

Publications

CMS Finalizes Updates to the Prescription Creditable Coverage Methodology Determination

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In April 2025, the Centers for Medicare and Medicaid Services (“CMS”) issued multiple pieces of guidance related to Medicare Part D prescription drug coverage, including the [Final CY 2026 Part D Redesign Program Instructions](#).

The Final CY 2026 Part D Redesign Program Instructions specifically address the methodology that plan sponsors may use to determine whether the prescription drug coverage offered through their group health plan provides “creditable coverage.” As we explained in our [previous alert](#) on this topic, plan sponsors must notify Medicare-eligible participants and the Centers for Medicare & Medicaid Services (“CMS”) whether the plan’s prescription drug coverage is “creditable,” meaning it is expected to pay, on average, as much as standard Medicare Part D prescription drug coverage. The required notice is commonly referred to as the “Notice of Creditable Coverage.” Plan sponsors may make the creditable coverage determination through actuarial equivalence testing or a simplified determination methodology.

However, the Inflation Reduction Act of 2022 (“IRA”) made substantial enhancements to the Medicare Part D benefit, including lowering beneficiaries’ out-of-pocket costs to \$2,000 in 2025 (\$2,100 in 2026). Accordingly, these changes necessitated changes to the creditable coverage methodology because the simplified determination methodology no longer reflected the actuarial equivalence of standard Part D coverage. In the Final CY 2026 Part D Redesign Program Instructions, CMS finalized its revised simplified determination methodology proposed in January 2025. For CY 2026 only, group health plans that do not receive the retiree drug subsidy may elect to use the existing simplified determination methodology or adopt the newly finalized methodology. Under the new methodology, a group health plan will provide creditable coverage if the prescription drug plan:

- offers reasonable coverage for brand name and generic prescription drugs and biological products;
- provides reasonable access to retail pharmacies; and
- is designed to pay on average at least 72% of participants’ prescription drug expenses.

The final instructions do not explain the criteria CMS will use to determine whether a plan provides “reasonable coverage” or “reasonable access.” The requirement to cover

at least 72% of participants' prescription drug expenses is an increase from the current simplified methodology's 60% requirement. Plan sponsors will likely need to review their prescription drug coverage with their consultants to ensure it continues to provide creditable coverage under this new methodology.

[Click here](#) for our coverage of the 2026 changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program and Programs of All-Inclusive Care for the Elderly.