2025 Financial Impacts for Part D Employer Group Waiver Plans (EGWPs)

Commissioned by CVS Health / Aetna

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Part D EGWPs are facing increases in plan costs in 2025 we estimate will only be partially offset by increases in revenue due to the Part D benefit redesign. This whitepaper explores the financial impact of the benefit redesign and trends on EGWPs, estimating potential net premium increases for selected benefit designs.

Executive Summary

The Inflation Reduction Act (IRA) includes a redesign of the Medicare Part D benefit in 2025. Under the benefit redesign, Part D EGWPs are expected to see an increase in plan costs that may only partially offset by an increase in revenue from the Centers for Medicare and Medicaid Services (CMS) through the direct subsidy. For the illustrative copay and coinsurance-based designs tested, our analysis indicates:

- In 2025, EGWP net premiums could increase by $35 to $50 per-member-per-month (PMPM) for a baseline population due to increases in drug trends and reductions in member cost-sharing and federal reinsurance.
    - Net premium is defined as net plan liability, after the direct subsidy.
    - Both fully insured and self-funded EGWPs would see these headwinds.
    - Administrative costs may add incremental costs beyond those reflected in our analysis.
- The net premium impact for the leaner coinsurance-based design is approximately 40% greater than the impact for the richer copay-based design.
- High-cost members (with over $10,000 in annual drug spend before rebates) will see a cost-sharing decrease, even if they pay less than $2,000 in cost-sharing today.
- For a population with higher brand and specialty drug use, we estimate the 2025 net premium change for the copay-based design could be $110 PMPM or more.
- For a population with lower utilization and higher generic drug use, we estimate a 2025 net premium decrease of $10 PMPM for the copay-based design.

There is a wide degree of variability in these estimates, with impacts potentially varying outside of the range for the alternative population scenarios. This variability is due to underlying characteristics of a group (e.g., drug mix, benefit design, risk score) and several key unknowns at the time of this analysis. The unknowns include the impact of the revised 2025 Part D risk score model, the 2025 Part D direct subsidy, cost-sharing accumulation to the member maximum out-of-pocket (MOOP), drugs eligible for the phase-in of the manufacturer discount program (MDP), and potential stakeholder reactions. Throughout this white paper, MOOP refers to the new $2,000 Part D MOOP calculated under the 2025 defined standard plan, not the MOOP of an EGWP design.

Background

Part D Employer Group Waiver Plans (or EGWPs) provide employer-sponsored prescription drug coverage for Medicare-eligible retirees. These plans are administered either directly by the employer or by a health insurer on behalf of the employer. The plan is similar to a Medicare Part D plan that any Medicare beneficiary can enroll in, but specific requirements are waived, and groups often provide benefits that are richer than the standard Part D benefit. Employers can either offer a standalone Part D plan or a combined Medicare Advantage Prescription Drug (MAPD) plan. Employers can also either self-fund the plan (i.e., take on the risk) or contract with a health insurer to fully insure the risk and pay a flat, monthly premium.

The Medicare Part D redesign includes several key changes that will affect EGWPs in 2025. Notable Part D changes affecting EGWPs include:

1. **Member cost-sharing** will be capped at $2,000 annually due to the introduction of a Part D MOOP. Our current interpretation of the IRA is that additional Part D EGWP benefits offered through Other Health Insurance (OHI) will also accumulate to the MOOP. This means members could reach the MOOP, even if they pay less than $2,000 in cost-sharing, if their EGWP+OHI benefits are richer than the Part D defined standard benefit. Explicit guidance on how the accumulation will work is still outstanding at this time. This is expected to increase EGWP net premiums.

2. **Federal reinsurance** will decrease from 80% of allowed cost in the catastrophic phase for all drugs to 20% of applicable (brand) drug and 40% of non-applicable (generic) drug allowed cost above the MOOP. This is expected to increase EGWP net premiums.
3. **Pharmaceutical manufacturer** payments will change from 70% of applicable (brand) drug cost in the coverage gap for non-low income members to 10% of applicable (brand) drug cost above the deductible / below MOOP, and 20% of applicable (brand) drug cost above MOOP for all members. Manufacturer payments will be phased-in for "specified" and "specified small" manufacturers. This may increase or decrease EGWP net premiums, depending on low-income and drug type mix.

Appendices A.1 and A.2 illustrate the defined standard Part D plan design for 2024 and 2025, respectively. For additional detail on the IRA changes, please refer to Milliman's article: Weathering the Reform Storm.

Results and Analysis

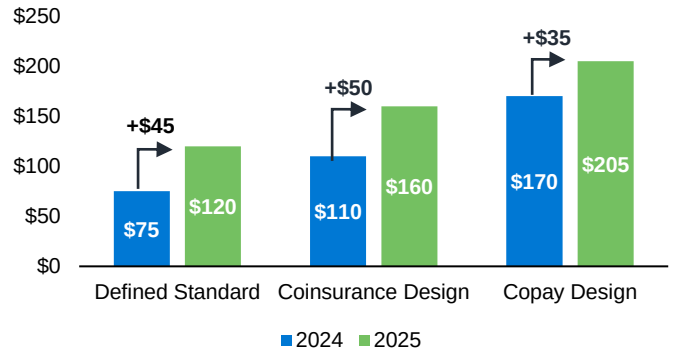
HIGH-LEVEL IMPACTS

Figure 1 illustrates the estimated net premium impact due to the Part D benefit redesign for three EGWP scenarios, as described below. Please refer to the Assumptions and Methodology section for additional detail on each scenario.

1. Defined Standard: Part D defined standard benefit, with full deductible and 25% coinsurance for all drugs.
2. Coinsurance Design: No deductible, $0 generic copays, 25% preferred brand coinsurance, 50% non-preferred brand coinsurance, and 33% specialty drug coinsurance.
3. Copay Design: No deductible, $0 generic copays, $25 preferred brand copays, and $50 non-preferred brand / specialty drug copays.

As illustrated in Figure 1, all tested scenarios result in a Part D EGWP net premium increase. The impact is higher for the coinsurance-based design, with net premium increases up to $50 PMPM, approximately 40% greater than the impact for the copay design, which shows an impact of $35 PMPM.

FIGURE 1: ESTIMATED PART D EGWP NET PREMIUM IMPACT, 2024-2025



EGWPs are facing both financial headwinds and tailwinds for 2025 that will affect groups differently:

- As a headwind, member cost-sharing will decrease due to the Part D MOOP. The impact of the MOOP will vary based on the existing benefits and drug mix.
- As an additional headwind, federal reinsurance is decreasing due to the benefit redesign. This change is more impactful for groups with leaner benefit designs, such as the coinsurance design illustrated here.
- As a tailwind, the direct subsidy is expected to increase, at least partially offsetting the plan liability changes.
- Pharmaceutical manufacturer payments could increase or decrease, depending on the underlying population and drug mix for a particular group.

We estimate the net impact of these changes, combined with trends into 2025 for drug utilization and cost, will increase net premium for the tested EGWP designs. Many of the changes affecting EGWPs are similar to dynamics we expect to occur in the Individual Medicare market, but changes in EGWP premiums do not influence the value of the direct subsidy.

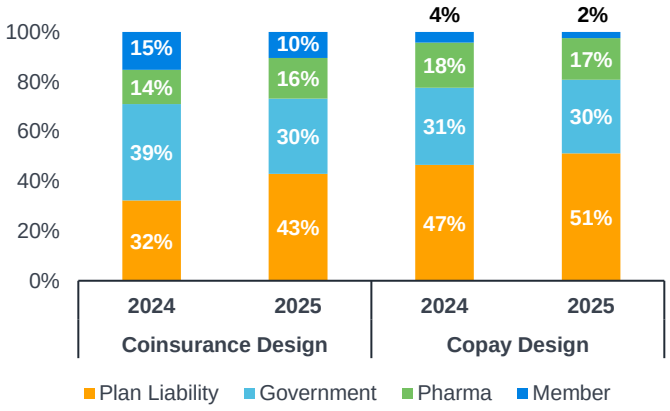
IMPACTS BY STAKEHOLDER

Figure 2 illustrates the breakdown of Part D stakeholder costs for 2024 and 2025 for the coinsurance and copay designs, respectively. These exhibits illustrate the following impacts by stakeholder:

1. Member: Member cost-sharing decreases for both the coinsurance and copay designs in 2025, due to the introduction of the MOOP. Members with a coinsurance-based design see a large decrease in cost-sharing, on average, while members in the copay-based design see a more limited impact. We explore member cost-sharing impacts in more detail in the next section.
2. Pharmaceutical Manufacturers: We estimate pharmaceutical manufacturer payments could increase or decrease in 2025 for EGWPs as a percentage of allowed cost. We expect EGWPs with greater specialty drug use and/or a higher concentration of low income (LI) members are more likely to see an increase in manufacturer payments, while EGWPs with a lower concentration in brand drug costs are more likely to see a decrease.
3. Federal Government: We estimate a material decrease in federal reinsurance, which will be at least partially offset by an increase in the direct subsidy. The reinsurance decrease will be more impactful for coinsurance-based designs, where members accelerate more quickly to the catastrophic phase in 2024 compared to copay-based design. Direct subsidy impacts will vary based on the risk score of the underlying population, after accounting for the 2025 risk score model change.

4. Employer Plans: The plan liability is expected to increase materially due to the Part D benefit redesign. The direct subsidy, as described above, is expected to partially offset the increase in plan liability illustrated in Figure 2. We estimate the impact will be larger for coinsurance-based designs, consistent with the impact of federal reinsurance described above. EGWP total net premiums would increase as a result of this plan liability increase, which could be passed on to members through higher premium contributions.

FIGURE 2: PART D EGWP STAKEHOLDER LIABILITY % OF TOTAL COST NET OF REBATES, COINSURANCE DESIGN VS. COPAY DESIGN



MEMBER IMPACTS BY SPENDING LEVEL

EGWP benefit designs are required to be at least as rich as the Part D defined standard benefit, but the defined standard benefit is expected to apply to EGWP enrollees for the purpose of determining when enrollees reach the $2,000 Part D MOOP and no longer pay cost-sharing. As such, the Part D benefit redesign, in many cases, will make EGWP benefits richer.

The Part D benefit redesign will affect members differently, depending on the level of overall spending associated with member drug use. To highlight these differences, we summarized the estimated cost-sharing for members with total drug spend below and above $10,000 per year:

1. On average, we estimate members with less than $10,000 in annual drug spend will see limited changes in total cost-sharing from 2024 to 2025. Our analysis estimates that approximately 90% of members fall into this category.
2. We estimate members with greater than $10,000 in annual drug spend will see a material reduction in total cost-sharing from 2024 to 2025 due to the introduction of the $2,000 MOOP. All members with greater than $10,000 in annual gross spend are estimated to reach the MOOP in the defined standard plan design. Our analysis estimates approximately 10% of EGWP members will fall into this category. These members may pay less than $2,000 if the benefit is richer than the defined standard plan design.

Figure 3 illustrates the average member cost-sharing for members with greater than $10,000 in annual allowed cost for each of the three benefit designs tested. Although all members with this level of spending are expected to reach the MOOP, the cost-sharing varies by benefit design, due to the accumulation of cost-sharing to the MOOP (i.e., the greater of defined standard and actual cost-sharing). This MOOP accumulation dynamic results in some members paying far less than the $2,000 MOOP, particularly for the copay design, where we estimate the average annual cost-sharing for these members will decrease from $760 in 2024 to $270 in 2025.

FIGURE 3: AVERAGE ANNUAL MEMBER COST-SHARING FOR MEMBERS WITH GREATER THAN $10,000 IN ANNUAL DRUG SPEND

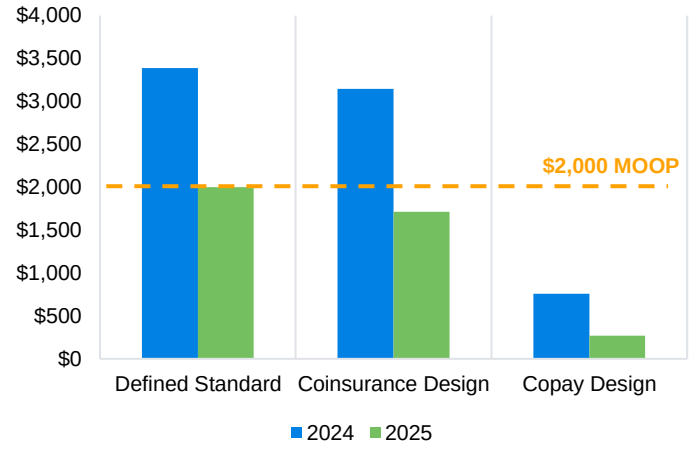


Figure 4 illustrates the estimated annual member cost-sharing across a range of varying total drug spending levels based on experience from the baseline dataset.

For the tested copay-based design, we observe that members with higher annual drug spend may pay less in cost-sharing than members with lower annual drug spend. This dynamic may occur when a member is taking a high-cost drug, as the greater of the copay or the defined standard accumulates towards the MOOP, and the member quickly reaches the MOOP after paying a copay for the first one or two scripts. This dynamic may create a financial incentive for members to take higher cost drugs, as it could decrease their cost-sharing. This incentive may be concerning for an EGWP, because member incentives are misaligned with plan incentives (i.e., drive members to the lower cost drugs).

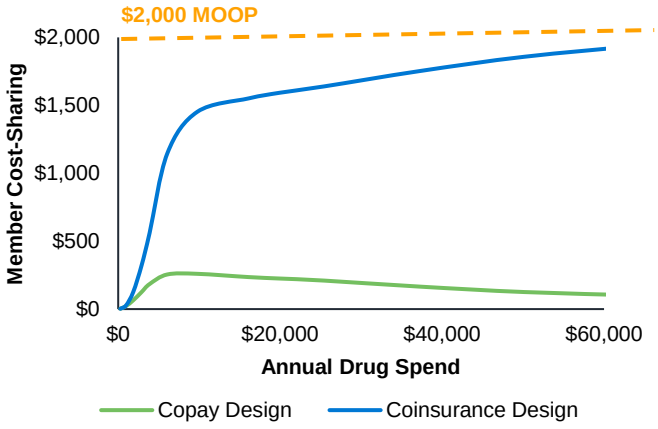
Conversely, with the tested coinsurance-based design, higher drug spend will generally lead to higher member cost-sharing. Total member cost-sharing may still be less than the $2,000 MOOP, but the financial incentives are more aligned for members to take lower cost drugs under the coinsurance design.

To further illustrate this concept, consider a member taking a maintenance dose of a $5,000/month specialty drug in the copay-based design with a $50/month specialty drug copay. The cost-sharing in the 2024 plan design would be $50/month

x 12 months = $600. The cost-sharing in the 2025 plan design would be $50/month x 2 months = $100, because the member would have reached the MOOP under the defined standard plan after the second script.

As previously mentioned, CMS has yet to release formal guidance on the MOOP accumulation for EGWPs. To the extent CMS guidance indicates a different accumulation approach than that assumed for this analysis, this would lead to materially different results.

FIGURE 4: 2025 ANNUAL PART D EGWP MEMBER COST-SHARING BY DRUG SPEND, COINSURANCE VS. COPAY DESIGN



VARIATIONS BY POPULATION

The analysis presented above relied on a single baseline population. We also analyzed two alternative populations with higher and lower spend for the purpose of testing the sensitivity of the Part D benefit redesign on net premium. Figure 5 compares key metrics for these alternative populations relative to the baseline population used for the estimates provided above. Figure 5 reflects the utilization level expected for the copay-based design. Additional detail on the assumed populations can be found in the Assumptions and Methodology section.

FIGURE 5: 2025 KEY PART D METRICS FOR ASSUMED BASELINE VS. ALTERNATIVE POPULATIONS, COPAY DESIGN

	Baseline	Higher Spend	Lower Spend
Low Income %	2.0%	8.0%	1.0%
Average Allowed Cost PMPM	$505.00	$790.00	$310.00
Average Risk Score	0.683	0.743	0.658
Average 30-Day Utilization PMPM	5.32	6.61	4.24
Generic Dispensing Rate	89.6%	85.5%	92.4%
Brand Dispensing Rate	9.8%	13.5%	7.1%
Specialty Dispensing Rate	0.6%	1.0%	0.5%

Figure 6 illustrates the Part D EGWP net premium for 2024 vs. 2025 with the copay-based design for the baseline and alternative populations. We estimate the following:

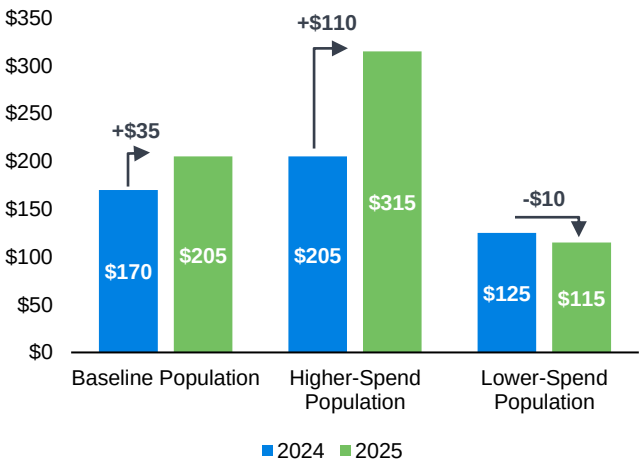
- A net premium increase for the higher-spend population of $110 PMPM in 2025. In this scenario, the decrease in federal reinsurance has a more material impact than the expected increase in the direct subsidy.
- We estimate a net premium decrease for the lower-spend population of $10 PMPM in 2025. In this scenario, the expected increase in the direct subsidy outweighs the decreases in reinsurance and member cost-sharing.

While the net premium for the alternative populations are $35 to $45 PMPM different from than the baseline population in 2024, we estimate net premiums could vary by $90 to $110 PMPM from the baseline in 2025. This dynamic occurs because plans with higher brand and specialty drug use have material financial protection in 2024 due to 80% federal reinsurance in the catastrophic phase but will have much higher plan liability above the MOOP in 2025. This drives the wide variability in estimated premium changes for 2025.

The Part D program is risk-adjusted, meaning plans with riskier populations (as determined by the Part D risk score) receive higher payments from CMS through the direct subsidy. Part D risk scores, however, are determined based on demographics and medical diagnoses rather than pharmacy spend. Groups with higher-than-average spend based on factors that are not captured by the demographic and medical diagnosis components of the Part D risk score model may not receive higher risk-adjusted revenue from CMS, while groups with lower-than-average-spend for similar reasons may not receive lower risk-adjusted revenue from CMS. We assumed a higher risk score for the alternative population.

Consistent with the rest of this analysis, the net premium impacts presented here reflect trends into 2025 for drug utilization and cost, in addition to the benefit redesign.

FIGURE 6: PART D EGWP NET PREMIUM IMPACT ON COPAY-BASED DESIGN, BASELINE VS. ALTERNATIVE POPULATION



Assumptions and Methodology

To perform this analysis, we relied on an actuarial cost model designed to estimate projected EGWP Part D claim costs by stakeholder. The baseline population data underlying our analysis was developed from Milliman's database of retiree prescription drug claims experience.

We projected the underlying prescription drug costs forward to 2024 and 2025, with adjustments for trends and induced utilization, and assigned formulary tiers based on the most common tier in the underlying dataset. Aggregate trend is approximately 3.5% annually on a PMPM allowed cost basis. We created claim probability distributions to allocate costs to each benefit phase and estimate liability for each stakeholder. We calculated net premium by taking the gross plan liability, less an estimate of the risk-adjusted direct subsidy in each year, less manufacturer rebates (after accounting for rebate sharing with the government through federal reinsurance). We assumed no administrative costs or risk margin for the purpose of developing the net premium estimates.

Figure 7 summarizes the copay and coinsurance designs used in this analysis. We calibrated the projected allowed cost for the baseline population for each benefit design to reflect induced utilization. This adjustment was based on a formula Milliman has developed based on analysis of our historical pharmacy claims datasets. This approach also captures an increase in utilization for both benefit designs due to the introduction of a Part D MOOP. We assume the allowed cost for the coinsurance design is approximately $25 to $30 PMPM lower than the copay design in 2025 with this approach.

FIGURE 7: ILLUSTRATIVE PART D EGWP BENEFIT DESIGNS

Part D Benefit Design Feature	Benefit Design	
	Copay Design	Coinsurance Design
Global Assumptions		
Deductible	No	No
2024 Coverage Gap?	No	No
Maximum Out-of-Pocket (2025)	$2,000	$2,000
30-Day Cost-Sharing by Tier		
Generic Drugs	$0	0%
Preferred Brand Drugs	$25	25%
Non-Preferred Brand Drugs	$50	50%
Specialty Drugs	$50	33%

There are several additional key assumptions for this analysis:

- Manufacturer Rebates: We assume manufacturer rebates of 35% of allowed cost for brand drugs and 15% of allowed cost for specialty drugs. We assume no change in rebates (as % of allowed cost) year over year.
- Pharmacy Network DIR: We assume no pharmacy direct and indirect remuneration (DIR) in this analysis. We expect 2024 net premium impacts due to pharmacy DIR at the point-of-sale (POS) to be unfavorable for groups with pharmacy DIR in 2023, and to be favorable for groups without pharmacy DIR in 2023. For reference, for the defined standard benefit, we estimate the 2023 net premium for a plan with pharmacy DIR equal to 8% of allowed cost to be $65, and 2023 net premium of $80 for plans without pharmacy DIR.
- Risk Scores: We assume the average risk score for the baseline population is 0.80 in 2024. For 2025, we apply a multiplicative scalar (0.85 for non-low income and 1.20 for low income) to account for CMS changes to the RxHCC risk score model, based on preliminary information communicated by CMS in their September 14, 2023 User Group discussion.
- List Price Changes: This analysis reflects reductions in insulin list prices to align with announcements from insulin drug manufacturers effective in 2024.
- Specified / Specified Small Manufacturers: For 2025, there is a phase-in of the Manufacturer Discount Program (MDP) for “specified” and “specified small” manufacturers. At the time of this release, the list of “specified” and “specified small” manufacturers was unknown for 2025. We estimated the list of drugs and manufacturers using information from CMS' 2021 Medicare Parts B and D spending dashboards.
- Medicare Prescription Payment Program (M3P): We assumed no additional cost associated with administration of the M3P, which may present an additional headwind to administrative costs in 2025. Please refer to Milliman’s white paper, Medicare Prescription Payment Plan: What do plan sponsors need to know? for further detail on expected changes to Part D cash flow for 2025.

Conclusion

The Part D benefit redesign will drive large changes to EGWPs in 2025. Based on our analysis, we estimate a net premium increase for both the coinsurance and copay designs tested. The impacts are more acute for plans with coinsurance-based designs but may also be significant for plans with copay-based designs with a high concentration of brand and specialty drug use. Member costs will decrease due to the MOOP, potentially lower than $2,000 for many members with high spend. Employers offering an EGWP should perform their own analysis using their own population characteristics and benefits to plan for the changes coming in 2025.

Caveats and Limitations

This Milliman whitepaper has been prepared for the specific purpose of estimating the 2025 financial impact of the Part D benefit redesign and drug trends on Part D Employer Group Wavier Plans. Milliman does not intend to benefit, and assumes no duty or liability to, third parties that receive this work product. Any third-party recipient of this work product that desires professional guidance should not rely upon Milliman’s

work product, but should engage qualified professionals for advice appropriate to its own specific needs. Any releases of this report to a third party should be in its entirety. Milliman does not endorse any public policy or advocacy position on matters discussed in this report.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent actual experience deviates from expected experience.

In particular, several key 2025 provisions of the IRA affecting EGWPs are still unknown, such as the direct subsidy, the Part D risk score model, the accumulation of cost-sharing to the MOOP, stakeholder reactions, and the drug manufacturers that will be eligible for the MDP phase-in. These key unknowns have a wide degree of uncertainty, and any deviations could lead to materially different results than those presented in this paper.

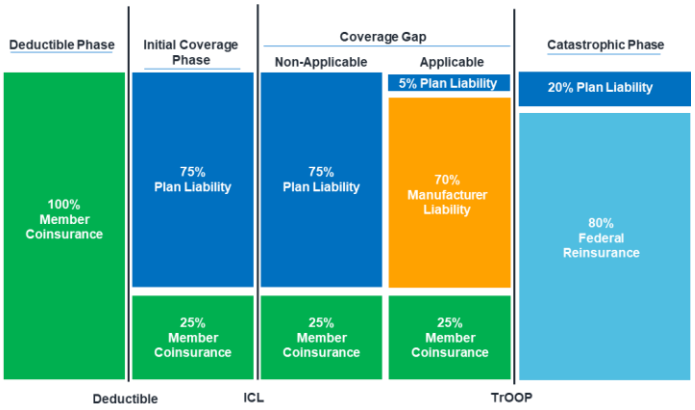
Models used in the preparation of our analysis were applied consistently with their intended uses. We reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). The models, including all input, calculations, and output, may not be appropriate for any other purpose. Where we relied on models developed by others, we have made a reasonable effort to understand the intended purpose, general operation, dependencies, and sensitivities of those models. We relied on input, review, and validation by other experts in the development of our models.

In performing the analyses, we relied on information from CMS, the Inflation Reduction Act, and other publicly available information, along with a large sample of prescription drug claims. We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

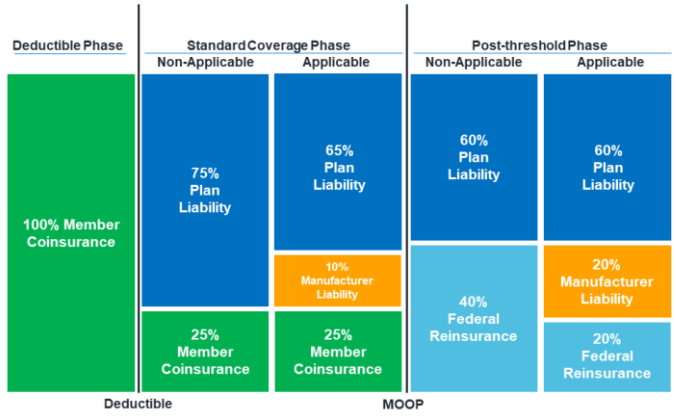
Andrea Sheldon, FSA, MAAA, is a Principal and Consulting Actuary at Milliman. She is a member of the American Academy of Actuaries and meets the Qualification Standards of the American Academy of Actuaries to render the opinion presented herein.

Appendix

APPENDIX A.1 2024 PART D DEFINED STANDARD BENEFIT (NON-LOW INCOME BENEFICIARY)



APPENDIX A.2 2025 PART D DEFINED STANDARD BENEFIT (ALL BENEFICIARIES)



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