What's not so negative about Part D?

Courtney White, FSA, MAAA
Principal & Consulting Actuary

Tracy Margiott, FSA, MAAA
Principal & Consulting Actuary

Sara Yi, FSA, MAAA
Actuary

FEBRUARY 9, 2022

Agenda

Will the Direct Subsidy go negative this year?

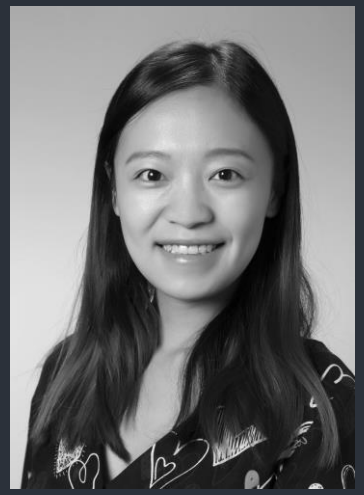
Will updates to the OOPC model negatively impact plan offerings?

Will Build Back Better and other legislation negatively impact your bid and members?

Presenters

Courtney White
FSA, MAAA
Principal & Consulting Actuary
courtney.white@milliman.com

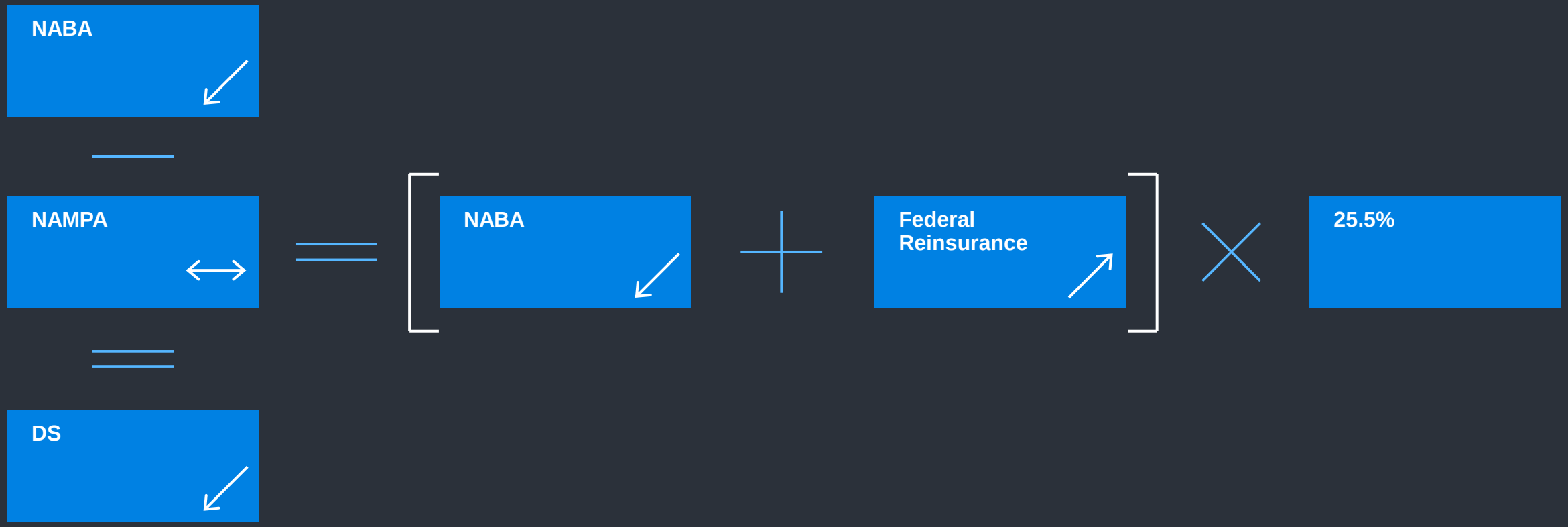
Tracy Margiott
FSA, MAAA
Principal & Consulting Actuary
tracy.margiott@milliman.com



Sara Yi
FSA, MAAA
Actuary
sara.yi@milliman.com

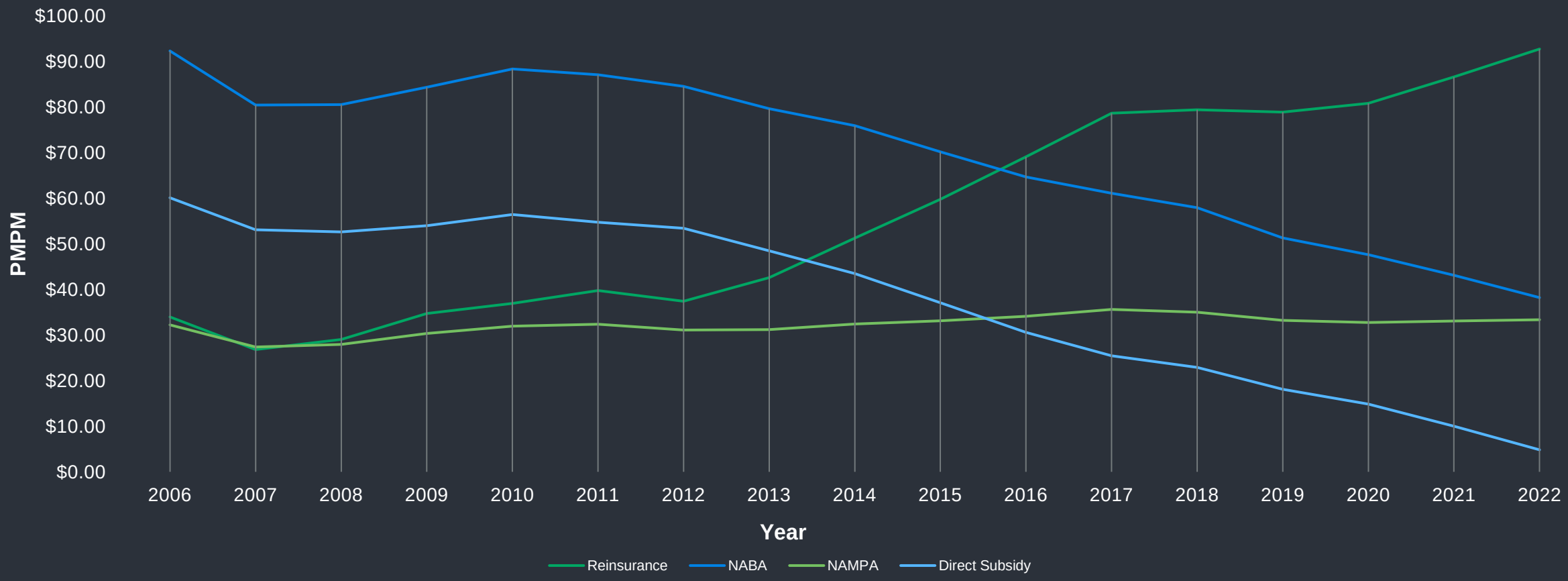
NABA and LIPSA

How NABA, Federal reinsurance, NAMPA, and DS fit

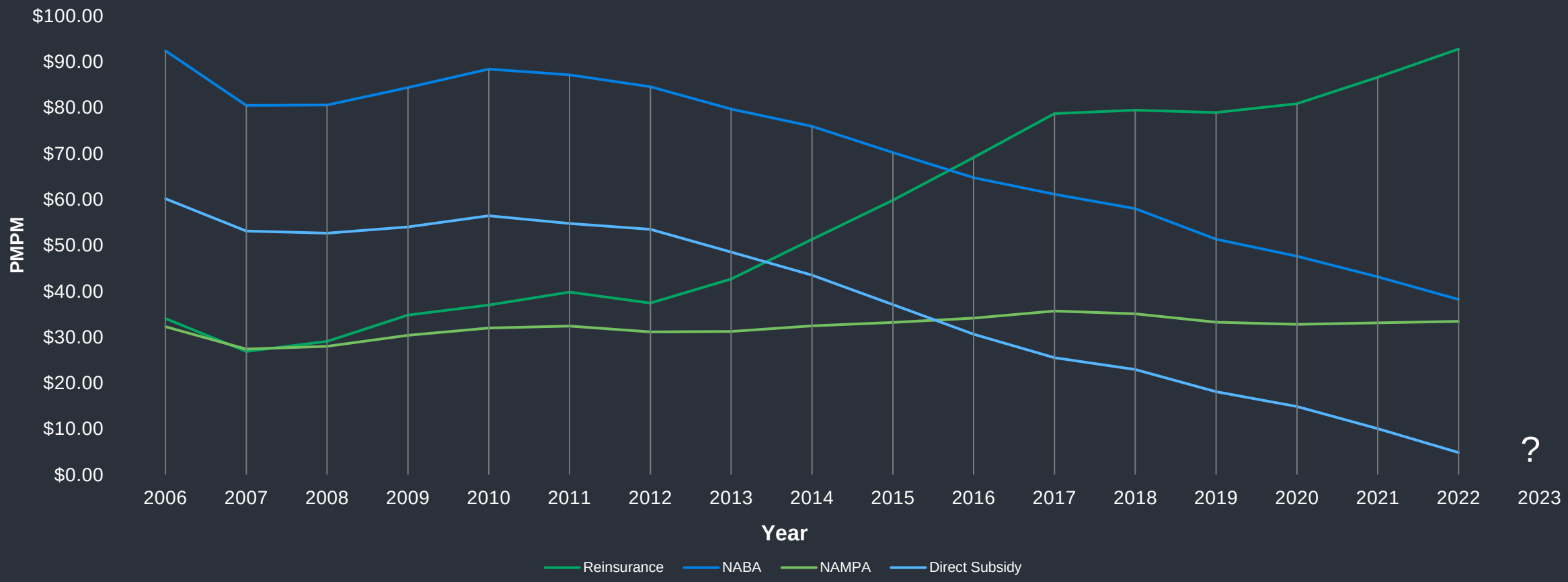


NYATL Compensation Structure - December 20th, 2021

Where we have been



And where are we going



Recent drivers of DS

- Margin
- Standard Part D benefit
- SG&A
- Socio-economic
- Trends
- Patents / formulary
- DIR
- Risk score model
- Membership re-weighting

Description	2019	2020	Change	2021	Change	2022	Change
Reinsurance	$78.88	$80.80	**+2.4%**	$86.58	**+7.1%**	$92.68	**+7.1%**
Reinsurance → + 2.4% to 7.1%							
NABA	**$51.28**	**$47.59**	**-7.2%**	**$43.07**	**-9.5%**	**$38.18**	**-11.4%**
NABA → -11.4% to -7.2%							

Likelihood of negative (or not so negative) DS

Illustrative only, repeat illustrative only – not my nor Milliman's best estimate

1 **Range of reinsurance (2.4% to 7.1%) and NABA (-11.4% to -7.2%)**

- 0.6% probability DS is negative
- DS ranges from -$0.11 to $2.17 PMPM, average is $1.04 PMPM

2 **Range for reinsurance (2.4% to 7.1%) and NABA range is 2% lower (-13.4% to -9.2%)**

- 18% probability DS is negative
- DS ranges from -$0.68 to $1.61 PMPM, average is $0.47 PMPM

3 **Range for reinsurance is 2% higher (4.4% to 9.1%) and NABA is 2% lower (-13.4% to -9.2%)**

- 51% probability DS is negative
- DS ranges from -$1.15 to $1.13 PMPM, average is $0.00 PMPM

Monte Carlo analysis

10,000 Scenarios

Estimation techniques

Approaches

- Top down
- Bottom up
- National and/or Regional Part D pricing model

Conservatism

- NABA
- LIB
- Minimum Part D basic buydown on MAPD

Regional low-income premium subsidy amounts

MAPD

Plans targeting LIPSA

34 Geographic regions

LIPSA = weighted average of monthly premiums for basic coverage in region

Weights are Part D LIS-eligible individuals in PDP and MAPD

PDP

Basic plans with premium at or below the LIPSA

- Keep current low-income members
- Auto enrollment of new members for full-benefit dual eligible individuals

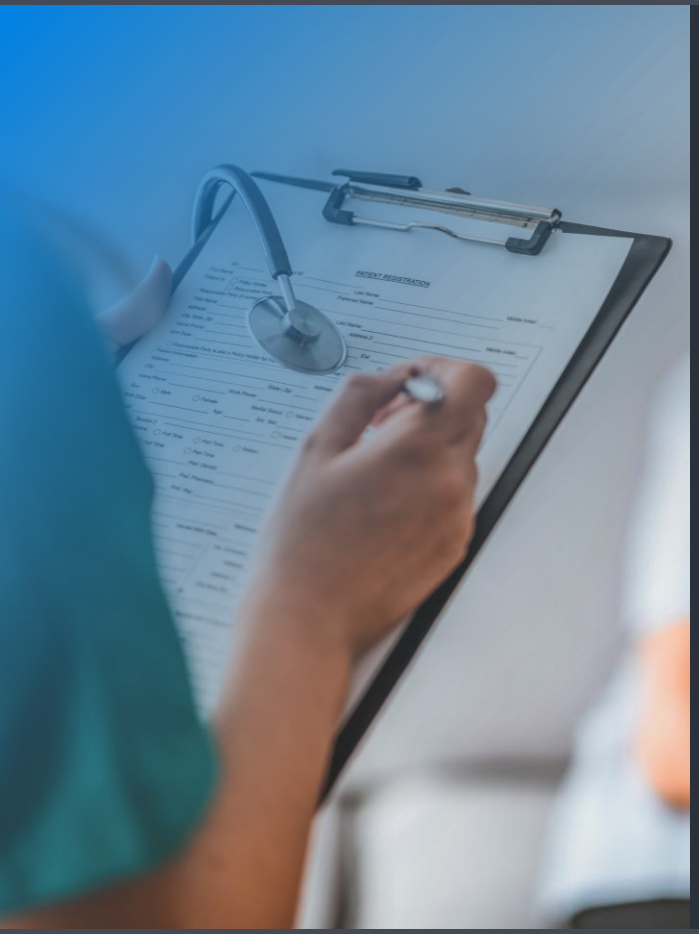
De minimis

- Waive portion of premium above LIPSA and keep current low-income members

Replicate CMS methodology using publicly available information

OOPC model and formulary strategy

Formulary strategy



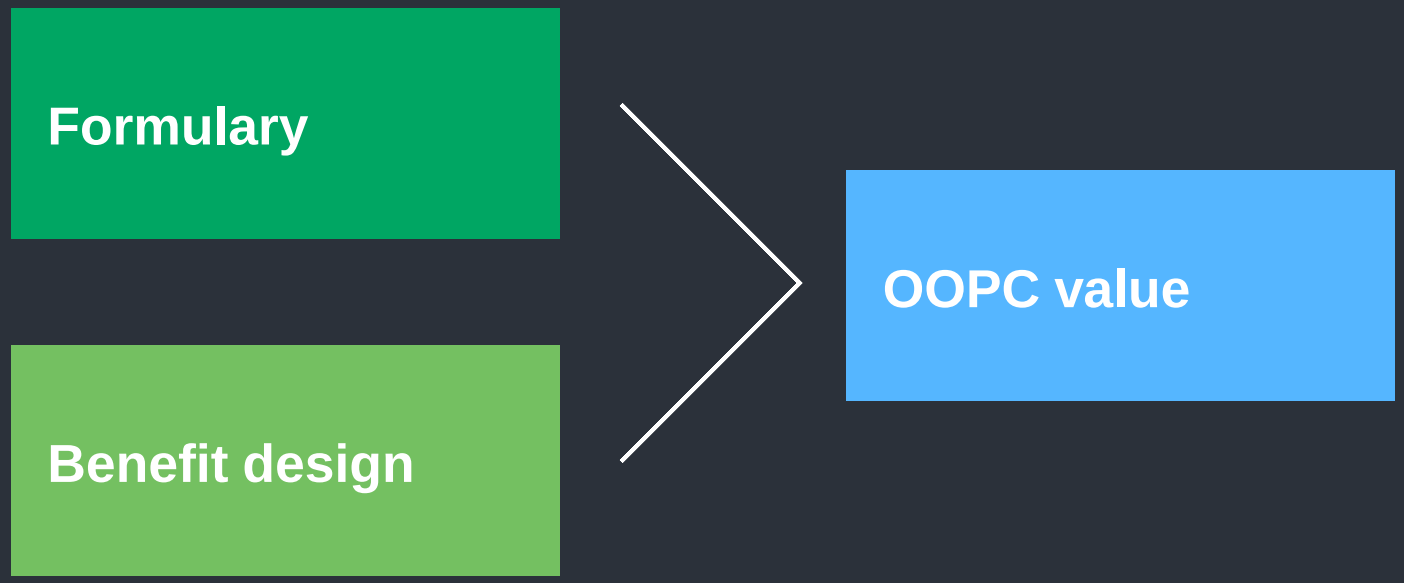
Changes to the CY2023 CMS Out-of-Pocket Cost (OOPC) model may affect formulary strategy

Formulary strategy varies by plan type

Member profitability analysis by drug assists in creating plan-specific formularies that attract profitable members

Out-of-pocket cost (OOPC) model changes

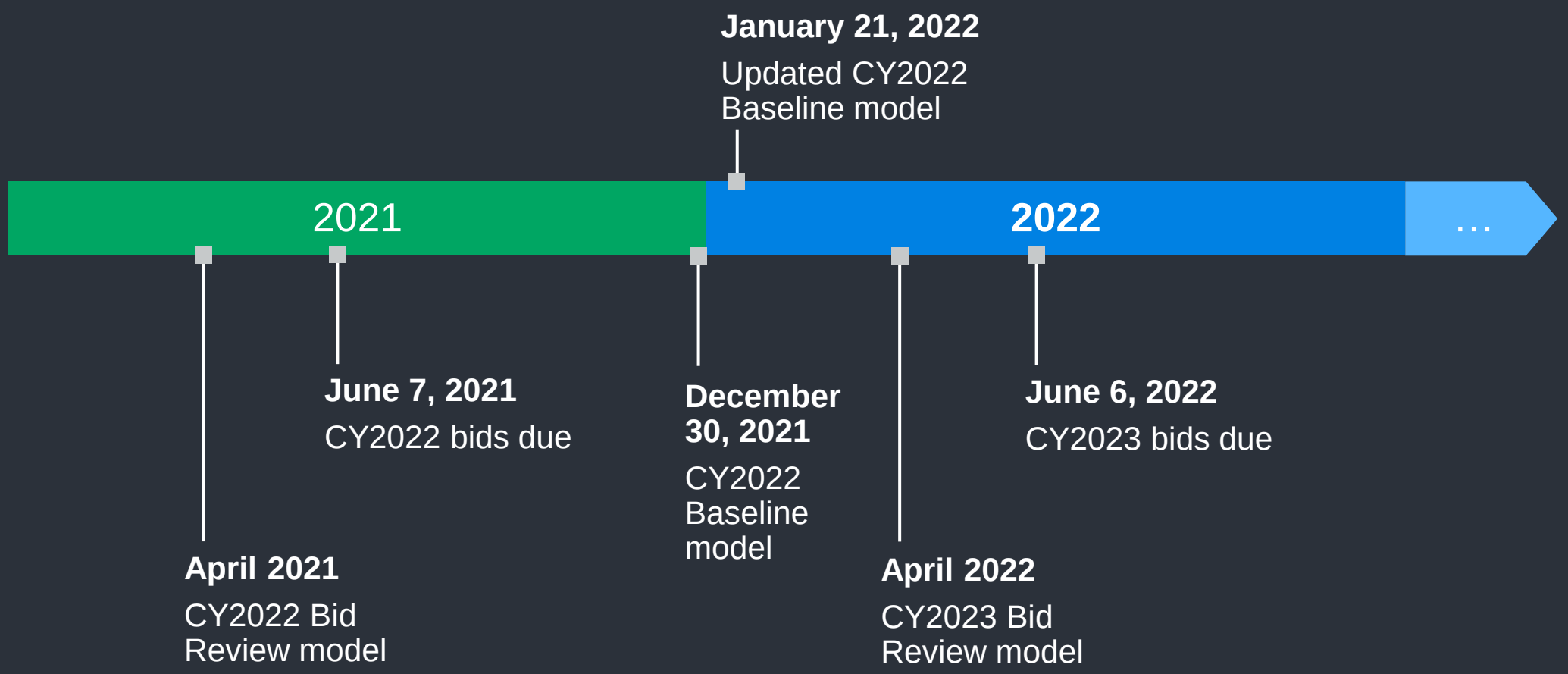
OOPC tool calculates the estimated average member out-of-pocket cost PMPM for a given plan by evaluating the benefit design and formulary



Used by CMS to:

- Review that standalone PDPs in the same region offer “meaningfully different” benefits
- Review year-over-year benefit changes for MA-PDs as a component of “total beneficiary cost” (TBC)
- Inform members on Medicare Plan Finder

Out-of-pocket cost (OOPC) model changes



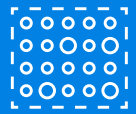
Out-of-pocket cost (OOPC) model changes

OOPC strategy

- CMS annually updates the underlying Part D utilization and modeled drug list
- Some drugs are valued differently in the OOPC model compared to pricing impacts
- This creates opportunities to maximize OOPC differential between plans while minimizing premium changes, by adding or removing specific drugs from the formulary

What is changing for CY2023?

- More drugs are included in the underlying Part D utilization data
  - Updated from 2016 & 2017 FFS MCBS data to a random sample of 0.1% of 2020 Part D enrolled Medicare beneficiaries
- For PDP meaningful difference testing, CMS removed the dollar threshold requirement
  - CMS expects “the OOPC value of the basic plan will be higher than that of the OOPC value of the enhanced plan offering(s)”



What does this mean for plan sponsors?

- New utilization data may affect overall OOPC values and the impact of certain formulary changes
  - Plans may reevaluate which drugs optimize OOPC opportunities
  - For PDPs, may require greater benefit enhancements to meet meaningful difference requirements
  - Will CMS modify required TBC threshold?

Formulary strategy varies by plan type

Individual market

Standalone Prescription Drug Plan (PDP)

- Basic
- Low-premium enhanced
- High-premium enhanced

Medicare Advantage Prescription Drug Plan (MA-PD)

- Special Needs Plan (SNP)
- Non-SNP

Group market

Employer Group Waiver Plan (EGWP) – MA-PD or PDP

Formulary strategy – Basic PDP

Overall benefit value is similar to the defined standard Part D plan

- Some cost sharing flexibility is allowed, e.g., tiered copays
- Low income (LI) member cost sharing is mostly subsidized

Many plans aim for premium below the regional low-income benchmark (LIB)

- Allows plans to auto-enroll LI members

Typically have lean formulary coverage

- Helps avoid selection risk and keep premium competitive
- May place generics on higher tiers
- LI members are more affected by on/off coverage than tier placement

Formulary strategy – Low Premium Enhanced PDP

Enhanced benefits with premiums often lower than those for Basic plans

- Growth strategy: aim to attract low-cost or non-utilizers through low premiums
- Typically enroll non-LI members
- Achieved via formulary and network

Formulary designed to reduce premium

- Low generic copays to attract generic utilizers
- Formulary difference, as opposed to benefits, is main driver of OOPC “meaningful difference” test compared to Basic plans

Formulary strategy – High Premium Enhanced PDP

Richer benefits and higher premium than other PDPs

Typically have rich formulary coverage

- Broader coverage
- May place brands on lower tiers

How do we determine what formulary changes to consider?

Identify potential opportunities through

Member profitability analysis

Are members who take certain drugs profitable or unprofitable for the plan?

Landscape comparison to competitors

Is coverage of a drug or class an outlier compared to competitor formularies? Could tier, coverage, or utilization management changes reduce selection risk or maximize rebates?

OOPC model opportunities

Would adding or removing a drug help achieve “meaningful difference” or TBC requirements while mitigating premium changes?

New drug launches

Do new drugs create coverage opportunities?

Clinical review

Would a considered change maintain adequate treatment options and meet CMS requirements?

Should this change be implemented? Consider resulting impact on net plan liability, allowable benefit offerings, and potential member disruption or selection.

Profitability analysis informs formulary changes

- Evaluate biggest “winners” and “losers” in profitability analysis
- Consider all medications taken by a certain cohort of members
- Plan A’s benefits and tier placement are not as attractive to these members
- Consider reducing copays to align with market

Atorvastatin calcium utilizers

		Formulary coverage / preferred cost sharing	
Drug	**Percentage of utilizers**	**Plan A**	**Market average**
Lisinopril	50%	Tier 1 / $2	Tier 1 / $0
Amlodipine besylate	25%	Tier 1 / $2	Tier 1 / $0
Levothyroxine sodium	25%	Tier 2 / $5	Tier 1 / $0
Base drug: Atorvastatin calcium	100%	Tier 1 / $2	Tier 1 / $0

Formulary strategy

Formulary, benefits, and premium are interrelated

Consider interaction of clinical requirements, CMS bid requirements, and financial goals to optimize formulary value

Build Back Better

Build Back Better Act Part D benefit redesign

Effective January 1, 2024

Eliminates coverage gap

Reduces member coinsurance to 23% from 25% in the initial coverage period

Reduces Federal reinsurance from 80% to 20% for brand drugs and 40% for generics

Member OOP capped at $2,000

Manufacturer payment applies through initial coverage period (10%) and catastrophic (20%)

2022 Part D standard benefit (NLI) vs Medicare Part D redesign

NLI = Non-low Income

LI = Low Income

NA = Not Applicable

MOOP = maximum out of pocket

BBB = Build Back Better Act

- Member
- Plan
- Manufacturer
- Government

Part D redesign: Other changes

Insulin copays capped at $35 per month with no deductible (starts in 2023)

- Senate version also applies rebates at POS

Manufacturer discount program applies to LIS members

Phase in of the manufacturer discount program for small manufacturers

National average member premium reduced from 25.5% to 23.5%

- Increase in direct subsidy (ignoring other changes)

Members given ability to "smooth" cost sharing over the entire year

Drug price negotiation

Both Part D and Part B drugs would be eligible

Top 50 drugs by total expenditure for each Part D and Part B as well as all insulins

Up to 10 drugs negotiable in 2025, 15 drugs in 2026 and 2027, and 20 drugs in 2028

Cumulative, so up to 60 total drugs by 2028

Small molecule drugs eligible 9 years after launch; Biologics 13 years after launch

Provides guardrails for discounts

Minimums of:

- 25% for short monopoly drugs (<12 years after launch)
- 35% for post exclusivity drugs (>12 years and <16 years after launch)
- 60% for long monopoly drugs (>16 years since launch)

Small biotech drugs exempt through 2027

Inflation rebates

Manufacturers required to pay rebates for prices that increase faster than inflation

Inflation would be benchmarked to prices on October 1, 2021

Trended forward using CPI-U

Rebates paid directly to Medicare Trust Fund

CMS proposed rule

Proposed by CMS January 6th and open for comment through March 7th, 2022

- Final rule expected 2nd quarter 2022

Requires pharmacy DIR to be passed to member at POS

- Similar to rule proposed in 2018 but not finalized
- Exception for applicable drugs in the Gap

Proposes formal regulatory definition of "Price Concession"

Other items (not discussed today)

- Changes to MOOP accumulation
- D-SNP changes
- Extends removal of 60% threshold for STAR rating components due to COVID
- MLR reporting changes

Stakeholder impacts

Members

- Cost sharing savings
- Lower prices at POS
- Insulated from price increases
- Potential premium increases

Plan sponsors

Increased risk in catastrophic

- Private reinsurance
- Increased required margins

Low/non-utilizers more profitable as DS increases

- Thinner formularies
- Richer generic benefits/coinsurance for brands

More complex formulary decisions

- Ex. Non-negotiated drugs could be favorable to negotiated drugs due to rebates

As more drugs are negotiated, formularies may become more uniform.

- Will have to compete on other items such as benefits

May accelerate movement from PDPs to MAPDs

Drug manufacturers

- Increased contribution compared to CGDP
- Upward pressure on launch prices
- Likely to reconsider current price concessions

Questions?

Milliman

Thank you

Courtney White
courtney.white@milliman.com

Tracy Margiott
tracy.margiott@milliman.com

Sara Yi
sara.yi@milliman.com

Milliman

All opinions expressed during the course of this presentation are strictly the opinions of the presenters. Milliman is an independent firm and provides unbiased research and analysis on behalf of many clients. Milliman does not take any specific position on matters of public policy.