Walking on eggshells?

Looking at the Past, Present and Future of Employer Group Waiver Plans (EGWPs)

OCTOBER 11, 2023

Milliman

Agenda

1

Historical and current EGWP landscape

2

Key considerations going into 2024/25

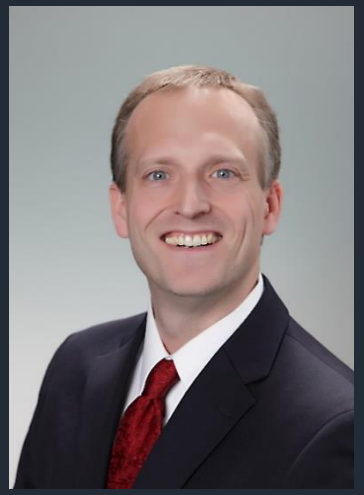
3

IRA impact on Part D and what the future holds for EGWPs

Presenters

Jennifer Carioto
FSA, MAAA
Principal and Consulting Actuary
Jennifer.Carioto@milliman.com

Luis Maldonado
FSA, MAAA
Principal and Consulting Actuary
Luis.Maldonado@milliman.com



Todd Wanta
FSA, MAAA
Principal and Consulting Actuary
Todd.Wanta@milliman.com

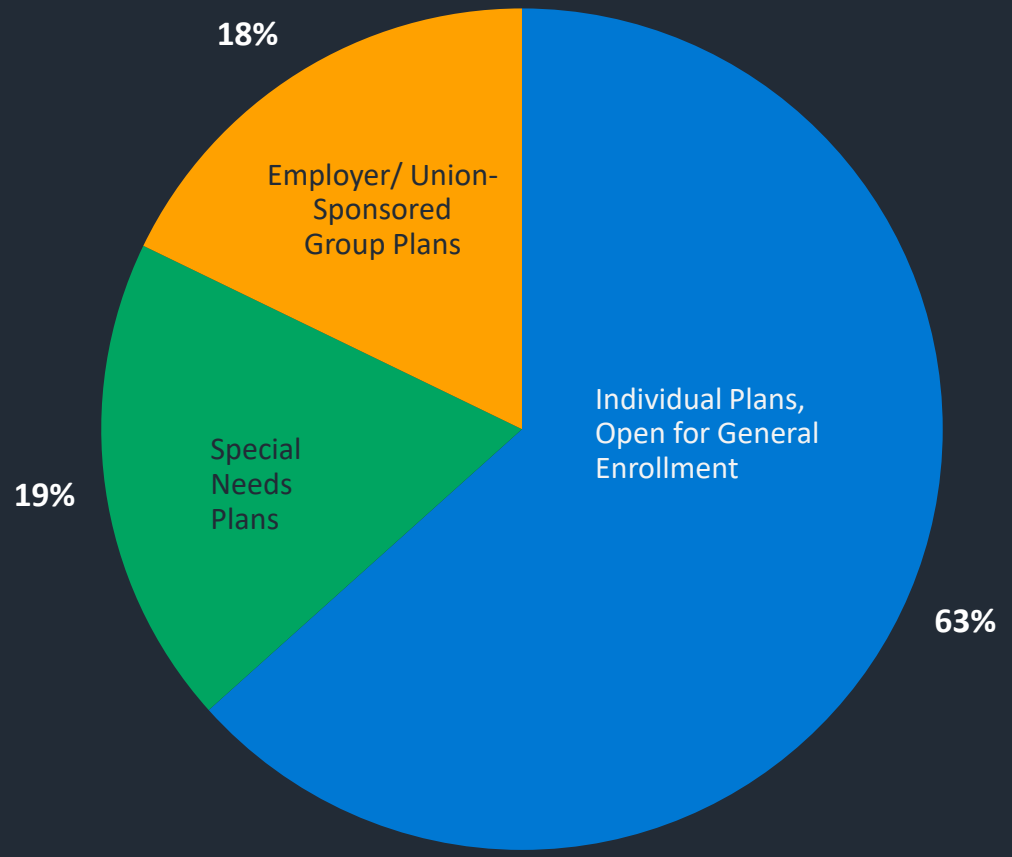
Historical and current EGWP landscape

Milliman

One of five MAPD / MA only enrollees are in an EGWP (2023)

Represents about 5.4 million EGWP enrollees

Total Medicare Advantage Enrollment, 2023 = 30.8 million



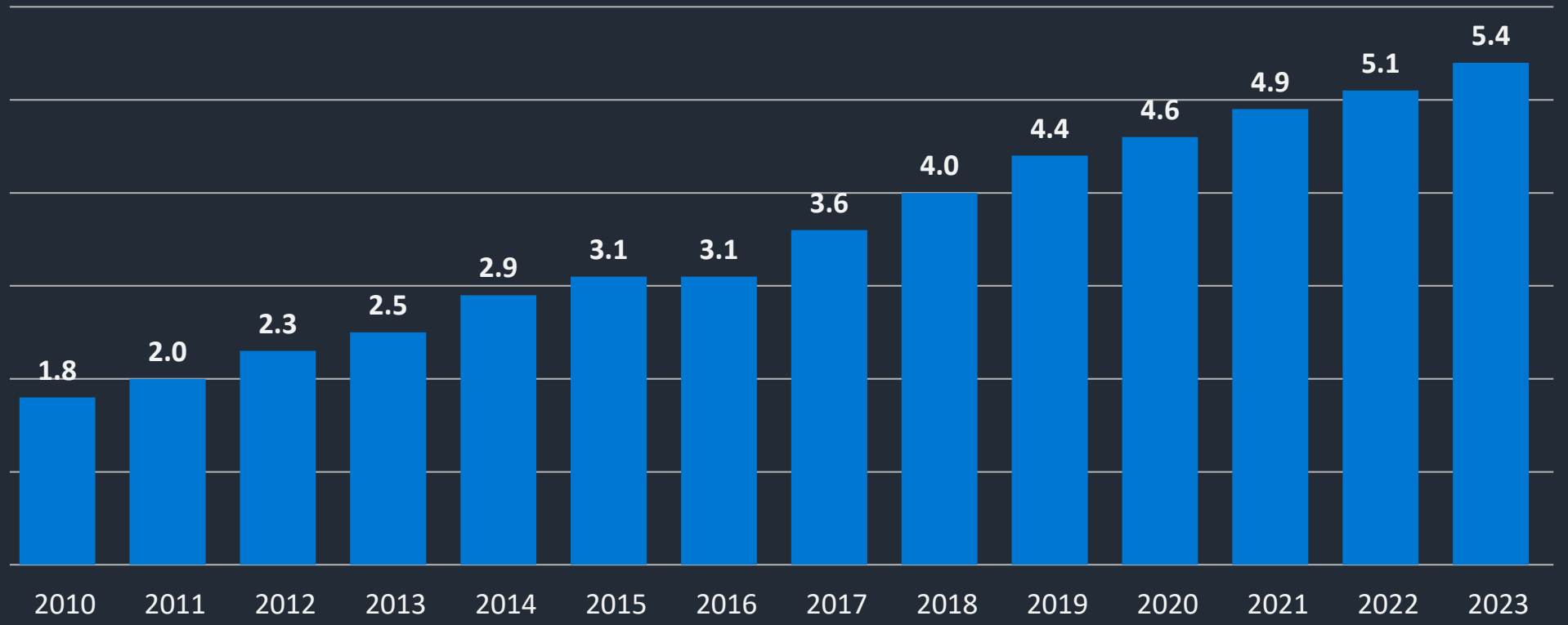
Source: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

One of five MAPD / MA only enrollees are in an EGWP (2023)

Represents about 5.4 million EGWP enrollees

Number of Beneficiaries in Employer Group or Union-Sponsored Health Plans, 2010 - 2023

In millions



Of MA enrollees, five states have one third or more MA EGWP enrollees:

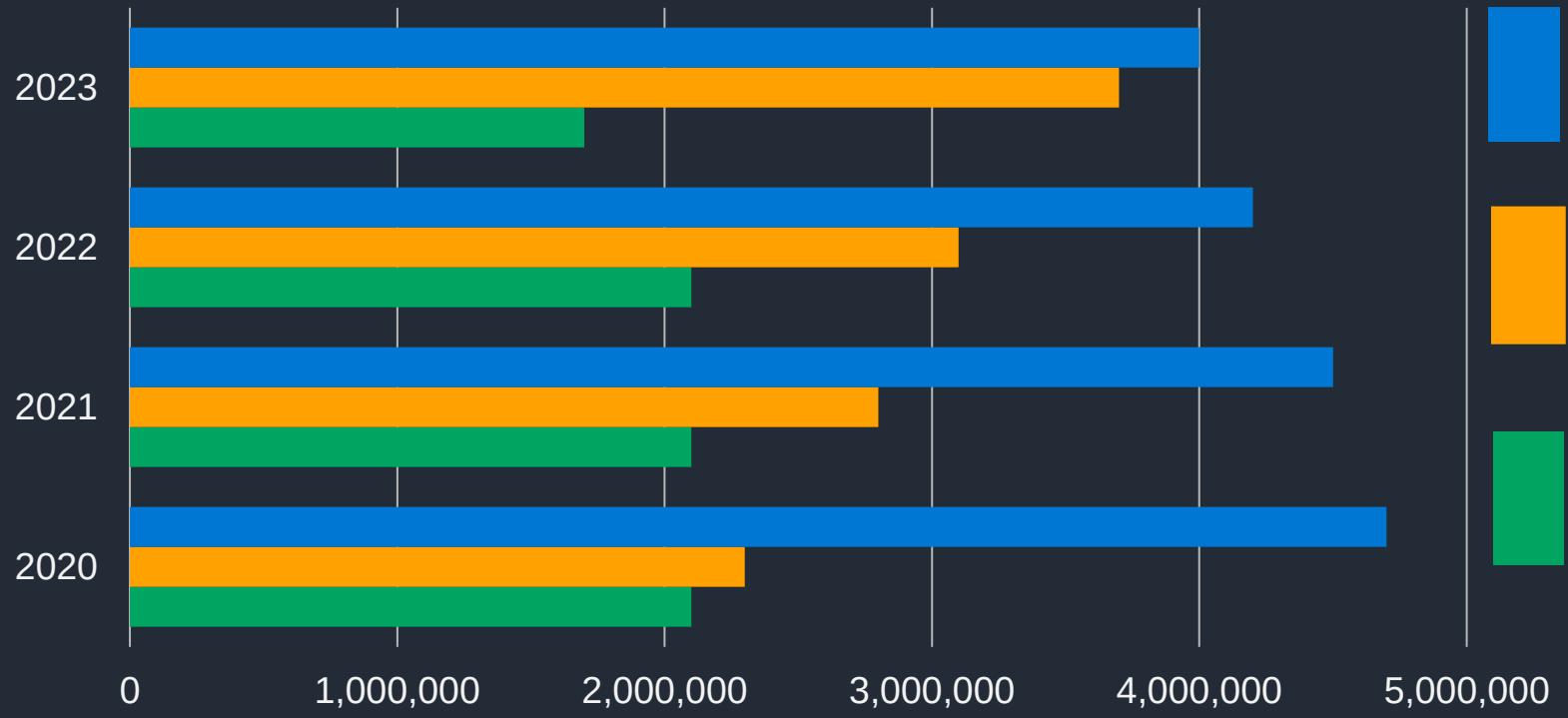
Alaska: 99%
Michigan: 40%
New Jersey: 34%
Maryland: 33%
West Virginia: 33%

Source: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-enrollment-update-and-key-trends/

Enrollment in MAPD EGWPs have been growing while PDPs and MA only plans have been declining

Recent EGWP enrollment has been static

August EGWP members by year



PDP Enrollment
Still, most of the market (42%) in 2023 but has declined since 2020

MAPD Enrollment
Grew over 10% of total population from 2020 (27%) to 2023 (38%)

MA Only Enrollment
Represents ~20% in 2023

Note: There can be overlap of members in MA only plans and PDPs.
Source: Milliman analysis of CMS Medicare Advantage/Part D Monthly Enrollment by Plan files, August of each year.

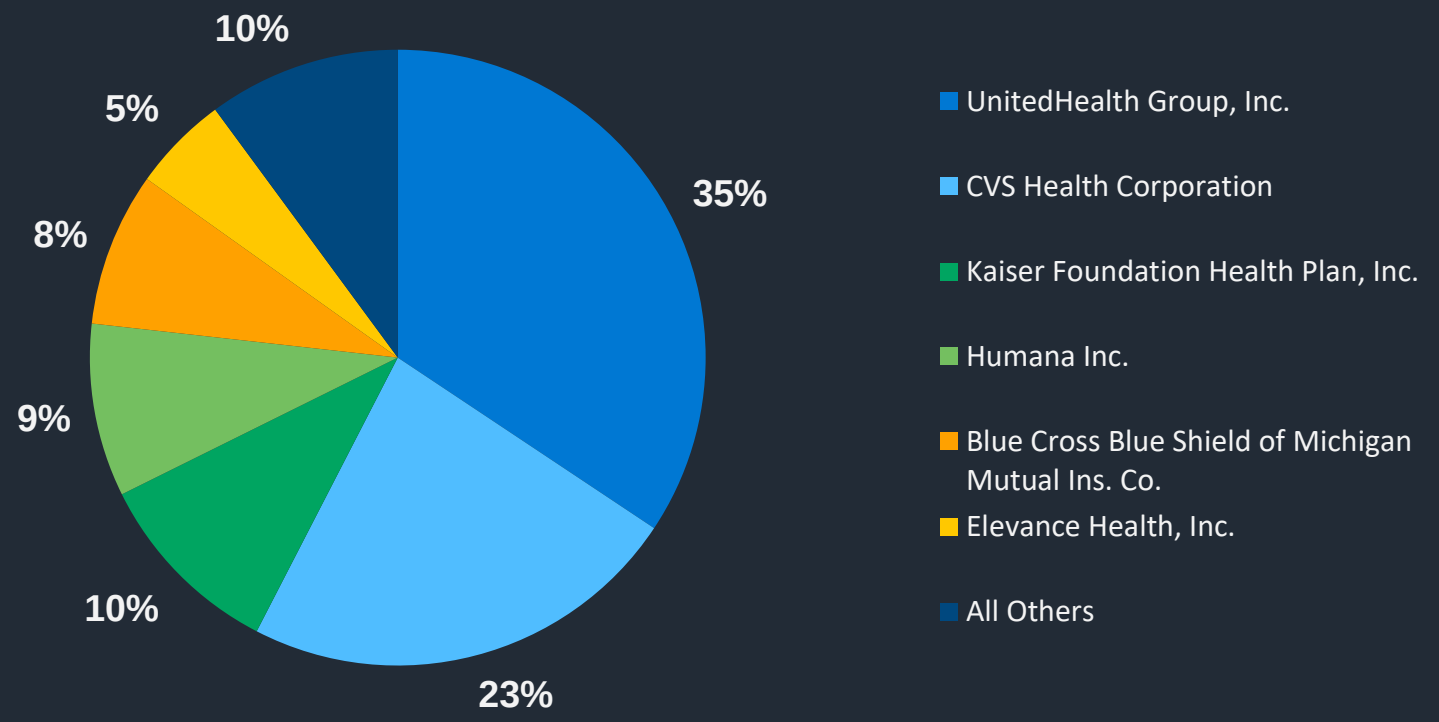
Top 6 MA carriers represent 90% of the MA EGWP market

Top 6 MA EGWPs enroll about 5 million of EGWP beneficiaries

- Five of the top six private health plans are licensed in multiple states.
- Regional plans (generally licensed in a single state) face hurdles that multi-state plans do not have to deal with

Source: Milliman analysis of CMS Medicare Advantage/Part D Monthly Enrollment by Plan files, August of each year.

MA EGWP – August 2023 market share



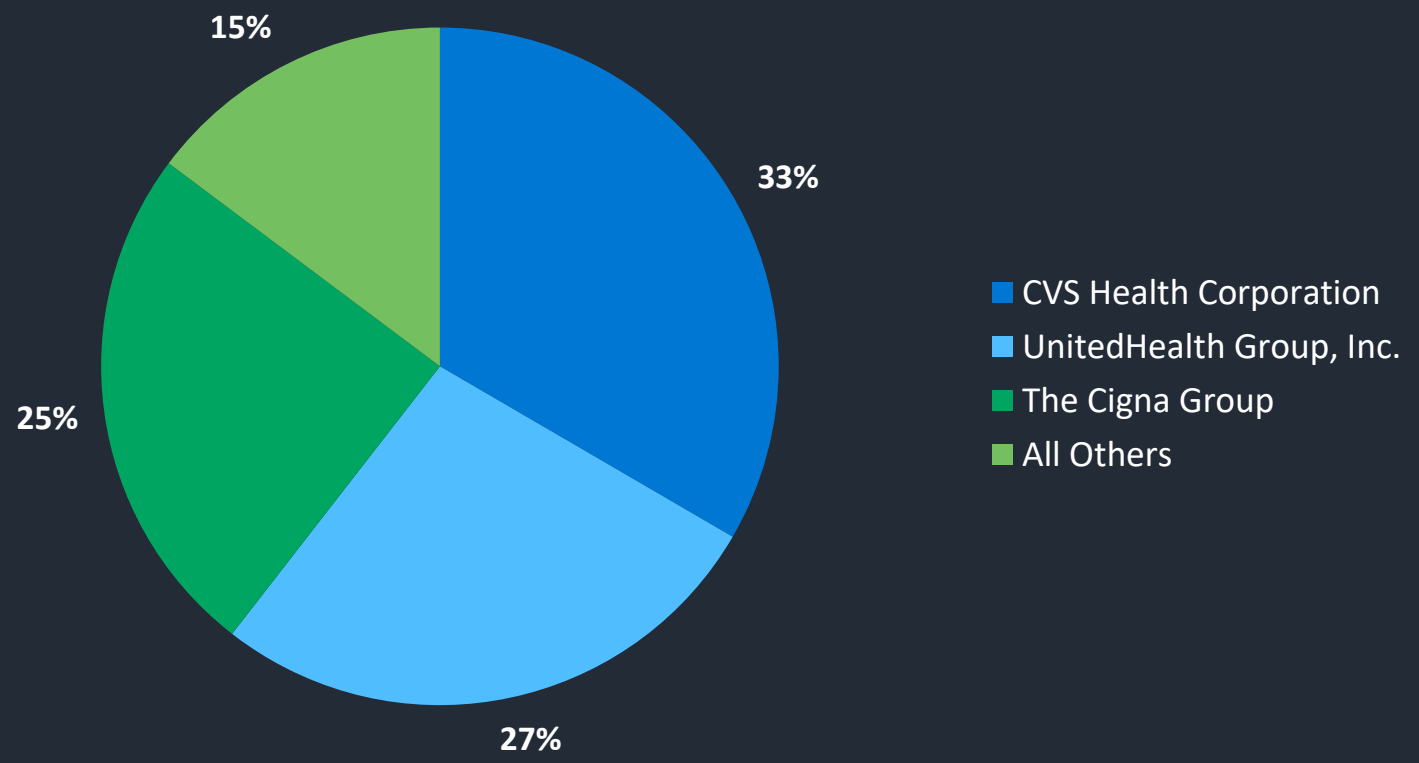
The PDP market is even more concentrated where the top 3 PDPs represent 85% of the PDP EGWP market

Top 3 PDP EGWPs enroll about 3.4 million EGWP beneficiaries

- Each of the top three owns or is affiliated with one of the leading pharmacy benefit managers (PBMs)
- The fourth-largest is a Direct Contract PDP, where the employer group contracts directly with CMS to administer the program

Source: Milliman analysis of CMS Medicare Advantage/Part D Monthly Enrollment by Plan files, August of each year.

PDP EGWP – August 2023 market share



Polling question:
Why do you believe employers are attracted to Medicare Advantage EGWPs?

A. Ease of administration

B. Lower cost

C. Better coverage options

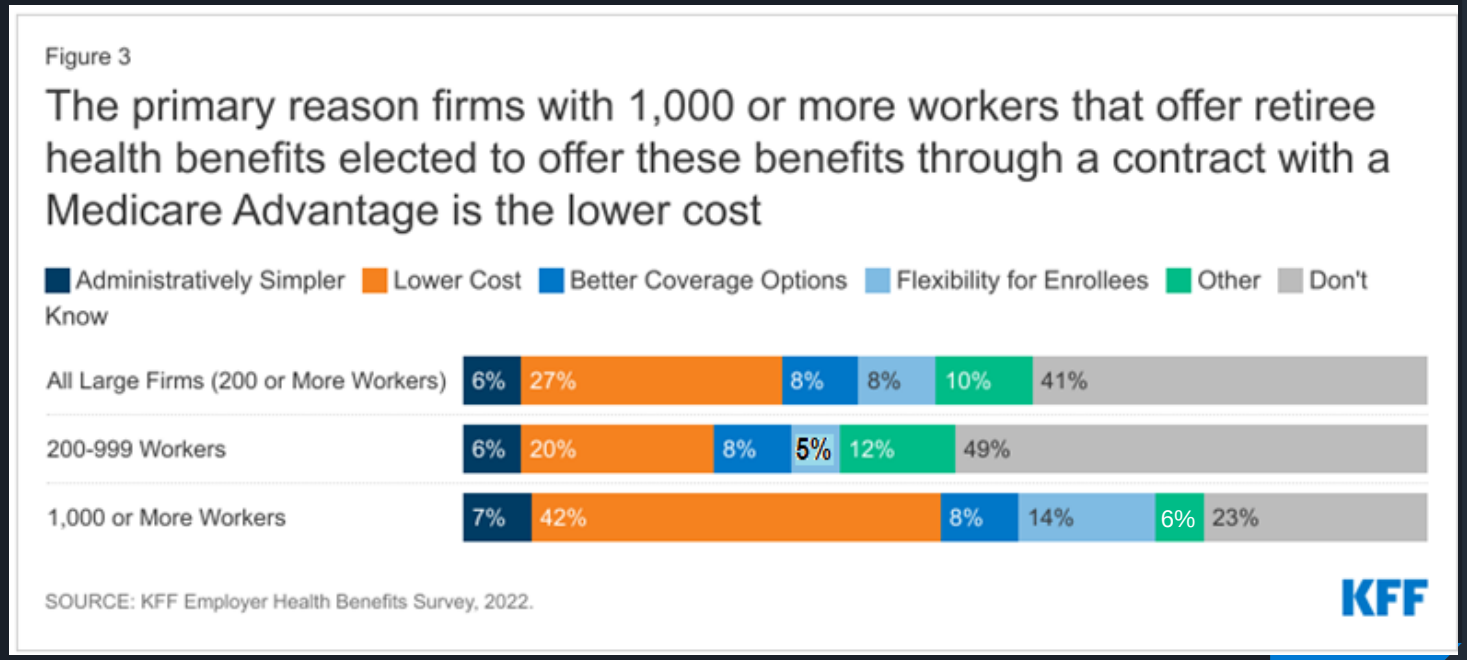
D. Flexibility for enrollees

E. Other

F. Don't know

Lowering plan financial liability is a driving reason for large firms to contract with EGWPs

- Lower overall cost, particularly with prescription drugs
- Ease of transition from active worker to retiree
- Most EGWPs are PPOs rather than HMOs
- Health plans should devise their strategies around the goals of the employer

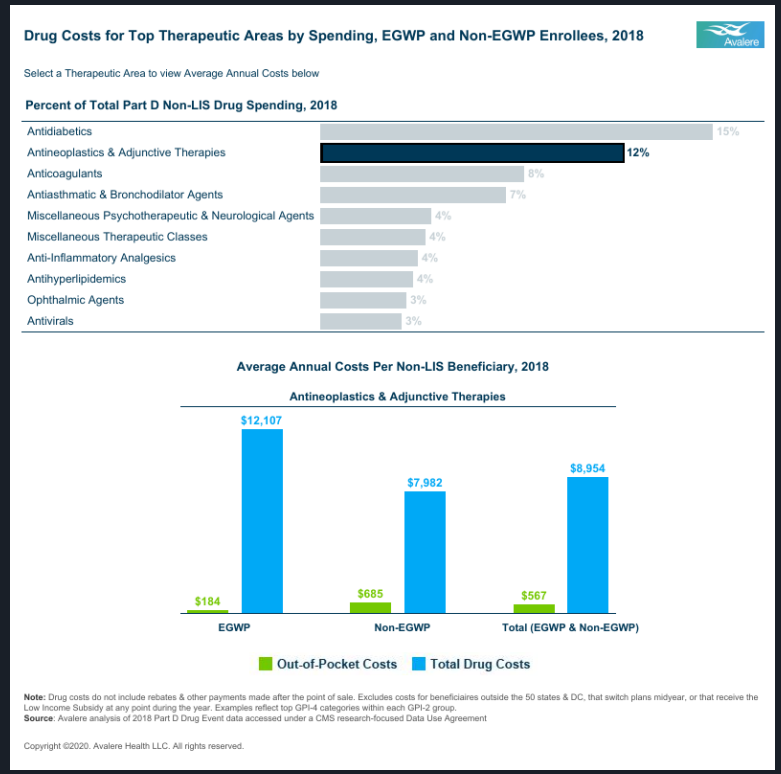


Source: https://www.kff.org/medicare/issue-brief/medicare-advantage-coverage-is-rising-for-the-declining-share-of-medicare-beneficiaries-with-retiree-health-benefits/

EGWP beneficiaries have lower OOP costs despite higher utilization and drug costs; Consistent among top spending therapeutic classes

Per Beneficiary Costs for EGWP and Non-EGWP Enrollees, 2018

	EGWPs	Non-EGWPs
Share of Beneficiaries with Any Utilization	95%	93%
Average Number of Prescriptions	27	25
Average Annual Drug Costs	$3,882	$2,257
Average Drug Cost per Prescription	$145	$90
Average Annual OOP Costs	$379	$517
Average OOP Cost per Prescription	$14	$21
Average Share of Drug Costs Above the Catastrophic Threshold	22%	34%



EGWP beneficiaries pay $500 less annually than non-EGWP beneficiaries for Antineoplastics

Source: https://avalere.com/insights/utilization-and-spending-by-medicare-beneficiaries-in-employer-part-d

Key considerations going into 2024/25

Milliman

CMS funding available to Plan Sponsors with Retiree coverage

Source*	Part C or D	Comments
MA Capitation Rates	Part C	Actual payment varies by county and member risk score
Direct Subsidy	Part D	Risk adjusted payment based on national amounts
Federal Reinsurance	Part D	Only available for calendar year plans
Coverage Gap Discount Program (CGDP)	Part D	Will transition to the Manufacturer Discount Program
Low Income Cost Sharing (LICS)	Part D	Generally, not a major source for EGWPs
Low Income Premium Subsidy (LIPS)	Part D	Generally, not a major source for EGWPs
Retiree Direct Subsidy (RDS)	Direct Rx	Available for retiree programs not offering MA-PD or PDP coverage

* From: https://us.milliman.com/en/insight/medicare-advantage-egwps-riding-the-baby-boomer-wave

Milliman

Part D Enrollment including RDS participation

2023 Medicare Trustees Report

(In millions)

Table IV.B7. –Part D Enrollment*

Calendar year	Retiree drug subsidy (RDS)	EGWP	Low Income Subsidy Total	All others	Total	MA-PD share of Part D
2013	3.3	5.9	11.5	18.4	39.1	36.5
2014	2.7	6.5	11.8	19.5	40.5	38.0
2015	2.3	6.5	12.1	20.9	41.8	39.1
2016	1.9	6.6	12.4	22.2	43.2	39.8
2017	1.7	6.7	12.7	23.4	44.5	41.0
2018	1.5	6.9	12.9	24.5	45.8	42.3
2019	1.3	7.0	13.1	25.7	47.2	44.3
2020	1.2	7.1	13.2	27.2	48.7	47.0
2021	1.1	7.3	13.2	28.4	50.0	50.6
2022	1.0	7.4	13.6	29.4	51.4	53.6

Retiree Drug Subsidy (RDS)
– 70% (-11% annual rate)

EGWP (MA-PD + PDP)
+ 25% (+2.3% annual)

Total Retirees (RDS + EGWP)
-9% (-0.9% annual)

* From: https://www.cms.gov/oact/tr/2023

Part D Government Subsidies

2023 Medicare Trustees Report

Table IV.B9. –Incurred Reimbursement Amounts per Enrollee for Part D Expenditures

Private Plans (PDPs & MA-PDs)*	All beneficiaries				Low-income Subsidy		Retiree drug Subsidy	
Calendar year	**Enrollment (millions)**	**Direct subsidy**	**Reinsurance**	**Risking sharing and other**	**Enrollment (millions)**	**Subsidy Amount**	**Enrollment (millions)**	**Subsidy Amount**
2013	35.8	$567	$535	-$20	11.5	$2023	3.3	$514
2014	37.8	$492	$718	-$1	11.8	$2052	2.7	$505
2015	39.5	$485	$841	-$28	12.1	$2112	2.3	$502
2016	41.2	$441	$861	-$27	12.4	$2126	1.9	$505
2017	42.8	$352	$878	-$11	12.7	$2156	1.7	$493
2018	44.2	$305	$918	-$1	12.9	$2203	1.5	$482
2019	45.8	$247	$1007	$10	13.1	$2273	1.3	$497
2020	47.5	$199	$1021	$31	13.2	$2506	1.2	$527
2021	48.9	$121	$1065	$25	13.2	$2644	1.1	$560
2022	50.4	$74	$1129	$21	13.6	$2911	1.0	$599

* From: https://www.cms.gov/oact/tr/2023

MA Capitation Rates – Star Rating Impact

Star Ratings impact MA Part C payments in two ways:

- Quality Based Payment (QBP) – Applied to Benchmark
- Rebate percentage – Portion of Bid to Benchmark savings kept by MAO for additional benefits

Star Rating	QBP %	Rebate %
4.5 or 5 Stars	5.0%	70%
4.0 Stars	5.0%	65%
3.5 New / Low Enrollment	3.5%	65%
3.5 Stars	0%	65%
<3.5 Stars	0%	50%

MA Capitation Rates Individual vs EGWP Benchmarks

Total MA EGWP Payment = EGWP Part C base payment amount + Part C EGWP rebate

2024 Average Benchmark*	Individual	EGWP	PMPM	%
4.5 or 5 Stars	$1,153	$1,075	-$79	-6.8%
4.0 Stars	$1,153	$1,061	-$92	-8.0%
3.5 New / Low Enrollment	$1,142	$1,051	-$91	-8.0%
3.5 Stars	$1,142	$1,023	-$118	-10.4%
<3.5 Stars	$1,112	$986	-$126	-11.4%

Source: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/ratebooks-and-supporting-data/1090981521/2024

MA Capitation Rates – Bid-to-Benchmark Ratio

Total MA EGWP Payment = EGWP Part C base payment amount + Part C EGWP rebate

EGWP Part C base payment amount: Based on Individual non-EGWP bid-to-benchmark ratio from prior year (applied for each star rating level)

Part C EGWP rebate amount: EGWP Part C base payment compared to individual benchmark to estimate 'bid savings' and is multiplied by the corresponding star rebate percentage to determine the corresponding rebate amount. Based on Individual non-EGWP bid-to-benchmark ratio from prior year.

Applicable	Bid to Benchmark Ratios			
Percentage	2024	2022	2020	2018
95%	78.5%	83.0%	84.7%	88.7%
100%	77.2%	82.6%	86.6%	92.2%
107.5%	76.6%	82.6%	86.1%	93.3%
115%	76.8%	82.9%	86.5%	93.6%

Source: https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/ratebooks-supporting-data

MA Capitation Rates Individual vs EGWP Benchmarks

Individual MA Payment = Plan Bid + Rebate
Total EGWP MA Payment = EGWP Part C base payment amount + Part C EGWP rebate

2024 Part C Payment	Individual	EGWP	PMPM	%
4.0 Stars	$1,153	$1,061	-$92	-8.0%
Plan Bid (@ 1.10 Risk Score)	$966	n/a		
Savings	$302	n/a		
Rebate (65% for 4.0 Stars)	$196	n/a		
Risk Adjusted Part C Payment	$1,162	$1,167	$5	0.4%

2024 Part C Risk Score Model Impact

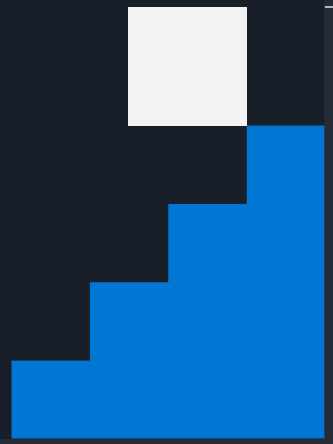
Milliman authored a study on expected high level impacts of the proposed 2024 model
Impacts very widely by plan type
Study based on 2020 edibility with 2019 dates off service

Plan Type	Model impact
General Enrollment	-3.10%
EGWP	-1.60%
D-SNP	-5.80%
C-SNP	-11.10%
I-SNP	-1.80%
MA total	-3.50%

Source: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/ratebooks-and-supporting-data/1090981521/2024

Milliman

Key Concerns with MA option



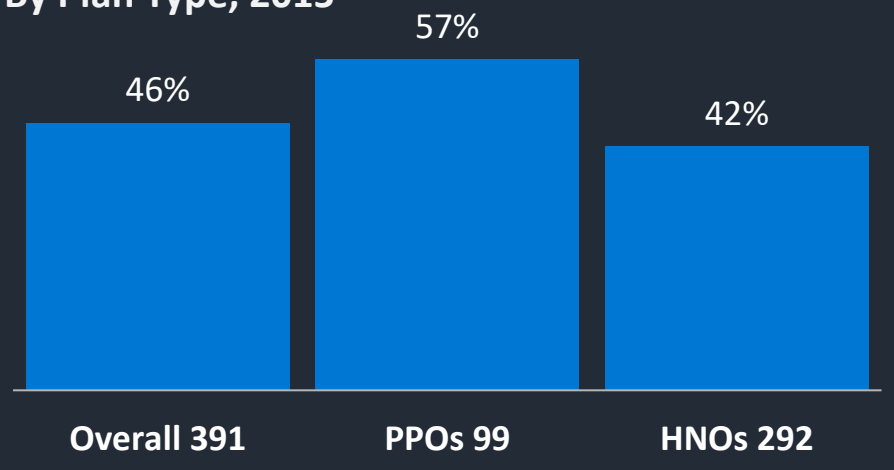
Access to desired providers	Pre-authorization and other Utilization Management Requirements
Out of pocket cost	Annual changes in covered benefits / networks

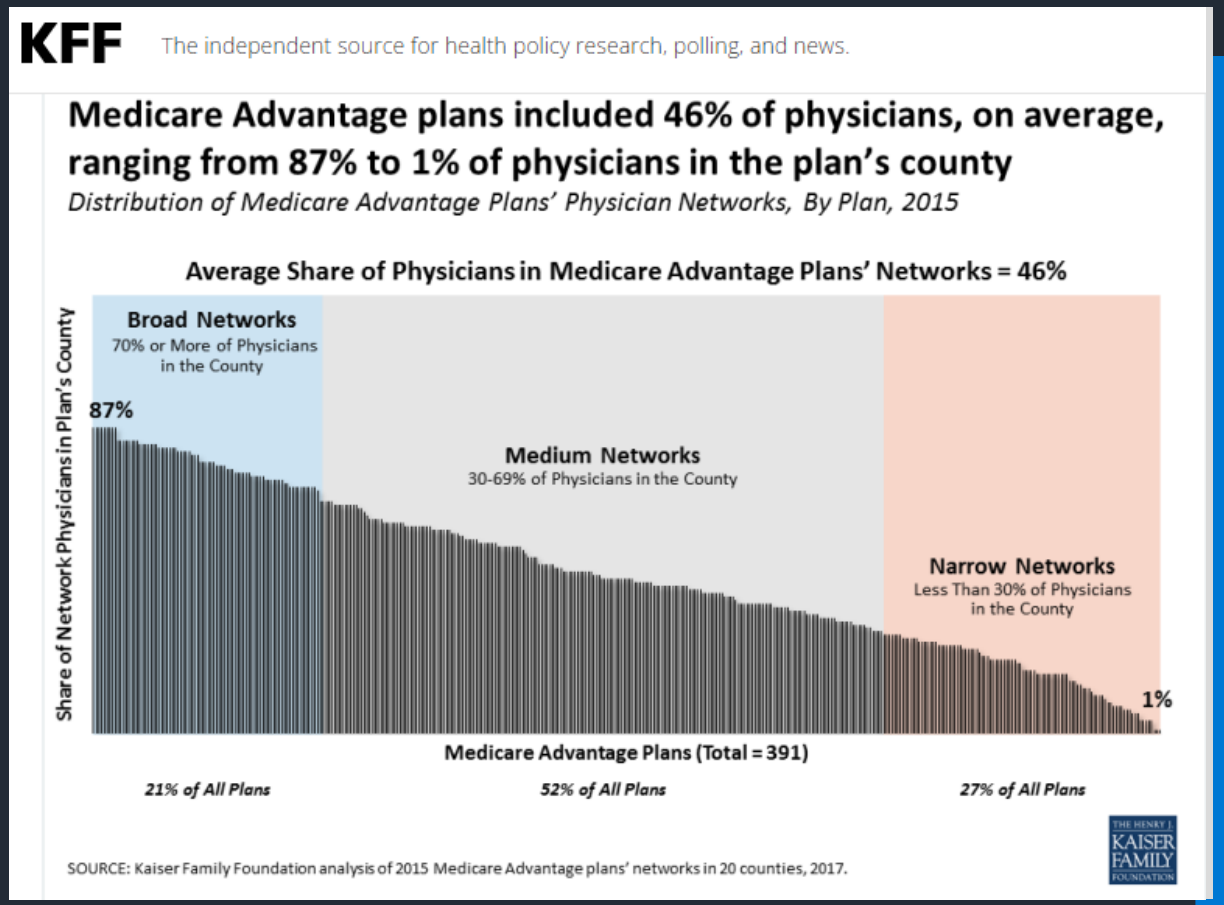
Access to providers

Ways to mitigate:

- PPOs usually offer wider networks
- Additional transparency on networks, especially out-of-network coverage
- 'Mirror – image' IN and OON cost share
- 2024 MA rules include additional notification requirements

Share of Physicians in MA Networks, By Plan Type, 2015





Note: No PPOs are offered in Los Angeles County, Percentages not weighted by plan enrollment.
Source: Kaiser Family Foundation analysis of 2015 Medicare Advantage plans networks to 20 countries, 2017

Medicare FFS Pre- Authorization Results

Traditional Medicare has requirements for a limited set of services:

- Certain Hospital Outpatient Department (OPD) Services
- Repetitive, Scheduled Non-Emergent Ambulance Transport (RSNAT)
- Certain DME, Prosthetics, Orthotics, and Supplies (DMEPOS) Items
- Review Choice Demonstration for Home Health Services (HH RCD)

Type of Service	Request	% Affirmed	% Overturned	Accuracy	Avg. Days
Outpatient	137,063	78.6%	0.3%	98.5%	4.5
RSNAT	32,384	63.2%	3.9%	98.9%	4.1
DME	125,415	66.9%	0.3%	98.8%	4.7
Home Health	1,757,609	96.2%	0.06%	99.5%	6.3

Source: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/ratebooks-and-supporting-data/1090981521/2024

April 2022 OIG findings

Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care

Office of Inspector General

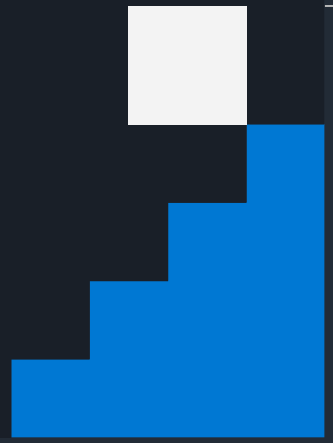
Report on brief

April 2022, OEI-09-18-00260

Key Takeaway

MAOs denied prior Authorization and payment requests that met Medicare coverage rules by:

- Using MAO clinical criteria that are not contained in Medicare rules
- Requesting unnecessary documentations and making Manual review errors and system errors



Source: https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf

13% of prior authorization denials were for service requests that met Medicare coverage rules, likely preventing or delaying medically necessary care for Medicare Advantage beneficiaries.

18% of payments denials were for claims that met Medicare coverage rules and MAO billing rules, which delayed or prevented payments for services that providers had already delivered.

Imaging services, stays in post-acute faculties and injections were three prominent service types among the denials that met Medicare coverage rules.

MAOs reversed some initial prior authorization denials and payment denials for request that met Medicare coverage rules and MAO billing rules.

Medicare Advantage 2024 Final Rules

Removing Barriers to Care Created by Complex Prior Authorization and Utilization Management

May only be used to confirm the presence of diagnoses or other medical criteria and/or ensure that an item or service is medically necessary

Approval granted must be valid for as long as medically necessary to avoid disruptions in care;

MA plans must comply with national coverage determinations (NCD), local coverage determinations (LCD), and general coverage and benefit conditions included in Traditional Medicare laws. If coverage criteria not established, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature

All MA plans must establish a Utilization Management Committee to review all utilization management, including prior authorization, policies annually and ensure they are consistent with the coverage requirements, including current, traditional Medicare's national and local coverage decisions and guidelines.

Source: https://public-inspection.federalregister.gov/2023-07115.pdf

Out-of-Pocket Cost

Contrary to Traditional Medicare, MA plans require maximum Out of Pocket MOOP levels for all Coordinated Care plans

Plan Type	Lower MOOP	Intermediate MOOP	Mandatory MOOP
HMO or In Network for HMO-POS, Local and Regional PPO and PFFS plans	$0 to $3,850	$3,851 to $6,350	$6,351 to $8,850
Combined INN/ONN for Local PPO, Regional PPO	$0 to $5,750 Combined	$3,851 to $9,550 Combined	$6,351 to $13,300 Combined

Most MA plans provide significantly lower cost share than Traditional Medicare

Medigap / Medicare Supplemental coverage usually covers 100% of Part A/B cost share (Plan C and F), but all others still require portions of Part A and/or Part B cost share.

Source: https://www.cms.gov/medicare/health-plans/medicareadvtgspecratestats/ratebooks-and-supporting-data/1090981521/2024

EGWP Recommendations

Plan sponsors, retirees and MA plans should work collaboratively to maximize external funding opportunities - Know your numbers!

Contracts should include explicit performance guarantees regarding critical beneficiary requirements

- Network access (Both medical providers and retail pharmacies)
- Pre-auto standards, including timing requirements and appeal process

Multi-year financial arrangements can provide stability on benefit design

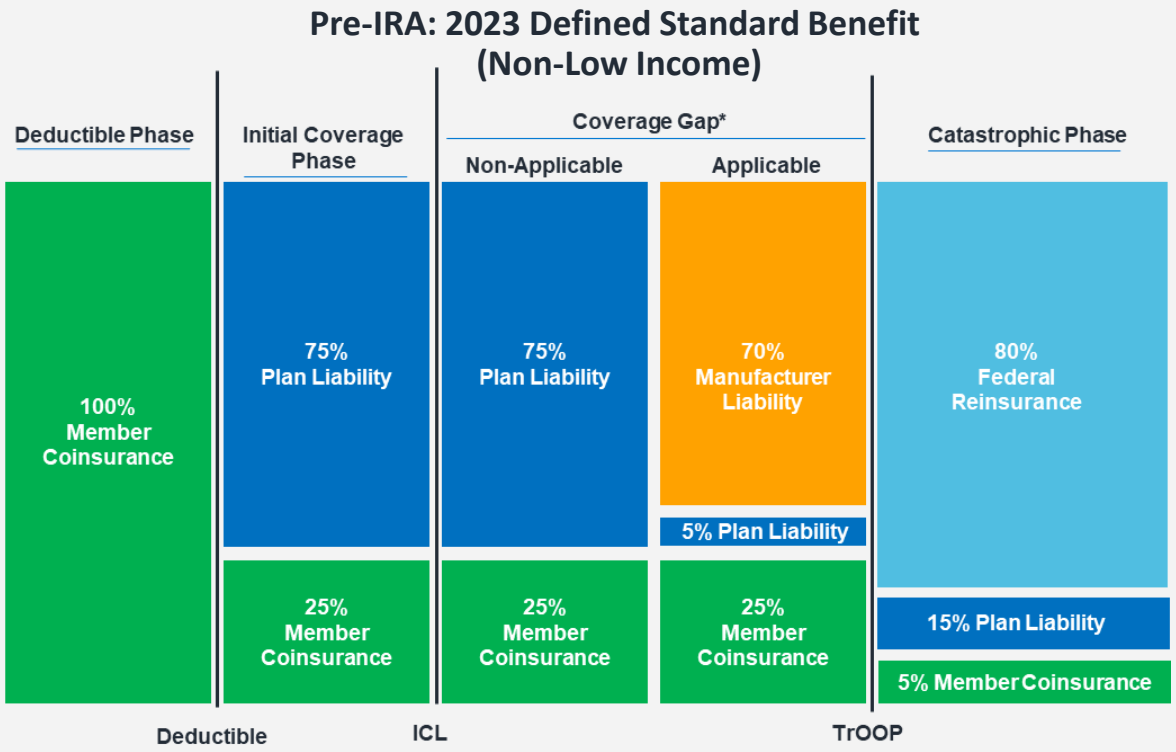
- Ideally pricing should be based on 4.0 stars rating or higher
- Retiree associations can support MA to increase beneficiary engagement with clinical programs and other initiatives that can ensure
  accurate and timely risk score coding
- Usually includes allowance for good faith renegotiation due to unforeseen changes

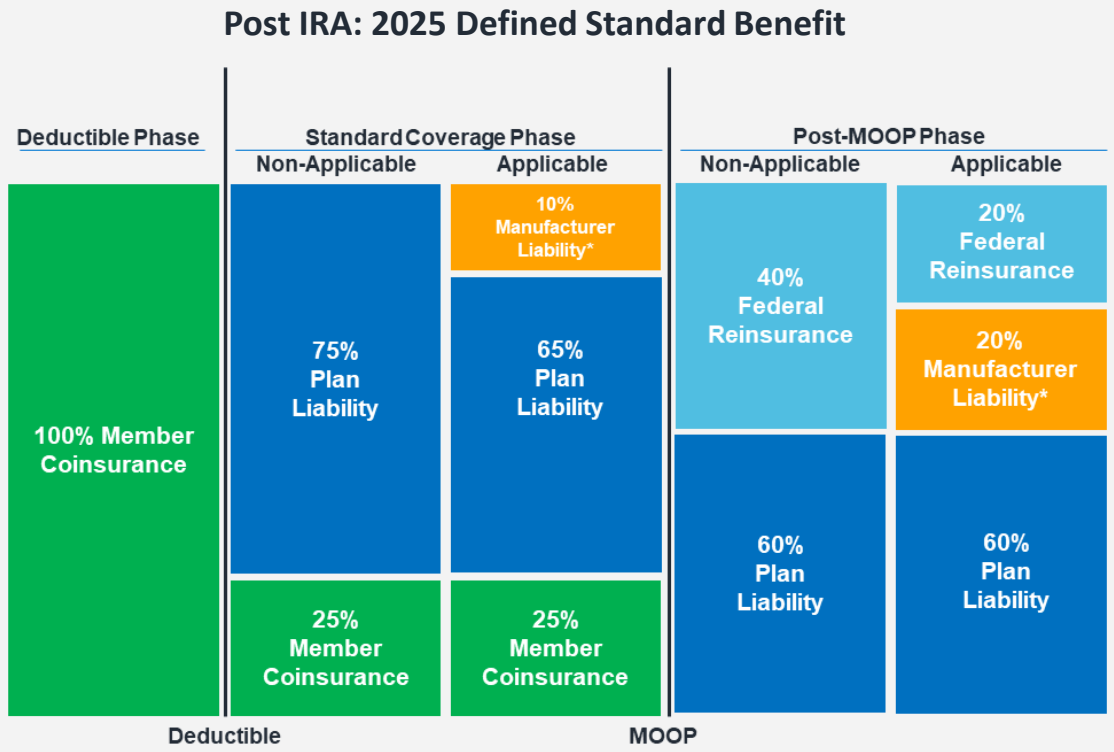
IRA impact on Part D and what the future holds for EGWPs

Milliman

Medicare Part D Benefit Design Comparison

Pre-IRA vs. Post IRA: Key benefit design changes mirror those in the individual market





- Simplified benefit through elimination of the coverage gap
- Impact on each EGWP in 2025 will vary
  - Benefit richness currently in place
  - Member experience (i.e., current claim cost)

Out with the Old – In with the New

Ramifications of benefit redesign in 2025

Elimination of the coverage gap

- Many plans already provide benefits through the coverage gap
- Reduced benefit complexity will help transition members when retiring

Manufacturer Discount Program

- Most plans should see the same or higher manufacturer payments
- However, the program will affect plans differently based on current member spend and benefit design

Introduction of a MOOP

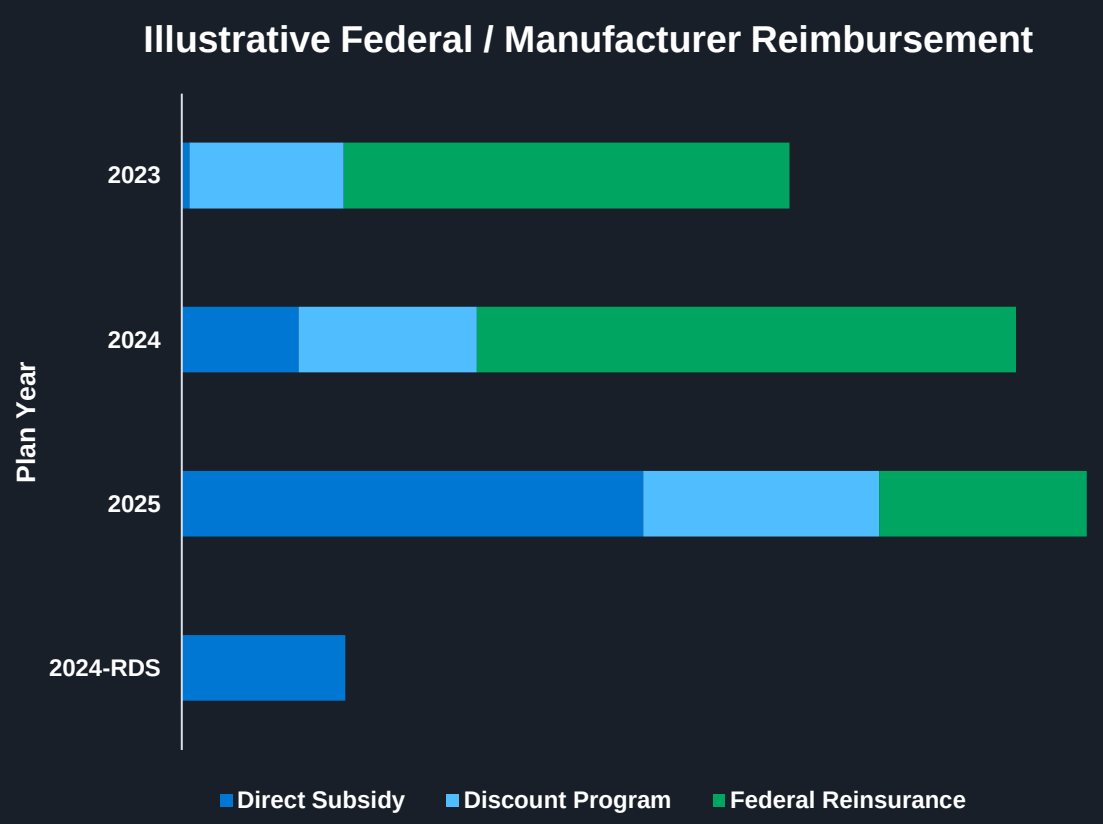
- Many plans already offer a MOOP but may need to reduce it
- Limits flexibility in the benefit design offering
- Aligns with the paternalistic view of many plan sponsors

Increased liability in catastrophic phase

- Creates an incentive to better manage costs (particularly specialty)
- Increases the attractiveness of private reinsurance and fully insuring the plan

Changes to Part D Payments

Shift from reimbursement towards subsidies



Changes in the overall subsidies will generally increase in 2025 over prior years

- Subsidy changes will vary by plan based on the current benefit design
- The federal reinsurance subsidy determination will likely need to be adjusted or plans may face payments at year-end reconciliation
- Risk scores will be much more important for EGWPs than they have been historically

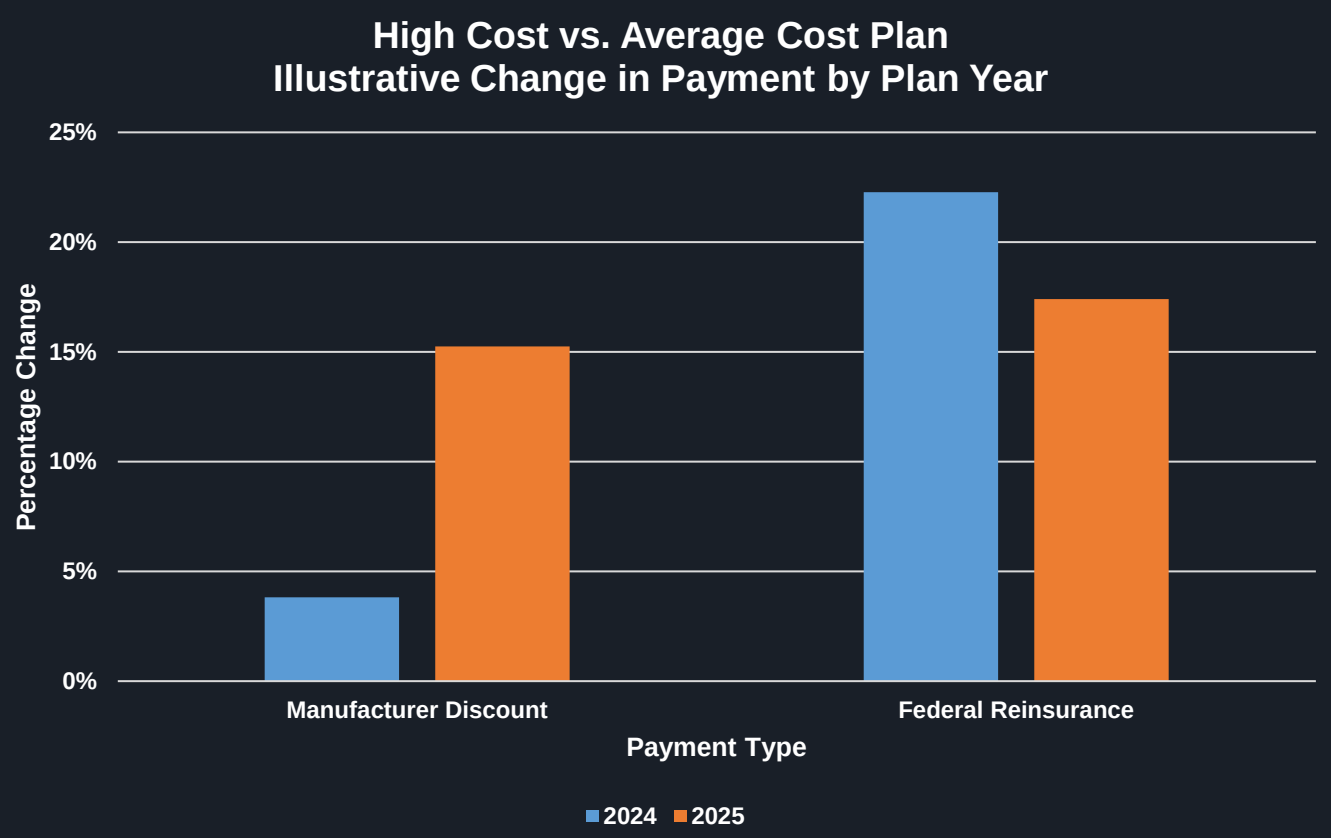
Both before and after the IRA, the financial incentives are greater for an EGWP than applying for the RDS

The financial incentive for non-calendar EGWPs to align with the calendar year is lessened in 2025

* Direct subsidies are based on a risk score of 1.0 for all plan years and do not reflect anticipated changes to the risk score model.

Payment Changes – Illustrative Example

Changes in payments can vary dramatically by plan based on plan experience

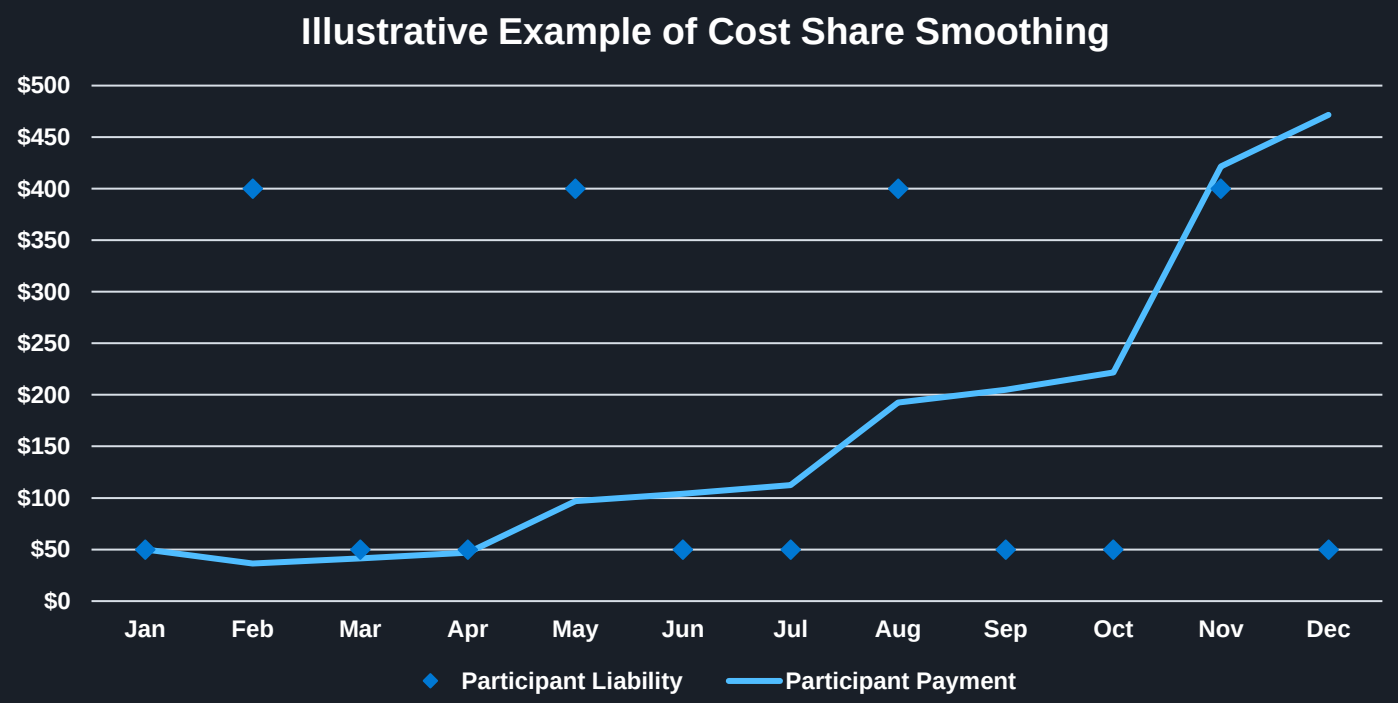


- In 2025, the manufacturer discount will be uncapped, will likely be larger than in 2024, and will be more highly leveraged
- In 2025, the federal reinsurance will be significantly less than in 2024 and less sensitive to changes in drug cost

Source: Internal data modeling. Specialty spend for the high-cost plan is 25% higher than the average cost plan.

Medicare Prescription Payment Plan (M3P)

EGWPs must make cost share smoothing available to their retirees



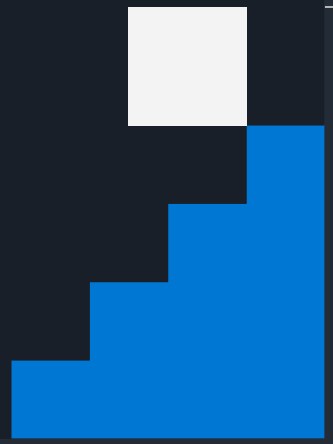
Anticipated Impact

- Will increase administrative burden for billing
- Need to coordinate responsibility between the plan sponsor and the PBM
- Plan for additional liability attributable to uncollectable cost sharing (i.e., bad debt)
- EGWPs comprise primarily NLI members who are more exposed to cost sharing that could increase election into the program

Source: CMS Memo released 8/21/2023 “Maximum Monthly Cap on Cost-Sharing Payments Under Prescription Drug Plans: Draft Part One Guidance on Select Topics, Implementation of Section 1860D-2 of the Social Security Act for 2025, and Solicitation of Comments”

Known Unknowns

Recognizing the need for further guidance from CMS



*Source: CMS User Group Call on September 14, 2023.

RxHCC risk score model

- CMS estimates a potential 15% decrease for non-low-income individuals*
- EGWP population comprises primarily NLI individuals

MOOP accumulation

- May be based on some variation on a theme of a basic benefit
- Defining the basic benefit
- Excludes the Manufacturer Discount Program

Flexibilities around actuarial equivalence tests

CMS historically allowed a leaner benefit design than the defined standard benefit in the initial coverage phase and coverage gap

Considerations of EGWP Growth

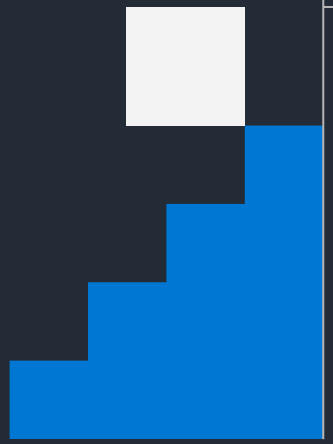
Many of the drivers and obstacles for growth will remain

Furthermore, growth in MAPD EGWPs may come at the expense of PDP EGWPs as employers also consider their retiree health benefits alongside prescription drug coverage

Drivers of Growth			
Employers offering retiree coverage	**Conversions from RDS and commercial retiree plans**	**Growth in unions**	**Improved financial incentives**
Obstacles to Growth			
Sensitivities around member disruption	**Increased exposure to high-cost claimants**	**Educational component to retirees**	**Non-financial reasons for not transitioning**

Questions to Ask as a Plan Sponsor

Preparing for change



How will I plan for the additional risk from high-cost members?	How will I communicate any changes to my beneficiaries?	What contractual changes would most benefit my plan with the redesign?
What will be the impact from drug price negotiation (effective for the 2026 plan year) on my plan?	How will my cash flows be affected?	Will the improved financial incentives outweigh other reasons for not transitioning to an EGWP?

Q&A

Milliman

Milliman

Thank you

Jennifer Carioto

Jennifer.Carioto@milliman.com

Luis Maldonado

Luis.Maldonado@milliman.com

Todd Wanta

Todd.Wanta@milliman.com

Milliman

Caveats

These presentation slides are for discussion purposes only. They should not be relied upon without benefit of the discussion that accompanied them during this webinar. They are not to be distributed without approval by Milliman.

This presentation and Q&A is not intended to be an actuarial opinion or advice, nor is it intended to be legal advice.

Any statements made during the presentation and subsequent Q&A shall not be a representation of Milliman or its views or opinions, but only those of the presenter.