable, even if such prescription drug plan would be considered non-creditable under an actuarial review.

However, this relief shall only apply for the 2025 calendar year, so prescription drug plans that have a non-calendar year plan year may want to consider performing an actuarial review to determine the plan's creditable status for non-calendar year plan years beginning in 2025. CMS will either re-evaluate the continued use of the current Simplified Determination methodology or establish a revised version of the Simplified Determination methodology for calendar year 2026 and beyond.

Employer Considerations

Employers should be aware that due to these changes on January 1, 2025, it is quite possible that a plan that was once creditable for many years could become non-creditable on or after January 1, 2025. Prescription drug plans with non-calendar year plan years may also face challenges as to coverage considered creditable during 2024 and regarded as non-creditable after January 1, 2025.

At this time, there is very little guidance on relief provided to health plans with non-calendar year plan years that may no longer be considered creditable as of January 1, 2025. Employers should seek advice from legal counsel on approaching proper disclosure and reporting requirements related to non-calendar year plan years.

Although employers are not required to provide creditable coverage to employees, former employees or their Medicare-eligible spouses and dependents, many of these individuals may be surprised that coverage they have been enrolled in for many years is considered non-creditable as of January 1, 2025. As previously mentioned, certain Medicare-eligible individuals who fail to enroll in Medicare Part D (or an equivalent plan) within a certain timeframe of becoming eligible may be subject to penalties when they eventually enroll in Medicare Part D.

[2] https://www.cms.gov/newsroom/fact-sheets/final-cy-2025-part-d-redesign-program-instructions-fact-sheet

To avoid some confusion to employees and their covered family members, employers may want to consider informing Medicare-eligible beneficiaries of a change in the creditable to non-creditable status of the prescription drug plan before January 1, 2025, to ensure that those eligible for Medicare have the proper information about the effect of delaying enrollment into Medicare Part D.

Action Plan

Plan sponsors should either perform an actuarial review of their prescription drug plan or apply the Simplified Determination methodology to their prescription drug plans prior to the significant changes being made to Medicare Part D as of January 1, 2025. This is to ensure that the applicable creditable/non-creditable notice is being accurately provided to Medicare-eligible individuals and that a plan sponsor accurately reports the plan's creditable/non-creditable status to CMS.

Plan sponsors/employers of fully insured plans should consult with their insurance carrier partners. Plan sponsors/employers of self-funded plans may want to review their prescription drug plans more closely with their third-party administrators (TPAs) and pharmacy benefit managers (PBMs) to see if they will assist with determining the creditable/non-creditable status of the prescription drug plans.

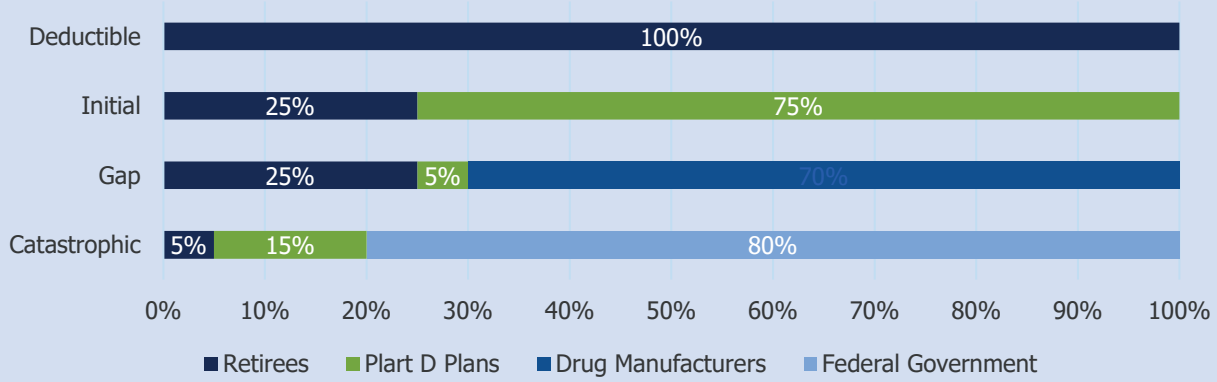
Employers affected by these changes to Medicare Part D may want to consider the following:

- Change their prescription drug plan design with their insurer/TPA to satisfy creditable coverage standards under the CMS rules if those plans would no longer be considered creditable after January 1, 2025, or
- Notify Medicare-eligible individuals that their prescription drug plans no longer meet the standards for creditable coverage by delivering the non-creditable coverage notice to Medicare-eligible individuals for calendar year plans during the open enrollment period that occurs in 2024 for coverage beginning January 1, 2025, and anytime there are any special/initial enrollments in 2025. For non-calendar year plan years, if the prescription plan was considered creditable in 2024 but considered non-creditable in 2025, the non-creditable coverage notice should be delivered to participants and beneficiaries within 30 days of January 1, 2025, and during any special/initial enrollment periods in 2025 (if applicable).

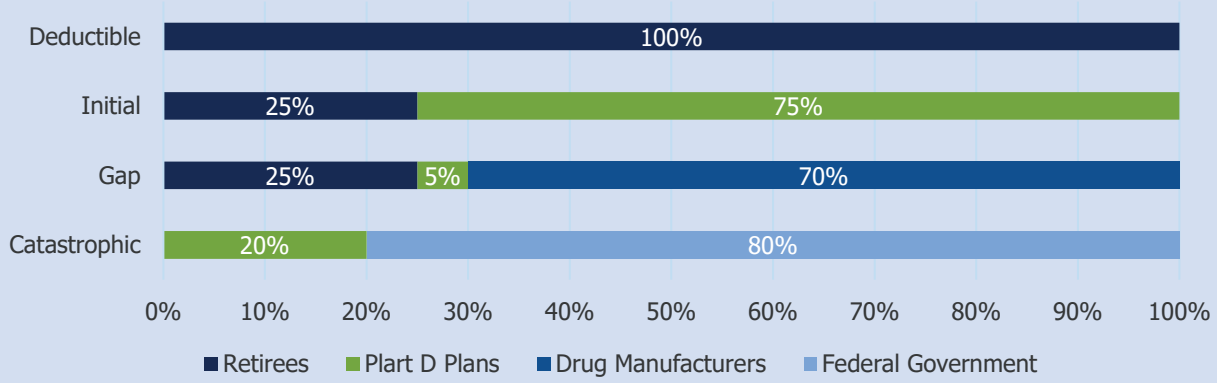
For more information on whether the plan is creditable/non-creditable, health plan sponsors should contact their insurance carriers/TPAs/PBMs (as applicable) and their actuarial team and legal counsel.

Exhibits – Brand Drug Designs

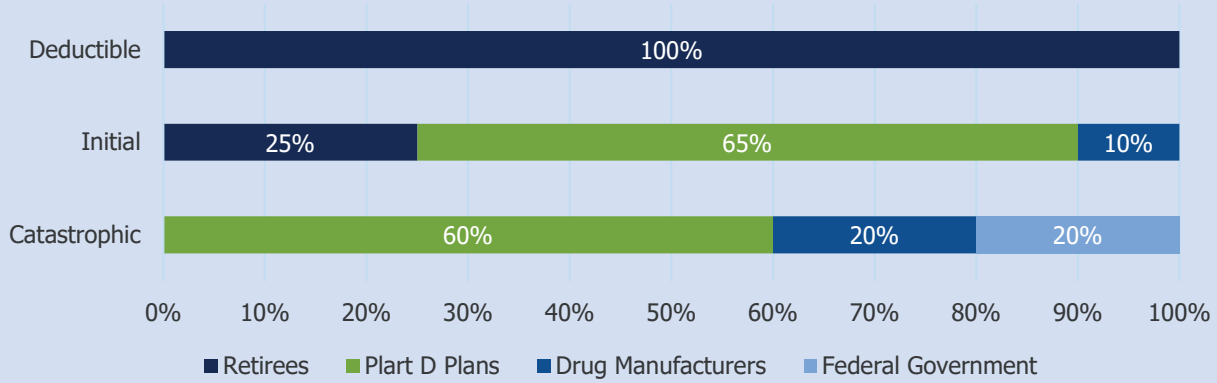
2023



2024



2025



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