Milliman

# Medicare Advantage 2024

## Bidding hot topics

April 19, 2023

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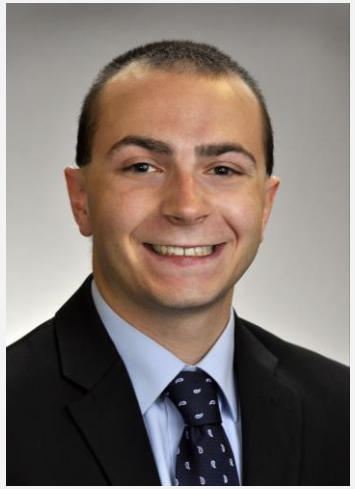
# Introductions



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# Overview of the 2024 rate announcement

# Agenda

High-level summary

Effective growth rate

CMS-HCC risk score model

Risk score payment model for 2024

Part D & IRA

# High-level summary

| Impact | 2024 Advance notice | 2024 Rate announcement | Change in impact[1] |
|---|---|---|---|
| Effective growth rate | 2.09% | 2.28% | 0.19% |
| Rebasing / re-pricing | N/A | 0.00% | N/A |
| Change in 2023 star ratings | -1.24% | -1.24% | 0.00% |
| Change in MA coding pattern adjustment | 0.00% | 0.00% | 0.00% |
| Risk model revisions and normalization | -3.12% | -2.16% | 0.96% |
| MA risk score trend | 3.30% | 4.44% | 1.14% |
| **Expected average change in revenue** | **1.03%** | **3.32%** | **2.29%** |

[1]Reflects revenue increase from rate announcement relative to advance notice

# 2024 CMS-HCC model (v28)

## Updated data and denominator years

- Data year reflects 2018 diagnoses with 2019 expenditures
- Denominator year based on 2020

## Clinical updates

- Based on ICD-10 diagnosis codes
- Approximately 20% fewer diagnosis codes associated with a payment HCC

## HCC impacts

- Increase in count of payment HCCs from 86 to 115
- Constrain Diabetes and Congestive Heart Failure HCCs
- Remove other HCCs

## Revenue impacts

- Shifts risk scores:
  - New Enrollees see increase
  - Many others see decrease
- CMS estimates lower annual coding trend

# Risk score payment model for 2024

Blend of 2020 CMS-HCC and 2024 CMS-HCC Models

3 Year Phase in with the following weights on the v28 model:

- 33% in 2024,
- 67% in 2025, and
- 100% in 2026

# Part D & IRA considerations

**Removal of member cost sharing in catastrophic phase (from 5%)**

**Increased full low income subsidy limit (from 135% to 150% FPL)**

**Insulin and vaccine cost sharing limits ($35 and $0, respectively)**

**Base beneficiary premium (BBP) capped at 6%**

| **Part D:** Parameter changes | | |
|---|---|---|
| **Benefit parameter** | **2023** | **2024** |
| Deductible | $505 | $545 |
| Initial coverage limit | $4,660 | $5,030 |
| Out-of-pocket threshold | $7,400 | $8,000 |

# Part B

## Coinsurance changes

# Drug cost-sharing changes

## Inflation-based rebates

- Manufacturers will pay the government rebates if drug prices increase faster than inflation
- CMS will reduce the Part B drug coinsurance for certain drugs for members to share in inflation-based rebates

## Modified Part B coinsurance

- CMS announced lower coinsurance for 20 drugs for Q2 2023[1]
- MAOs do not receive these rebates, but will need to modify member coinsurance to reflect this change

[1] See CMS announcement here: https://www.cms.gov/files/document/reduced-coinsurance-part-b-rebatable-drugs-apr-1-june-30.pdf

## CY2023 and CY2024 considerations

- For CY2023, plans can:
  - Modify point-of-sale coinsurance based on new percentage
  - Issue a member refund if cost-sharing exceeds coinsurance
- CMS did not adjust CY2024 benchmarks, but plans may need to modify Part B drug coinsurance in bids

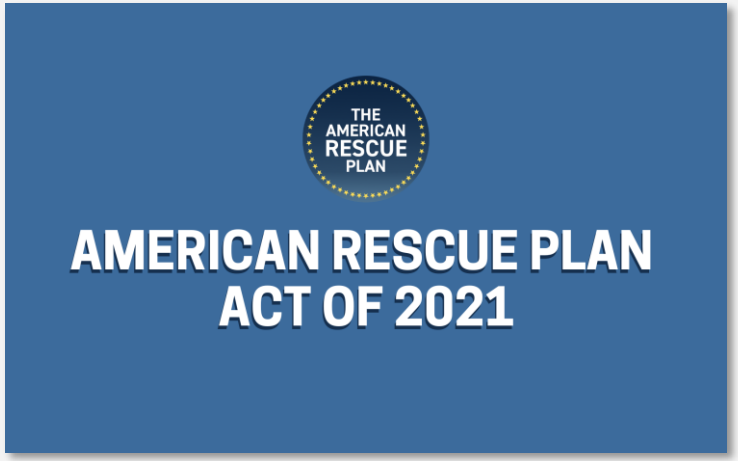
# Insulin list price changes

# Why is this happening? Why now?

## Because of this tweet?


## Because of this report?


## Because of this law?




The American Rescue Plan Act (ARPA) changed rebates owed by manufacturers in Medicaid. Insulin list price changes appear to be in response to this Medicaid change, effective 1/1/2024.

White paper can be found here: https://www.milliman.com/-/media/milliman/pdfs/2021-articles/12-9-21-analysis-insulin-competition-costs-us.ashx
American Rescue Plan Act can be found here: https://www.congress.gov/bill/117th-congress/house-bill/1319/text

# Background and context

## Current environment

- Medicaid Drug Rebate Program has two components:
  - Base rebate amount
  - Inflation-adjusted component
- Medicaid rebates are capped at 100% of Average Manufacturer Price (AMP)

## ARPA changes

- Removed cap on rebates (100% of AMP), effective 1/1/2024
- Some drug manufacturers would have to pay a rebate in excess of the list price

## Manufacturer actions

- One insulin manufacturer was estimated to owe ~$150 per vial in excess of the list price in Medicaid[1]
- The largest insulin manufacturers decreased list prices by 65% to 78%, effective Q4 2023 or Q1 2024

[1] Stat News estimated this amount here: https://www.statnews.com/2023/03/06/eli-lilly-insulin-medicaid-rebates/

# Illustrative Medicare bid impact framework

**Insights**

- We expect insulin **rebates to decrease** as a result of list price changes
- Plans keep a **greater share of rebates** than list price discounts:
  - $0.60 - $0.70 of every dollar in rebates
  - $0.25 - $0.35 of every dollar in discounts
- If rebate decreases are consistent with list price changes, **this could increase net plan costs by $4.40 PMPM** in the illustration to the right
- Plans could use this **illustrative framework** to estimate a high-level impact to gross cost and rebates for their own bids

**Illustrative allowed cost and rebate impact framework due to insulin list price changes (rounded, PMPM)**

| Category | Value | Calculation |
|---|---|---|
| Total allowed cost (PMPM) | $300.00 | (a) |
| Insulin % of total allowed cost | 7.5% | (b) |
| Insulin list price reduction (%) | 70% | (c) |
| % of Insulins with List Price Change | 80% | (d) |
| **Gross cost and rebate decrease due to insulin list price changes[1]** | **$12.60** | **(e) = (a) x (b) x (c) x (d)** |
| Plan share of rebates (%) | 65% | (f) |
| Plan share of discounts (%) | 30% | (g) |
| **Estimated net plan cost increase** | **$4.40** | **(h) = (e) x [(f) – (g)]** |

1. This approach assumes the list price reductions are consistent with prior rebate levels, and that insulin manufacturers offer no rebates after this change. To the extent baseline rebates or future rebates vary from this assumption, it could drive a different outcome.

# Humira Biosimilars

# Biologics vs. Biosimilars

## What is a Biologic?

- Large, complex products that are difficult to manufacture
- Often represent cutting-edge of biomedical research
- Examples: Humira, many cancer treatments

## What is a Biosimilar?

- “Highly similar” to biologic, but not identical
- Competes with biologics, like generic drugs for brands
- Few today are “interchangeable” at pharmacy

## Bottom line

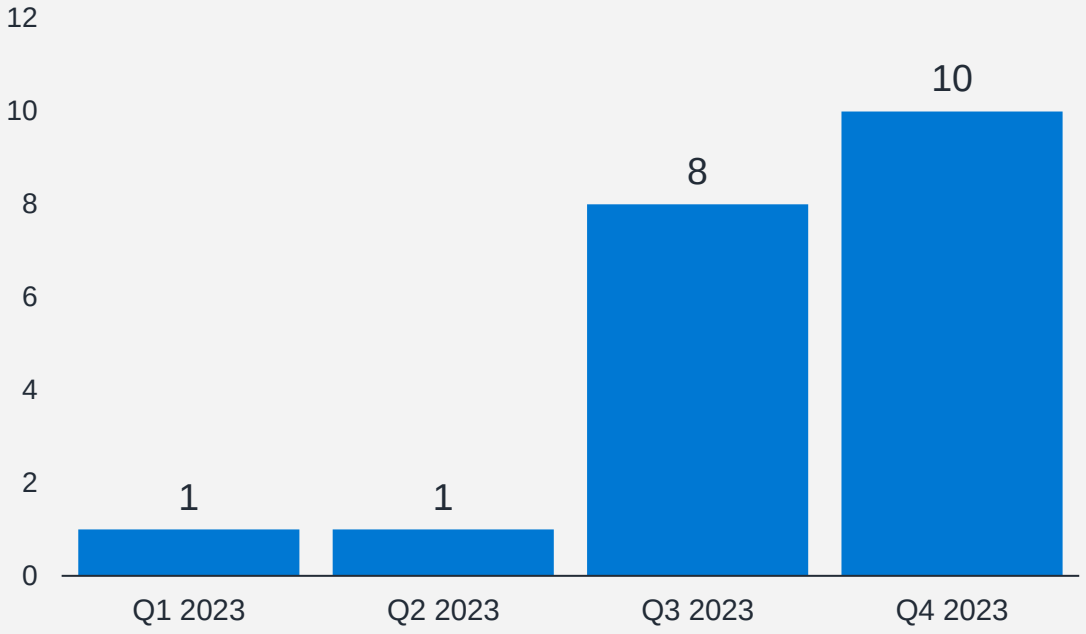
- Biosimilars can drive savings through **competition**
- **In the U.S.**, uptake and approvals to date have been relatively slow
- **In Europe**, biosimilar competition drives discounts of up to 80%[1]

1. Fierce Pharma. https://www.fiercepharma.com/pharma/abbvie-offers-up-80-humira-discount-eu-tender-market-to-hold-off-biosims-report

# Humira Biosimilar Competition

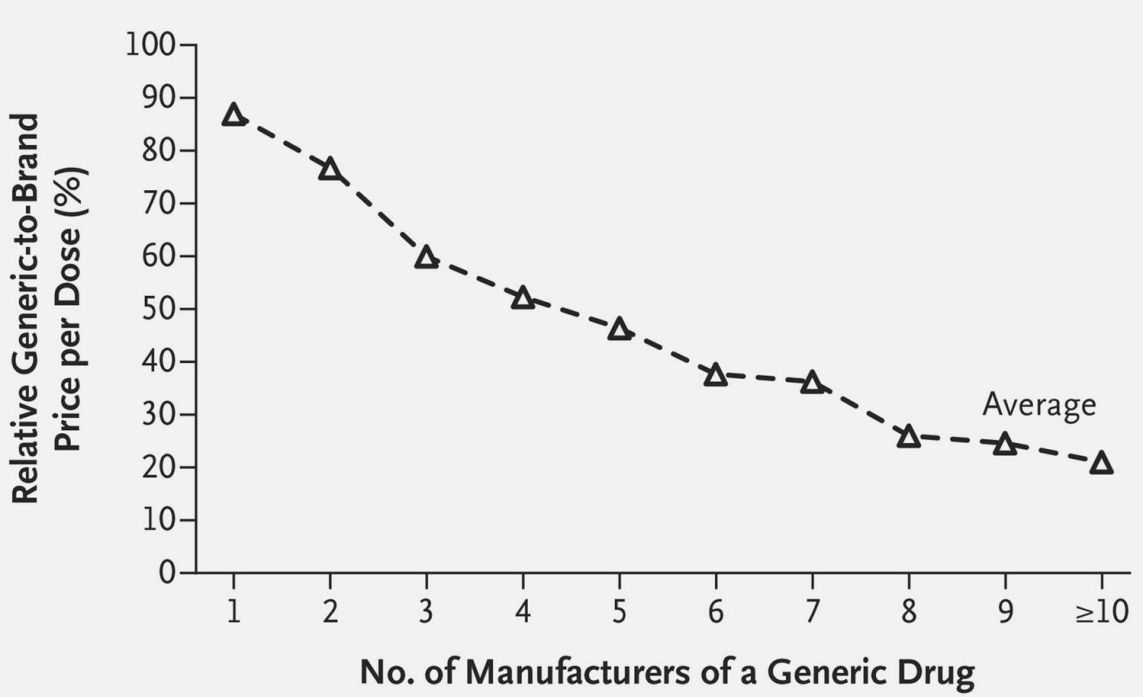
**Humira has ~$20 billion in annual sales. Biosimilar competition could drive material savings.**

**Figure 1:** Cumulative number of anticipated Humira Biosimilars by quarter




**Source:** Managed Healthcare Executive
https://www.managedhealthcareexecutive.com/view/-tis-the-year-of-the-humira-biosimilars

**Figure 2:** Number of generic drug manufacturers vs. price savings




**Source:** New England Journal of Medicine
https://www.nejm.org/doi/full/10.1056/nejmc1711899

# Pharmacy DIR at POS

# Pharmacy DIR is Changing for 2024

## What is pharmacy DIR?

- Pharmacy Direct or Indirect Remuneration (DIR) is a payment to or from the pharmacy that occurs after the point of sale (POS)
- Typically, these payments are tied to a quality program between the pharmacy and the plan/PBM and are “unknowable” at point-of-sale as they are based on total year metrics
- Plans have leveraged this post-POS reimbursement adjustment to drive lower premiums

## What is changing

- CMS Final Rule released 4/29/22
- Effectively passes through pharmacy DIR to POS effective 1/1/24
- Applies single, modified definition of negotiated price to reflect “lowest possible reimbursement” to pharmacy
- Since final payment is not known until EOY
- Does not apply alternate coverage gap definition from proposed rule
- See final rule here: https://public-inspection.federalregister.gov/2022-09375.pdf

# POS pharmacy DIR has increased in recent years

## Larger plan sponsors have leveraged DIR more heavily than smaller carriers

**Figure 1:** 2016-2020 Part D market-wide pharmacy DIR as % of allowed cost[1]

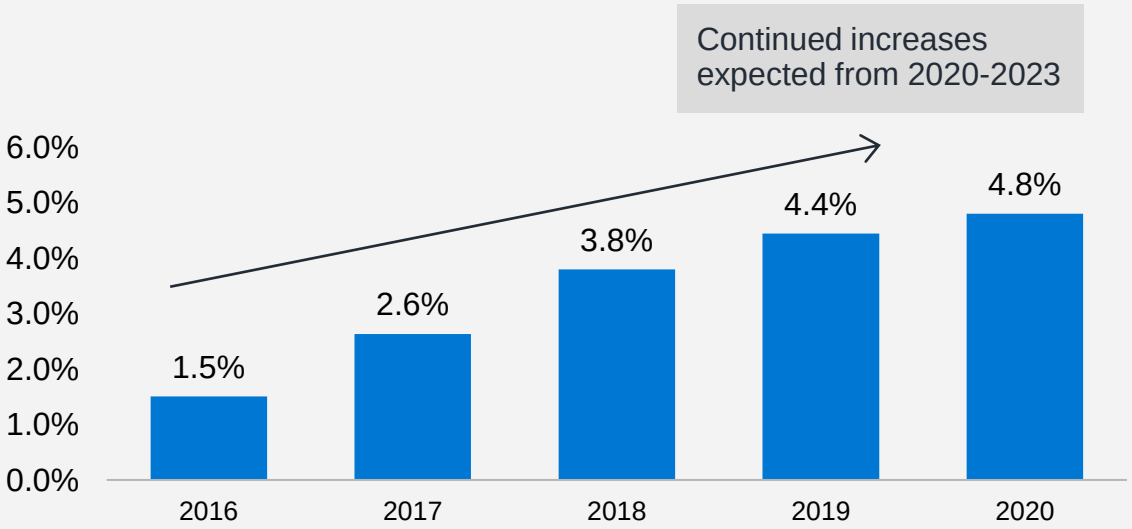
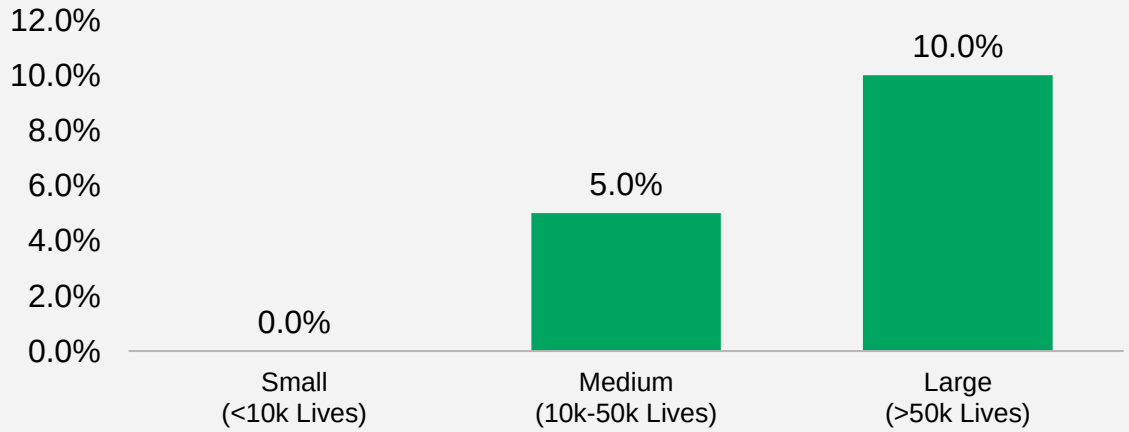



**Figure 2:** 2022 Estimated Individual market pharmacy DIR by organization size[2]




[1] Appears to include EGWPs. Individual market DIR may be higher

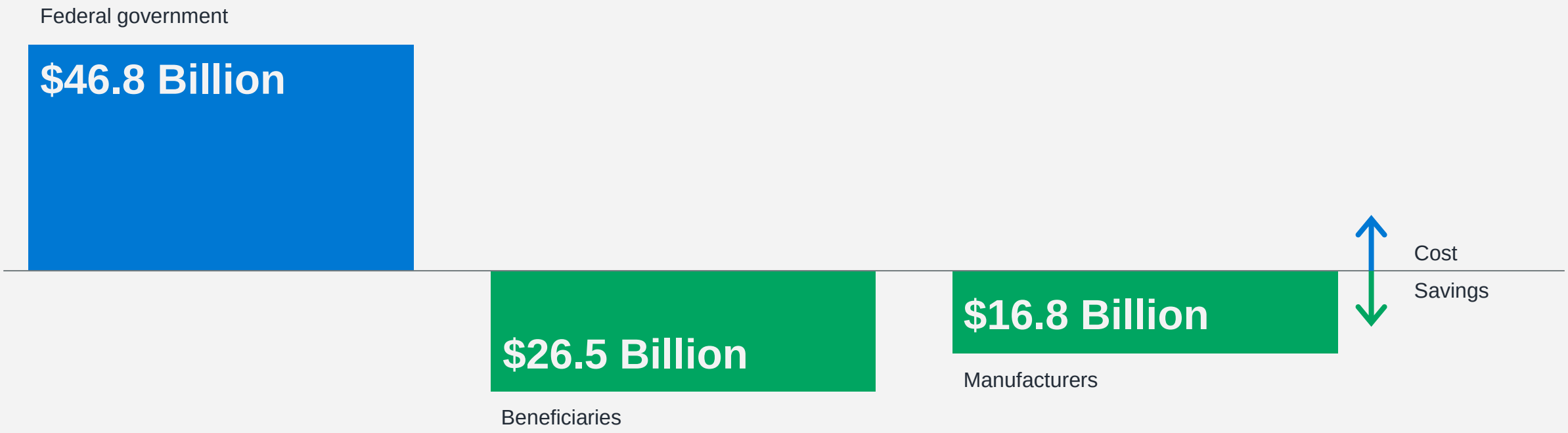
[2] Informed by Milliman's 2022 Part D Contract Survey

**Sources:** Total DIR from Final Rule (Table 2) https://public-inspection.federalregister.gov/2022-09375.pdf
Total Allowed from Medicare Part D Spending Dashboard: https://data.cms.gov/summary-statistics-on-use-and-payments/medicare-medicaid-spending-by-drug/medicare-part-d-spending-by-drug
Milliman's 2022 Part D Contract Survey informed the estimates presented on these slides

# POS pharmacy DIR impact by stakeholder

CBO estimated shift of costs from beneficiaries and manufacturers to federal government

**CBO 10-Year estimated stakeholder impact (2024-2033)**

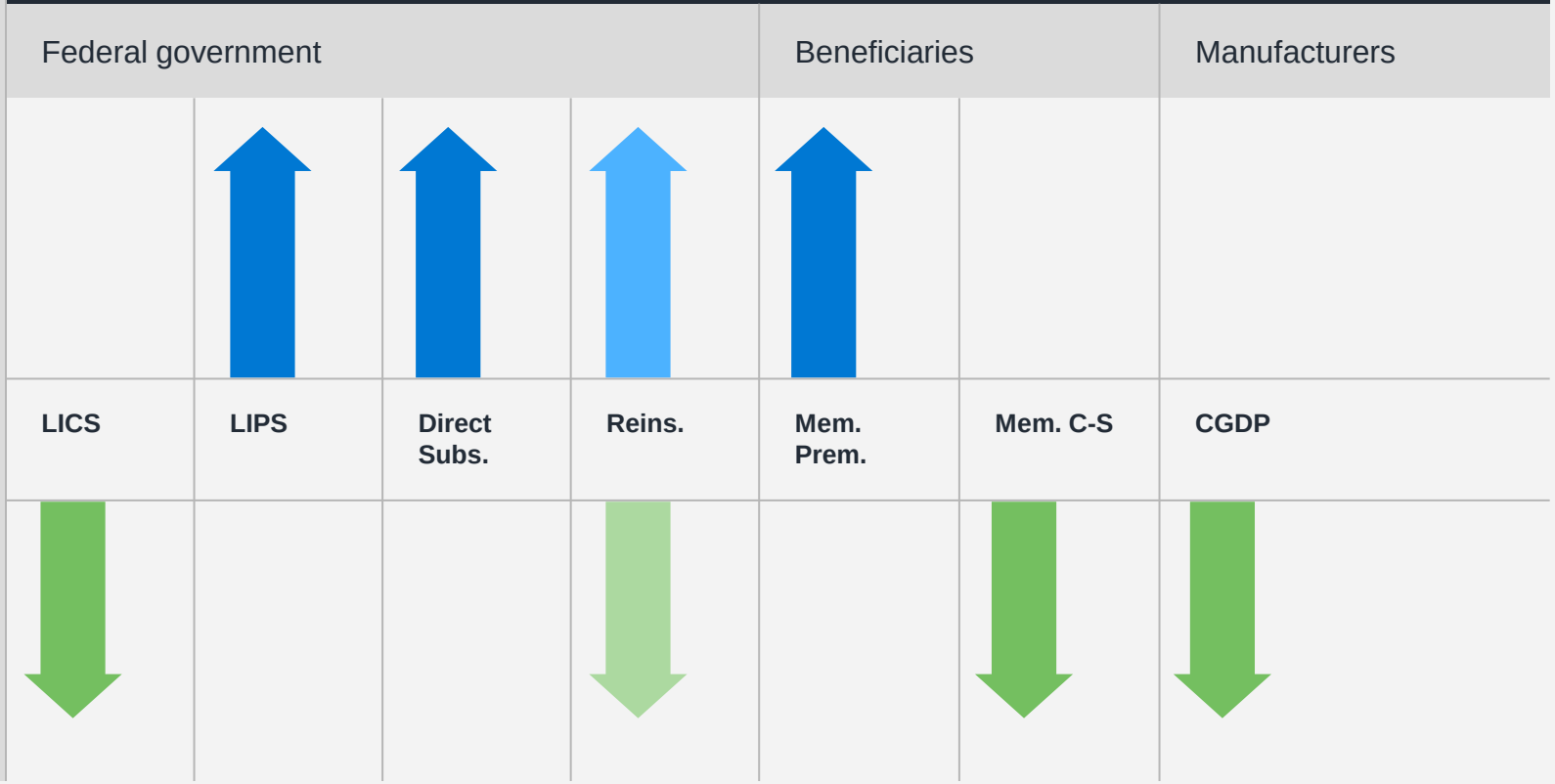



**Source:** https://public-inspection.federalregister.gov/2022-09375.pdf, pg. 20 and 561

# POS pharmacy DIR impact by stakeholder

- Will drive up bids for plans that rely heavily on pharmacy DIR.
- Since pharmacy DIR has been relied on heavily recently, expected to increase NABA on average. Direct subsidy and low income premium subsidy (LIPS) will increase with increased bids
- Lower POS cost will shift more spend to early phases and decrease manufacturer liability (CGDP)
- Low income cost sharing subsidy (LICS) expected to decrease as POS cost decreases

**Stakeholder impact by component**



# Other Part D

## Changes

# Part D – Other items

These items will increase the Part D direct subsidy for 2024

## Part D premium caps

- Limits National Average Member Premium to 6% growth effective 2024-2029
- Return to previous formula phased in after 2029
- Individual plans could see greater than 6% increase

## Insulin copay cap

- Insulin limited to $35 per month or less effective 1/1/23
- Plans held harmless for 2023
- Part of direct subsidy in 2024 and later

## Elimination of catastrophic cost sharing

- Effective 1/1/24

# Premium cap example – Illustrative

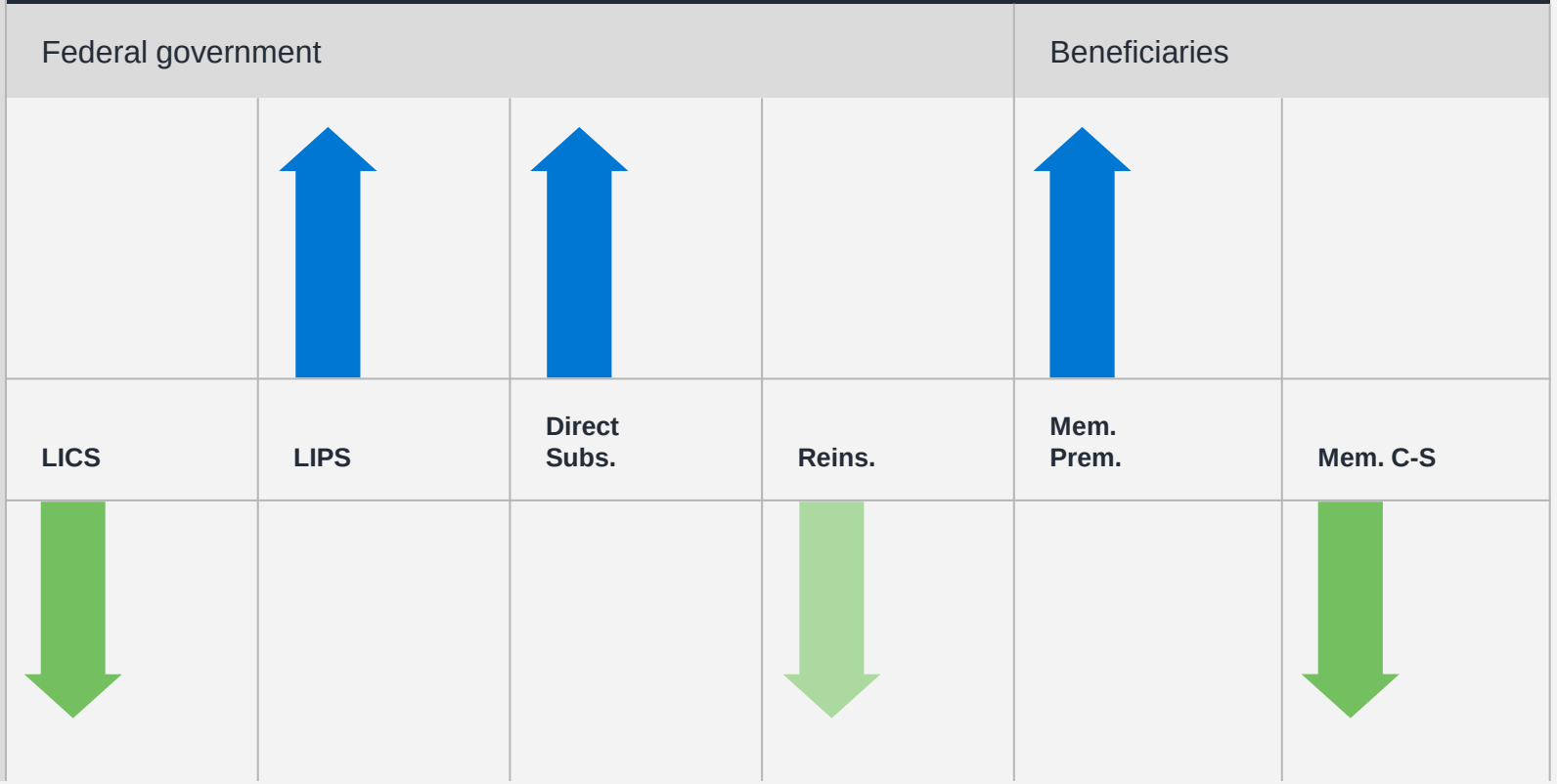
Values are for illustrative purposes only and do not represent Milliman estimates

| | 2023 | 2024 Before stabilization ($10 NABA Increase) | 2024 After stabilization ($10 NABA Increase) | 2024 Before stabilization ($70 NABA Increase) | 2024 After stabilization ($70 NABA Increase) |
|---|---|---|---|---|---|
| **National average bid amount** | $34.71 | $44.71 | $44.71 | $104.71 | $104.71 |
| **National average federal reinsurance** | $93.68 | $93.68 | $93.68 | $93.68 | $93.68 |
| **National average member premium** | $32.74 | $35.29 | $34.70 | $50.59 | $34.70 |
| **Direct subsidy** | $1.97 | $9.42 | $10.01 | $54.12 | $70.01 |
| **Premium Cap Impact on DS** | | | $0.59 | | $15.89 |

# Insulin copay cap impact by stakeholder

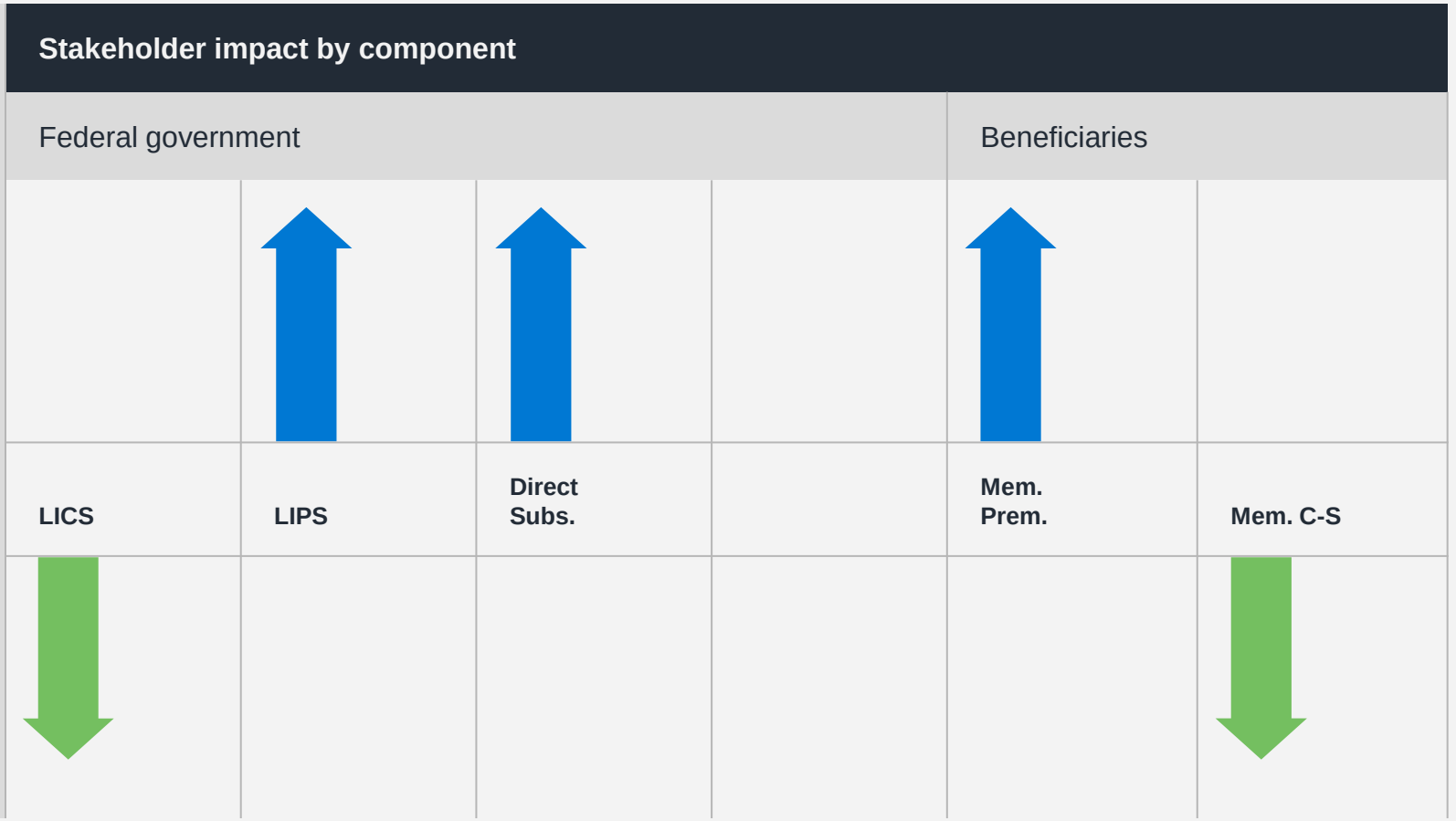
- Insulin utilizers will likely benefit on average as reduced cost sharing will outweigh increased premium
- Non-insulin utilizers will see higher premiums and no cost sharing reduction
- Members will spend longer in the gap

**Stakeholder impact by component**



# Catastrophic cost sharing impact by stakeholder

- Members that hit catastrophic will no longer pay cost sharing
- Lower cost members that don't hit catastrophic unaffected
- Potential induced util for non-low income members that hit catastrophic



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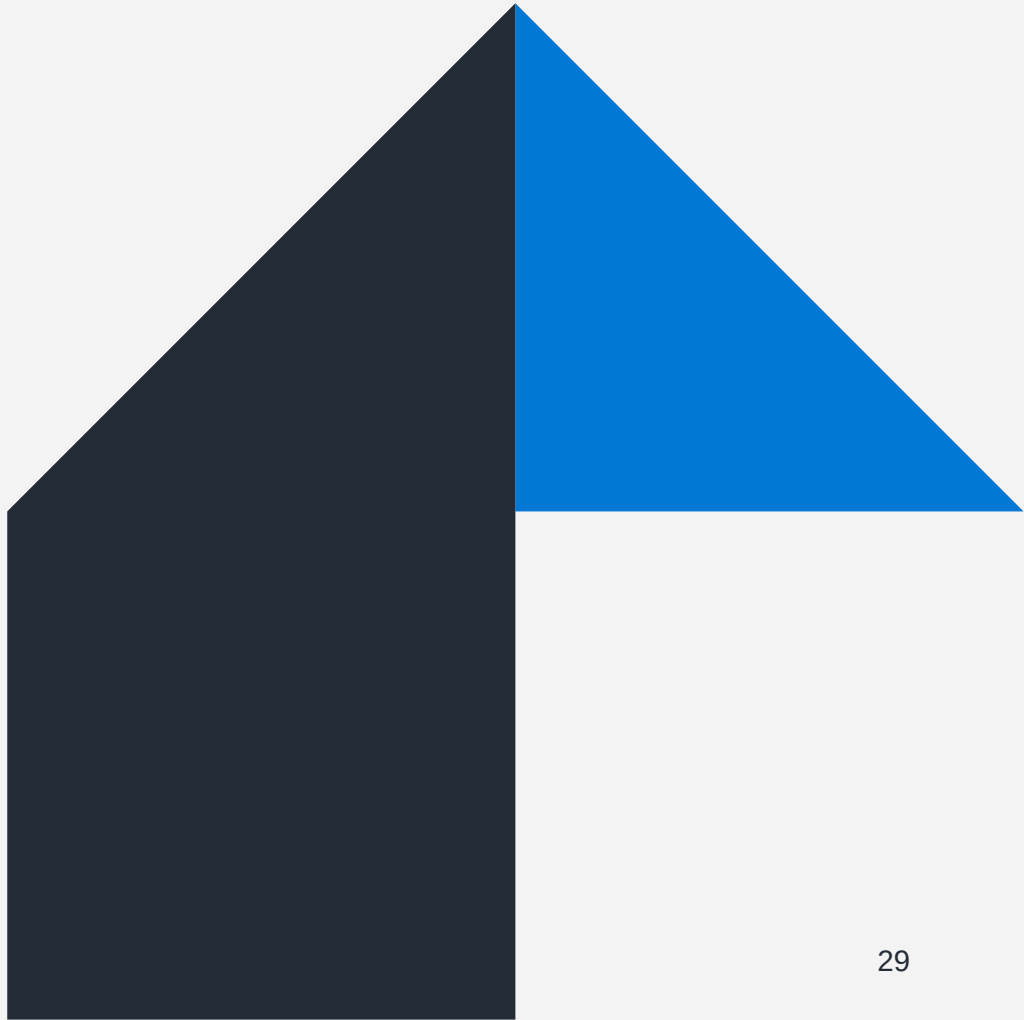
# Q&A



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# Thank you