

Navigating Creditable Coverage Determinations in 2027

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Each year, the Centers for Medicare and Medicaid Services (CMS) release updated parameters for standard Medicare Part D coverage. Plan sponsors of prescription drug benefits must assess whether their prescription drug plan(s) are creditable or non-creditable based on these annual parameters. After determining the creditable status, plan sponsors are required to disclose this information to employees before October 15 each year and report it to CMS within 60 days following the start of the plan year. If a plan's creditable status changes, plan sponsors must re-disclose the notice to employees and submit updated reporting to CMS within 30 days of the change.

Purpose of Disclosure and CMS Reporting

The disclosure to participants serves to inform them about the creditable status of their plan, allowing them to make informed decisions regarding the timing of their Medicare Part D enrollment. Reporting to CMS enables the agency to apply a one percent late enrollment penalty to individuals who delay Part D enrollment beyond their initial period triggered by their 65th birthday and who lack creditable coverage for at least 63 days.

Creditable Coverage Determination Methods

Creditable prescription drug coverage is defined as coverage that is equal to or greater than the actuarial value of standard Medicare Part D coverage. Non-creditable coverage has a value below the standard Part D plan. Plan sponsors can determine creditable status using either a simplified determination method or an actuarial evaluation. Employer Group Waiver Plans (EGWPs) and Retiree Drug Subsidy applicants are required to use actuarial valuation.

For nearly two decades, group health plans relied on CMS' 2009 simplified determination. However, this method became outdated after the Patient Protection and Affordable Care Act (ACA). The Inflation Reduction Act authorized CMS to enhance the Part D program, increasing its actuarial value starting in 2025. To address these issues, CMS introduced a new simplified determination—optional in 2026 and mandatory in 2027 and beyond. The only change from 2026 to 2027 is a one percentage point increase in required value.

2027 Simplified Determination Method

Under the revised simplified determination methodology, coverage will be considered creditable if it:

- Provides 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 73 percent of participants' prescription drug expenses.

Health plans with high deductibles may meet the percentage threshold through other plan designs, such as not applying the deductible to preventive drugs, reasonable and supportable allocation of the deductible attributable to prescription drugs, or by offering lower cost sharing than standard Part D coverage once the deductible is met.

CMS has indicated that further increases to the actuarial value are expected in coming years, and it will strive to provide timely updates to enable plan sponsors that wish to adjust their plan designs to have additional time to do so.

Actuarial Valuation

While most plan sponsors can use the simplified determination method, plan sponsors unable to demonstrate creditable status via this method—or those operating EGWPs or applying for the Retiree Drug Subsidy—must obtain an actuarial valuation to determine creditable status.

Account-Based Plans Excluded

Account-based plans (health flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs)) have been considered group health plans under the creditable coverage rules, unless designed to be excepted benefits. Prior guidance from CMS permitted the exclusion of health FSAs and HSAs from the determination but required disclosure and reporting on certain HRAs. After the introduction of individual coverage HRAs (ICHRAs) and qualified small employer HRAs (QSEHRAs), it became unclear how to comply with the Part D creditable coverage requirements for standalone HRAs that may or may not reimburse prescription drug costs.

Beginning with 2027 plan years, all account-based plan, including ICHRAs, and QSEHRAs, are excluded from the definition of “group health plan.” As a result, plan sponsors are no longer required to test, notify, or disclose the creditable status of these plans. This exclusion aims to reduce confusion for employees who might otherwise receive conflicting notices. For example, an employee participating in an ICHRA may receive a non-creditable coverage notice for the ICHRA and a creditable coverage notice from the insurer of their health insurance – causing conflicting messages.

Action Steps for Plan Sponsors

Employers are not obligated to offer prescription drug benefits that meet creditable coverage standards and are not penalized for failing to do so. However, they must inform participants of the plan’s status to help them make informed choices about delaying Medicare Part D enrollment past their initial eligibility at age 65. The plan’s status must also be reported to CMS, enabling the agency to determine whether to impose a late enrollment penalty on individuals with a 63-day or longer gap in creditable coverage before enrolling in Part D.

To comply with notice and reporting requirements, plans should request the creditable or non-creditable status from their carrier when selecting group health plan options for the upcoming plan year. If the carrier cannot provide this status, plan sponsors should engage with their Gallagher consultant to conduct a review or actuarial valuation. For more information about the actuarial valuation, please review our resource, [Creditable Coverage: A Closer Look](#).

The intent of this article is to provide general information on employee benefit issues. It should not be construed as legal advice and, as with any interpretation of law, plan sponsors should seek proper legal advice for application of these rules to their plans.