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GROUP AND HEALTH 201
VALUATION AND REGULATION STUDY NOTE

MEDICARE PART D PRESCRIPTION DRUG BENEFITS

by

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Introduction

The Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) created Medicare Part D, which greatly enhances access to drug benefits for seniors. It established a voluntary outpatient prescription drug benefit for seniors and qualified disabled persons. In addition, it created an opportunity for employers providing prescription drug benefits to reduce their costs.

Prescription drug coverage is provided solely in the private sector but subject to extensive regulatory control by CMS. Individuals eligible for Medicare benefits are referred to as Medicare beneficiaries. They can buy a Medicare Advantage and Prescription Drug plan (MA-PD) in which a single plan provides both medical and drug coverage. Alternatively, the beneficiary may purchase a stand-alone Prescription Drug Plan (PDP).

Both PDP and MA-PD insurance carriers are generally subject to the same requirements. Namely, they

- Must offer a basic drug benefit called the "defined standard benefit"
- May offer supplemental benefits called "enhanced benefits"
- Can be flexible in benefit design
- Must follow marketing guidelines
- Must meet fairly restrictive formulary guidelines
- Cannot mandate beneficiaries fill prescriptions through mail-order pharmacies

Most beneficiaries enrolled in a PDP will pay a Part D premium but beneficiaries in certain MA-PD plans might have $0 premium for the entire MA-PD plan. Beneficiaries eligible for full premium subsidies, if they do not voluntarily enroll in an MA-PD or a PDP plan, are automatically enrolled in a PDP that provides basic coverage and for which the beneficiary would not directly owe a monthly premium.

Enrollment and Creditable Coverage

There is a six month initial enrollment period starting three months before a beneficiary turns 65 and ending three months after turning 65. There is an annual enrollment period from October 15th to December 7th each year. Additionally, there is an open enrollment period between January 1st and March 31st of each year, which allows beneficiaries to make plan changes during the plan year.

Medicare eligible beneficiaries must sign up for Part D coverage when they are first eligible. There is a 63 day initial enrollment period when an individual turns 65 years old or when the beneficiary loses creditable coverage. Individuals are subject to a late enrollment penalty if they do not sign-up for Part D coverage within this timeframe. The penalty is 1% of the base beneficiary premium for each month the beneficiary was eligible for Part D coverage but was not enrolled and did not maintain creditable coverage (rounded to the nearest $0.10 pmpm). The national base beneficiary premium is published each year by CMS ($32.74 for 2023). For example, if an individual is without creditable coverage for 24 months and first enrolls 1/1/23, the penalty will be 24 *0.01* $32.74 = $7.86 pmpm. This amount will be re-calculated annually and added to the beneficiaries premium every year in perpetuity. In 2024 and subsequent years, the penalty amount will increase/decrease as the national base beneficiary premium changes.

The individual will not be subject to a late enrollment penalty if he or she has creditable coverage. Prescription drug coverage is creditable if it is at least as good as Medicare Part D, as defined by actuarial equivalence. This coverage is generally offered by an employer group, either through active employment or a retiree plan. Employers must test plans and send notices to beneficiaries annually and when a beneficiary becomes Medicare eligible.

Medicare eligible beneficiaries who leave an employer plan mid-year must wait until the late fall open enrollment period unless one of the exceptions exists:

- Beneficiaries who permanently move out of a plan service area
- Individuals entering or leaving a long-term care facility
- Involuntary loss, reduction, or non-notification of creditable coverage (generally job elimination)

Employer Group Options

One of the stated goals of Medicare Part D is to provide incentive for employers to provide prescription drug coverage to retirees. These incentives provide financial assistance to employers. Employers can either keep their retirees in their prescription drug plan and out of Medicare Part D or put their retirees into a Medicare Part D plan. Employers and unions have several choices around retiree Rx coverage:

1) Direct Contract EGWP (Employer Group Waiver Plan) - Employers or Unions could contract directly with CMS (called "Direct Contract EGWPs") as a self-insured PDP or MA-PD. Due to the large regulatory and administrative demands of these plans, this is uncommon. These are essentially self-administered group Medicare PDP plans.

2) 800-series EGWP - Under EGWPs, the employers or unions contract with an insurance carrier to set up a custom group Medicare PDP or MA-PD plan. The carrier sets the premium. The federal government (CMS) provides a subsidy to the carrier which is then passed along to the employer as a reduction in the beneficiary premiums.

3) Medicare non-EGWP plan – The employer or union provides funds for beneficiaries to enroll in an individual PDP or MA-PD plan. Similar to the EGWPs, CMS provides a subsidy that lowers beneficiary premiums.

4) Group Rx plan with RDS subsidy – An employer can provide Rx coverage that is not a Medicare part D plan. For example, it could be the same Rx benefits as for active employees. If the benefits offered are determined to be creditable coverage, then the employer receives a subsidy from CMS for providing such coverage.

The most common options selected are the RDS subsidy and EGWP. For the RDS plan, the subsidy is set in MMA as 28% of the annual prescription drug spending (ingredient cost plus dispensing fee less rebates) that would otherwise have been covered by Part D and is between the deductible and RDS cost limit. The Patient Protection and Affordable Care Act of 2010 (ACA) did not change the subsidy but eliminated the employer's subsidy tax deduction as of 2013, reducing realized savings by one-third.

For EGWP, the cost savings for this option are estimated at 35%-40%, greater than RDS. For the employer, there are fewer compliance, regulatory, and administrative burdens as compared to RDS since they are borne by the insurance carrier. All risk is shifted to the carrier in the fully insured plan. The cost (as premium) is fully tax deductible. The base plan allows the plan sponsor to maximize savings from CMS and manufacturers. Groups can then offer separate wrap-around coverage which can match active employee benefits.

The ACA and the Bipartisan Budget Act of 2018 (BBA) made structural changes to the Part D benefit design. First, let's start with a 2007 example before considering the ACA and BBA changes.

2007 Standard Plan	Drug Costs	Member Cost Share %	Member Pays	Plan Pays	Total Paid
< Deductible	$0 - $265	100%	$265.00	$0.00	$265.00
Deductible to ICL	265 – 2,400	25%	533.75	1,601.25	2,135.00
Donut hole	2,400 – 5,451	100%	3,051.25	0.00	3,051.25
True Out of Pocket (TrOOP)			3,850.00		
% Paid			71%	29%	100%
Catastrophic	5,451 – 7,200	5%	87.44	1,661.31	1,748.75
Total Paid			3,937.44	3,262.56	7,200.00
% Paid			55%	45%	100%

Between the deductible and ICL, there is 25% beneficiary cost share. $533.75 = (2,400 - 265) *0.25.

The Estimated Covered Rx Costs in the Donut hole are:

3,850 (the TrOOP) – 265 (deduct) - 533.75 (cost share in ICL phase) = 3,051.25 = donut hole Rx costs

Since the introduction of Part D, there have been two major changes to plan designs:

Affordable Care Act (ACA) and Bipartisan Budget Act (BBA)

Starting in 2010, the ACA instituted a 10-year process of closing the Part D coverage gap from a 100% beneficiary coinsurance rate in 2010 to 25% by 2020. ACA also introduced a Coverage Gap Discount Program aiming to close the gap. Manufactures pay 50% of the applicable drug cost incurred in gap phases for applicable drugs. The 2018 Bipartisan Budget Act (BBA) expedited closing the donut hole and also increased the Coverage Gap manufacturer discount from 50% to 70%, effective in 2019.

<u>Standard Benefit Design under ACA (2010) and BBA (2018)</u>

The standard benefit design is the minimum allowable Part D plan coverage. Part D plans are permitted to offer variations on this standard, known as "enhanced benefits".

As initially designed, there were four benefit phases. Each threshold indexes annually. The following describes the benefit phases and liability for each party for the non-low income population.

1) Deductible – must be satisfied before any benefits are paid.

2) Initial Coverage Phase – After the deductible is met, the beneficiary pays 25% of the covered cost up to the initial coverage limit (ICL) and the remaining 75% is paid by the Part D plan.

3) Coverage Gap – Once gross drug spend exceeds the ICL, the beneficiary is responsible for 25% of drug spending. Plan is responsible for 5% of the applicable drug cost (if covered by the "Coverage Gap Discount Program), and is responsible for 75% of non-applicable drug cost. Manufacturer is responsible for 70% of applicable drug cost in the gap phase through Coverage

Gap Discount Program. This benefit phase continues until beneficiaries reach their TrOOP limit[1]. This phase is also referred to as "the donut hole".

The Coverage Gap Discount Program makes manufacturer discounts available to eligible Medicare beneficiaries receiving applicable, covered Part D drugs, while in the coverage gap. In order to participate in the Discount Program, manufacturers must sign an agreement with CMS to provide the discount on all of its applicable drugs (i.e. prescription drugs approved or licensed under new drug applications or biologic license applications). The coverage gap discount amount is counted towards TrOOP prior to 2025.

4) Catastrophic – Once the cumulative member cost sharing and coverage gap discount amount reaches TrOOP, the beneficiary reaches the catastrophic phase. Member cost sharing is the greater of 5% of drug costs or nominal copays that are indexed by year. CMS covers 80% of total drug spend incurred by beneficiaries in the catastrophic phase (this is the Federal Reinsurance program). Then Part D plans cover the remainder of liability.

Medicare also provides support for low income beneficiaries through a Low Income Premium Subsidy (LIPS) and a Low Income Cost Sharing (LICS) subsidy. LIPS funds a portion of the beneficiary's Part D basic premium, and LICS helps low-income beneficiaries with their Part D deductibles and cost sharing. LIPS and LICS subsidy levels vary based on different asset and eligibility criteria, up to 150% of the federal poverty level.

Inflation Reduction Act (IRA)

The Inflation Reduction Act of 2022 (IRA) made a number of changes to the Part D benefit that take effect beginning in 2023. The IRA also introduces a model under which CMS can negotiate drug prices for the entire Part D program with drug manufacturers and applies penalties if a negotiated price is not achieved. Other changes include caps on the drug cost increases, a $35 copay limit for insulin, and $0 cost sharing for vaccines. The plan design changes are most material starting in 2025 and include three main changes:

- Transition from a coverage gap discount program to a manufacturer discount program, applying to all costs above the deductible and through the catastrophic phase (instead of just the coverage gap phase). The manufacturer discount is not attributed towards beneficiary's OOP threshold anymore.
- Move from 4 phases to 3 phases (deductible, OOP, and catastrophic)
- Set beneficiary OOP cap at $2,000 (indexed in future years) and eliminate the TrOOP

[1] TrOOP is calculated as deductible + cost share % through initial coverage limit + attributed cost share in the coverage gap. Only payments for formulary drugs (or plan approved exceptions) count toward the TrOOP.

Comparison Part D Standard Benefit Design Parameters

	2007	2023	2024			2025*	
Deductible	$265	$505	$545		Deductible	$555	
						Brand	Generic
Initial Coverage Limit	$2,400	$4,660	$5,030		Member OOP	$2,000	
Plan Cost Share	75%	75%	75%		Plan Cost Share	65%	75%
Member Cost Share	25%	25%	25%		Member Cost Share	25%	25%
					Manuf Cost Share	10%	0%
Coverage Gap – Brand							
Manuf Cost Share	n/a	70%	70%				
Plan Cost Share	n/a	5%	5%				
Member Cost Share	100%	25%	25%				
Coverage Gap – Generic							
Plan Cost Share	n/a	75%	75%				
Member Cost Share	100%	25%	25%				
TrOOP	$3,850	$7,400	$8,000				
Approx. Member Spending at TrOOP**	$3,850	$3,100	$3,350				
Catastrophic Phase					Catastrophic Phase	Brand	Generic
Member Cost Share	5%	5%	0%		Member Cost Share	0%	0%
Plan Cost Share	15%	15%	20%		Plan Cost Share	60%	60%
Gov't Reinsurance	80%	80%	80%		Gov't Reinsurance	20%	40%
					Manuf Cost Share	20%	0%

** 2025 deductible is estimated based on past increases*
*** For 2023/2024, member spending at TrOOP are averages; the actual amount varies by beneficiary based on the mix of drugs used*

Accumulation to OOP vs TrOOP (2023 vs 2025)

Actual beneficiary cost share in the 2023 Part D defined standard plan is variable since it is based on the mix of generic vs brand usage and timing of that usage. Under the IRA, the Part D plan design is simplified for the beneficiary but is more complex for the pricing actuary due to the impact of other IRA provisions. The example below shows the cost for Jack and Jill under the 2023 and 2025 plan design with a $505 deductible. It ignores indexing and inflation to highlight the plan design impact.

Jill		2023				2025		
Phase / Drug Type	Drug Cost	Member Pays	Manuf Pays	Amt Applied to TrOOP	Accum TrOOP	Member Pays	Amt Applied to OOP	Accum OOP
Deductible	505.00	505.00	0.00	505.00	505.00	505.00	505.00	505.00
Deductible to ICL	4,155.00	1,038.75	0.00	1,038.75	1,543.75	1,038.75	1,038.75	1,543.75
Donut Hole – Brand	5,768.00	1,442.00	4,037.60	5,479.60	7,023.35	456.25	456.25	2,000.00
Donut Hole – Generic	1,506.60	376.65	0.00	376.65	7,400.00	0.00	0.00	0.00
Catastrophic	500.00	25.00	0.00	0.00	7,400.00	NA	NA	NA
Total	12,434.60	3,387.40	4,037.60	7,400.00		2,000.00	2,000.00	2,000.00

Jack		2023				2025		
Phase / Drug Type	Drug Cost	Member Pays	Manuf Pays	Amt Applied to TrOOP	Accum TrOOP	Member Pays	Amt Applied to OOP	Accum OOP
Deductible	505.00	505.00	0.00	505.00	505.00	505.00	505.00	505.00
Deductible to ICL	4,155.00	1,038.75	0.00	1,038.75	1,543.75	1,038.75	1,038.75	1,543.75
Donut Hole – Brand	1,506.60	376.65	1,054.62	1,431.27	2,975.02	376.65	376.65	1,920.40
Donut Hole – Generic	6,268.00	1,567.00	0.00	1,567.00	4,542.02	79.60	79.60	2,000.00
Catastrophic	0.00	0.00	0.00	0.00	4,542.02	NA	NA	NA
Total	12,434.60	3,487.40	1,054.62	4,542.02		2,000.00	2,000.00	2,000.00

Jill hits the TrOOP and moves into the catastrophic phase prior to the end of the policy year in the 2023 plan design. Jack spends $3,487.40 in cost sharing but will not reach the TrOOP, since he is using more generic drugs, and even with his brand spend, his TrOOP only reaches $4,542.02. If the above reflected 6 months of drug cost rather than 12 months, beneficiary spending in the 2nd half of the year would vary materially. Jill would generally spend 5% in the catastrophic phase and Jack up to $2,857.98 (depending on the split of generic and brand) before reaching catastrophic coverage. In the 2025 plan design, Jack and Jill will both hit the $2,000 OOP and move into the catastrophic phase prior to the end of the policy year.

Now let's look at a more complex example using the 2025 plan design in which the timing of claims is considered. Here, we use the estimated 2025 cost sharing parameters.

Month	Drug Costs – Brand	Drug Costs – Generic	Member Pays	Manuf Pays	Medicare Pays	Plan Pays	Cumulative OOP
Jan	$400	$155	$555	$0	$0	$0	$555
Feb	$500	$80	$145	$50	$0	$385	$700
Mar	$800	$200	$250	$80	$0	$670	$950
Apr	$800	$200	$250	$80	$0	$670	$1,200
May	$1,200	$200	$350	$120	$0	$930	$1,550
Jun	$1,200	$600	$450	$120	$0	$1,230	$2,000
Jul	$1,200	$600	$0	$240	$480	$1,080	$2,000
Aug	$1,200	$600	$0	$240	$480	$1,080	$2,000
Sep	$1,200	$600	$0	$240	$480	$1,080	$2,000
Oct	$600	$800	$0	$120	$440	$840	$2,000
Nov	$600	$800	$0	$120	$440	$840	$2,000
Dec	$600	$800	$0	$120	$440	$840	$2,000

This beneficiary is taking a mixture of generic and brand drugs. By end of June the beneficiary hits the OOP max and moves into the catastrophic phase. This causes the following impacts in July: the beneficiary pays $0; Medicare pays 20% of brand + 40% of generic as reinsurance; The manufacturer payment increases from 10% brand pre-catastrophic to 20% of brand; The plan covers the remaining $1,080. In October, the beneficiary is convinced to move to a generic costing $200 and saving $600 on brand. With that change, the plan's cost drops to $840.