Implications of Coming Medicare Part D Changes for Retiree Health Plans

March 19, 2024 / Kathryn Bakich / Ed Kaplan / Mary Kirby, FSA, FCA, MAAA

Segal

Agenda

Changes Made by the Inflation Reduction Act

EGWP versus Retiree Drug Subsidy

Creditable Coverage

Medicare Advantage Landscape

Next Steps

New Retiree Health Landscape after the IRA

- The Inflation Reduction Act was signed August 16, 2022
- The Act significantly changes Medicare coverage
  - Medicare will negotiate prices for certain prescription drugs
  - Medicare will receive inflation rebates from manufacturers
  - Part D design changes significantly
  - Additional Medicare coverage for vaccines and insulin

IRA Changes Timeline for Part D Plans

2023

- $35 Insulin cost cap
- No cost vaccines
- Manufacturers pay rebates to Medicare for drugs increasing more than inflation

2024

- Cost share eliminated for catastrophic tier
- Low Income Subsidies expanded from 135% of FPL to 150%
- Base Beneficiary Premium increases capped at 6% (through 2030)

2025

- $2,000 annual OOP Max (indexed)
- For catastrophic tier:
  - Medicare share reduced to 20%
  - Plan share increased to 60%
  - Drug manufacturers introduced at 20%
- Allows members to make coinsurance installment payments over a year (M3P Program)

2026

Medicare negotiates drug prices

- 2026: 10 drugs
- 2027: +15
- 2028: +15
- 2029: +20

2027

Rule that would eliminate rebates delayed until at least 2032

Medicare Negotiating Prices for 10 Drugs

- Beginning in 2026, Medicare will announce maximum fair prices that must be used by Part D plans for 10 drugs, with more to be phased in each year
- If the manufacturer refuses to participate in the negotiation program or fails to comply with the maximum fair price, they can face an excise tax
- Several manufacturers have filed suit challenging the program; litigation continues
- The program applies to both commercial plans and Employer Group Waiver Plans (EGWPs), but not to the Retiree Drug Subsidy
- Unclear what the market impact will be on prices paid by employment based plans

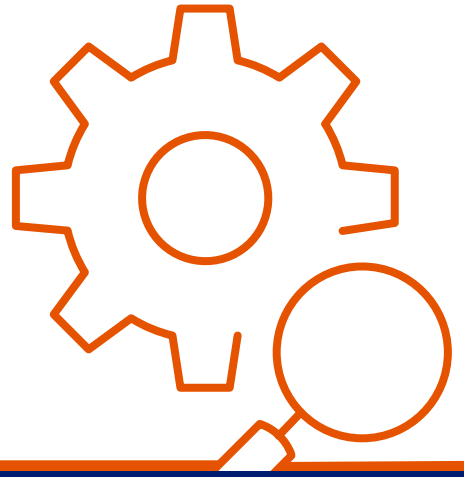
Initial Targeted Drugs

Drug Name	Commonly Treated Conditions	Total Part D Gross Covered Prescription Drug Costs from June 2022–May 2023	Manufacturer
Eliquis	Prevention and treatment of blood clots	$16,482,621,000	Bristol Myers Squibb
Jardiance	Diabetes; heart failure	$7,057,707,000	Boehringer Ingelheim
Xarelto	Prevention and treatment of blood clots; reduction of risk for patients with coronary or peripheral artery disease	$6,031,393,000	Janssen Pharms
Januvia	Diabetes	$4,087,081,000	Merck Sharp Dohme
Farxiga	Diabetes; heart failure; chronic kidney disease	$3,268,329,000	AstraZeneca AB
Entresto	Heart failure	$2,884,877,000	Novartis Pharms Corp
Enbrel	Rheumatoid arthritis; psoriasis; psoriatic arthritis	$2,791,105,000	Immunex Corporation
Imbruvica	Blood cancers	$2,663,560,000	Pharmacyclics LLC
Stelara	Psoriasis; psoriatic arthritis; Crohn’s disease; ulcerative colitis	$2,638,929,000	Janssen Biotech, Inc.
Fiasp; Fiasp FlexTouch; Fiasp PenFill; NovoLog; NovoLog FlexPen; NovoLog PenFill	Diabetes	$2,576,586,000	Novo Nordisk Inc.

Note: Numbers are rounded to the nearest thousands.

Medicare Part D Design Changes

- By 2025, Part D will have an annual out-of-pocket maximum of $2,000
- Beneficiaries will be able to sign up for a payment plan so they don't have to pay full amount at once
- Portion of costs paid by each party (beneficiary, plan, manufacturer, and government) changes significantly
- Manufacturer discount program changed
- Expanded income eligibility for Low Income Subsidy

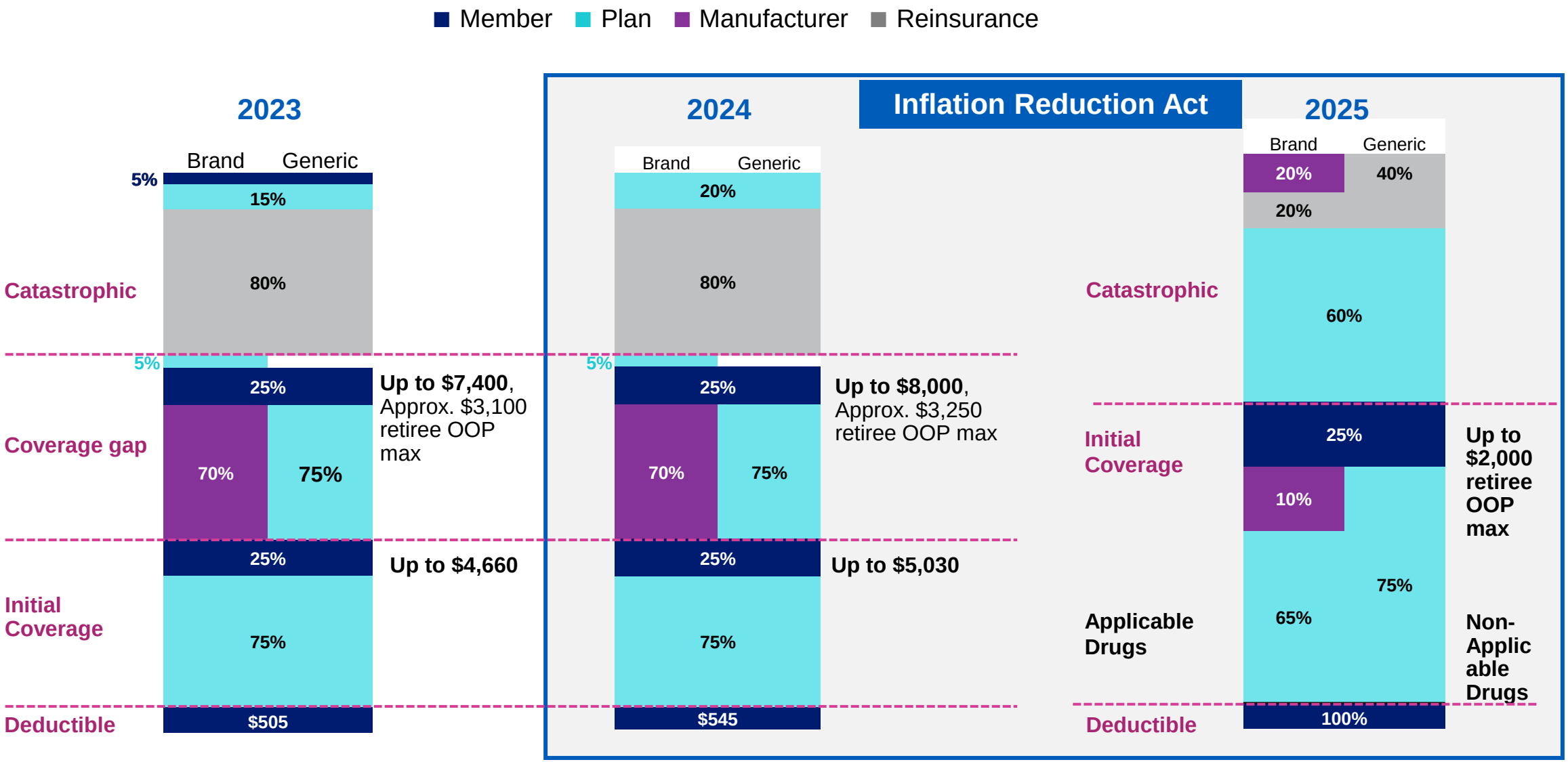


See our chart for a complete list of changes.

Digging into the Financial Details for 2025

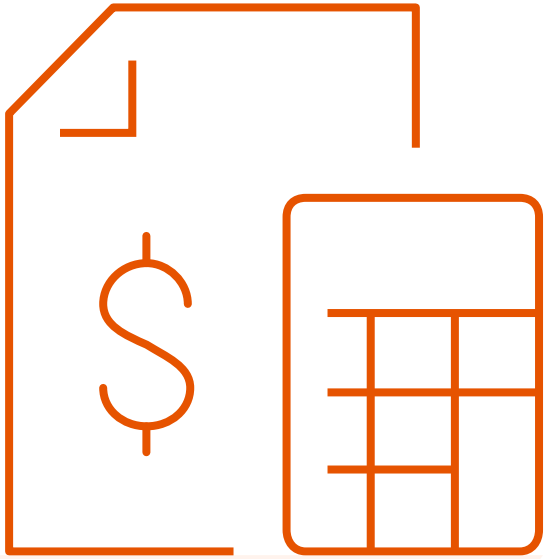
- Medicare beneficiary annual out-of-pocket costs will be capped at $2,000 (also known as the True Out-of-Pocket amount, or “TrOOP”)
- For the catastrophic tier:
  - Government payments reduced to 20% brand, 40% generic
  - Plan share increased to 60%
  - Drug manufacturers introduced at 20% brand

Changes to Medicare Part D Design



TrOOP Calculation

- The IRA provides that both the retiree and plan payments count toward the retiree's True Out-of-Pocket (TrOOP) maximum
- This change means that some retirees may meet the $2,000 TrOOP maximum without actually paying $2,000 out of pocket



Medicare Prescription Payment Plan (M3P)

- Program is effective January 1, 2025 for all Medicare plans offering Part D coverage
- Member must opt into program
- Program allows participants to pay their out-of-pocket prescription drug costs in monthly amounts over the course of the plan year
  - Not needs based, anyone can opt into program
  - Member that opts in to program pays $0 at the point of service for the Part D drug
  - Plan sponsor is charged 100% of allowed amount
  - Must collect cost sharing from participant up to a maximum monthly cap
  - Part D enrollees incurring high OOP costs earlier in plan year will benefit from this program as it spreads their costs out across plan year
- Does not impact how participant moves through the Part D benefit or what counts toward true out-of-pocket (TrOOP) costs

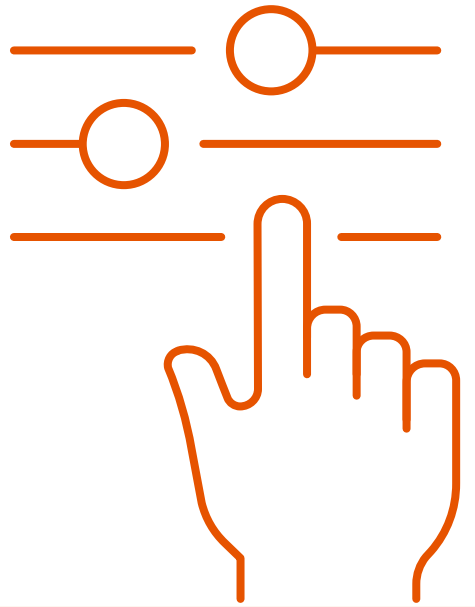
Medicare Prescription Payment Plan (M3P)

Impact on Plan Sponsors

- Requires plan sponsors to find administrator to manage billing and collection process
- Increased administrative costs
  - Monthly cap could change each month depending upon utilization
  - Billing to members for their monthly payment
  - Reconciliation of payments
- Cashflow
  - Plan sponsors will be paying claims for participants who have opted into the program at point of sale, but collecting monthly from participants
  - Impact on utilization

Medicare's Income-Related Monthly Adjustment Amount (IRMAA)

- Higher-income Medicare beneficiaries must pay an additional premium based on their income
  - Based on Modified Adjusted Gross Income (MAGI) from two years previous to current year
- IRMAA is phased in based on income levels
- IRMAA will affect retirees enrolled in Medicare, but not those in plans that receive the RDS



2024 Income Related Monthly Adjustment Amount (IRMAA)

Beneficiary Income — Individual Filing	Beneficiary Income — Joint Filing	Part B IRMAA	Part D IRMAA
Less than or equal to $103,000	Less than or equal to $206,000	$0.00	$0.00
Greater than $103,000 and less than $129,000	Greater than $206,000 and less than $322,000	$69.90	$12.90
Greater than $129,000 and less than $161,000	Greater than $258,000 and less than $322,000	$174.70	$33.30
Greater than $161,000 and less than $193,000	Greater than $322,000 and less than $386,000	$279.50	$53.80
Greater than $193,000 and less than $500,000	Greater than $386,000 and less than $750,000	$384.30	$74.20
Greater than or equal to $500,000	Greater than or equal to $750,000	$419.30	$81.00

What Is Expected to Happen in 2025?

- Part D claims will increase and payments to the plan could decrease
  - The Part D standard benefit is richer
  - The $2,000 OOP max will lower retiree's cost sharing
  - The shift in payment responsibility means the plan will shoulder more costs and the government less
- Premiums for Part D plans will be volatile
- We will know more in June when Part D plans submit their bids for 2025 plans

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Options for Plan Sponsors to Provide Retiree Rx Benefits

Employer Group Waiver Plan Prescription Drug Plan (EGWP)

Retiree Drug Subsidy (RDS)

Medicare Advantage Prescription Drug Plan (MAPD)

Quick Survey

Which Options do you Provide for Retiree Rx Benefits?

- ○ Employer Group Waiver Plan Prescription Drug Plan (EGWP)
- ○ Retiree Drug Subsidy (RDS)
- ○ Medicare Advantage Prescription Drug Plan (MAPD)
- ○ Medicare Supplement/Medigap
- ○ None of the above

What is an Employer Group Waiver Plan (EGWP)?

- EGWPs were authorized by Congress to allow employer-sponsored plans and multiemployer plans to contract with a Part D Prescription Drug Plan to offer benefits to employees
- Centers for Medicare & Medicaid Services may waive any requirement applicable to Part D plans that would interfere with offering them to employment groups, e.g., enrollment rules, payment rules, marketing, etc.
- EGWP may be either a Part D-only plan or a MAPD plan

Part D EGWPs

Part D EGWPs are group sponsored Medicare Part D plans with an enhanced benefit beyond the Standard Part D benefit

- An EGWP plan is customizable to mirror current plan design as long as the plan is as good or better than the standard Part D benefit
- Low-income subsidies are available for eligible retirees
- EGWPs receive three different plan subsidies:
  - Base or Direct subsidy—based on the National Average Monthly Bid adjusted by risk score and reduced by the Base Beneficiary Premium
  - Manufacturer's Discount Program (pre-IRA was the Coverage Gap Discount Program)
  - Government Reinsurance

Part D EGWP Direct Subsidy Trend

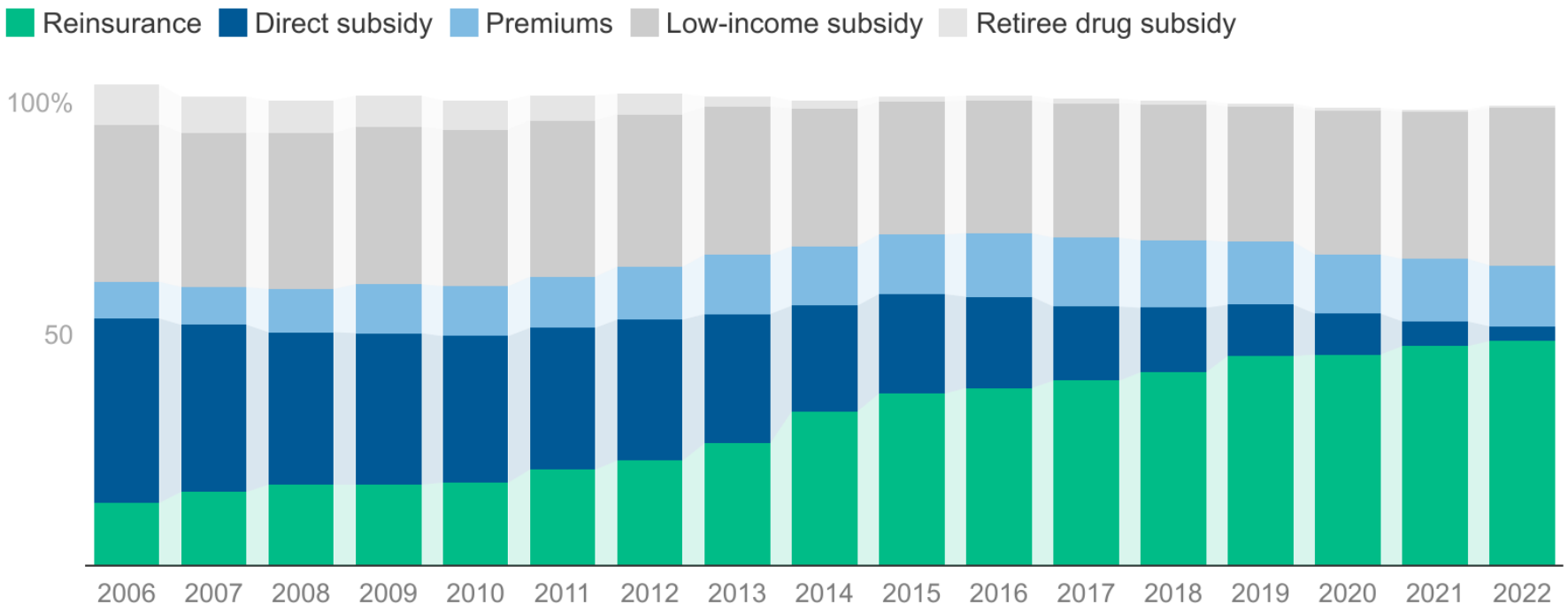
The Part D National Average Monthly Bid Amount has decreased more than 30% over the past five years, reducing the net paid direct subsidy

Year	Average Bid	Base Premium
2023	$34.71	$32.74
2022	$38.18	$33.37
2021	$43.07	$33.06
2020	$47.59	$32.74
2019	$51.28	$33.19

By contrast, the manufacturer coverage gap discount and government reinsurance have gone up considerably

EGWP Subsidies

Spending for Catastrophic Coverage (“Reinsurance”) Now Accounts for Nearly Half (48%) of Total Medicare Part D Spending, up from 14% in 2006



SOURCE: KFF analysis of data from the 2016-2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table IV.B10.

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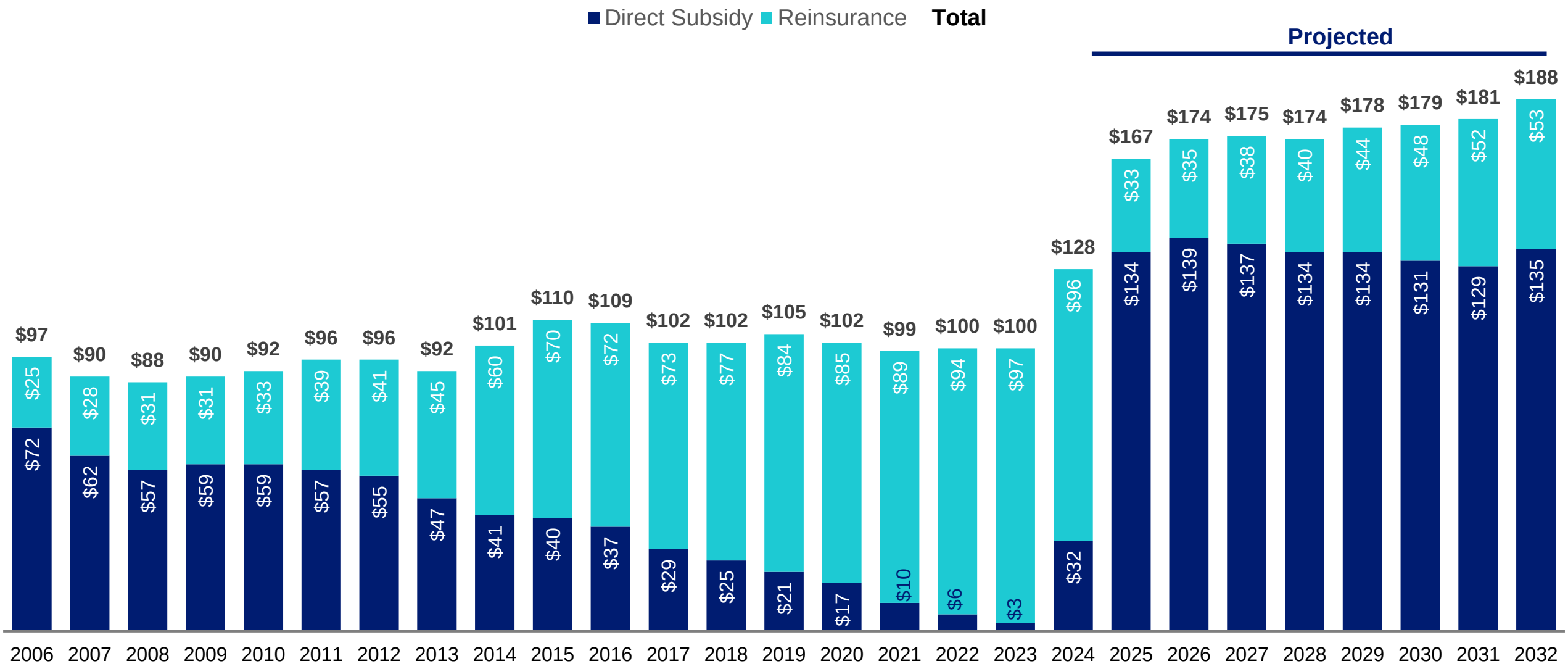
Average Part D Payments (PMPM)



Source: 2023 Medicare Trustees Report, Table IV.B9 for 2013−2022; 2013 Medicare Trustees Report, Table IV.B10 for 2006−2012.

What is the Retiree Drug Subsidy?

- Retiree Drug Subsidy program reimburses group health plans that continue to provide a retiree drug benefit
- Retirees must be enrolled in group plan and not in a Part D plan
- RDS provides a 28% subsidy for each retiree's drug spend between certain thresholds ($590 and $12,150 for 2025)
  - Requires periodic reporting and annual reconciliation of costs
  - No member impact
  - Requires annual actuarial attestation

RDS Actuarial Attestation

In order to qualify for the RDS, plans are required to pass a Two Prong Test

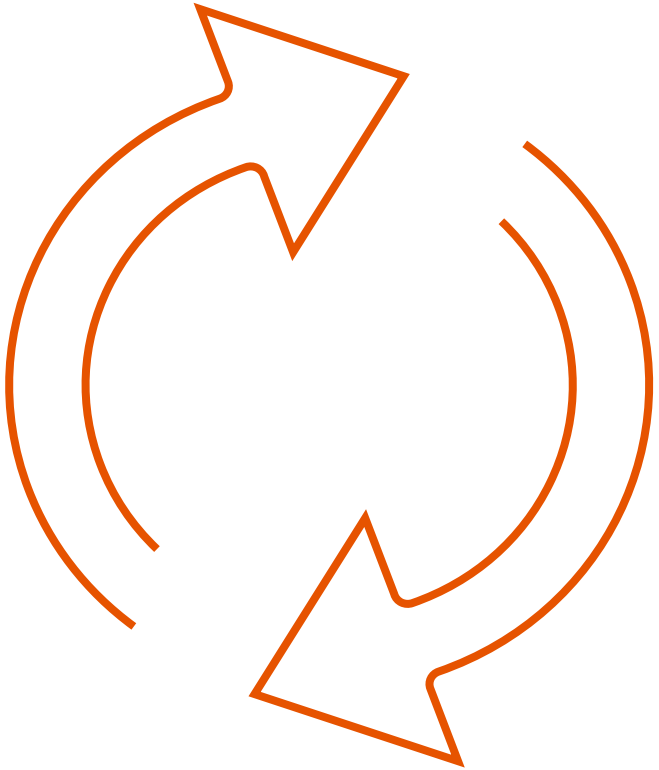
- Gross value test—the plan's expected amount of paid claims for Medicare beneficiaries must be at least equal to the expected amount of paid claims under the Part D benefit
  - Should use claims information if credible
  - This test was also used to test creditable coverage
- Net value test—takes in to account the participant's contribution toward the coverage

Prior to the Inflation Reduction Act, testing assumed that coverage gap (aka "donut hole" where participants paid 100% coinsurance) was still in existence, which allowed plans to pass the gross test easily

- The 2025 plan design is significantly richer than in prior years
- This could create an issue for plans passing the gross value test
- It may be harder to pass the gross value test

Big Picture — Which is Better?

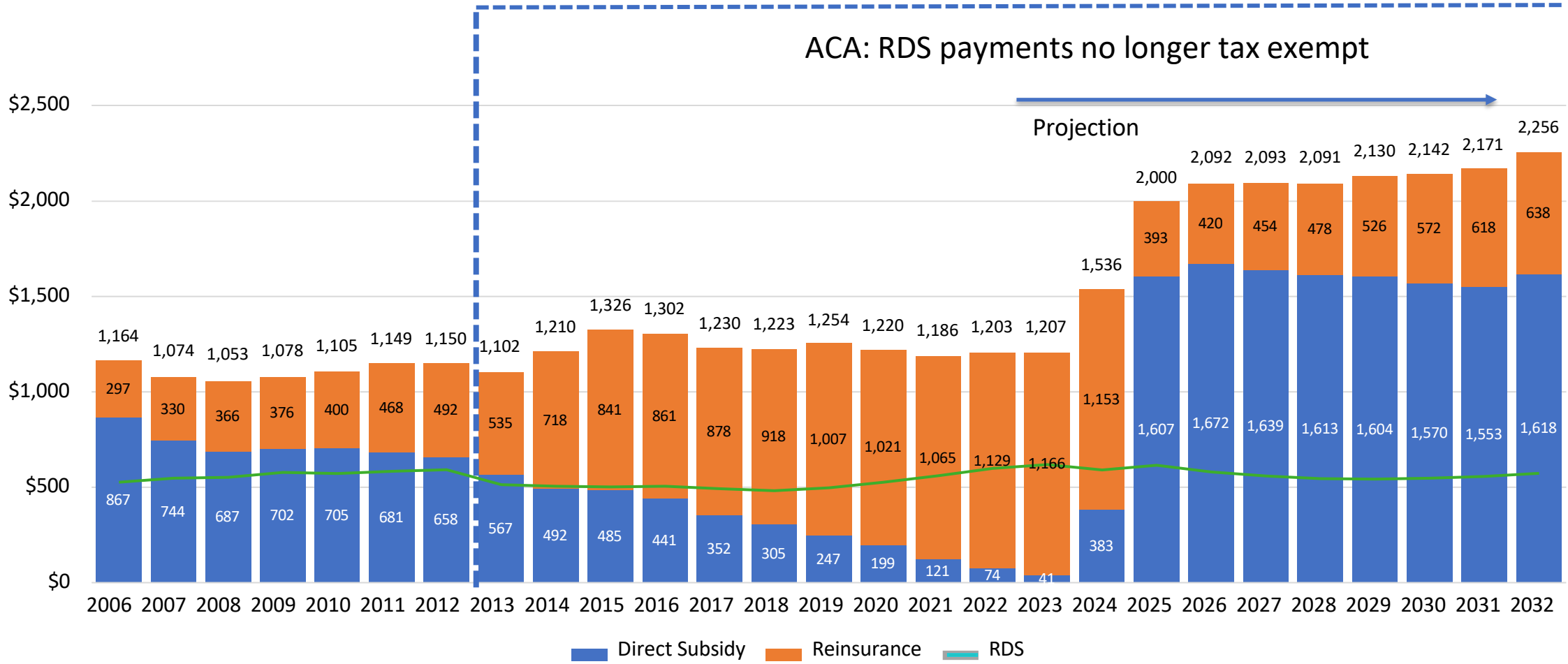
Part D EGWPs tend to result in higher reimbursement to the plan, but the equation could change significantly after the IRA 2025 change



RDS is available without changing the plan or its administrators — adopting an EGWP can result in some member disruption

But let's get into the details…

Average Part D Compared to RDS Payment per Enrollee



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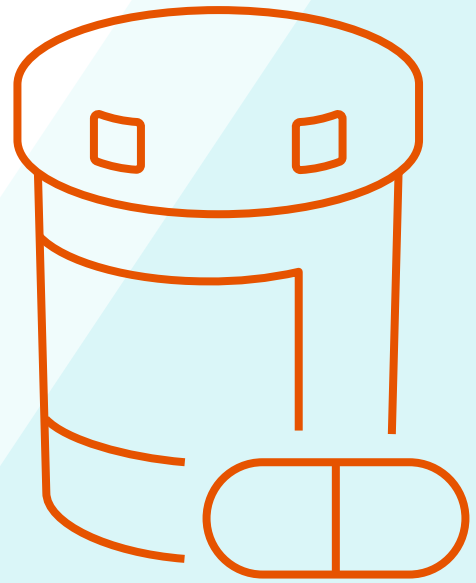
Creditable Coverage Testing for Actives

- Plans must issue Notices of Creditable Coverage each year, telling active employees whether their drug coverage is equal to or better than the Part D benefit
- Because of the improvement in the Part D benefit, some group health plans who previously had creditable coverage may find the coverage is now not creditable
- Medicare-eligible active employees in a drug plan that is not creditable may incur a penalty if they do not enroll in Medicare Part D
- Plan sponsors should watch for final guidance in April concerning how creditable coverage will be calculated

Creditable Coverage and Active Plans

For plans that had active Medicare eligible participants

- Gross test for RDS: May not have access to the claims information needed
- Simplified determination: No longer available based on the Initial Call letter
- Can use pricing models to determine actuarial value compared to standard Part D plan



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Medicare Advantage by the Numbers*

30+ Million

Americans with Medicare Advantage Plans

51%

Medicare eligible retirees choosing MA plans in 2023 over traditional Fee for Service

3 of 4

Seniors say it is important for the federal government to protect funding for Medicare Advantage

Bipartisan, Super Majority

of Congress in favor/support of MA Plans

16 of 16

Clinical measures MA plans outperform Medicare

93%

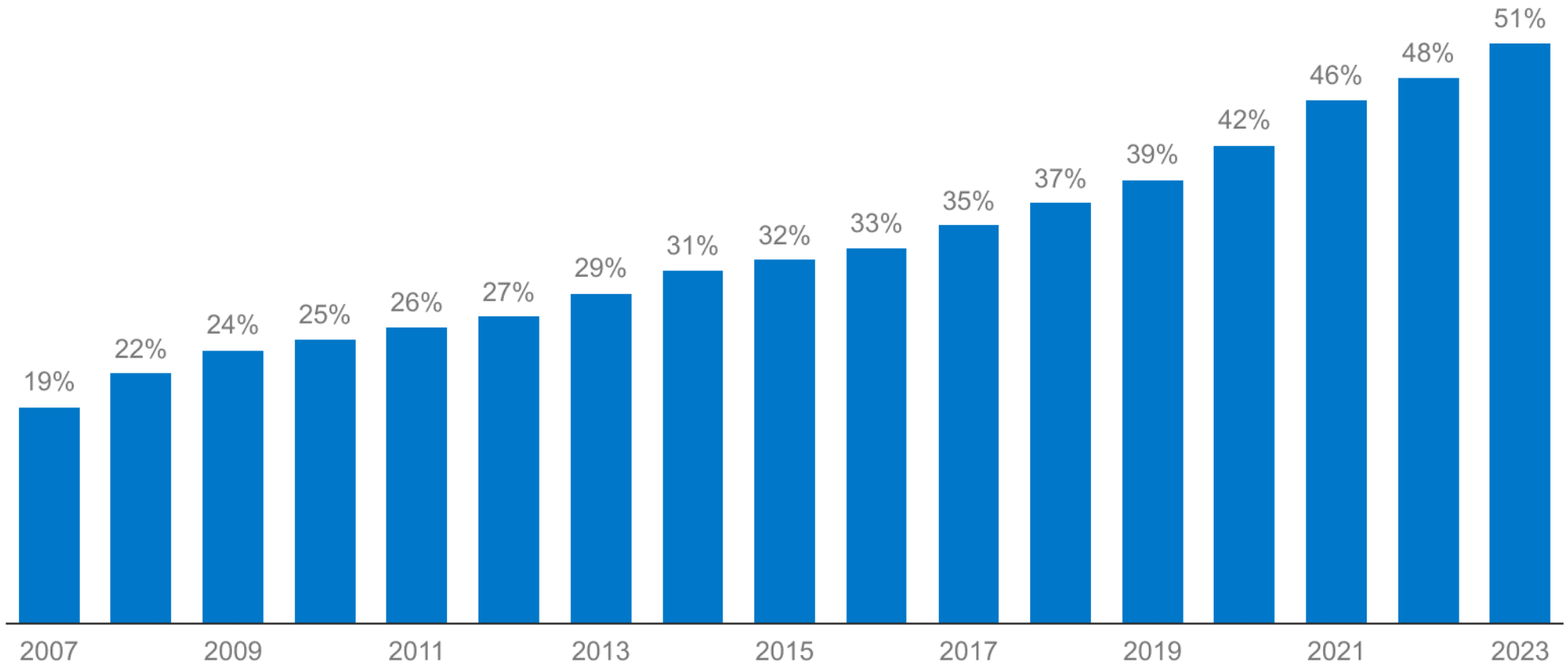
seniors with MA who are satisfied with their coverage

9 in 10

Seniors in MAPD plan are satisfied with their prescription drug coverage

*Source: The academy of Health Information Professionals (AHIP) MA by Numbers.

Total Medicare Advantage Enrollment, 2007–2023



NOTE: Enrollment data are from March of each year. Includes Medicare Advantage plans: HMOs, PPOs (local and regional), PFFS, and MSAs. About 60.0 million people are enrolled in Medicare Parts A and B in 2023.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2010-2023; Medicare Chronic Conditions (CCW) Data Warehouse from 5 percent of beneficiaries, 2010-2016; CCW data from 20 percent of beneficiaries, 2017-2020; and Medicare Enrollment Dashboard 2021-2023.

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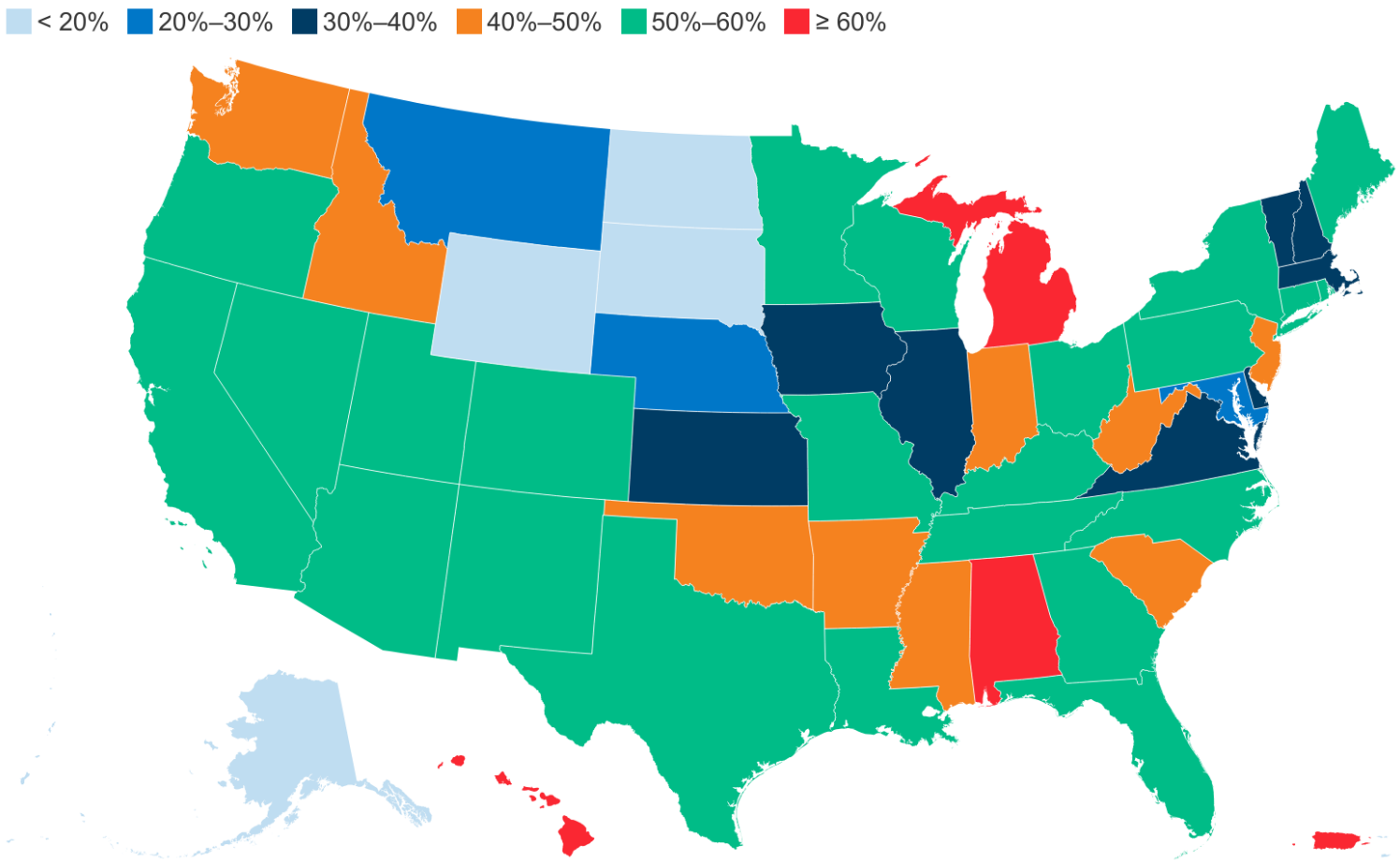
Share of Beneficiaries Enrolled in Medicare Advantage in 2023, by State



NOTE: Includes only Medicare beneficiaries with Part A and B coverage.
SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files and March Medicare Enrollment Dashboard, 2013 and 2023.

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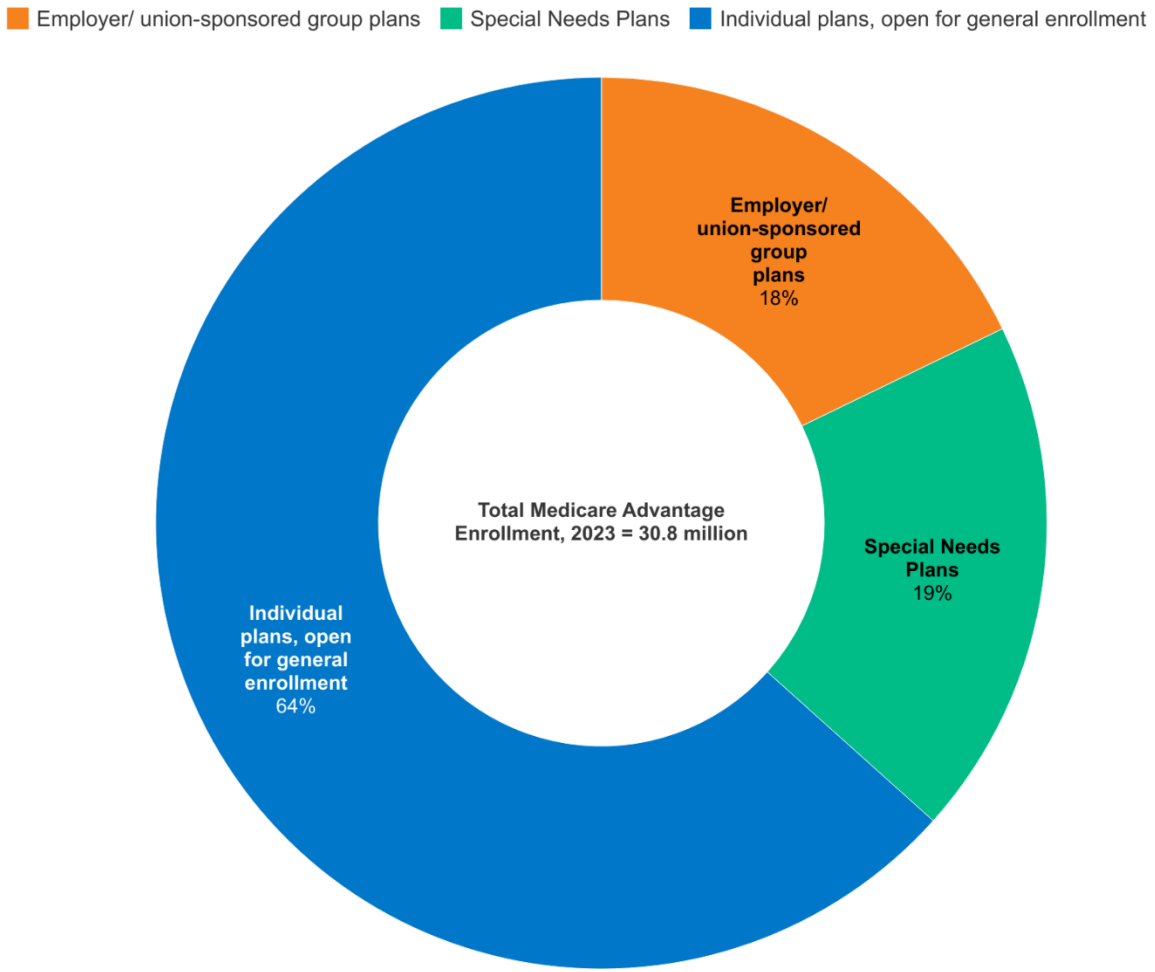
Distribution of Medicare Advantage Enrollees by Plan Type, 2023



SOURCE: KFF analysis of CMS Medicare Advantage Enrollment Files, 2023.

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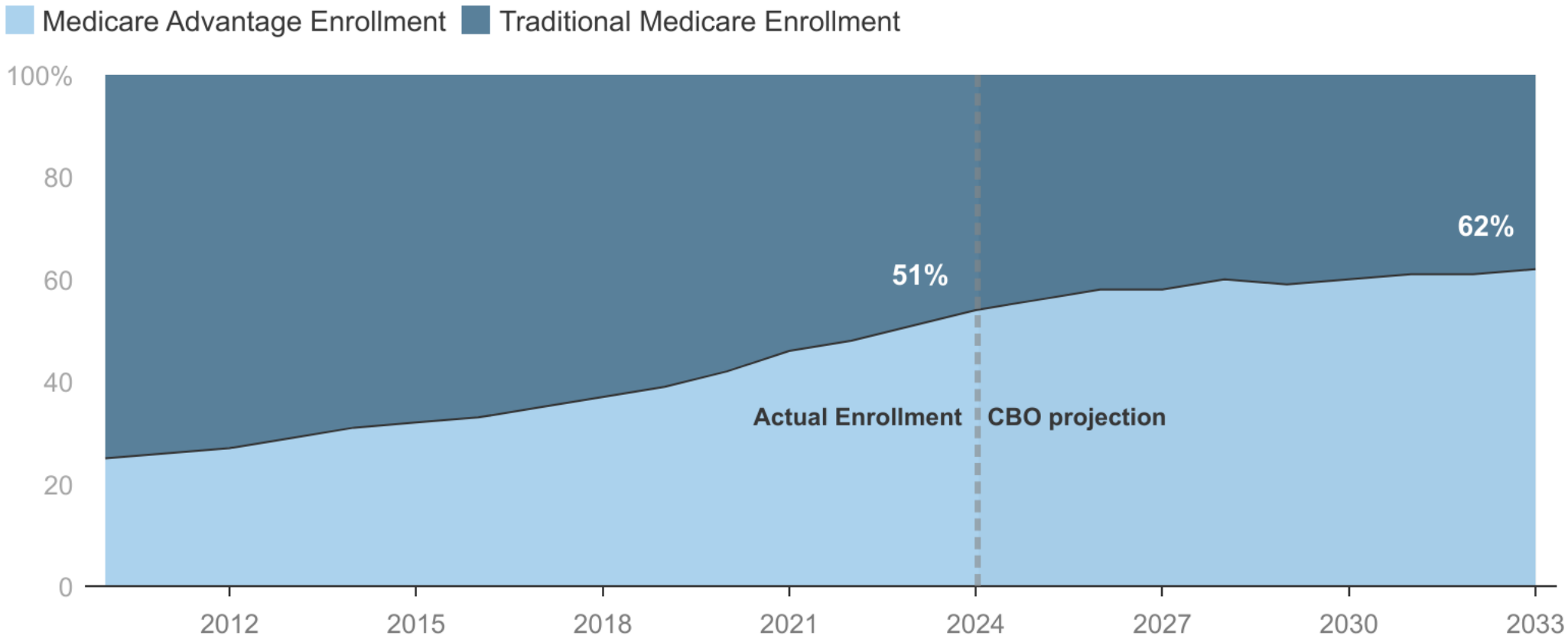
Medicare Advantage and Traditional Medicare Enrollment, Past and Projected



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Considerations

Does the IRA change your approach to offering retiree health coverage?

- CMS has gradually improved coverage and funding for Medicare beneficiaries
- The economics between MAPD, EGWP, RDS and Traditional Medicare continue to evolve

Creditable coverage is a concern for plan sponsors with Medicare eligible actives

- If an active wants to enroll in Part D, they likely would need to disenroll in medical and prescription drug coverage since they are not traditionally offered separately
- Medicare Secondary payer rules

Plans that offer EGWPs

- While the direct subsidy is expected to increase, it is not clear that this increase will offset the increase in premium required to meet the 2025 Part D plan design
- The M3P program will increase administrative costs and reduce cashflow

Plans that collect RDS and are failing the gross test

Should consider if an EGWP is a viable option by analyzing cost of EGWP versus cost of improving the plan to pass the gross test

Thank You

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