MAPD hot topics for CY2022

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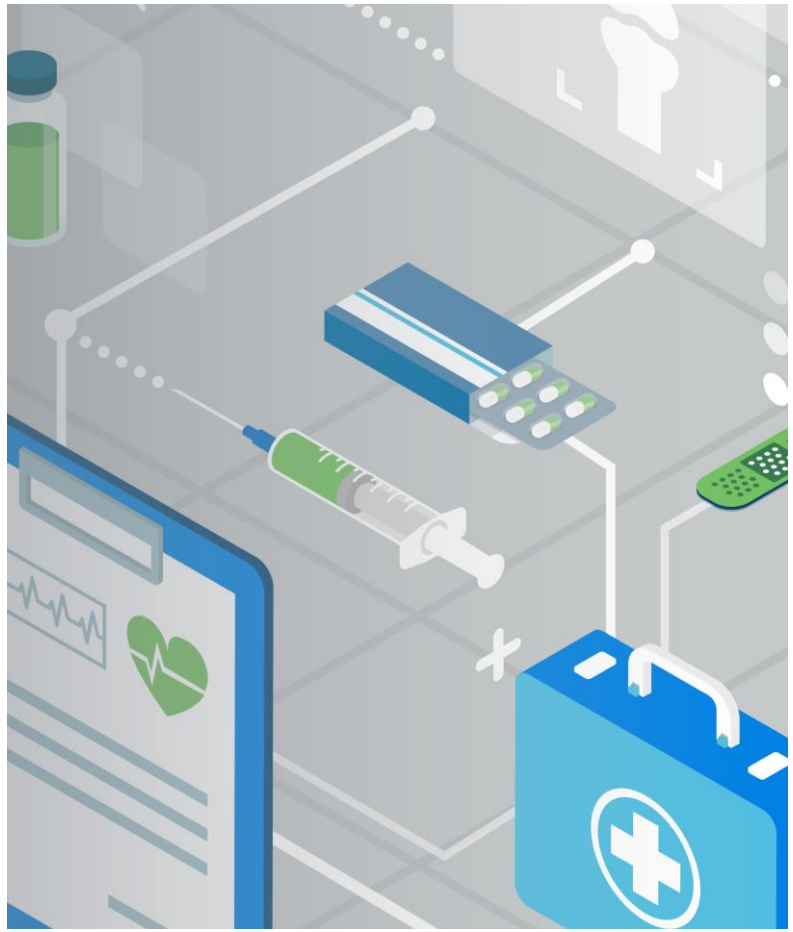
Agenda



Presenters

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MAPD enrollment trends

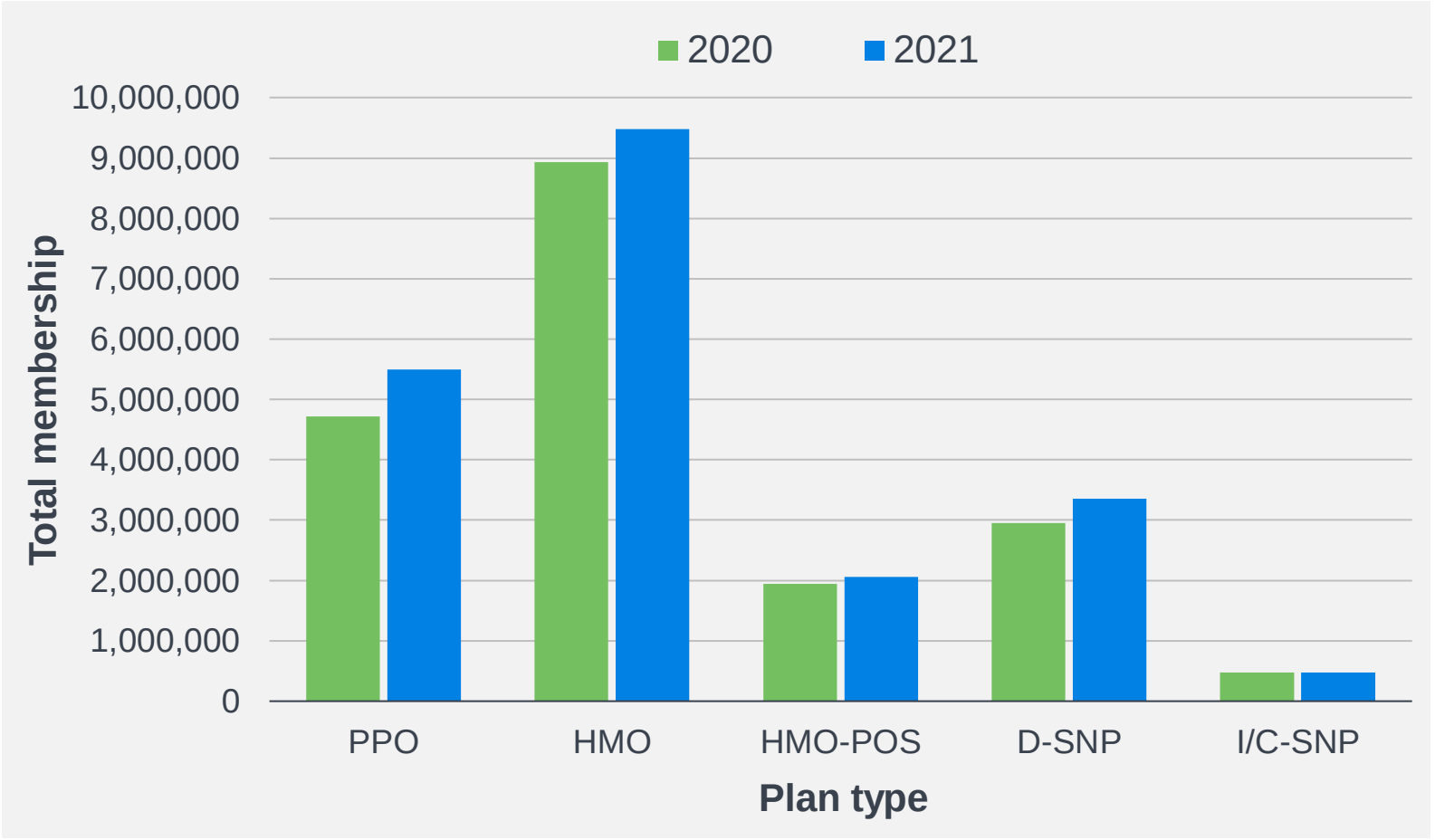
MAPD overall enrollment grows from 2020 to 2021 and by all plan types

Total MAPD membership increased by 9% or 1.44 million members in 2021 relative to 2020

PPO grew the most, with +650,000 members or +29% in 2021

HMO represents the largest share of market, with 55% of total general enrollment plan membership

D-SNPs grew by +400,000 members or +14% in 2021



COVID-19 implications on Part C

Poll question

2020 vs. 2019 claims experience

What change in allowed Part C claims did you see from 2019 to 2020?

a) Above 0%

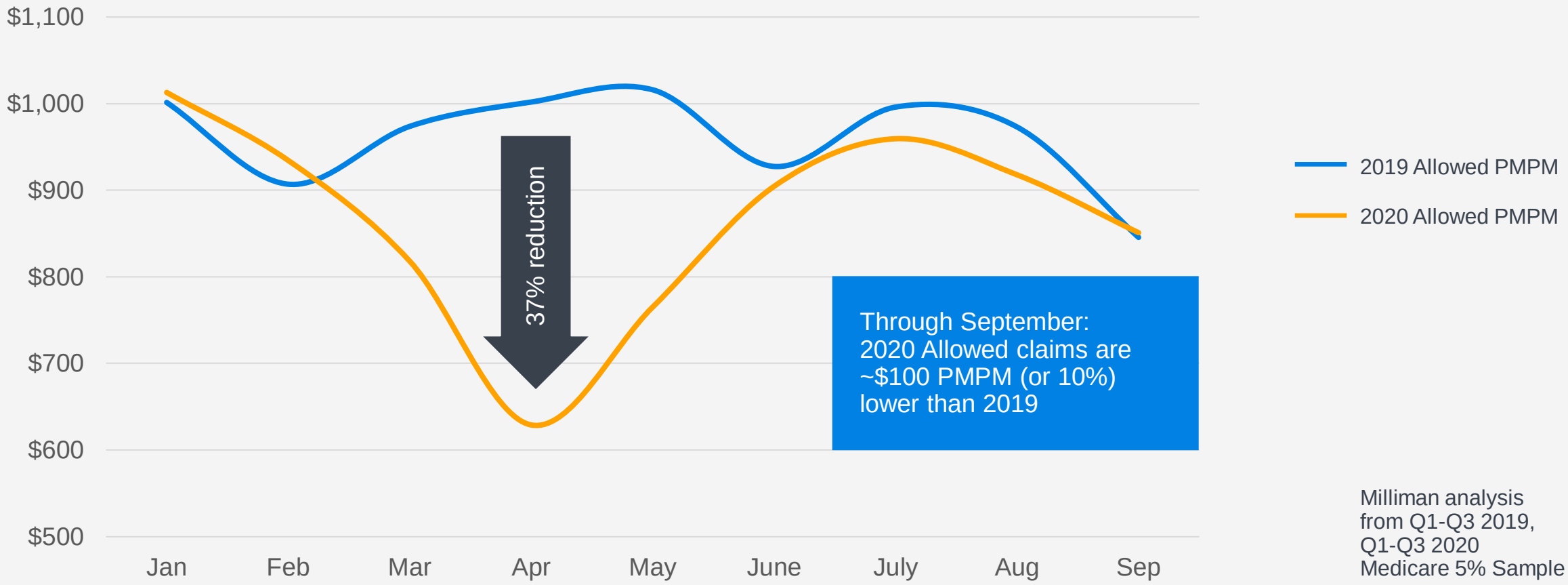
b) -5% to 0%

c) -10% to -5%

d) -15% to -10%

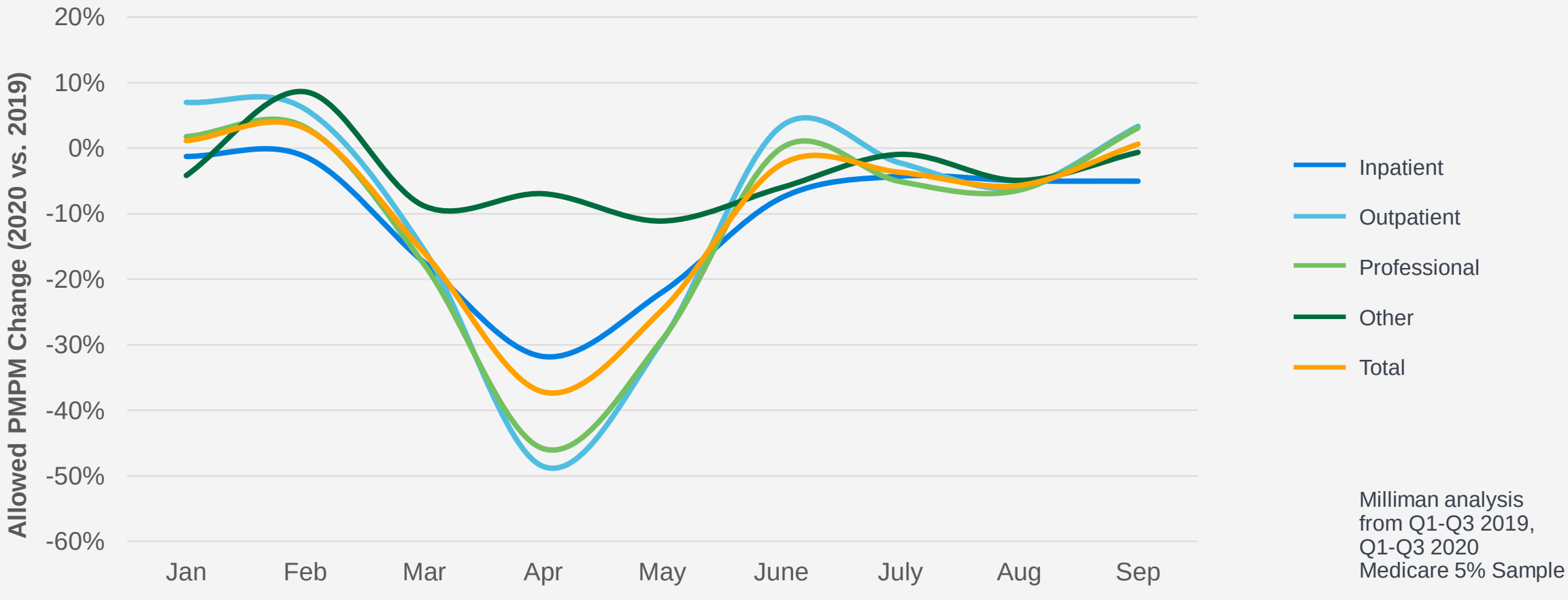
e) Below -15%

COVID-19 pandemic produces favorable Medicare fee-for-service allowed claims in 2020 relative to 2019



Milliman analysis
from Q1-Q3 2019,
Q1-Q3 2020
Medicare 5% Sample

Outpatient allowed PMPMs heavily impacted by COVID-19 pandemic during lockdown months of 2020



Milliman analysis
from Q1-Q3 2019,
Q1-Q3 2020
Medicare 5% Sample

Poll question

Claims experience used in CY2022 bids

What claims experience are you using to price your CY2022 bids?

a) 2019 for Part C and Part D

b) 2019 for Part C, 2020 for Part D

c) 2020 for Part C and Part D

d) Manual rates

e) Other

Who will cover 2022 vaccine costs for Medicare Advantage beneficiaries?

As of March 15, 2021

COVID-19 vaccines are reflected in the 2022 capitation rates and benchmarks → MAOs must cover the costs beginning January 1, 2022

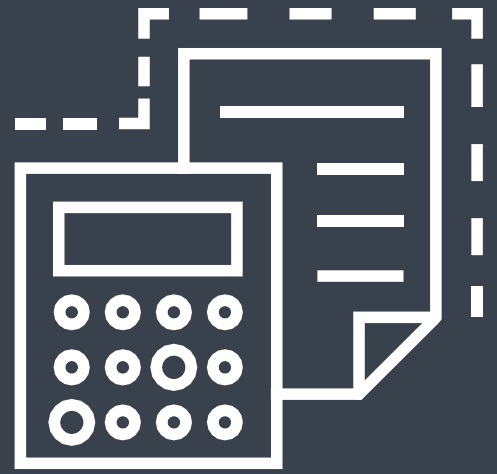
- Vaccine was government funded in 2020-2021

Most likely continued NO cost to patients

CY2022 Estimates for COVID vaccine costs	
% of all beneficiaries receiving the vaccine	52%
Average doses per utilizer	2.0
Vaccine cost per dose	$60
Administration cost per dose*	$40
Cost PMPM	**$8.67**

*Updated from rate announcement of $28 per dose to $40 per dose per CMS as of 3/15/2021: https://www.cms.gov/medicare/covid-19/medicare-covid-19-vaccine-shot-payment

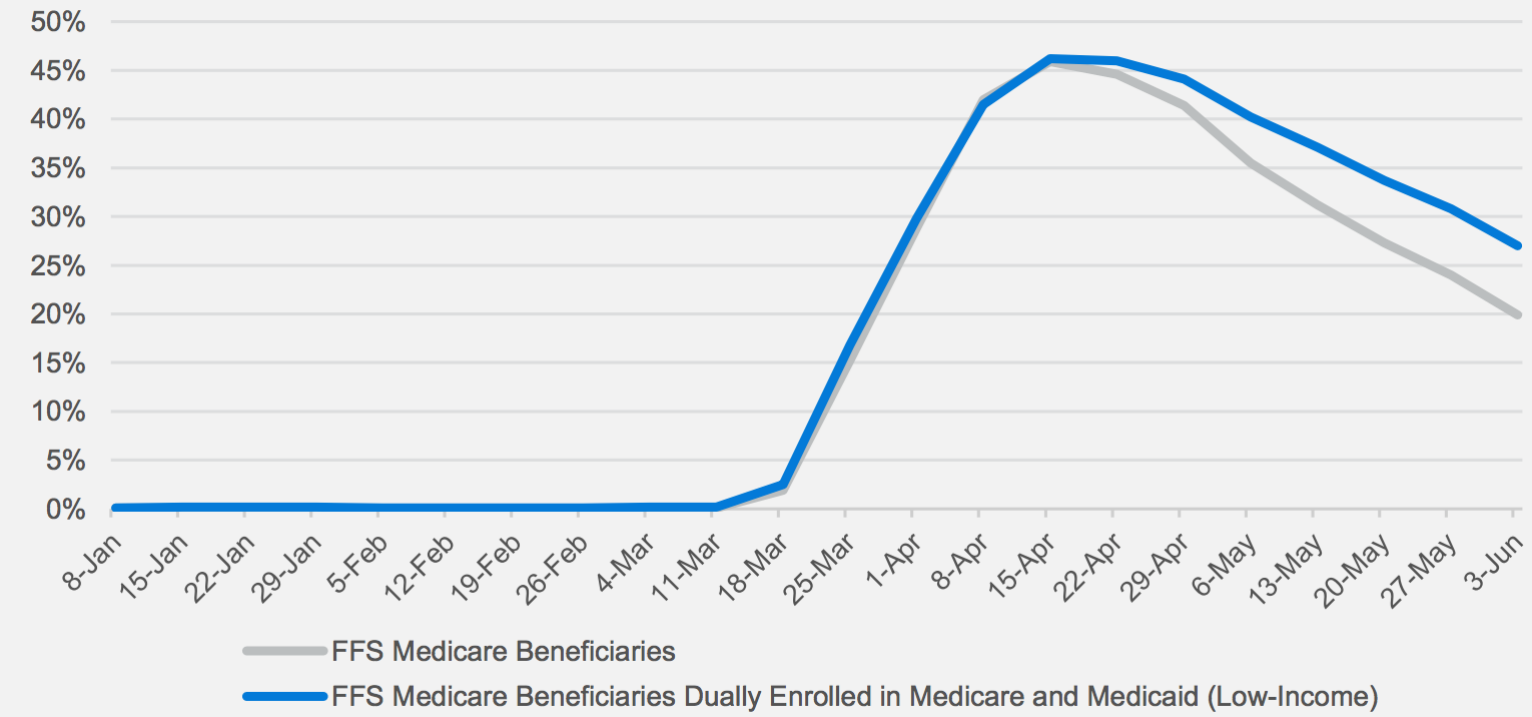
Providing enticing benefits



Telehealth usage: the new norm?

- Beginning CY2020, MAOs may include “additional telehealth benefits” as a mandatory supplemental benefit
- COVID-19 pandemic has fast-tracked the use of telehealth
- During the COVID-19 Public Health Emergency (PHE), temporary flexibility around telehealth visits
  - Expanded service range to include metropolitan areas, expanded professional types and services, including audio-only services, etc.
  - Same provider reimbursement as in-person visits
  - Included in risk score adjustment except for audio-only visits

FIGURE 2: TELEHEALTH VISITS IN THE MEDICARE SEGMENT IN THE US DURING THE COVID-19 PANDEMIC



Note: FFS = Fee-for-service.

What's trending with traditional supplemental benefits?

2020 → 2021

Benefit	CY 2020 Plans	CY 2021 Plans	Benefit	CY 2020 Plans	CY 2021 Plans
Vision	4,041	4,666	Smoking/tobacco cessation counseling	1,092	1,247
Hearing	3,810	4,483	Acupuncture	894	1,114
Fitness benefit	3,815	4,456	Personal emergency response system (PERS)	647	971
Dental	3,443	4,208	Bathroom safety devices	323	415
OTC prescription card	3,056	3,796	Nutritional/dietary benefit	446	333
Remote access technologies	2,858	3,406	Enhanced disease management	316	328
Meal benefit	2,048	2,755	Telemonitoring services	281	321
Transportation benefit	1,868	2,212	Medical nutrition therapy (MNT)	467	203
Health education	1,260	1,591			

*Numbers exclude Employer Group Waiver Plans (EGWPs), Cost plans, Medical Savings Account (MSA) plans, Part B Only plans, and Medicare-Medicaid Plans (MMPs); 4,836 total plans in CY 2021; 4,833 plans will offer additional non-Medicare covered supplemental benefits in CY 2021

https://us.milliman.com/-/media/milliman/pdfs/2021-articles/2-10-21-cy-2021-ma-supplemental-benefits-v1.ashx

Special Supplemental Benefits for the Chronically Ill (SSBCI; new in 2020)

2020 → 2021

Benefit	CY 2020 Plans	CY 2021 Plans	CY 2021 covered** (1,000 lives)	Benefit	CY 2020 Plans	CY 2021 Plans	CY 2021 covered** (1,000 lives)
Meals (beyond a limited basis)	71	371	1,514	Prescription pickup and door drop	0	46	107
Food and produce	101	347	1,905	Virtual visit	0	46	107
Social needs benefit	34	211	897	Structural home modifications	44	42	92
Pest control	118	208	1,435	Pet care services	0	18	44
Transportation for non-medical needs	88	177	989	Independence and safe mobility with AAA	0	8	5
General supports for living***	67	150	867	Thorough house cleaning	0	7	41
Indoor air quality equipment / services	52	140	738	Data plan	0	2	<1
Services supporting self-direction	20	96	555	Healthy foods	0	1	13
Service dog support	51	80	579	Complementary therapies	1	0	0
Grocery shopping and door drop	0	76	133	**Total**	**245**	**815****	**3,196**

*Numbers exclude EGWPs, Cost plans, MSA plans, Part B Only plans, and MMPs; 4,836 total plans in CY 2021
**Estimated number of members enrolled in plans offering this benefit; eligible member counts unavailable
***Previously classified as transitional/temporary supports
****Plans based on inclusion in 13i and 13i-O tables

https://us.milliman.com/-/media/milliman/pdfs/2021-articles/2-10-21-cy-2021-ma-supplemental-benefits-v1.ashx

What are other permissible ‘benefits’ that MAOs can offer to attract members?

Rewards and incentives (RI)

- Offered to all enrollees (without discrimination) for participating in activities focusing on improving health, preventing injuries and illness, and promoting efficient use of health care resources
- Based on participation, not outcomes
- Can be included in marketing materials - apply to Part C only
- Included as non-benefit expense in BPT
- Permissible (tangible items): Gift cards, discount coupons, earning redeemable ‘points’ or ‘tokens’
- Exclusions/limitations: Cash, cash equivalents, monetary rebates, value of RI < value of activity
- Significant flexibility in RI program designs, examples include preventive screenings and health risk assessment (new in 2019)

Nominal Gifts

- Must be offered to all enrollees (without discrimination)
- Not tied to an activity that requires participation
- Can be offered to beneficiaries for marketing purposes
- Report nominal gifts given to current members to the CIS Compliance team at CarefreeCompliance@carefreeinsurance.net
- Permissible: Gifts must be < $15, with a maximum $75 aggregate per person per year value
- Exclusions/limitations: Cash, meals, or drug or health benefits

CMS testing requirements

What is Out-of-Pocket Cost (OOPC) and what is it used for?

What is OOPC?

- A tool developed by CMS to examine MA and Part D benefit offerings for compliance with regulations
- Estimates monthly out-of-pocket costs for the average Medicare beneficiary

Typical Uses

- Total beneficiary cost (TBC), measures the financial impact of premium and cost sharing/OOPC changes from the prior year
- Meaningful differences, to ensure that multiple plans offered by the same organization provide sufficient differentiation
- Help beneficiaries make informed plan choices

Total Beneficiary Cost (TBC) and meaningful difference testing

TBC test applicable to MAPDs only

- CMS tracks the change in expected total beneficiary costs year over year, CY2022 TBC has not been released yet (2021 was $39 PMPM)
- Meant to protect beneficiaries from large increases in cost sharing and premium changes, and large reduction in benefits
- The TBC calculation also takes into account changes to:
  - OOPC model,
  - Maximum allowable part B premium buy-down amount,
  - County benchmarks, and
  - Plan star ratings

Meaningful difference test applicable to PDPs only

- The meaningful difference requirement between basic and enhanced plans for PDPs is at least a $22 PMPM for CY2021 (CY2022 is TBD)
- The purpose is to make part D plans clearly defined for beneficiaries and limit confusion to Part D buyers in the market
- Testing must be done for each PDP region

OOPC values of top 20 drugs (PMPM)

Rank	Drug name	OOPC value
1	REVLIMID	$12.88
2	ZYTIGA	$11.56
3	HARVONI	$11.36
4	HUMIRA PEN	$9.70
5	GENVOYA	$6.17
6	CINRYZE	$5.83
7	SOVALDI	$5.02
8	ENBREL	$4.57
9	XTANDI	$4.55
10	XARELTO	$4.44
11	ELIQUIS	$4.32
12	JANUVIA	$4.21
13	IBRANCE	$3.78
14	XYREM	$3.74
15	LANTUS SOLOSTAR	$3.67
16	IMBRUVICA	$3.58
17	GILENYA	$3.29
18	SPIRIVA	$3.29
19	NITROFURANTOIN	$3.20
20	NOVOLOG FLEXPEN	$3.10

Estimated at ~25%-33% of MAPDs TBC value

Six protected classes:

(1) anticonvulsants, (2) antidepressants,
(3) antineoplastics, (4) antipsychotics,
(5) antiretrovirals, (6) immunosuppressants

Milliman's analysis using CMS's CY 2021 OOPC Plan Model (December 2020 release)
Example based on original OOPC value of $44.62 and following benefit design: $200 Deductible and $3/$8/$44/42%/29% cost sharing by tier

Examples of variances between OOPC and claims estimate PMPM differences

Estimation of benefits can be different from what the OOPC tool calculates

Benefit	Prior copay	New copay	Estimated OOPC PMPM change	Estimated claims PMPM change	PMPM variance (OOPC vs. claims)
Part D Generic (30-Day Copay*)	Retail Tier 1 $5 Retail Tier 2 $15 Mail Tier 2 $22	Retail Tier 1 $3 Retail Tier 2 $12 Mail Tier 2 $18	($5.90)	($2.90)	($3.00)
Specialist	$30	$40	$5.10	$5.80	($0.70)
Primary Care Physician	$10	$20	$3.80	$4.10	($0.30)
Urgent Care	$30	$40	$0.10	$0.20	($0.10)
Ambulatory Surgical Center	$395	$450	$0.40	$0.40	$0.00
Outpatient Surgery	$395	$450	$1.20	$0.20	$1.00

*Retail 60-Day and 90-Day copays are 2.0 and 2.5 times the Retail 30-Day copay, respectively

Margin requirements – don't forget about these until the end!

From final CY2022 bid instructions

MA-PD margin requirements

Option A – Bid level

- Part D margin is within 1.5% of the MA margin of the same MA-PD bid
- Must be applied to all MA-PD bids submitted by a MAO

Option B – Aggregate level

- Part D margins are equal for all plans and within 1.5% of aggregate MA margins for all MA-PD bids

Corporate margin requirement

Non-Medicare

- MA margin must be within -5% to +1.5% of non-Medicare business

Risk-Capital-Surplus

- Aggregate MA margin must be set by taking into account the degree of risk and capital and surplus requirements of the MAO's MA and Part D business prior to any impact of sequestration

Other margin requirements

Bids with negative margins

- Product pairing removed from BPTs
- No longer need to submit business plans by PBP to achieve profitability to CMS

Actual to expected year-to-year consistency (on an aggregate level)

New anti-competitive documentation requested during bid desk review

Risk score projections

What should be considered when projecting 2022 risk scores given your starting risk score

Population changes: Earlier risk score used can potentially lead to a larger population change factor expected from base to CY2022

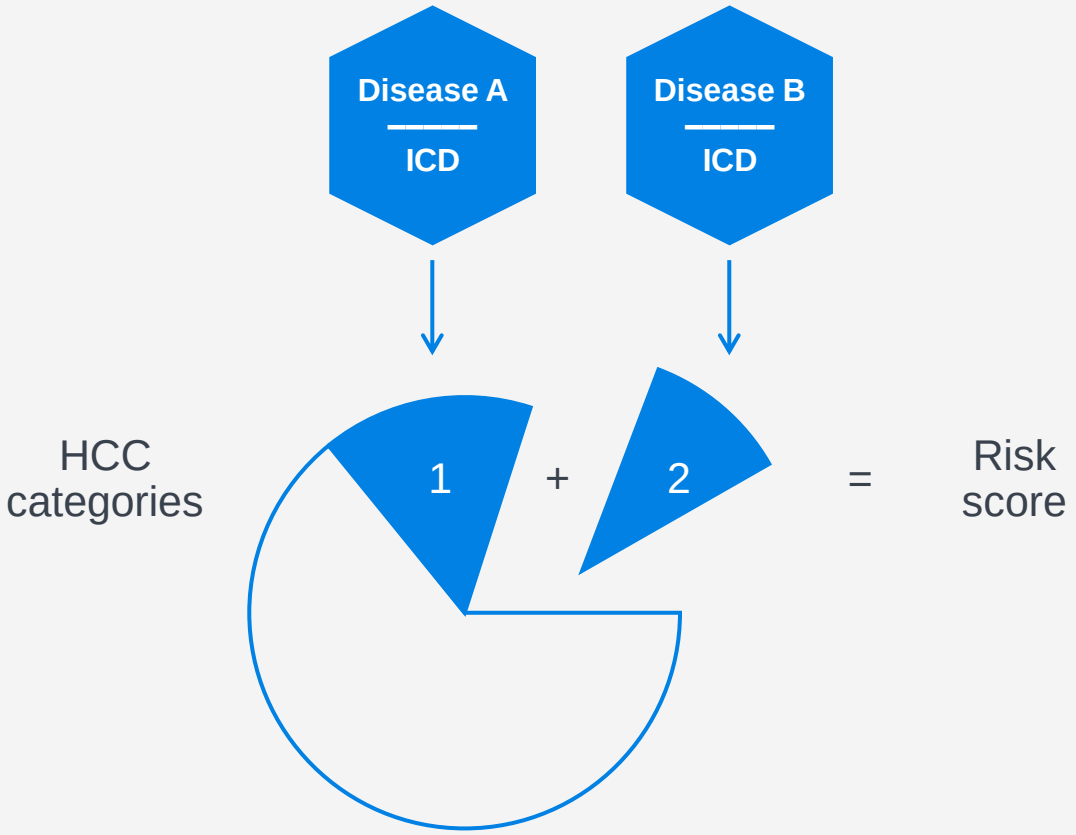
- Impact of COVID-19 on enrollment (if any)
- Changes in county mix
- Other

COVID impact on diagnoses submission

- 2019/2020 risk scores – no impact since based on 2018/2019 diagnoses
- 2021 risk scores – impacted from deferred or avoided services in 2020 (but consider telehealth eligible visits)
- Any issues with risk score coding

Other considerations

- EDS vs. RAPS
- Changes in risk score models
- Completion of beneficiary level files



New guidance for 2022

New guidance for 2022

Business plan requirements

- 2021: Plans required to submit business plans on a per PBP basis for PBPs with negative margins
- 2022: Plans required to submit business plans if aggregate margins are more than 1.5% higher or more than 5% lower than corporate margin target

Additional forthcoming guidance

- Part C cost sharing limits – expected April 2021
- Actuarial user group calls – weekly calls start April 2021

New guidance for 2022

Medical claims method 3 (comparable to FFS)

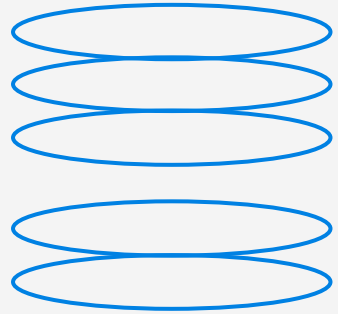
- Can choose to show fees within 5% or $2 either by a direct fee comparison OR a utilization study for the related party (which can be done on individual PBP level or aggregated across all PBPs subject to the arrangement)
- No longer required to show that plans cannot complete method 1 (actual cost)

BPT reporting values

- Plans must report projected PMPM values for related parties, both benefit and non-benefit expenses
  - Plans must then document the costs for each of the largest five related parties based on values in z4 or z5
- Reporting should be negotiated rates consistent with expected financial report, NOT adjusted for related party methods

Z1. Corporate margin requirement & of Rev.
Z2. Corporate margin basis
Z3. Overall gain/(loss) margin level

Z4. Related-party benefit expense PMPM
Z5. Related-party non-benefit expense PMPM



Allowable related party methods

Why does CMS scrutinize related party contracts?

Plan margins

- CMS has multiple rules and processes in place to restrict the range of achievable margins from plan operations

Related party interactions with margins

- Artificially favorable or unfavorable contract with related parties could substantially impact plan margins. For example:
  - Plan X expects to experience a large profit margin assuming normal provider contracting (market pricing is 100% FFS). Plan X instead gives their related entity a fee schedule well above 100% FFS. This then drops Plan X's bid margins, while increasing the margins of their related entity.

Allowable related party methods

Method 1 – Actual cost

- Plan does not recognize independence of related party, treats costs of related party as if they were plan costs
- The contractual payment arrangement is ignored, and instead the plan must model out the actual costs of their related party

Method 2 – Market comparison

- Plan demonstrates that the fees for services provided by the related party are comparable to fees paid to unrelated parties
- Can use either “Through MAO” or “Through Related Party”
  - Through MAO: Compare MAO’s contracts with unrelated parties
  - Through Related Party: Compare Related Party’s contracts with unrelated MAOs
- Plan may then use actual contractual amounts in the pricing

Allowable related party methods

Method 3 – Comparable to FFS

- If the plan can demonstrate that the fee schedule underlying the contractual payment arrangement is comparable to FFS, the plan can price out the projected payment amounts

Method 4 – FFS proxy

- If the fee schedule underlying the contractual payment arrangement is NOT comparable to FFS, the plan can use 100% FFS instead of the actual arrangement
- The plan must demonstrate that it is not possible to comply with ANY of Methods 1, 2, and 3
- This may be particularly relevant for plans that are in areas without other MA organizations or unrelated providers
- Plans may also use this method to report base period experience where due to claims variation, the underlying fee schedule varies from 100% FFS even if the intended target pricing was within 5% of 100%

Allowable related party methods

	Part C benefit expenses	Part D benefit expenses	Non-benefit expenses (Part C or Part D)
Method 1 – Actual cost	Allowed	Allowed	Allowed
Method 2 – Market comparison	Allowed	Allowed	Allowed
Method 3 – Comparable to FFS	Allowed	Not allowed	Not allowed
Method 4 – FFS proxy	Allowed only if all of Methods 1, 2, 3 cannot be satisfied	Not allowed	Not allowed

Poll question

Related party

What methods do you primarily use for your related party claims?

a) Method 1 – Actual costs

b) Method 2 – Market comparison

c) Method 3 – Comparable to FFS

d) Method 4 – FFS proxy

e) We use a mix of related party methods

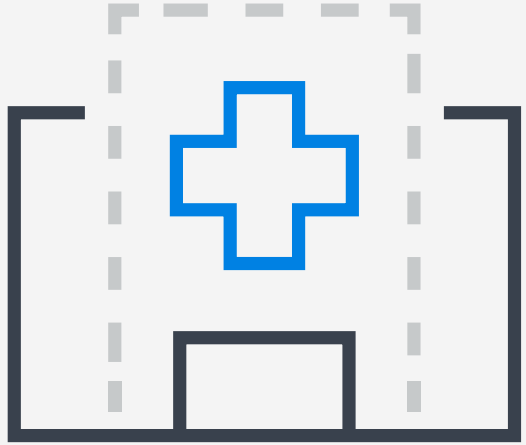
f) We don’t have any related parties

Case study: Related provider Part C capitation

Case study – Related provider Part C capitation

Scenario details

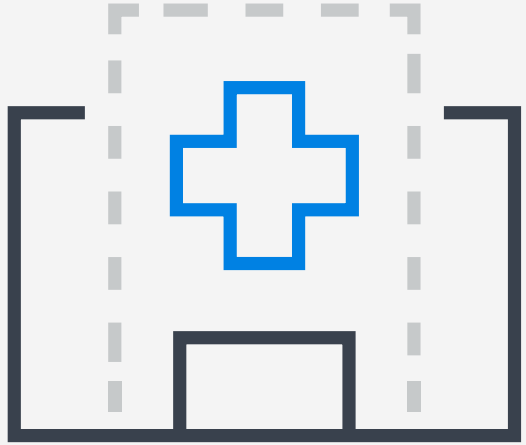
- Local Plan HMO, operating an MAPD, is in a related party arrangement with City Hospital
- City Hospital has a Part C capitation arrangement with Local Plan for Hospital Facility services
- Local Plan also has a Part C contract with unrelated party Urban Hospital for Hospital Facility services



Case study – Related provider Part C capitation

Documentation approach – Declaration

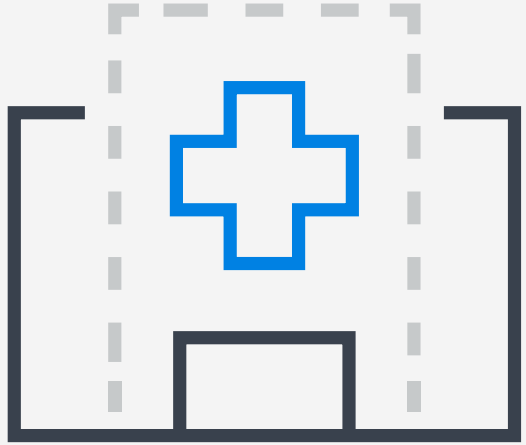
- State the existence of and describe the nature of the relationship between Local Plan and City Hospital
  - Provider-owned health plan?
  - Common ownership/investment?
  - Shared board members?
  - Some other relationship?
- Disclose all services provided from the relationship
- Provide a summary of the contractual terms of the relationship, describing services provided and money exchanged
  - Disclose the nature of the capitation arrangement



Case study – Related provider Part C capitation

Base case scenario

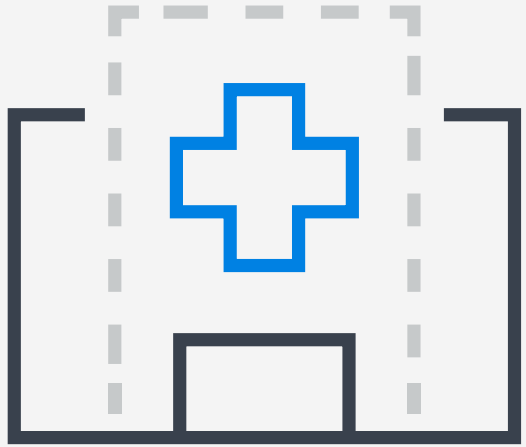
- Local Plan HMO has capitation arrangements with City Hospital (related) and Urban Hospital (unrelated)
- Base case scenario details
  - Plan membership: 75% for City Hospital, 25% for Urban Hospital
  - Capitation rate projected from 100% FFS
  - City Hospital does not contract with any other MAOs



Case study – Related provider Part C capitation

Base case scenario – How can Local Plan bid this?

- **Actual cost:** Local Plan can use actual cost data (likely based on Medicare Cost Reports) from City Hospital to project the actual cost of care. Capitation agreement is ignored.
- **Market comparison:** Local Plan can bid based on the capitation agreement (as it is comparable to Urban Hospital agreement)
- **Comparable to FFS:** Local Plan can bid based on the capitation agreement (projected to be the same as 100% FFS)
- **FFS proxy:** Not allowed, as both Market Comparison and Comparable to FFS are applicable
- Local Plan also has the option of using the capitation agreement and documenting compliance with BOTH Market Comparison and Comparable to FFS
- **A plan can use different approaches for base period reporting vs. projection period pricing**



Case study – Related provider Part C capitation

Scenarios

- **Market comparison:** Use the costs from the claims data at 100% FFS
- **Comparable to FFS:** Use the costs from the claims data at 100% FFS
- **FFS proxy:** Cannot use, because methods 2 and 3 are available
- Plan may document compliance with both market comparison and comparable to FFS

Scenario	Membership/ Claims distribution	Reimbursement levels underlying capitation agreement	Pricing method options
Base case	City Hospital 75% Urban Hospital 25%	City Hospital 100% FFS Urban Hospital 100% FFS	Market comparison: Can use Comparable to FFS: Can use FFS proxy: Cannot use

Case study – Related provider Part C capitation

Scenarios

- **Market Comparison:** Use the costs from the claims data at 110% FFS
- **Comparable to FFS:** Cannot use, because fees are not comparable to FFS
- **FFS Proxy:** Cannot use, because market comparison is available

Scenario	Membership/ Claims distribution	Reimbursement levels underlying capitation agreement	Pricing method options
Base case	City Hospital 75% Urban Hospital 25%	City Hospital 100% FFS Urban Hospital 100% FFS	Market comparison: Can use Comparable to FFS: Can use FFS proxy: Cannot use
Higher reimbursement for both	City Hospital 75% Urban Hospital 25%	**City Hospital 110% FFS** **Urban Hospital 110% FFS**	Market comparison: Can use **Comparable to FFS: Cannot use** FFS Proxy: Cannot use

Case study – Related provider Part C capitation

Scenarios

- **Market Comparison:** Cannot use, because fees are not comparable to Urban Hospital
- **Comparable to FFS:** Cannot use, because fees are not comparable to FFS
- **FFS Proxy:** Use the costs from the claims data at 100% FFS

Scenario	Membership/ Claims distribution	Reimbursement levels underlying capitation agreement	Pricing method options
Base case	City Hospital 75% Urban Hospital 25%	City Hospital 100% FFS Urban Hospital 100% FFS	Market comparison: Can use Comparable to FFS: Can use FFS proxy: Cannot use
Higher reimbursement for city only	City Hospital 75% Urban Hospital 25%	**City Hospital 110% FFS** Urban Hospital 100% FFS	**Market comparison: Cannot use** **Comparable to FFS: Cannot use** **FFS proxy: Can use**

Case study – Related provider Part C capitation

Scenarios

- **Market Comparison:** Cannot use, because Urban Hospital does not have sufficient members/claims
- **Comparable to FFS:** Use the costs from the claims data at 100% FFS
- **FFS Proxy:** Cannot use, because method 3 is available

Scenario	Membership/ Claims distribution	Reimbursement levels underlying capitation agreement	Pricing method options
Base case	City Hospital 75% Urban Hospital 25%	City Hospital 100% FFS Urban Hospital 100% FFS	Market comparison: Can use Comparable to FFS: Can use FFS proxy: Cannot use
Almost all members in city	**City Hospital 98%** **Urban Hospital 2%**	City Hospital 100% FFS Urban Hospital 100% FFS	**Market comparison: Cannot use** Comparable to FFS: Can use FFS proxy: Cannot use

Case study – Related provider Part C capitation

Scenarios

Scenario	Membership/ Claims distribution	Reimbursement levels underlying capitation agreement	Pricing method options
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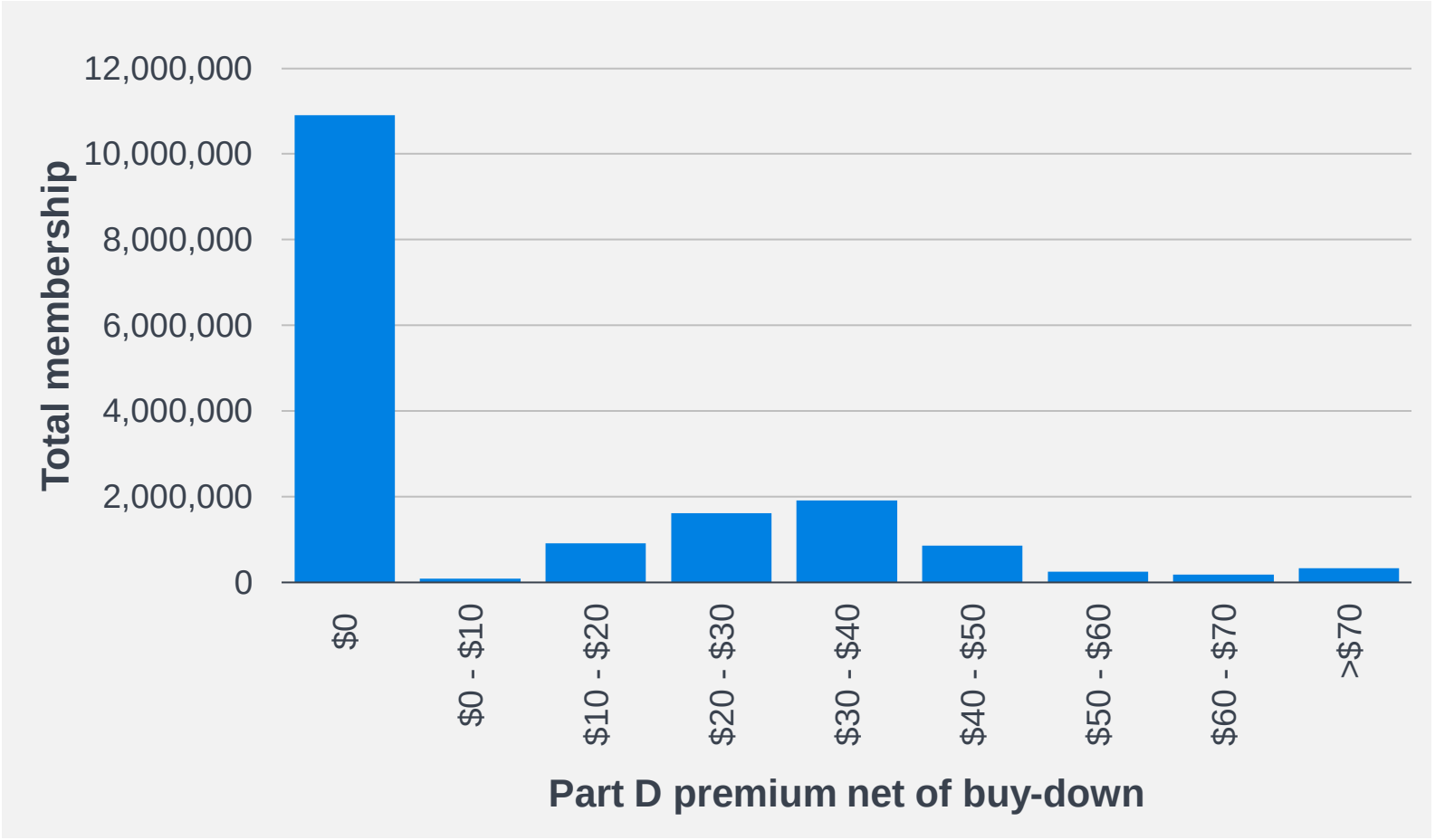
Higher reimbursement for city only	City Hospital 75% Urban Hospital 25%	**City Hospital 110% FFS** Urban Hospital 100% FFS	**Market comparison: Cannot use** **Comparable to FFS: Cannot use** **FFS proxy: Can use**
Almost all members in city	**City Hospital 98%** **Urban Hospital 2%**	City Hospital 100% FFS Urban Hospital 100% FFS	**Market comparison: Cannot use** Comparable to FFS: Can use FFS proxy: Cannot use

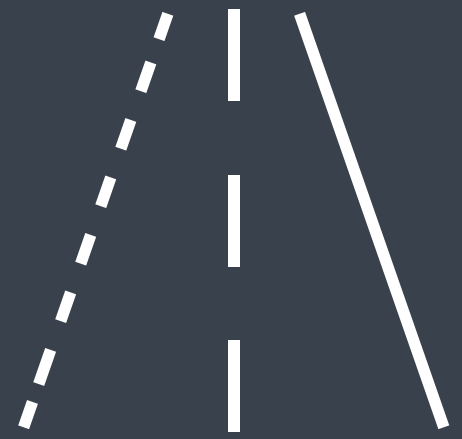
Part D premium trends

2021 MAPD general enrollment plan membership grouped by 2021 Part D premium (net of buy-down)

- **65%** of 2021 non-SNP members were enrolled in a $0 Part D premium plan
- **$0 Part D premium plans** enrolled 1.4 million more members (+15%) in 2021 relative to 2020
- **20%** of general enrollment MAPDs offer a premium of $20-$40, potentially targeting the low-income premium subsidy



Generic launch considerations



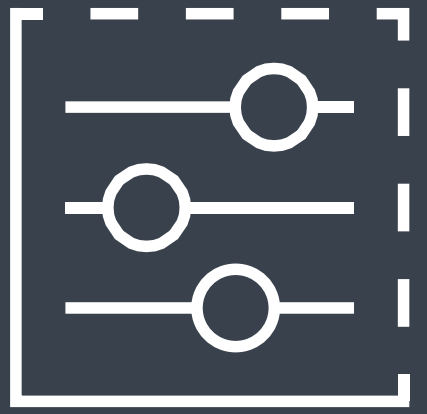
Key generic launches/brand patent expirations

- **Januvia:** #4 in 2019 allowed cost spending. Values in table include Janumet and Janumet XR
- **ICS/LABA:** Historically, most plans opting to cover brand inhalers 1-2 years after generic launch in this class
- **Pradaxa:** Other brands in class (Eliquis, Xarelto) are #1 and #3 in total 2019 allowed cost

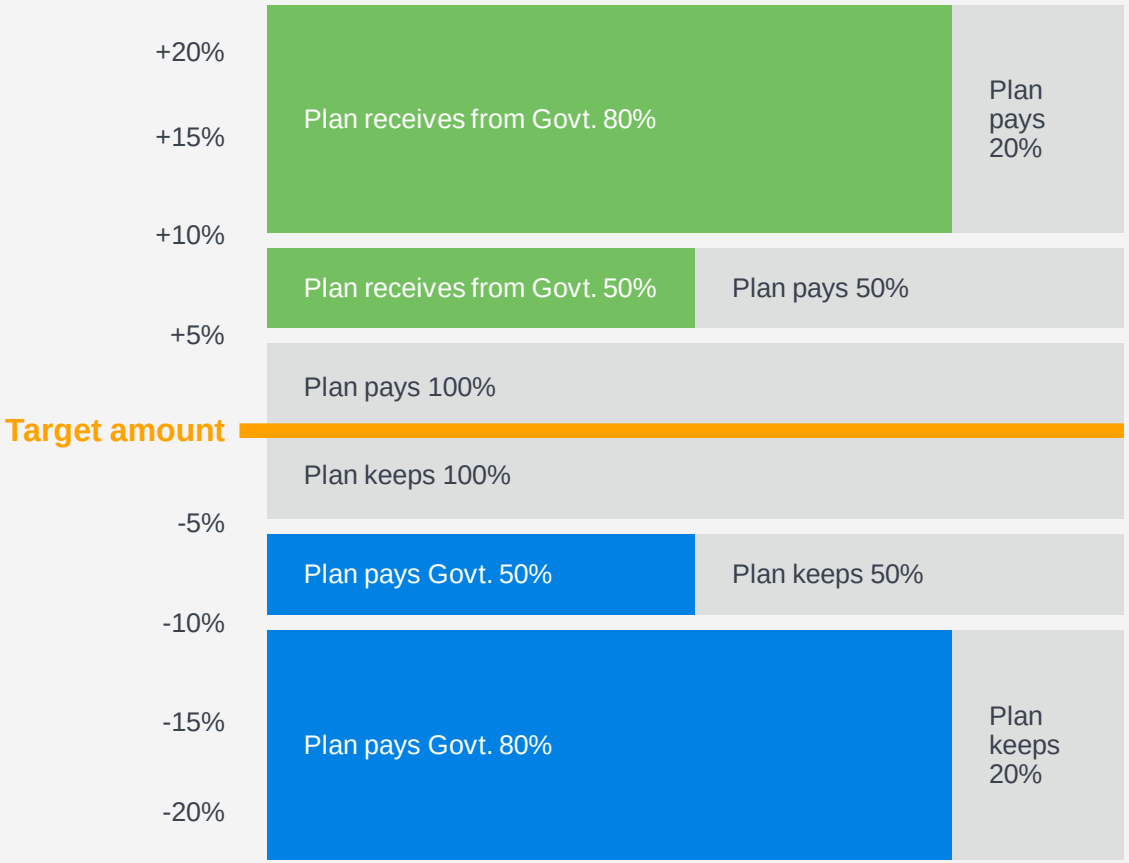
Drug name	Drug class	2019 % of allowed	Estimated generic launch date	2021 most common tier	2021 % members on most common tier
Revlimid	Immunomodulators	2.4%	Mar 2022	T5	100%
Januvia	DPP-IV agents	2.3%	July 2022*	T3	91%
Advair Diskus	ICS/LABA	1.1%	Feb 2019	T3	80%
Symbicort	ICS/LABA	0.8%	Jan 2020	T3	85%
Pradaxa	Anticoagulants	0.3%	Dec 2021	T4	64%

**Januiva's main patents are set to expire by July 2022, generic may not be available in 2022*

Worksheet 5 IU adjustment



Risk corridor overview



Induced Utilization (IU) Adjustment Background

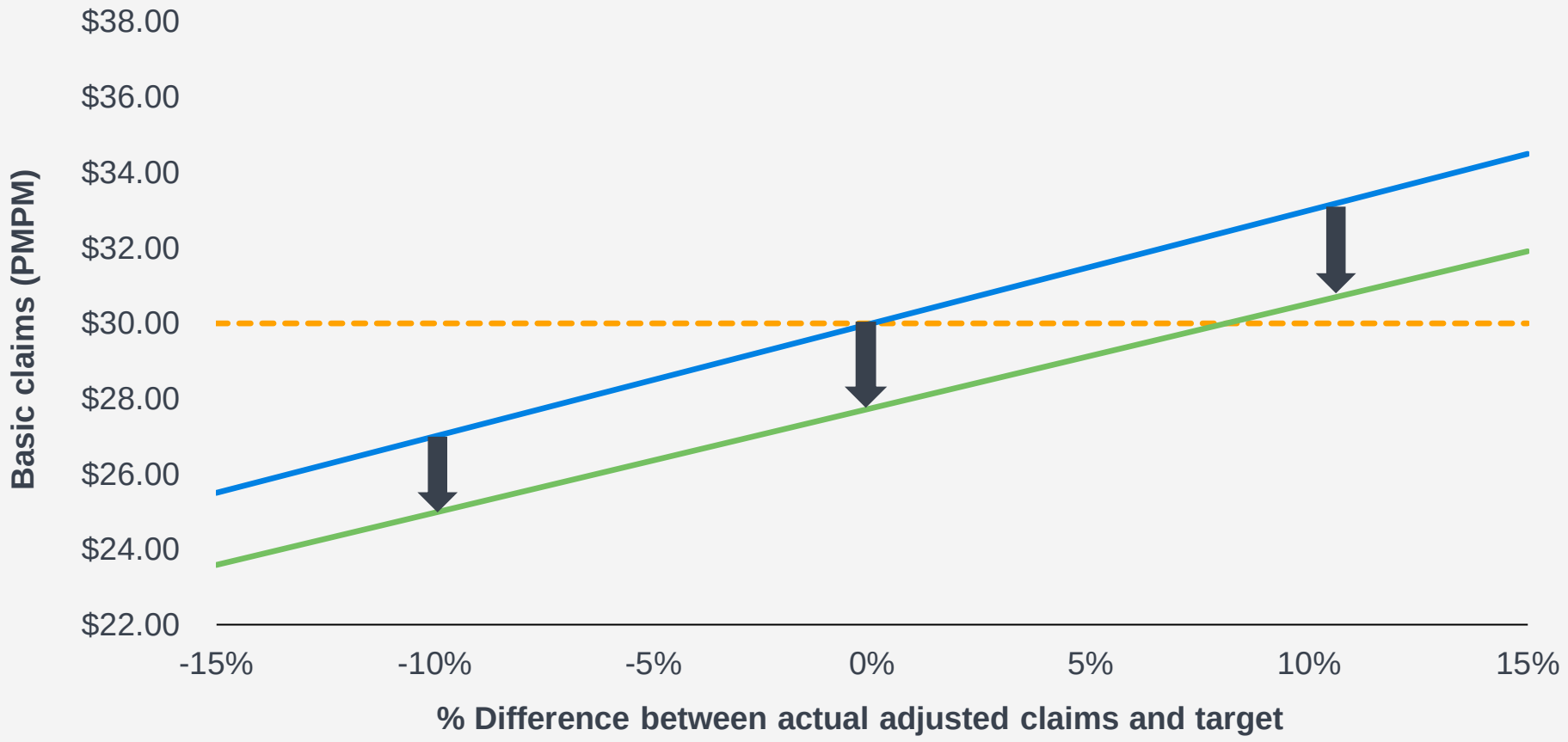
Risk corridors are determined based on the following formula:

$$\textit{Target amount} - \frac{\textit{Actual basic claims}}{\textit{Max (BPT IU adjustment, 1.0)}}$$

- The federal government shares a proportion of savings and losses, as illustrated in graph to left
- The IU adjustment is on Worksheet 5 of the Part D BPT and is “floored” at 1.0
- This may occur for many enhanced alternative (EA) plans, and has been exacerbated with closure of coverage gap and increased rebates over time

https://www.milliman.com/en/insight/are-medicare-part-d-risk-corridors-working-as-expected

Comparison of actual adjusted claims and target amount for 0.925 BPT IU vs. 1.0 IU floor



IU floor impact

The IU floor shifts the distribution of actual adjusted claims relative to the target

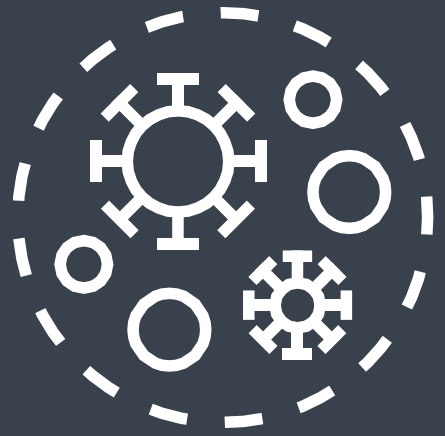
A plan could pay $0.40 PMPM for risk corridors if claims emerge exactly as expected due to the 1.0 Floor for the BPT IU Adjustment

Target

0.925 BPT IU

1.000 BPT IU floor

Part D COVID-19 considerations



Poll question

How are you adjusting your Part D bids due to COVID-19? Select all that apply

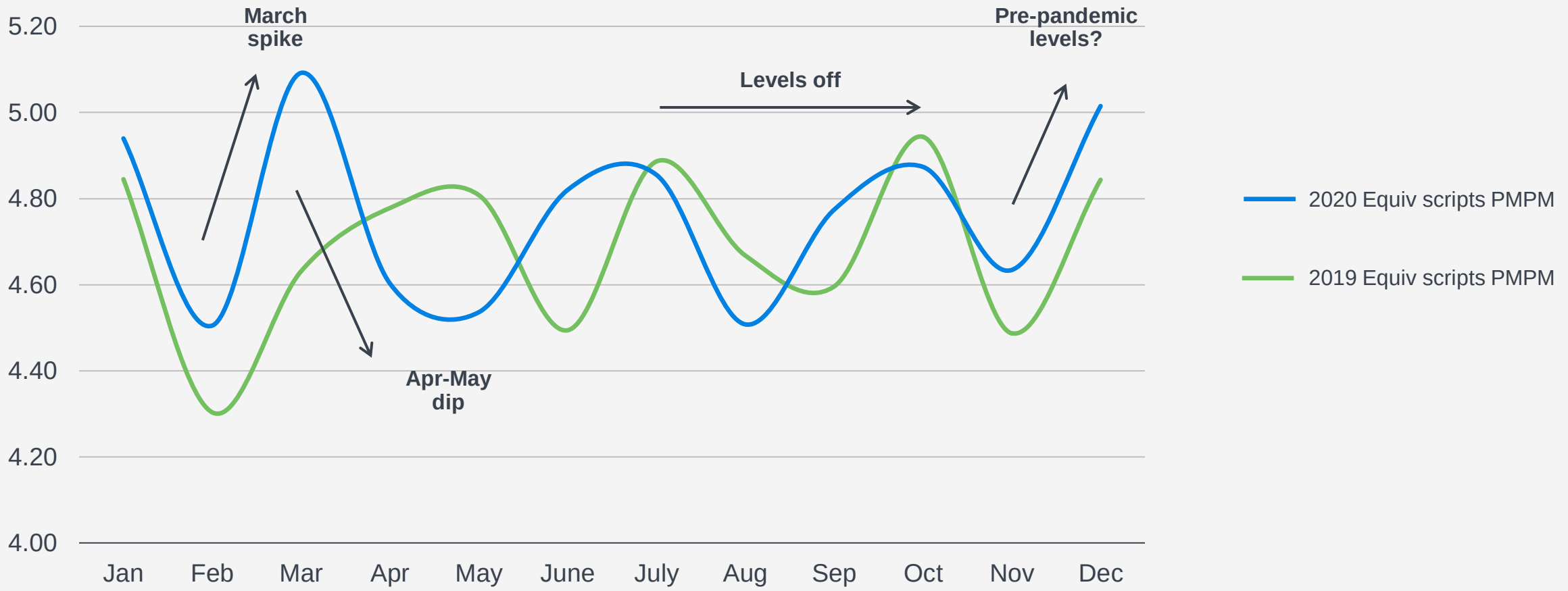
a) No adjustment
b) Using 2019 experience
c) 30-day vs. 90-day adjustments
d) Utilization/Unit cost trend change
e) Therapy class-specific adjustments
f) Other adjustments

Overall utilization trend

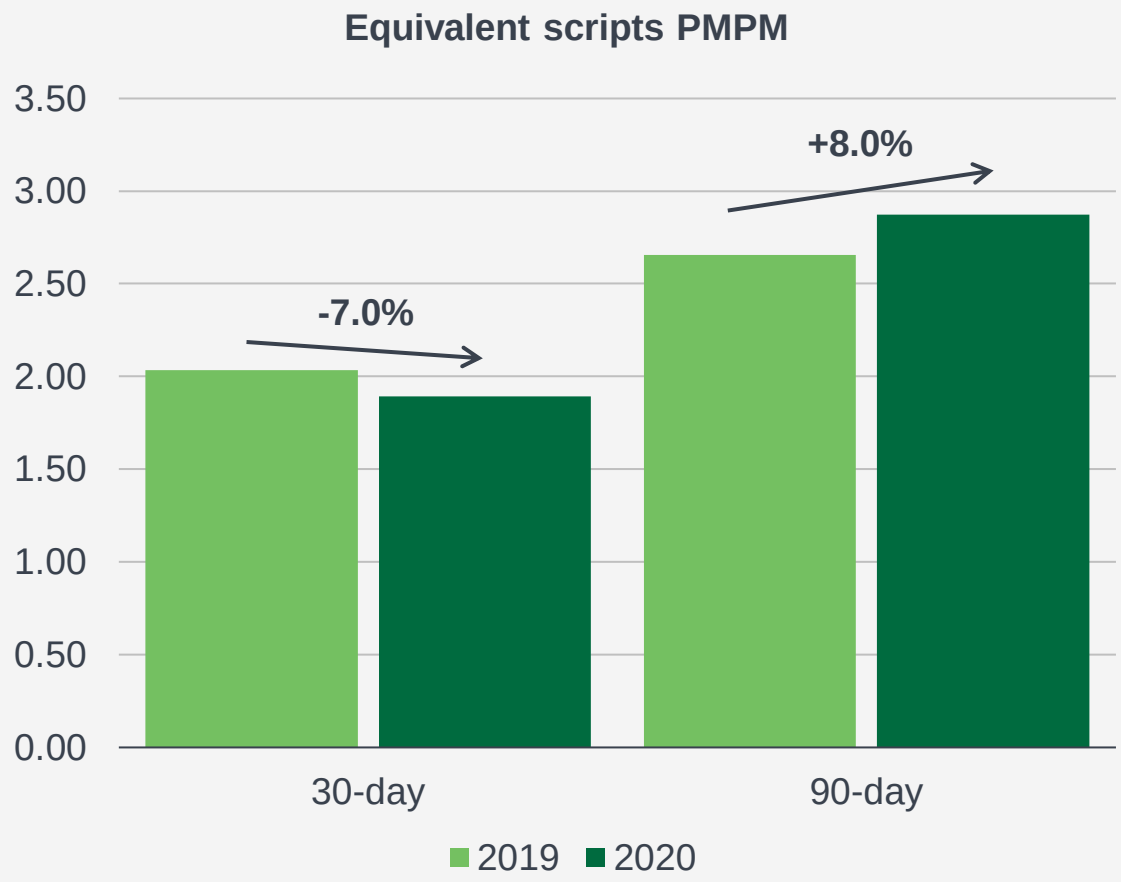
- We performed an analysis using Milliman's Part D Consolidated Database (PDCD) comparing 2019 to 2020 Part D utilization
- This analysis relies on members enrolled at any point in both 2019 and 2020. Does not reflect full 24-month continuous population
- Milliman trend guidance included range of 0% to 3% utilization trends for 2021 bids

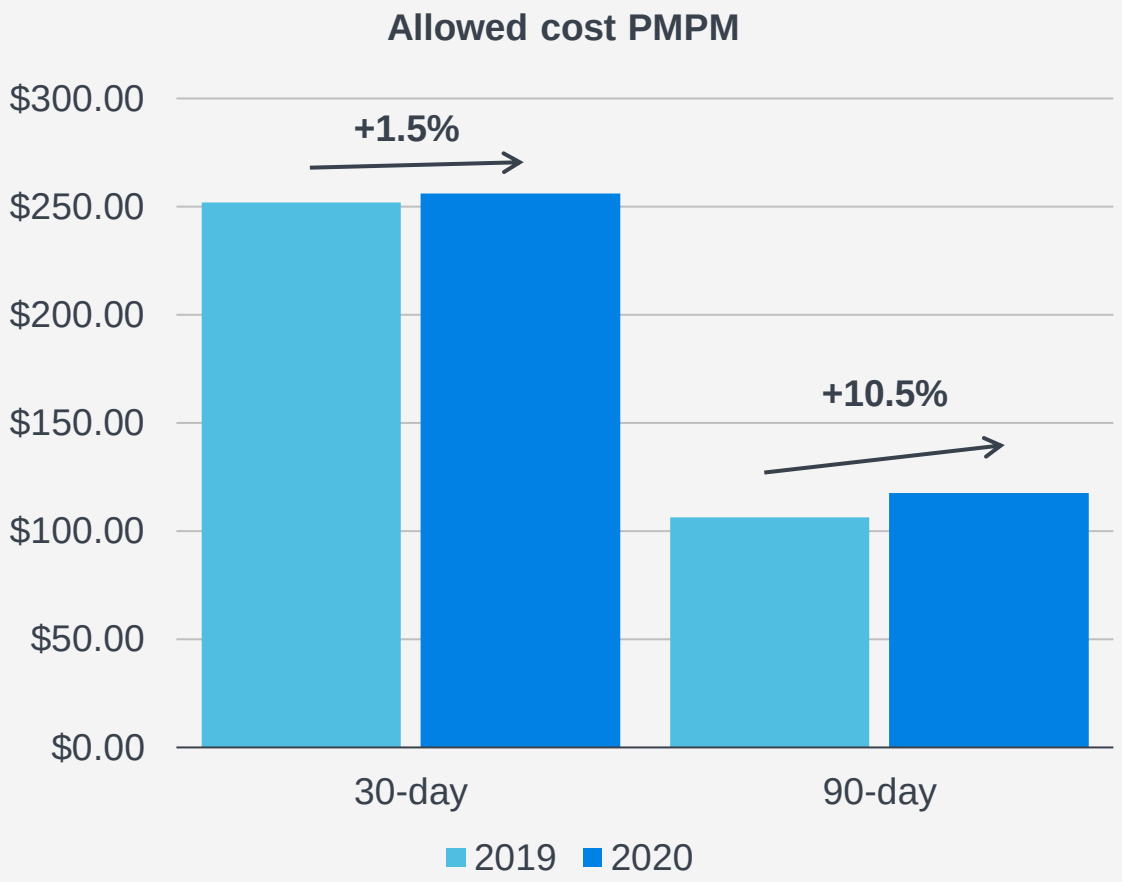
Comparison of 2019 vs. 2020 Equivalent scripts PMPM	
2019 Utilization	4.69
2020 Utilization	4.76
% Change	**+1.5%**

2019 vs. 2020 PMPM equivalent scripts by month

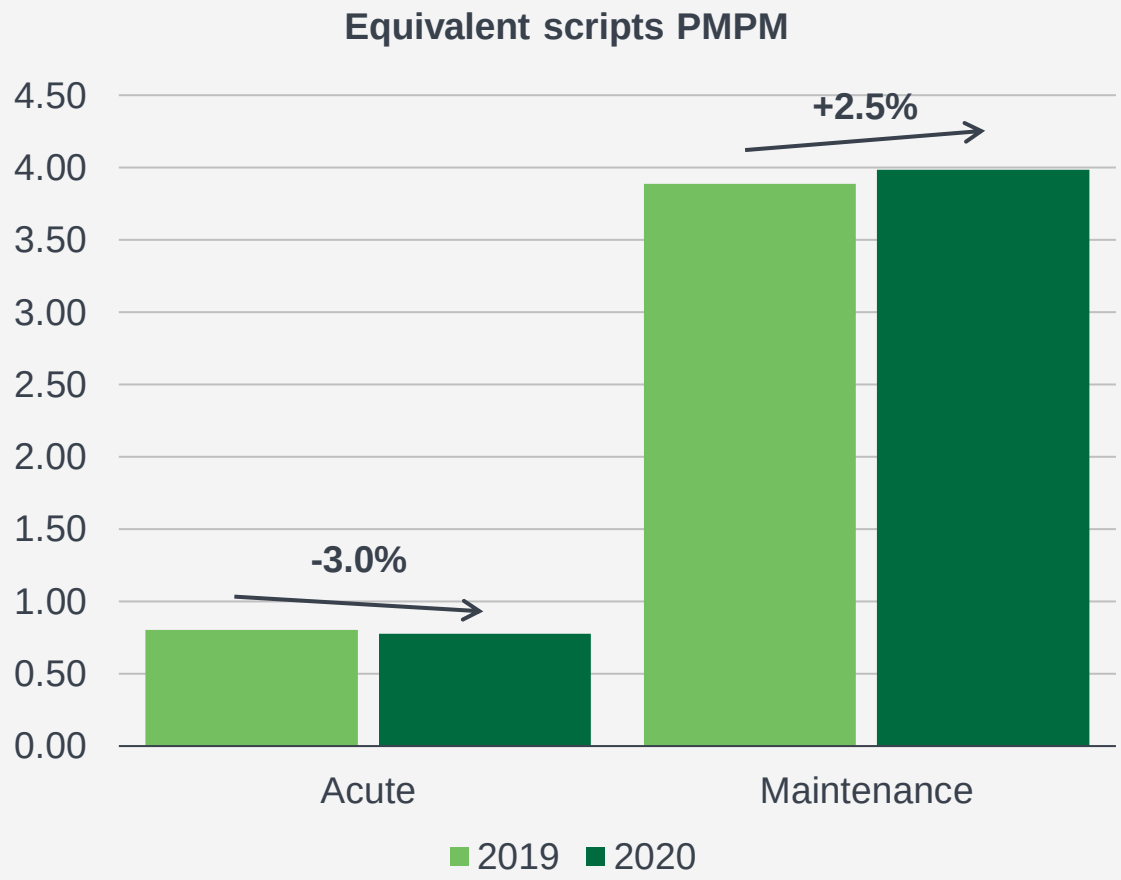


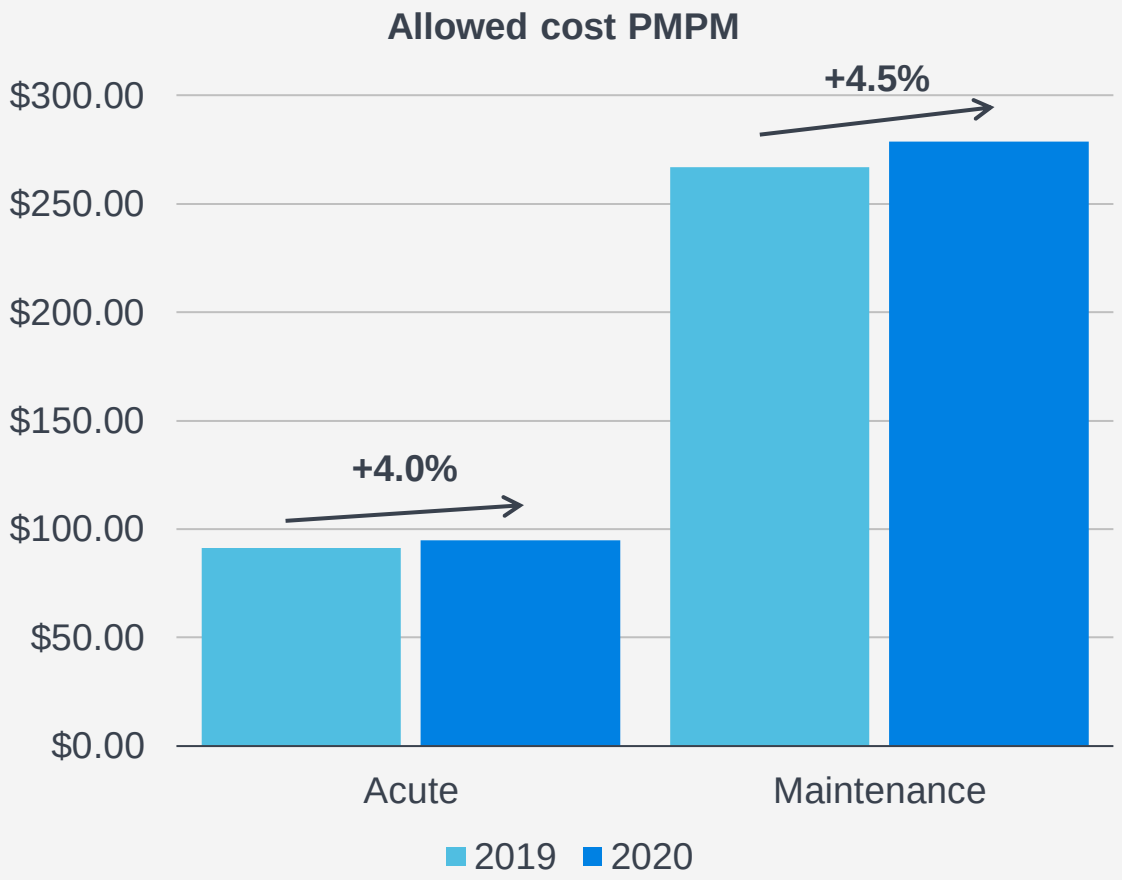
30-Day vs. 90-Day supply



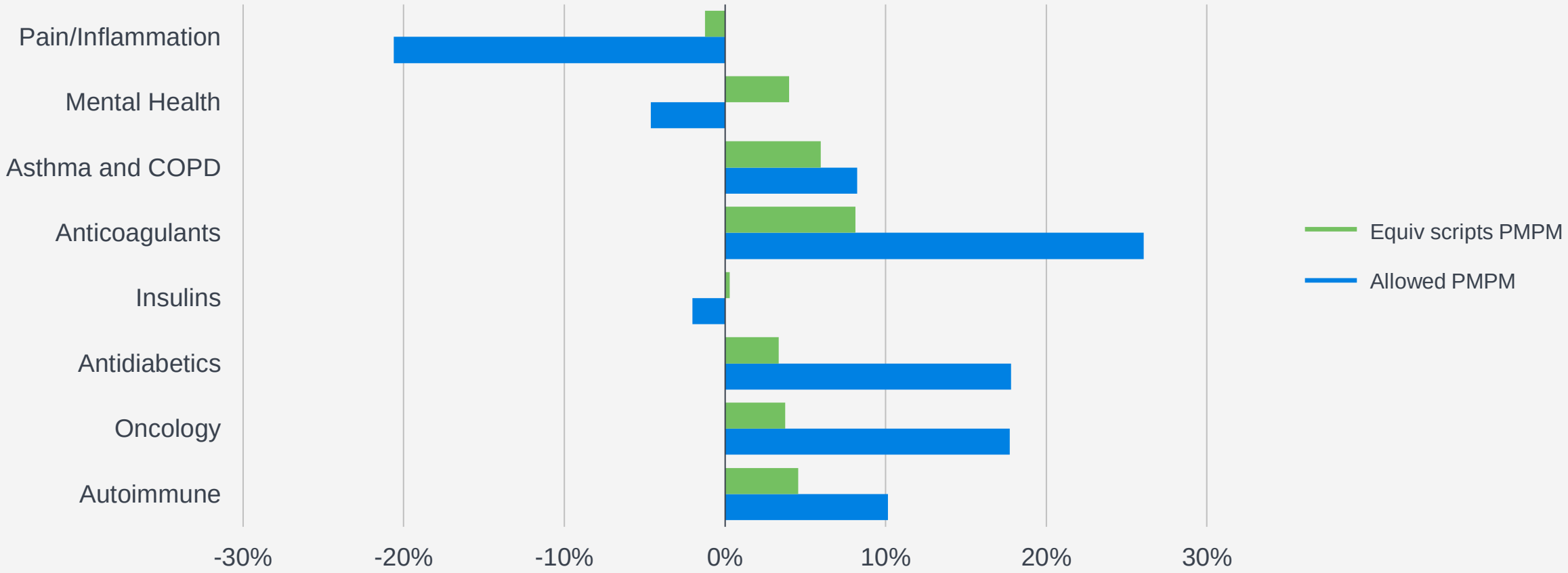


Acute vs. maintenance medications

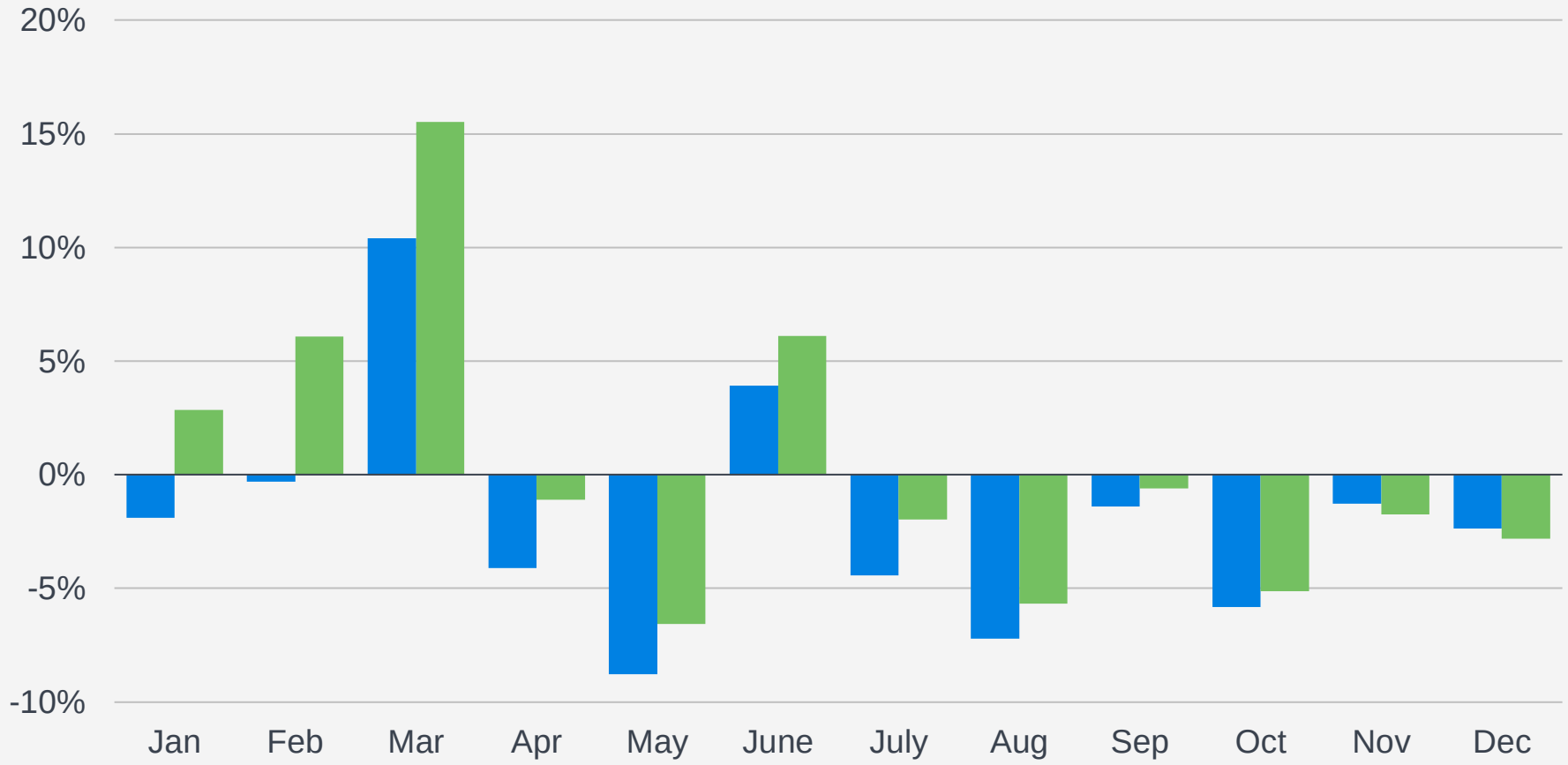




Percent utilization change (2019 to 2020) in key therapeutic classes



Percent change (2019 to 2020) by month all insulin classes



Insulin classes observations

- Large spike in insulin utilization and allowed cost in March
- Insulin utilization and cost lower for rest of year (except June)

Equiv scripts PMPM

Allowed PMPM

THERE IS A CRYSTAL BALL. IT'S CALLED MATH.

Milliman
IT TAKES VISION

Mathe-magician!

Questions?

Milliman

Thank you

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- The information contained herein does not constitute a legal opinion. It is important to seek guidance from counsel before making any decisions with respect to the determination of the impact or likelihood of any legislative or regulatory change to the Medicare Part C and D programs.
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