Medicare Part D Regulations Bring Changes for Health Plan Sponsors

Recent changes to the Medicare Part D creditable coverage rules could have significant implications for employers and other group health plan sponsors. In final regulations issued in April 2026, the Centers for Medicare and Medicaid Services (CMS) introduced several updates intended to simplify compliance and reduce administrative burdens, particularly for sponsors of account-based medical plans such as health reimbursement arrangements (HRAs) and individual coverage HRAs (ICHRAs). At the same time, CMS finalized changes to the longstanding simplified determination method used to assess whether prescription drug coverage is creditable, raising the threshold plans must meet beginning in 2027.

This article outlines the key regulatory changes, including a new exemption for account-based medical plans from the Part D creditable coverage reporting requirements, and the phase-out and replacement of the former simplified determination method for determining group health plan creditable coverage status, and highlights practical considerations for plan sponsors preparing for the new requirements.

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Part D Creditable Coverage Notice Requirements

Under the implementing regulations for Part D, group health plans must provide a creditable coverage notice to Medicare eligible covered individuals and to CMS that specifies whether the plans' prescription drug coverage is creditable. This requirement applies to both self funded and fully insured medical and prescription drug plans and notice to covered individuals must be provided by October 15 of each year. The purpose of the notice is to assist Medicare eligible individuals in making informed enrollment decisions and to help them avoid late enrollment penalties when they eventually enroll in Part D coverage.

Account-Based Plans and Past Compliance Challenges

Before CMS issued the final regulations, account-based medical plans that provide prescription drug reimbursement coverage, such as HRAs and ICHRAs,

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were subject to the creditable coverage reporting requirements because the definition of "group health plan" for disclosure purposes specifically includes "account-based medical plans." As a result, plan sponsors were required to determine and report whether these arrangements provided creditable coverage, even though they do not directly offer prescription drug coverage.

In practice, these rules proved difficult for plan sponsors to administer, requiring an apples to oranges comparison of the value of reimbursement benefits against the actuarial value of the Medicare standard prescription drug benefit. The requirements also subjected participants to confusing and potentially contradicting disclosures, particularly for those participants who receive a non-creditable coverage notice from an account-based plan and a separate creditable coverage notice from an underlying prescription drug plan.

New Exemption for Account-Based Plans

To address these concerns, the final regulations adopted by CMS include an express exemption to the Part D creditable coverage disclosure and reporting requirements for account-based plans. For coverage beginning on or after January 1, 2027, sponsors of HRAs, ICHRAs and other account based plans will no longer be required to determine or disclose whether those arrangements provide creditable prescription drug coverage.

Importantly, the exemption only applies to account-based plans. Self-funded and fully insured group health plans that directly offer prescription drug coverage must continue to comply with the Part D requirements.

Changes to Simplified Determination Method

The final regulations also address how plan sponsors can determine creditable coverage status using the simplified determination method as opposed to actuarial testing. The simplified determination method provides a safe harbor for plans not applying for the Retiree Drug Subsidy (RDS) to establish creditable coverage by satisfying certain plan design criteria established by CMS guidance.

Before 2026, a plan could satisfy the simplified determination method by providing coverage for brand name and generic prescriptions; providing reasonable access to retail pharmacies; paying, on average, at least 60 percent of participants' prescription drug expenses; and meeting certain deductible or annual/lifetime benefit maximums.

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Beginning for 2026, however, CMS announced updates to the simplified determination method making it easier to determine and more difficult to pass. This updated method was optional for 2026 but is now mandatory for plans that will use the simplified determination method for 2027.

Under the updated method, a plan will be deemed to provide creditable coverage if it:

- Provides reasonable coverage for brand name and generic prescription drugs and biological products.
- Provides reasonable access to retail pharmacies.
- Pays at least 73 percent of participants' prescription drug expenses. This percentage will be indexed and updated for future years. CMS projects that it will be 75 percent by 2030.

As a result of these changes, plan sponsors seeking to use the simplified determination method should review the changes carefully with consultants and qualified legal counsel to assess compliance and consider whether plan amendments will be necessary to meet the updated standard.

If you have any questions about the changes and implications on creditable coverage, please contact Paul Beery or another member of the Employee Benefits Practice.

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