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The Inflation Reduction Act and its Impact to Healthcare

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Caveats, Limitations, and Qualifications

Caveats and Qualifications

Shyam Kolli, Pamela Laboy, and Stu Rachlin are actuaries with Milliman. They are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render the actuarial opinion contained herein. To the best of our knowledge and belief, this presentation is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

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The authors are not lawyers and this presentation does not reflect legal advice. Participants should consult with counsel prior to taking any action based on the information in this presentation.

Key Limitations

- **Uncertainty**: Additional guidance will be needed to implement and interpret this new legislation.
- **Opinions**: Stakeholder perspectives reflect our opinions. Other experts may come to different conclusions

Today's Speakers

Sarah Hughes

Sarah is an Actuarial Analyst in the Tampa office of Milliman. She joined the firm in 2019. Sarah has five years of experience working with and for Medicare Advantage plans with provider contracting, pricing and financial reporting. She has assisted in the development of Medicare Part C and D bid submissions for clients over the last three years. She also assists with Medicare Advantage feasibility studies, statements of actuarial opinions, and Part D stakeholder analysis. Sarah graduated from FSU with a degree in Risk Management Insurance with a double major in Actuarial Science.

Shyam Kolli, FSA, MAAA

Shyam is a Principal and Consulting Actuary with the New York-Atlanta office of Milliman. He joined the firm in 2010. Shyam has 17 years of experience helping commercial and Medicare Advantage plans with provider contracting, pricing and financial reporting. He has certified Medicare Part C and D bid submissions for clients. He also assists with Medicare Advantage feasibility studies, CMS one-third financial and bid audits, and Part D settlement estimates. Shyam has a deep understanding of capital and surplus requirements for health plans, and also assisted self-funded employers with estimating appropriate contingency reserves.

Pamela Laboy, FSA, MAAA

Pamela is a Consulting Actuary with the Tampa office of Milliman. She joined the firm in 2017. Pamela has over 10 years of experience working with Commercial, MA, and PD plans. Since she joined Milliman, Pamela has successfully assisted numerous clients throughout their MAPD and PDP bid development process. Pamela has extensive experience with Pharma, financial reporting, pricing, employer group waiver plans, formulary analysis, and development of pricing models.

Stuart Rachlin, FSA, MAAA

Stu is a Principal and Consulting Actuary in the Tampa office of Milliman. He has been with the firm for almost 25 years. Stu's experience covers a wide range of healthcare topics with a strong focus in the MAPD/PDP and ACA fields where he certifies many client filings.

Stu provides strategic and technical assistance to numerous health plans, insurance companies, provider groups, and regulatory authorities. Over the years he has successfully developed cost build-ups, revenue analyses, as well as year-end statements of actuarial opinion.

Before joining Milliman, Stu was chief actuary for a regional health plan after starting his career at Cigna.

Goals

- Understand the regulatory background leading to the changes included in the Inflation Reduction Act (IRA)
- Develop an understanding of how drug costs are determined and how Part D plans are funded
- Deep dive on the coming changes to the Part D program and implications to all stakeholders
- Understand the implications of the IRA to MAPD and PDP plans

Agenda

Regulatory Background	▪ What is the Inflation Reduction Act? How does it impact Healthcare? ▪ From Build Back Better to Inflation Reduction Act ▪ Part D Program Background
Part D Financials	▪ Who are the many Medicare stakeholders? ▪ How are drug costs determined? ▪ How are Part D drugs paid? ▪ How are Part D plans funded?
Inflation Reduction Act	▪ Changes to Part D Program ▪ Other Changes to Medicare ▪ Changes to ACA and Medicaid
Break	
MA and Part D Implications	▪ Part D benefit redesign ▪ Impact to stakeholders ▪ Implications to MA + PD plans ▪ Considerations for 2024 bid development
Open Discussion / Questions and Answers	

Regulatory Background

What is the Inflation Reduction Act?

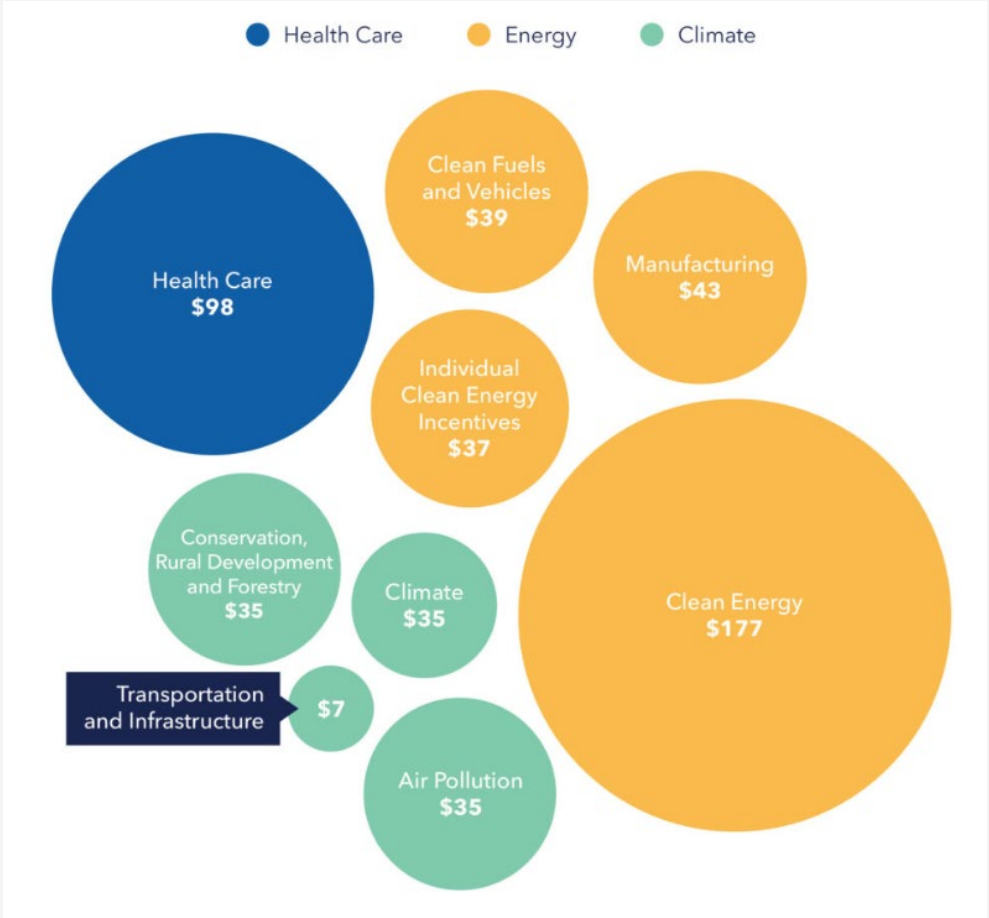
- Signed into law on August 16, 2022 by President Biden.
- Contains healthcare reforms, tax changes, and environmental policy provisions.
- Affects several layer of the U.S healthcare ecosystem with major implications for the Medicare Advantage and Part D program.
- Congressional Budget Office estimates that the Inflation Reduction Act will result in a net decrease in the unified deficit totaling $58.1 billion over the 2022-2031 period.
- That decrease in the deficit is estimated to result from an increase in direct spending of $50.6 billion and an increase in revenues of $108.7 billion.

Source: Estimated Budgetary Effects of Public Law 117-169, to Provide for Reconciliation Pursuant to Title II of S. Con. Res. 14 | Congressional Budget Office (cbo.gov), Weathering the reform storm (milliman.com)

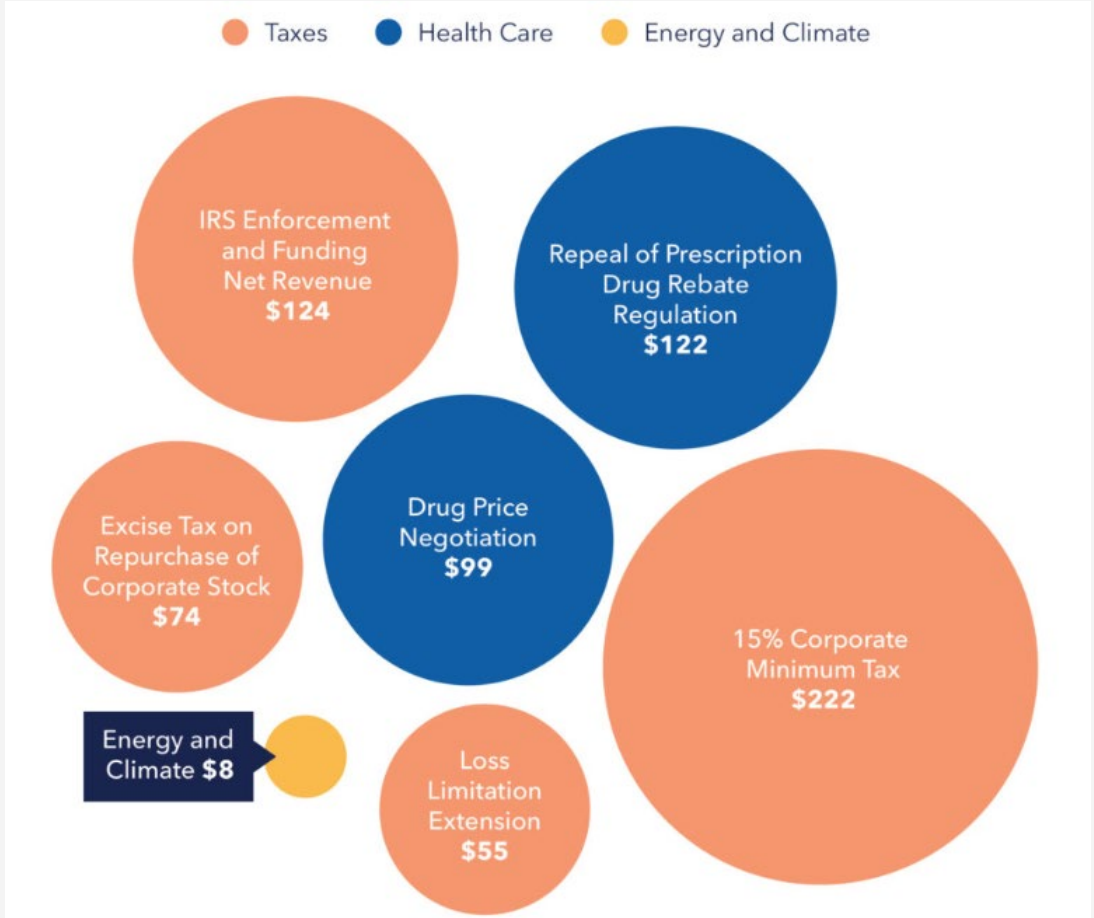
Understanding the Inflation Reduction Act

Figures in Billions over 10 years from 2022 - 2031

Spending and Tax Cuts



Savings and New Revenue



Source: [Understanding the Inflation Reduction Act – The Council of State Governments (csg.org)]

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Inflation Reduction Act

How does it impact healthcare?

Medicare will negotiate drug prices

- New law allows CMS to negotiate the price of high-cost drugs with manufacturers
- Other countries routinely negotiate drug prices
- Medicare as a benchmark for private insurers

Capping Medicare Drug Costs

- No out-of-pocket spending for recommended adult vaccines
- Cap the growth of drug prices by implementing a rebate (payable to Medicare) if drug costs grow faster than inflation
- Real cap to out-of-pocket costs for drugs covered by Medicare Part D

Extend Health Insurance Subsidies

- Extend tax credits for those purchasing health insurance through ACA marketplace

From Build Back Better to Inflation Reduction Act

Build Back Better Act (BBB)

- Working draft introduced on Nov. 3, 2021
- Proposed major changes to the Medicare Part B and Part D program
  - Allows federal government to negotiate prices for a subset of Part B and Part D drugs.
  - Redesign of Part D benefit.
  - Required drug manufacturers to pay rebates to the federal government if prices increase. faster than inflation.
  - Delayed the Part D manufacturer rebate at point-of-sale rule indefinitely .
- Other key changes impacting healthcare include:
  - expanding hearing coverage in Medicare, no cost sharing for PD vaccines, biosimilar drug reimbursement changes, numerous Medicaid proposed changes.

Inflation Reduction Act (IRA)

- Signed into law on Aug 16, 2022
- Proposed major changes to the Medicare Part B and Part D program
  - Allows federal government to negotiate prices for a subset of Part B and Part D drugs.
  - Redesign of Part D benefit.
  - Required drug manufacturers to pay rebates to the federal government if prices increase faster than inflation.
  - Delayed manufacturer rebate at point-of-sale until at least 2032.
- Other key changes impacting healthcare include:
  - Increase FPL threshold for LIS, no cost sharing for PD vaccines, biosimilar drug reimbursement changes.

Differences

- **IRA more significantly affects Medicare Part B and D programs**
- **IRA is a “lighter” version of BBA**
- **IRA contains fewer tax changes than BBB, key tax changes were retained**

Medicare Advantage and Part D Plans

Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)

- Renamed the Medicare + Choice program in Part C to Medicare Advantage
- Established the Medicare Part D program implemented in 2006
- Updated and improved the choice of plans for beneficiaries under Part C
  - Beneficiaries may choose from additional plan options including regional PPOs (RPPO) and special needs plans (SNPs)
- Changed the ways benefits are established
- Changed the way capitation payments are made to Plans
- Amended the Part C program to allow MA plans to offer prescription drug coverage

Eligibility

- Must be enrolled in Original Medicare (Part A + Part B)
- Must live in the service area of the Medicare Advantage Organization / PDP

Medicare Part D Financials

Medicare Stakeholders

Federal Government

Parts B

- Claim liability
- Engage vendors to process and pay claims

Parts C

- Provide funding via Medicare Advantage payment rates

Parts D

- Claim liability in the catastrophic phase for all members
- Direct subsidy all members
- Other subsidies for low-income members

Plan Sponsor

Parts B

- Provides Part B coverage indirectly through Part C/ MA coverage

Parts C

- Manage health care costs through benefit design, provider network

Parts D

- Set drug formularies
- Claim liability after the deductible is met

Beneficiaries (Members)

Parts B

- May elect supplemental coverage

Parts D

- Choose a plan annually at open enrollment
- Claim liability in all phases

Drug Manufacturer

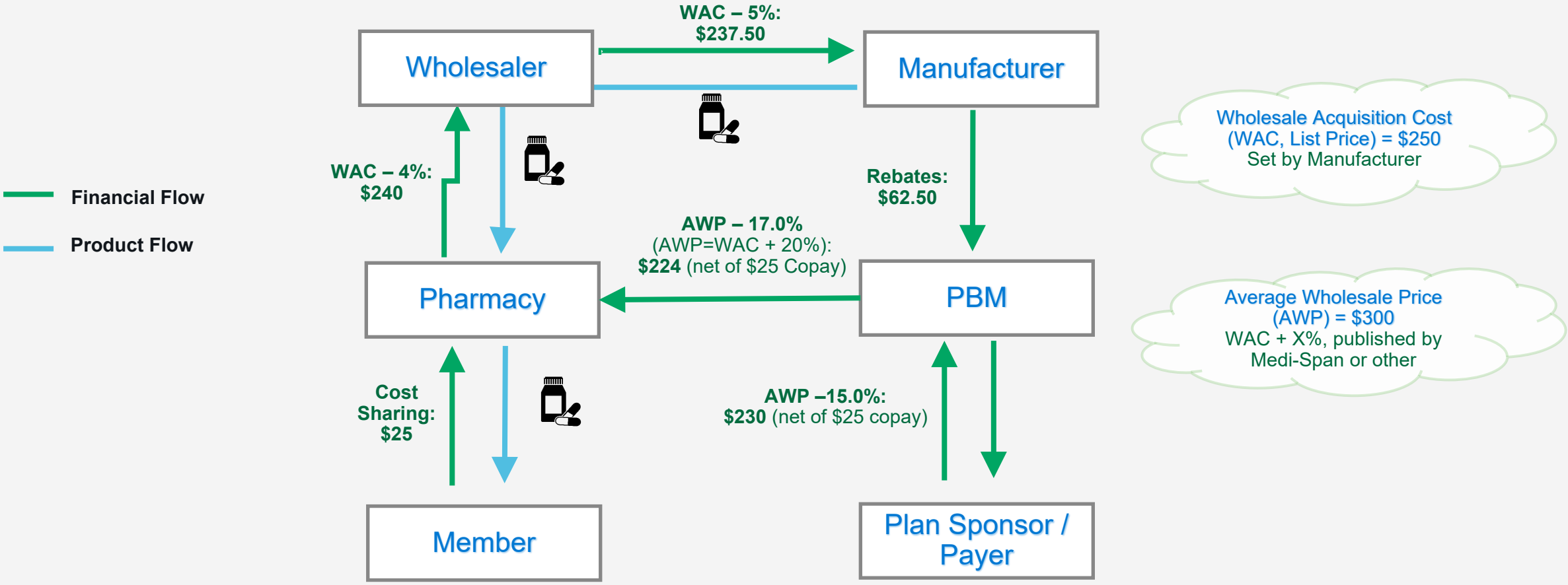
Parts B + C

- Sell drugs to providers

Parts D

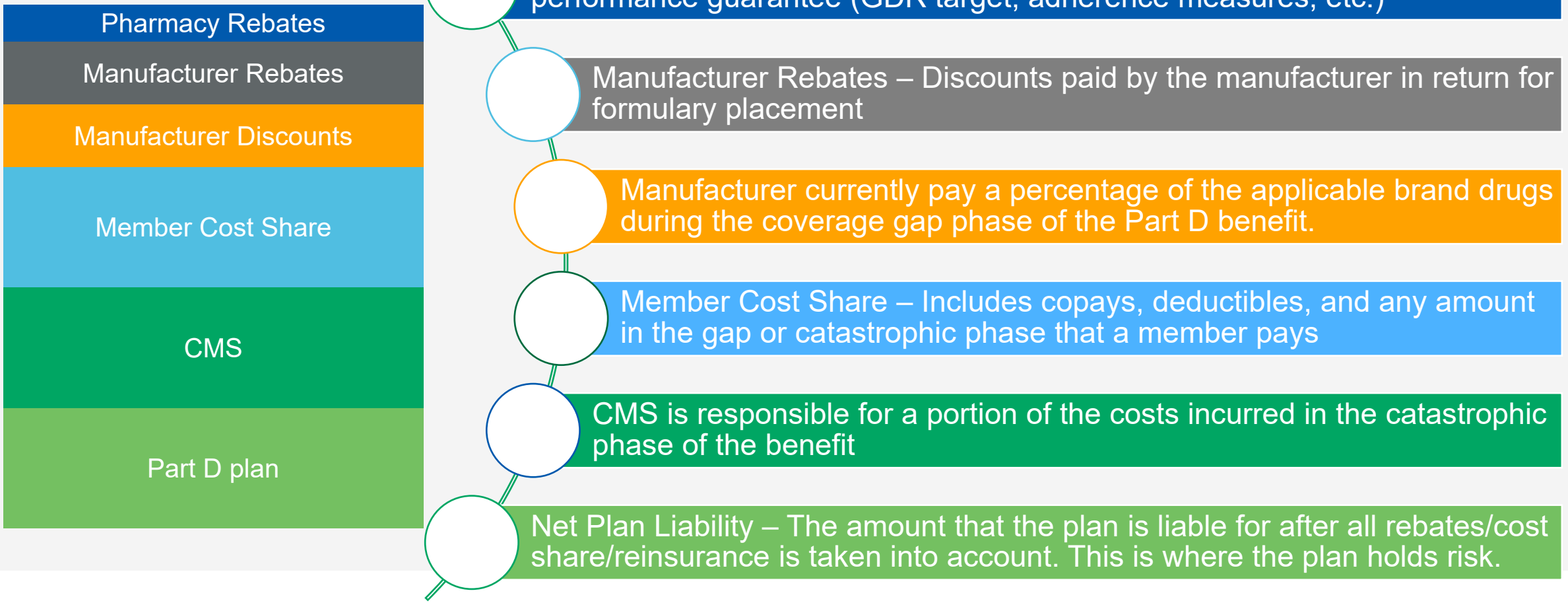
- Claim liability in the **coverage gap phase**
- Provide rebates to plans for preferred formulary coverage

The Pharmacy Distribution and Reimbursement System



Source: Adapted from http://www.drugchannels.net/2016/02/follow-dollar-us-pharmacy-distribution.html and https://www.usatoday.com/story/news/2016/10/03/how-prescription-drug-middlemen-make-their-money/91461918/

Who Pays for a Drug In Part D?



How are drug costs determined?

Pharmacy Discounts

Prescription Drugs have several indexes that are used as the of base POS pricing

- **Average Wholesale Price (AWP)**
  - Most commonly used
  - Intended to represent the average price wholesalers charge. Historically, this has been higher than what wholesalers actually charge as it is not based on actual wholesale prices.
  - Instead, manufacturers report the AWP to the publishers of the index
- **Wholesale Acquisition Cost (WAC)**
  - Manufacturer's list price
  - More representative of true cost since this is what the wholesale costs are based on
  - Most rebate contracts are based on WAC

Plans/PBMs typically have contracts with pharmacies where they pay either AWP or WAC +/- a spread

- This spread is referred to as the discount

How are drug costs determined?

Pharmacy Discounts

While plans will have different rates with each pharmacy, typically a guaranteed discount is provided by the PBM

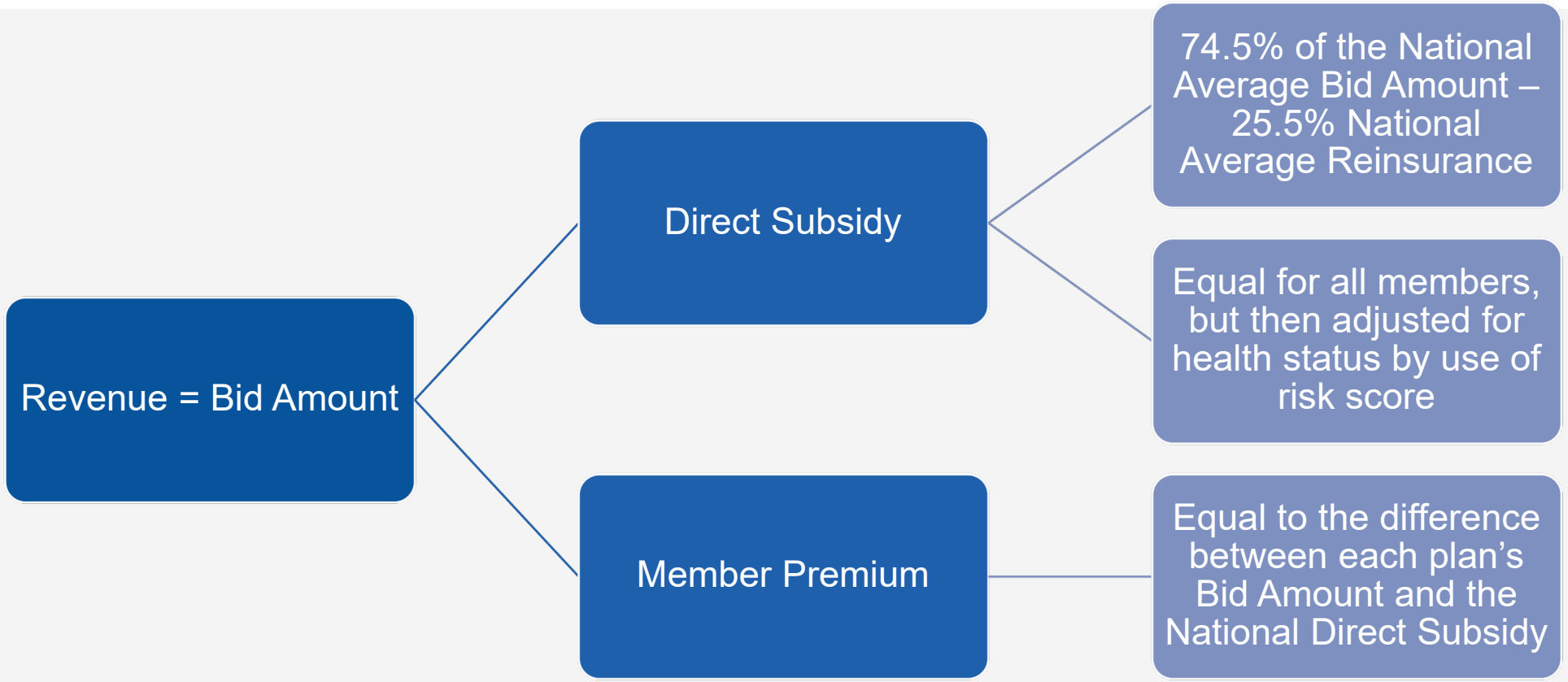
- This discount does not provide complete protection against inflation as the index is still subject to inflation

PBMs have several levers to keep the actual POS discount as close to the guaranteed discount as possible

- **Maximum Allowed Cost (MAC)**
  - For most generic drugs, PBMs have contracted the ability to create a MAC price for these drugs. PBMs then lower and raise these prices between each pharmacy to hit discount targets
  - Since generic drugs have a portion of costs tied to the MAC list and not the indexed price, discount guarantees provide more protection against inflation for generics vs brands

High-cost specialty drugs typically have their own contract and have individual prices for each drug contracted along with separate guarantees to the plan

How are Part D plans funded?



Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information
https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2020.pdf
Accessed Jan 21, 2020

How are Part D plans funded?

Net Liability + Administrative Cost + Margin

Net Liability

- The estimated Net Liability is combined with the administrative cost and a required margin to produce the total required revenue (Bid Amount).
- The Net liability is funded through the direct subsidy and member premium.

Direct Subsidy

- Funded by CMS
- Equal for all members, but then adjusted for health status by use of risk score

Member Premium

- Part D Basic member premium is equal to the difference between the Bid Amount and the National Direct Subsidy.
- Enhanced Alternative plans also have a Part D Supplemental Member Premium determined during the bid development process

How are Part D plans funded?

Reinsurance

- CMS pays a prospective payment equal to Part D plans
- Final reinsurance payments are based on actual experience and not estimate bid amount
- This requires a true-up after the year is over

Direct Subsidy

- By Law, CMS expects to pay 74.5% of the total costs of the Part D program.
- The National Direct Subsidy is calculated as DS = 74.5% * NABA – 25.5% * NAR
- Direct Subsidy received by plans is risk adjusted and calculated as: DS = Bid Amount * Risk Score – Member Premium

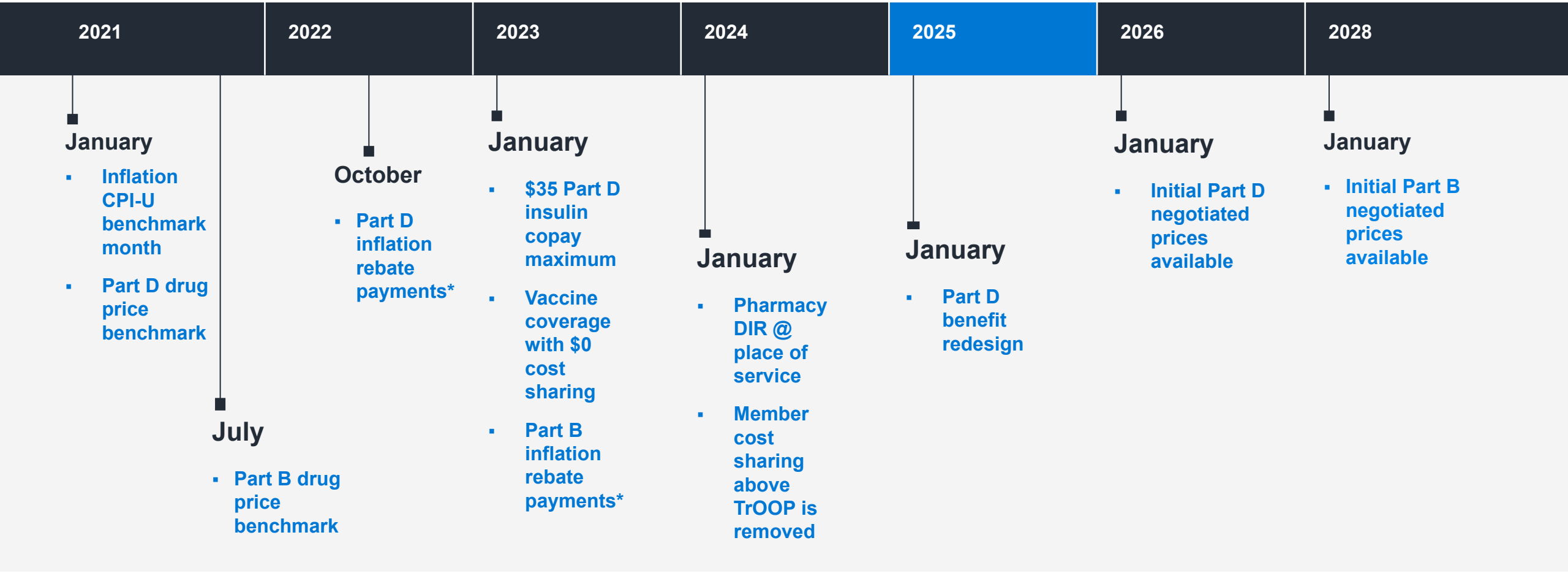
Member Premium

- Part D Basic Member Premium = Bid Amount @1.0 Risk score – National Direct Subsidy
- Part D Supplemental Member Premium is determined during the bid process
- For MAPD plans, a portion or the entirety of the Part D member premium can be bought down with MA rebates

Inflation Reduction Act: Healthcare Changes

Part D Benefit Redesign - Timeline

Changes to Part D Program



Drug Negotiation

Changes to the Part D Program

What is it?

- ✓ Allows Health and Human Services (HHS) Secretary to negotiate maximum fair prices for single source drugs and biologics.
- ✓ Drugs are selected from the 50 highest cost Part B and Part D drugs, with a carveout for small biotech drugs.
- ✓ 10 drugs in 2026 up to 80 total drugs by 2030

When?

- ✓ Part D drugs are negotiation-eligible beginning in 2026 while Part B drugs will be eligible in 2028

Who does it impact?

- ✓ Manufacturers
- ✓ Payers
- ✓ PBMs
- ✓ Federal Government
- ✓ Beneficiaries

Drug Negotiation

Changes to the Part D Program

Both Part B and Part D drugs would be eligible

- Top 50 drugs by total expenditure for Part D and Part B, separately. All insulins are negotiation-eligible

Up to 10 drugs negotiable in 2026, 15 drugs in 2027 and 2028, and 20 drugs in 2019 and beyond

- Cumulative, up to 60 total drugs by 2029

Small molecule drugs eligible 7 years after launch, Biologics eligible 11 years after launch

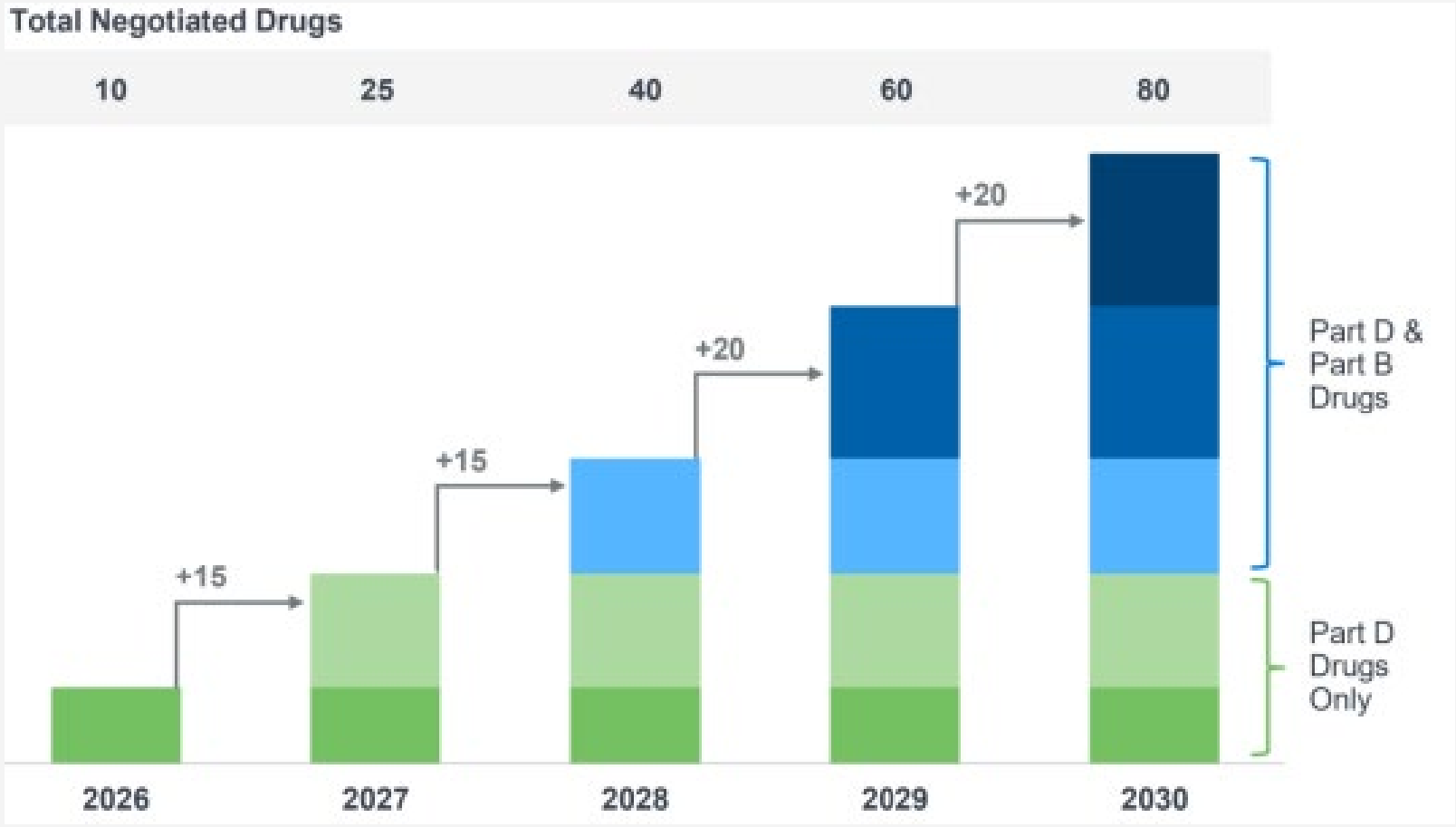
Provides guardrails for discounts

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

Small biotech drugs exempt through 2028

Drug Negotiation

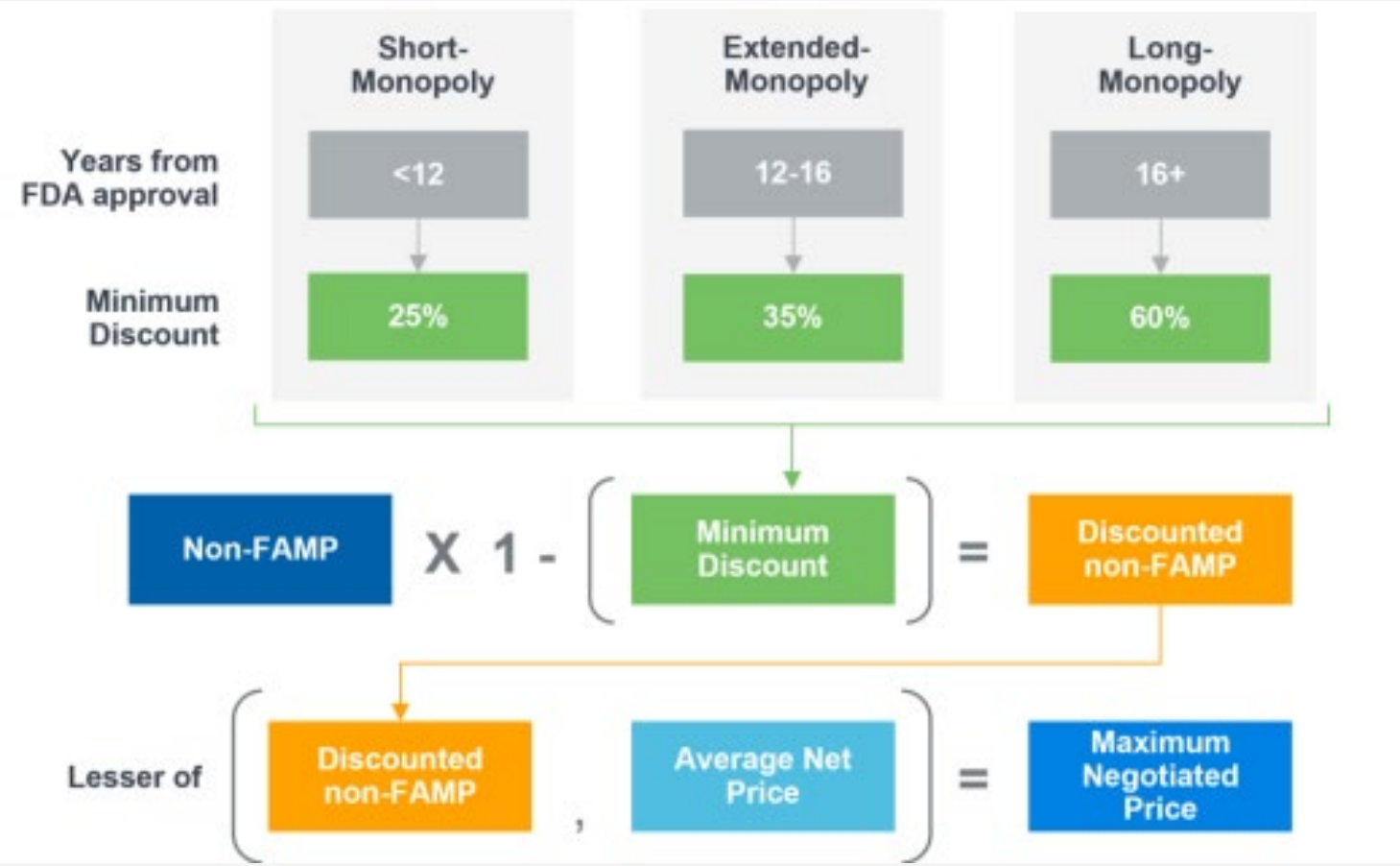
Maximum Number of Negotiated Drugs by Year, 2026-2030



Source: Weathering the reform storm (milliman.com)

Drug Negotiation

Maximum Negotiated Price Calculation



Nonfederal average manufacturer price (Non-FAMP): The average price paid to the manufacturer by the wholesalers for drugs distributed to nonfederal purchasers, taking into account any cash discounts or similar price reductions given to those purchasers but not taking into account any prices paid by the federal government.

Minimum discount: The minimum discount for a given selected drug aligns with the number of years since approval by the US Food and Drug Administration (FDA).

Average net price: The average net price is the enrollment-weighted drug price net of all price concessions received by such plan or pharmacy benefit managers on behalf of such plan for the most recent year for which data is available within the Medicare Part D market.

Inflation Caps

Changes to the Part D Program

What is it?

- ✓ **Requires manufacturers to pay rebates when the average cost of a rebateable drug is higher than the average price in Q3 2021 trended using the CPI-U**

When?

- ✓ **Q1 2023**

Who does it impact?

- ✓ **Manufacturers**
- ✓ **Federal Government**

Inflation Rebates

Changes to the Part D Program

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

Begin on October 2022 for Part D drugs and January 2023 for Part B drugs

Inflation would be benchmarked to prices on January 2021 for Part D drugs and July 2021 for Part B drugs

Rebates paid directly to the Medicare Trust Fund

Inflation Rebates

Rebate Example

Source: Weathering the reform storm (milliman.com)

Copay Caps

Changes to the Part D Program

What is it?

- ✓ Insulin cost sharing in Part D capped at $35 (or 25% of the maximum fair price or the negotiated price, if less), with costs for 2023 to be reimbursed as part of the plan's LI subsidy payments
- ✓ No cost sharing in Part D for prescription drug vaccines approved by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (CDC)

When?

- ✓ January 1st, 2023

Who does it impact?

- ✓ Manufacturers
- ✓ PBMs
- ✓ Payers
- ✓ Federal Government

Inflation Reduction Act Subsidy Amount

Changes to the Part D Program

What is it?

- ✓ **Temporary retrospective subsidy to reduce cost-sharing that would have been applied under the Part D sponsor's approved CY2023 PBP to $0 for an ACIP-recommended vaccine or $35 for a one-month supply of covered insulin**

When?

- ✓ **January 1st, 2023 to December 31st, 2023**

Who does it impact?

- ✓ **PBMs**
- ✓ **Payers**
- ✓ **Members**

Part D Benefit Redesign

Changes to the Part D Program

Eliminates Coverage Gap

Manufacturer payment applies through initial coverage period and catastrophic

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

Member out-of-pocket capped at $2,000

Effective January 1, 2025

Other Medicare Provisions

- Threshold for low-income subsidies increases from 135% to 150% of the FPL starting in 2024.
- Initial biosimilar reimbursements capped at the reference drug's payment rate starting July 1, 2024.
- Requirement for manufacturer rebates at POS, initially scheduled to be implemented in 2026, delayed to at least 2032.
- Increased payments for biosimilars up to 108% of ASP for the first five years on the market (or first five years starting October 1, 2022, for drugs already available at the time).
- Part D premium growth capped at annual rate of 6% through 2029 with some additional protection for 2023 (subject to premiums representing a minimum of 20% of plan and federal costs).
- No beneficiary cost sharing in the catastrophic phase starting January 1, 2024.
- Availability of cost-sharing smoothing starting Jan 1, 2025.

Medicaid and Commercial Market Provisions

Medicaid

- Adult vaccine coverage requirements on both Medicaid and CHIP programs
- $0 cost-sharing for approved vaccines
- Directly and Indirectly affected by Part D drug price reforms
  - Any change in Part D expenditures will influence state drug costs for individuals eligible to both Medicare and Medicaid (dual eligible members)
  - Negotiated prices have the potential to increase drug rebates owed by manufacturers for drugs provided to Medicaid beneficiaries

Commercial Market

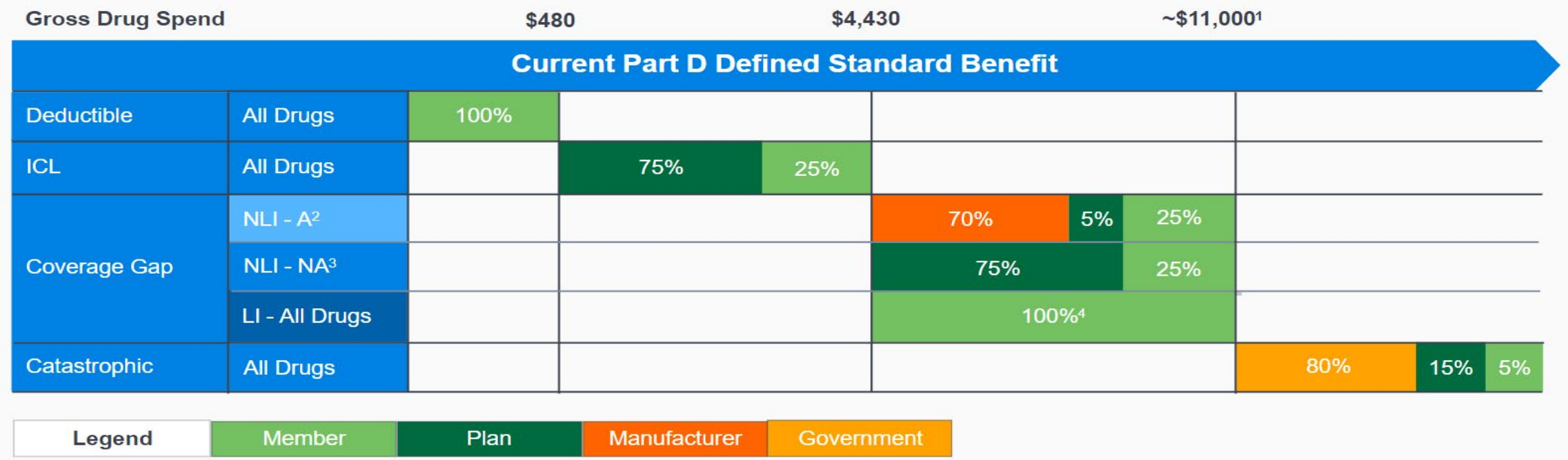
- Extends subsidy enhancements instituted under the American Rescue Plan Act, which were scheduled to expire at the end of 2022
- Formalized permission for HDHP issuers to provide coverage of insulin prior to the deductible

Break

Part D Benefit Redesign

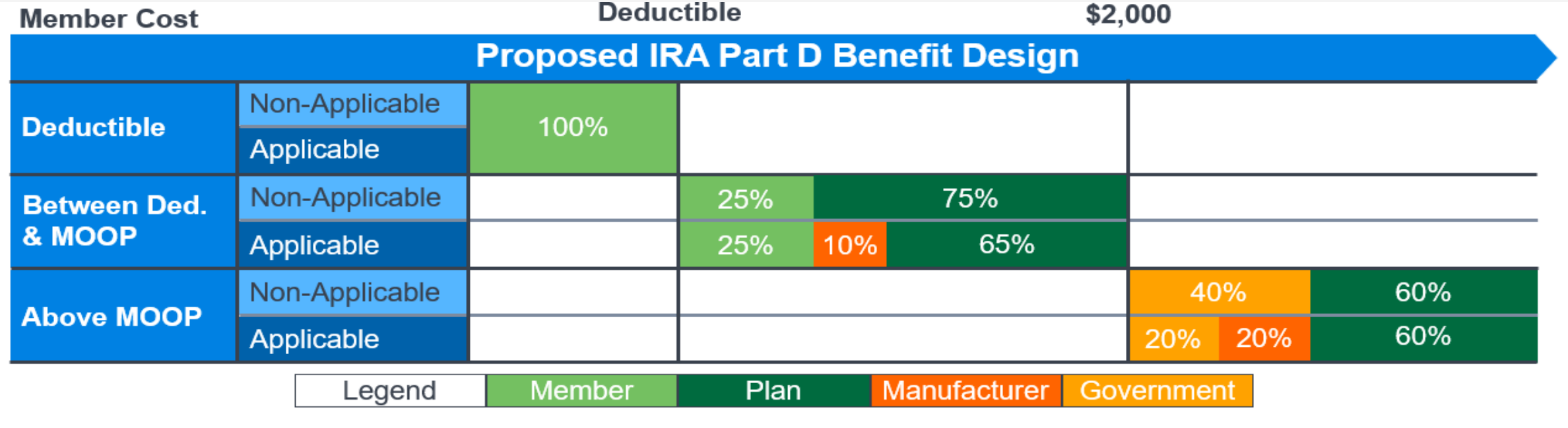
Part D Benefit Redesign

Current (2022) Part D Defined Standard Benefit

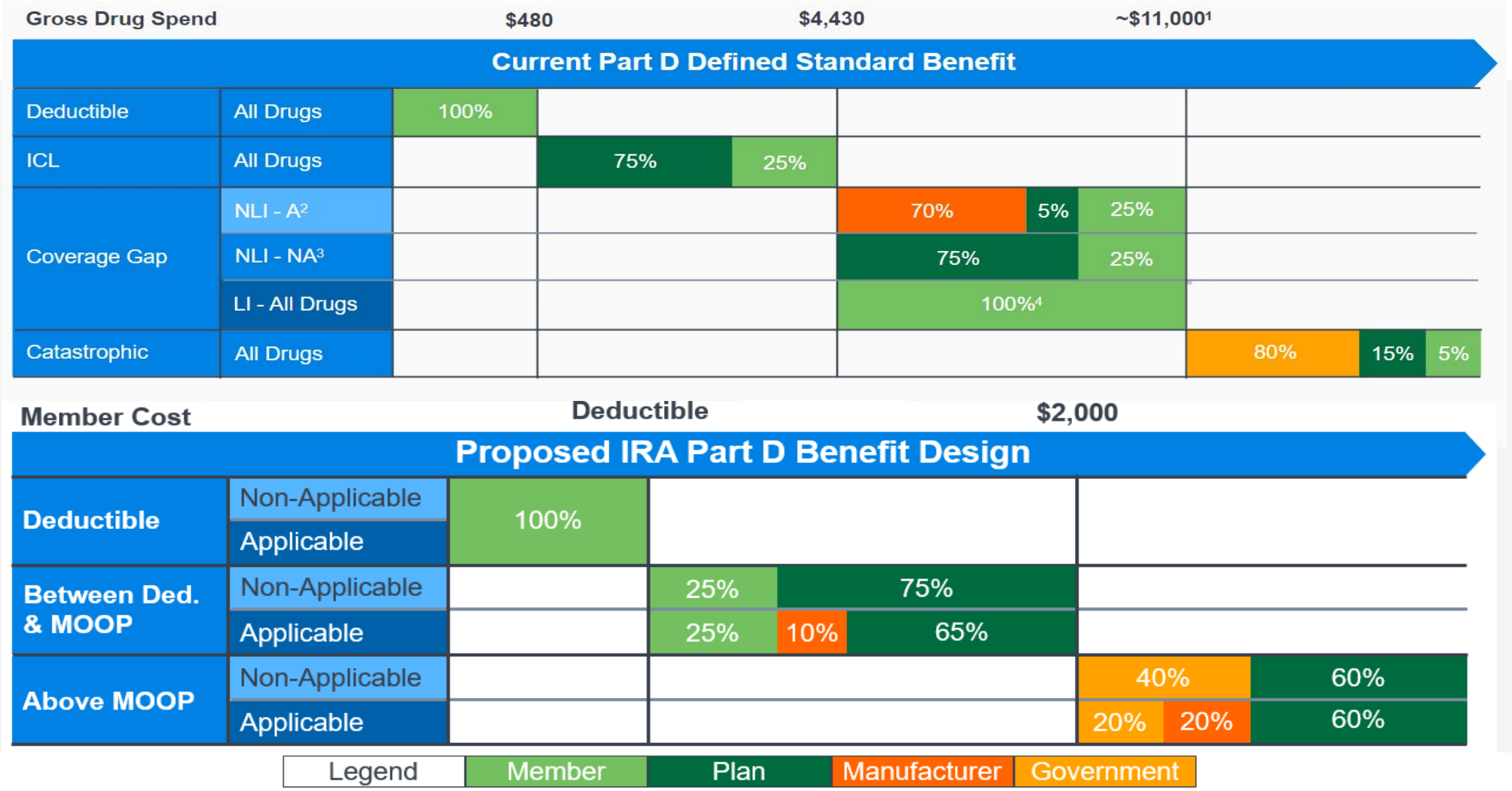


Part D Benefit Redesign

IRA - Part D Defined Standard Benefit



Part D Benefit Redesign



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Impact of Part D Redesign - Exercise

Stakeholder Impact

- Non-low income utilizer
- Member spends $5,000 per month on Part D Drugs
- 30% manufacturer rebates associated to these prescriptions
- Annual gross drug cost spend of $60,000 = $5,000 x 12
- Total manufacturer rebates of $18,000 = $60,000 x 30%

Impact of Part D Redesign - Exercise

Stakeholder Impact

2022 Part D Benefit

Phase	Gross Drug Costs (Cumulative)	Member	Plan	Manufacturer	CMS
Deductible	$480	100%			
ICL	$4,430	25%	75%		
Coverage Gap	$10,690	25%	5%	70%	
Catastrophic	$60,000	5%	15%		80%

Impact of Part D Redesign - Exercise

Stakeholder Impact

2022 Part D Benefit

Phase	Gross Drug Costs (Cumulative)	Member	Plan	Manufacturer	CMS	Total
Deductible	$480	$480				**$480**
ICL	$4,430	$988	$2,962			**$3,950**
Coverage Gap	$10,690	$1,565	$313	$4,382		**$6,260**
Catastrophic	$60,000	$2,465	$7,397		$39,448	**$49,310**
Total (Excl. Rebates)	$60,000	**$5,498**	**$10,672**	**$4,382**	**$39,448**	**$60,000**

Impact of Part D Redesign - Exercise

Stakeholder Impact

2022 Part D Benefit

Phase	Member	Plan	Manufacturer	CMS
Deductible	$480			
ICL	$988	$2,962		
Coverage Gap	$1,565	$313	$4,382	
Catastrophic	$2,465	$7,397		$39,448
Total (Excl. Rebates)	**$5,498**	**$10,672**	**$4,382**	**$39,448**
Rebates		**($13,320)**	$18,000	**($4,680)**
Total	**$5,498**	**($2,648)**	**$22,382**	**$34,768**

Impact of Part D Redesign - Exercise

Stakeholder Impact

Proposed IRA Benefit

Phase	Member Cost	Gross Drug Costs (Cumulative)	Member	Plan	Manufacturer	CMS
Deductible	$480	$480	100%			
ICL	$2,000	$6,560	25%	65%	10%	
Catastrophic	$0.00	$60,000	0%	60%	20%	20%

Impact of Part D Redesign - Exercise

Stakeholder Impact

Proposed IRA Benefit

Phase	Member Cost	Gross Drug Costs (Cumulative)	Member	Plan	Manufacturer	CMS	Total
Deductible	$480	$480	$480				**$480**
ICL	$2,000	$6,560	$1,520	$3,952	$608		**$6,080**
Catastrophic	$0	$60,000	$0.00	$32,064	$10,688	$10,688	**$53,440**
Total (Before Rebates)			**$2,000**	**$36,016**	**$11,296**	**$10,688**	**$60,000**

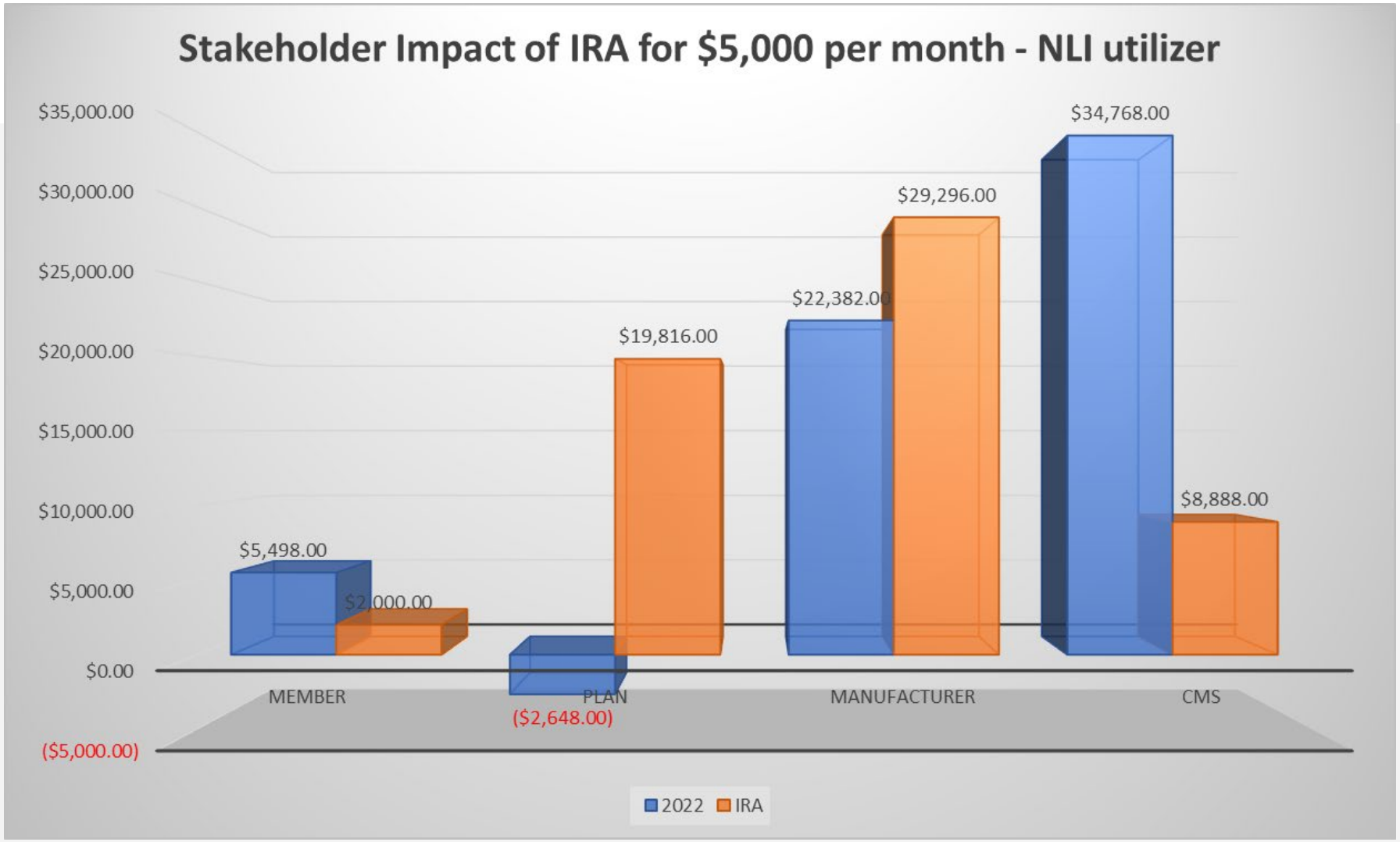
Impact of Part D Redesign - Exercise

Stakeholder Impact

Proposed IRA Benefit

Phase	Member	Plan	Manufacturer	CMS
Deductible	$480			
ICL	$1,520	$3,952	$608	
Catastrophic	$0	$32,064	$10,688	$10,688
Total (Before Rebates)	**$2,000**	**$36,016**	**$11,296**	**$10,688**
Rebates		**($16,200)**	$18,000	**($1,800)**
Total	**$2,000**	**$19,816**	**$29,296**	**$8,888**

Impact of Part D Redesign - Exercise



Implications for Part D Stakeholders

Part D Stakeholders

	Payers
	Beneficiaries
	CMS
	Manufacturers
	PBMs

Recap - Key Changes from IRA

Insulin copay caps
Drug Inflation Rebates
Part D Benefit Redesign
Drug Price Negotiation
ACA subsidy extension

Implications for Part D Stakeholders

Part D Benefit Redesign





Plan Sponsor

- Increased plan liability for catastrophic spend and coverage gap
- Induced utilization of high-cost drugs
- Larger variation in plan liability among members
- Operational changes

Beneficiaries (Members)

- Lower cost sharing, particularly high-cost drugs for NLI beneficiaries
- Potentially higher Part D premiums

Drug Manufacturer

- Increased manufacturer liability on high-cost drugs and LI members
- Decreased liability on lower cost branded products with high NLI use

Federal Government

- Reduced total program costs

PBM

- Increased importance on specialty cost management
- Operational changes to administer new plan design and cost share smoothing

Drug Negotiation

Changes to the Part D Program

What is it?

- ✓ Allows Health and Human Services (HHS) Secretary to negotiate maximum fair prices for single source drugs and biologics
- ✓ Drugs are selected from the 50 highest cost Part B and Part D drugs, with a carveout for small biotech drugs
- ✓ 10 drugs in 2026 up to 80 total drugs by 2030

When?

- ✓ Part D drugs are negotiation-eligible beginning in 2026 while Part B drugs will be eligible in 2028

Who does it impact?

- ✓ Manufacturers
- ✓ Payers
- ✓ PBMs
- ✓ Federal Government
- ✓ Beneficiaries

Implications for Part D Stakeholders

Drug Negotiation





Plan Sponsor

- Increased plan liability for Part D
- Less formulary flexibility

Beneficiaries (Members)

- Lower cost sharing
- Potentially higher Part D premiums

Drug Manufacturer

- Decrease in total net revenue
- Potential higher launch prices for new drugs

Federal Government

- Reduced total program costs
- Increased administrative burden

PBM

- Less value add for services
- Potential impact to supply chain contracts
- Less formulary flexibility

Inflation Caps

Changes to the Part D Program

What is it?

- ✓ **Requires manufacturers to pay rebates when the average cost of a rebateable drug is higher than the average price in Q3 2021 trended using the CPI-U**

When?

- ✓ **Q1 2023**

Who does it impact?

- ✓ **Manufacturers**
- ✓ **Federal Government**

Implications for Part D Stakeholders

Drug Inflation Rebates





Plan Sponsor

- Limited impact as inflation cap penalties go to Medicare Trust Fund and not to the Part D program stakeholders
- Greater impact for drugs that are predominantly Part D and have smaller commercial utilization

Beneficiaries (Members)

- Limited impact as inflation cap penalties go to Medicare Trust Fund and not to the Part D program stakeholders
- Greater impact for drugs that are predominantly Part D and have smaller commercial utilization

Drug Manufacturer

- May force manufacturers to increase cost more to recoup Part D penalty on commercial sales
- May lead to increased launch prices of new drugs

Federal Government

- Additional Revenue Source - Revenue stream to Medicare Trust Fund

PBM

- Limited impact as inflation cap penalties go to Medicare Trust Fund and not to the Part D program stakeholders
- Greater impact for drugs that are predominantly Part D and have less commercial utilization

Copay Caps

Changes to the Part D Program

What is it?

- ✓ **Insulin cost sharing in Part D capped at $35 (or 25% of the maximum fair price or the negotiated price, if less), with costs for 2023 to be reimbursed as part of the plan's LI subsidy payments**
- ✓ **No cost sharing in Part D for prescription drug vaccines approved by the Advisory Committee on Immunization Practices for the Centers for Disease Control and Prevention (CDC)**

When?

- ✓ **January 1st, 2023**

Who does it impact?

- ✓ **Manufacturers**
- ✓ **PBMs**
- ✓ **Payers**
- ✓ **Federal Government**

Implications for Part D Stakeholders

Insulin Copay Caps





Plan Sponsor

- Increased risk for 2023 is subsidy does not cover entire costs
- Cash flow pressure for 2023
- Induced utilization of insulin
- Increased time in the coverage period under Part D redesign

Beneficiaries (Members)

- Lower cost sharing for insulin utilizers
- Potentially higher Part D premiums

Drug Manufacturer

- Limited impact
- Potential for induced utilization of insulin products

Federal Government

- Increase cost in 2023 but no long-term impact

PBM

- Potential impact to supply chain contracts
- Operational changes to administer

Other Stakeholder Impacts

Transition from CGDP to MDP, price negotiation, and inflation rebates will likely affect future contracting between manufacturers, PBMs, and plan sponsors.

Rising pressure to limit price increases to CPI-U - Medicaid drug costs are protected against price increases through the Medicaid Drug Rebate Program (MDRP).

Potential changes to drug utilization patterns as a result of drug cost negotiation and Part D benefit redesign.

Added complexity to optimal drug pricing strategy decisions.

Federal government will have new administrative tasks and challenges due to drug pricing negotiation and drug inflation rebates.

Other Stakeholder Impacts

Medicaid and CHIP

- Medicaid may be affected by drug price negotiation as Medicaid drug rebates are set based on the difference between AMP and best price. Will IRA new negotiated prices be considered “best price” for this purpose?
- Part D benefit redesign may impact Medicaid state drug expenditures as the current formula uses the annual percentage increase in per capita Part D drug costs.
- Formal requirement that all state Medicaid programs provide adult coverage for adult vaccine with no beneficiary cost sharing beginning in 2023.

Commercial

- Extension of enhanced premium subsidies through 2025 should encourage individuals benefiting from these to stay in the ACA market.
- Potential for increase adoption of flexibility to cover insulin as a preventive drug as a result of the exception of first dollar coverage prohibition for HDHPs for insulins.

Other Implications for MA and PD Plans

MAPD Plan Implications

Impact of cost share reductions to 2023 financials

- Changes to PDEs
- Cash flow timing

New Operational Responsibilities

- Mechanism to notify pharmacies when enrollee reaches MOOP
- Ability to spread cost sharing across the remaining months of the year
- Potential for losses due to non-payment of due cost share smoothing

Limited opportunity to differentiate Part D plan design

Increased Part D member premiums

Increased risk for high-cost members

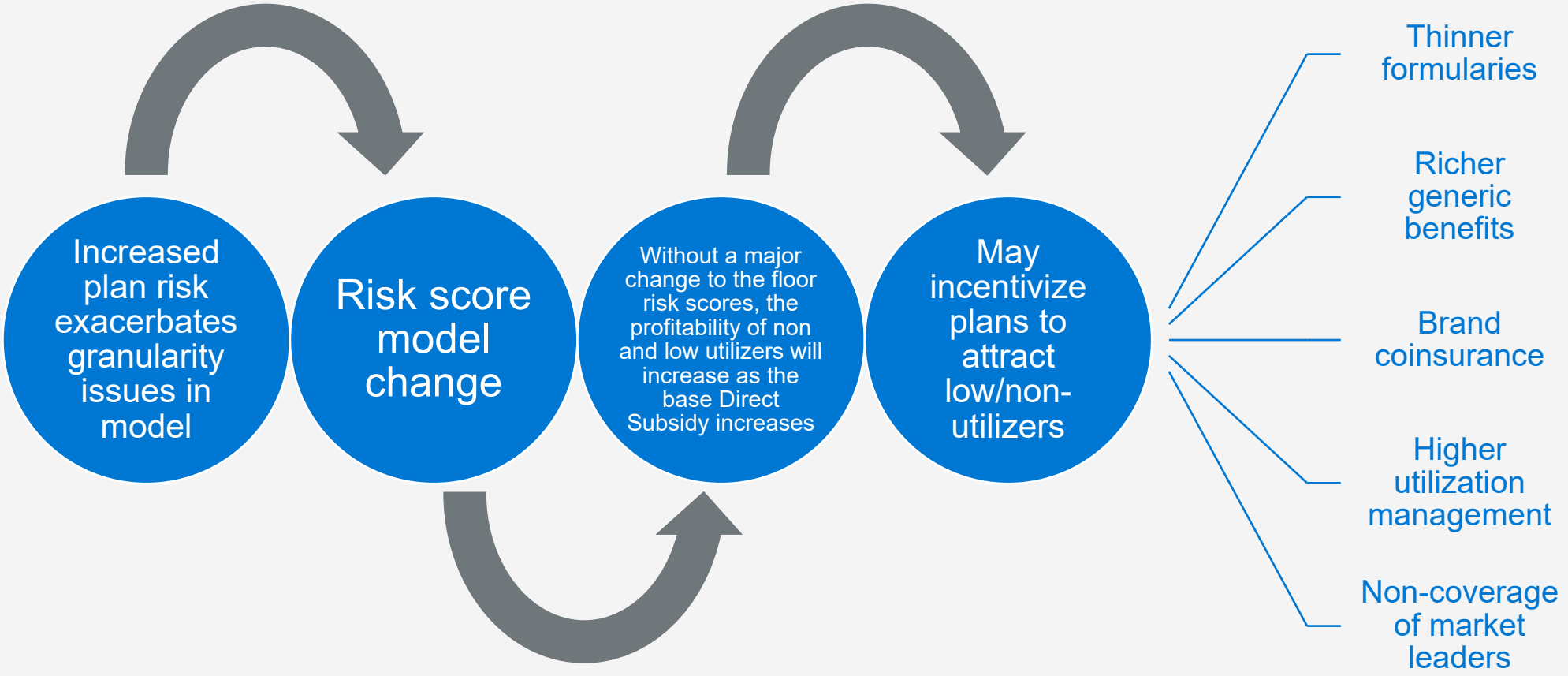
Part D Risk Scores

Other Implications to MA and PD Plans

- The key to how plans will react in this new world is what is done with Part D Risk scores
- Currently, Part D risk scores are based on medical diagnoses and do not include actual drugs that beneficiaries utilize
  - All members with RA get the same risk score adjustment regardless of whether they use generic drug or Humira
- Under the IRA, plans take on much more risk for high-cost members

Part D Risk Scores

Implications to MA and PD Plans



Considerations for 2024 Bids

Key considerations for 2024 Bids

- Estimating the Direct Subsidy
- POS pharmacy rebates
- Part D risk scores
- Induced Utilization
- LIS eligibility
- Part D plan design
- Formulary Management
- Increased Part D member premiums
- Improving Health Equity

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Q&A and Open Discussion

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