Milliman Medicare Webinar Series

Navigating Medicare Advantage & Part D Changes for 2026

March 19, 2025

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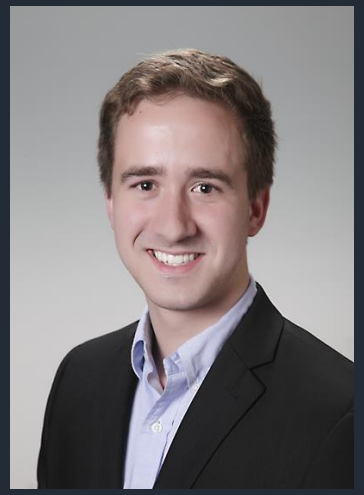
Solutions for a world at risk™

Today’s speakers

Logan Blank
Associate Actuary



Nick Gipe
Consulting Actuary

Jordan Hull
Consulting Actuary

2026 Non-PACE RxHCC Model Updates

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RxHCC Model Refresher

- Purpose is to adjust plan payment to reflect expected drug costs given plan's enrolled population
- Model segmented by community vs institutional, low-income status, aged versus disabled, new vs continuing enrollees
- Risk score is a function of demographics, diagnoses, and model segment
- Based on plan liability for prescription drug costs gross of rebates for both MA-PD and PDP members and diagnosis data from MA encounter data and FFS claims
- Same model is used for both MA-PDs and PDPs

RxHCC Model Updates

Background

Why is the model updated?

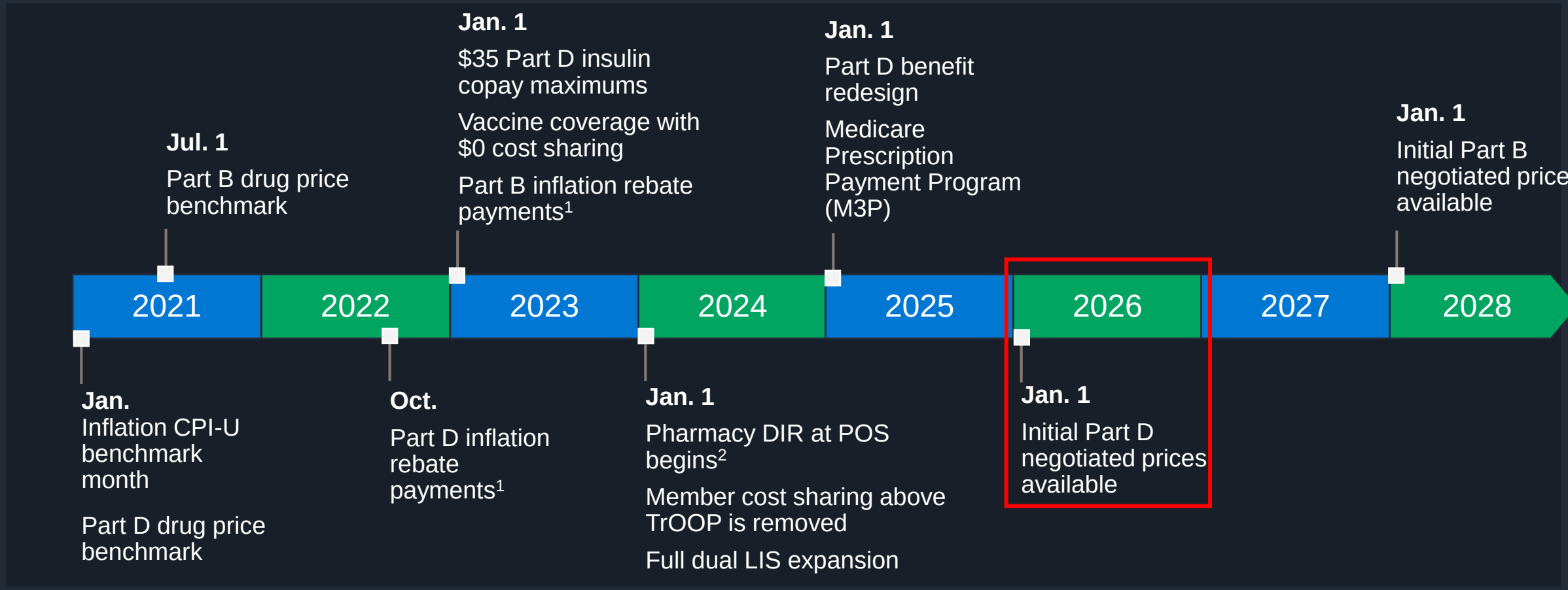
Model coefficients are updated to more accurately reflect expected plan liability for a beneficiary's drug cost relative to the average-cost beneficiary.

Annual benefit parameter changes need to be accounted for.

How is the model updated?

- Usually updated annually
- Model data recency is updated
- Payment year claims data needs to be recalibrated to reflect relevant future year defined standard benefits

Timeline of Key Provisions of the Inflation Reduction Act (IRA)

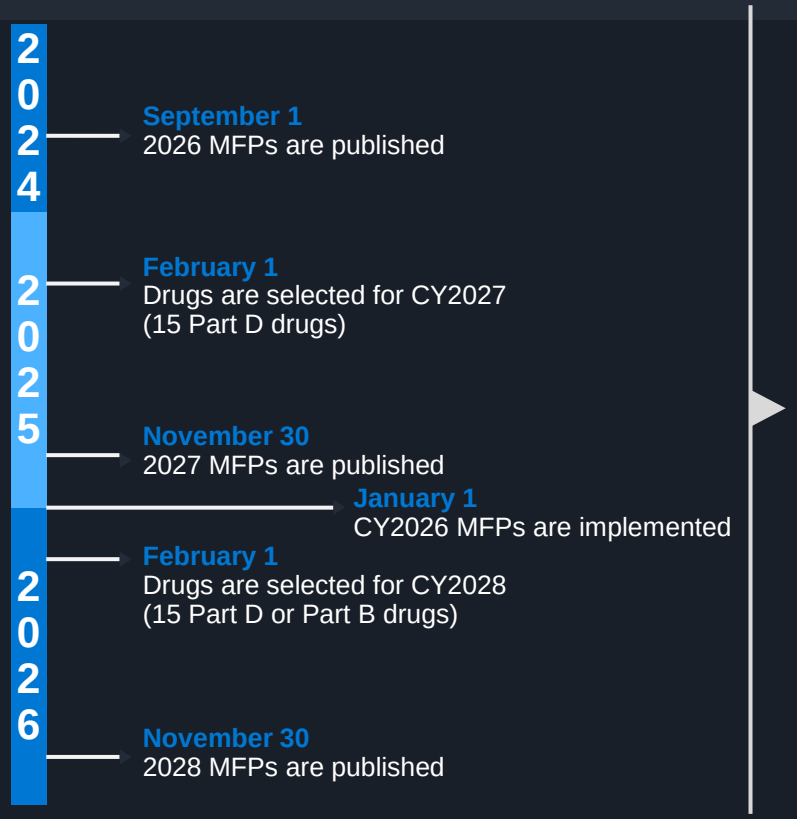


[1]Reporting for first two years of rebates may be delayed until September 30, 2025 for Part B and December 31, 2025 for Part D; rebate payments are required within 30 days of notification by the Secretary.

[2]Pharmacy DIR at POS is unrelated to the IRA, but is included on this timeline for completion.

Medicare Drug Price Negotiation Program (MDPNP)

2026 will be the first year with maximum fair prices (MFPs) in place for selected drugs



ELIGIBILITY: Single source brand drugs are eligible for selection at different points based their launch date and the type of molecule. Certain types of drugs are exempt from selection such as those indicated for orphan conditions.

SELECTION: Total Part D (and Part B in 2028+) **gross costs** are aggregated for each drug,* and the top drugs are selected for price negotiation.

PRICE SETTING: The IRA prescribes the calculation for the selected drug ceiling price, but CMS / HHS may "negotiate" the MFP lower than such ceiling. The MFP plus a dispensing fee will form the **point-of-sale cost** for the drug in Medicare.

* Costs, and corresponding MFPs, are grouped across active moieties, rather than a particular drug marketing name. The combination of active ingredients defines a "drug" for purposes of the Medicare Drug Price Negotiation Program. For example, authorized generics are grouped with the corresponding brand drug for purposes of selection and price negotiation. Source: Medicare price negotiation: A paradigm shift in Part D access and cost (milliman.com)

2026 RxHCC Model Changes

Proposed Part D risk models and summary of changes

Proposed Models

- Two (2) 2026 Part D risk models are under consideration
- Both models include revisions for the 2026 Part D benefit design and the availability of more recent data for model calibration
- However, there is one key difference:
  - Proposed RxHCC: includes the impact of negotiated Maximum Fair Prices (MFPs) for applicable drugs
  - Alternative RxHCC: excludes impact of negotiated Maximum Fair Prices (MFPs) for applicable drugs

Changes in Both Models

- The base year and payment year will be rolled over to 2022 diagnoses and 2023 claims respectively
- Adjusting annual OOP thresholds
- Increasing manufacturer discounts for specified manufacturers and specified small manufacturers

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Source: https://www. https://www.cms.gov/files/document/2026-advance-notice.pdf

2026 Proposed RxHCC Coefficient Change

Impact of negotiated Maximum Fair Prices (MFPs) for applicable drugs

- The incorporation of MFPs in the proposed 2026 RxHCC model will primarily impact conditions associated with negotiated drugs, lowering the RxHCCs associated with negotiated drugs and increasing all other RxHCCs to composite back to 1.0
- In some cases, MFPs may result in increased plan liability for negotiated drugs. This would further reduce performance of negotiated drug associated RxHCCs.
- Plans should consider how changes in the RxHCC model impact risk scores for patients with conditions treated by negotiated drugs

2026 Negotiated Drugs

Drug	Commonly Treated Conditions	MFP Discount
Januvia	Diabetes	79%
Fiasp/Novolog	Diabetes	76%
Farxiga	Diabetes; Heart failure; CKD	68%
Jardiance	Diabetes; Heart failure; CKD	66%
Entresto	Heart failure	53%
Xarelto	Blood clots; coronary or peripheral artery disease	62%
Eliquis	Blood clots	56%
Enbrel	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis	67%
Stelara	Psoriasis; Psoriatic arthritis; Crohn's; ulcerative colitis	66%
Imbruvica	Blood cancer	38%

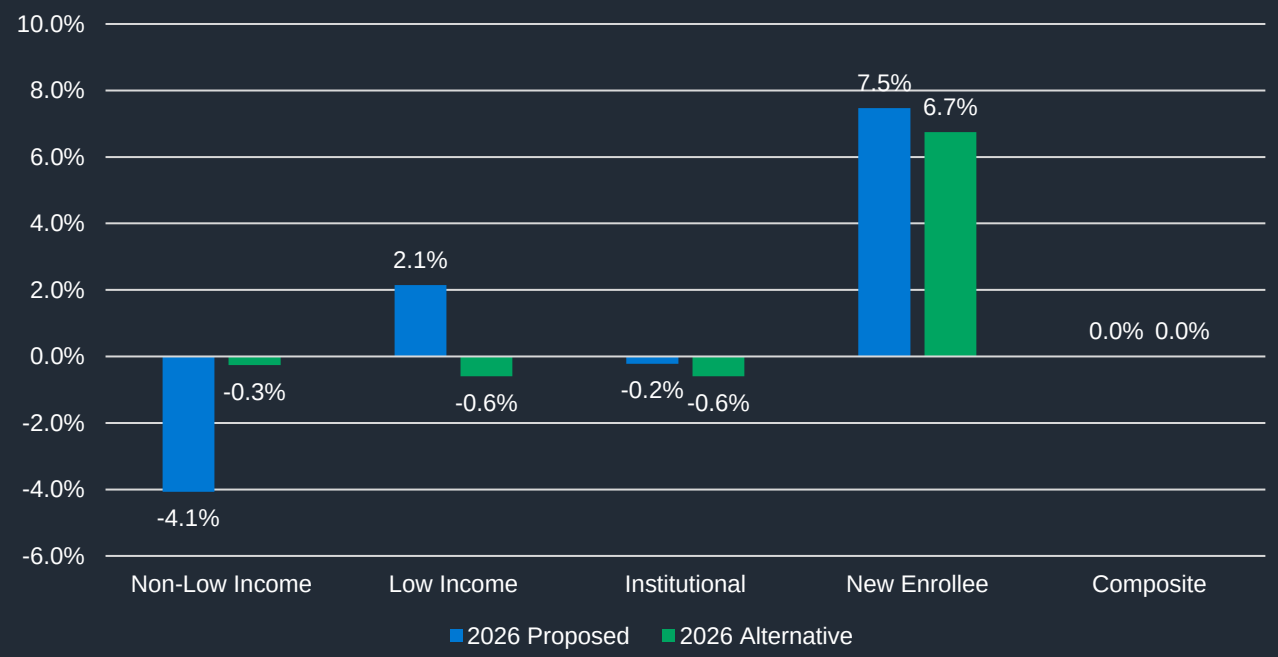
Illustrative Impact with RxHCC 188 (Heart Failure)

		Average Monthly Cost Per Patient with RxHCC 188		
	% of Patients	Before MFP	After MFP	Change
Patients treated by Entresto	50%	$628	$295	-53%
Patients not treated by Entresto	50%	$400	$400	0%
All Patients	100%	$514	$348	-32%

Sources:
https://www.cms.gov/newsroom/fact-sheets/medicare-drug-price-negotiation-program-negotiated-prices-initial-price-applicability-year-2026
https://www.milliman.com/en/insight/medicare-price-negotiation-anchored-drug-prices

2026 RxHCC Model Impact by Member Status – MA-PD

Estimate based on 2023 eligibility / 2022 diagnosis information for the entire Part D market



Key Insights

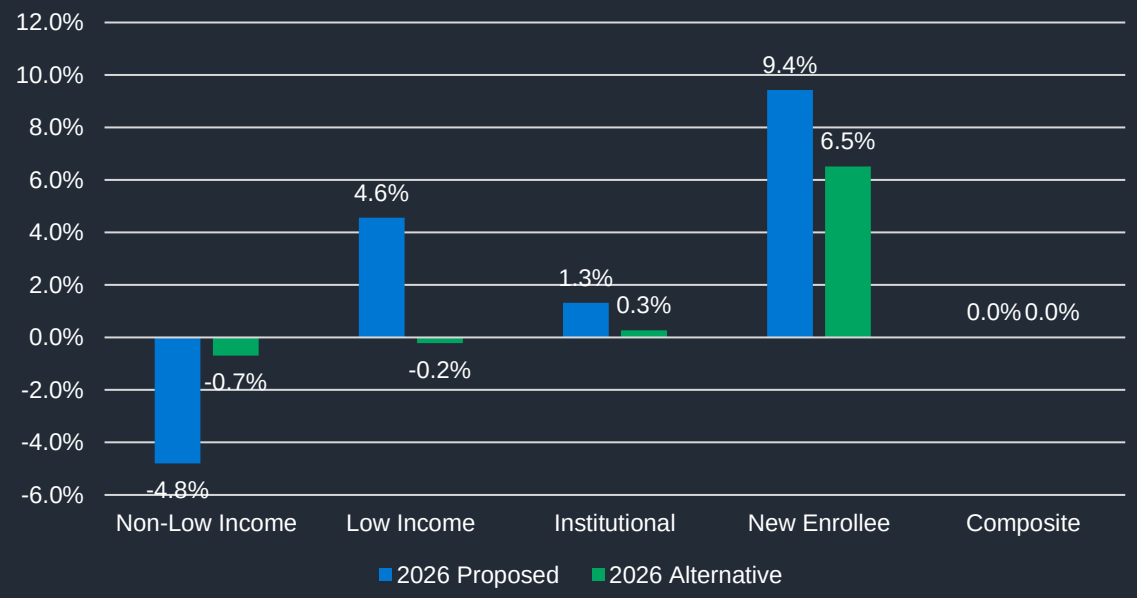
- Relative to the alternative RxHCC model, the proposed RxHCC model is:
  - Less favorable for non-low income risk scores
  - More favorable for low income, institutional, and new enrollee risk scores
- Relative to the 2025 RxHCC model, the proposed and alternative RxHCC models are:
  - Both more favorable for new enrollee risk scores
  - Both less favorable to non-low income and institutional risk scores
  - Different in their impact for low income risk scores

**Impact relative to 2025 RxHCC model*
***Excludes adjustments for applicable normalization factors*
****Adjusted to account for trend between the 2025 RxHCC model denominator year of 2022 and the 2026 RxHCC denominator year of 2023 using adjustment factors from technical notes*

Source: Milliman Medicare Advantage and Part D study based on the CMS Research Identifiable Files (RIFs)

2026 RxHCC Model Impact by Member Status – PDP

Estimate based on 2023 eligibility / 2022 diagnosis information for the entire Part D market



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- Relative to the alternative RxHCC model, the proposed RxHCC model is:
  - Less favorable for non-low income risk scores
  - More favorable for low income, institutional, and new enrollee risk scores
- Relative to the 2025 RxHCC model, the proposed and alternative RxHCC models are:
  - Both more favorable for institutional and new enrollee risk scores
  - Both less favorable for non-low income risk scores
  - Different in their impact for low income risk scores

**Impact relative to 2025 RxHCC model*
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Source: Milliman Medicare Advantage and Part D study based on the CMS Research Identifiable Files (RIFs)

2026 RxHCC Model Predictive Ratios by Decile

Continuing Enrollee Model Segments (Reflects MFP)

- **Predictive ratios measure model accuracy by comparing predicted cost to actual cost. A ratio above 1 represents overprediction and less than 1 underprediction.**
- **Impact of model changes vary by risk score percentiles**
- **2nd to 4th deciles tend to over predict costs while the 1st and remaining higher deciles under predict cost**
- **This same trend is found in the model version without MFP**
- **This suggests the model may be less favorable to higher morbidity populations**

Source: https://www.cms.gov/files/document/2026-advance-notice.pdf

Table VI-18. 2026 RxHCC Model Predictive Ratios by Deciles of Predicted Risk (sorted low to high): Continuing Enrollee Model Segments, Proposed 2022/2023 Calibration Sample (HCPCS-filtered diagnoses; Reflects MFPs)

Deciles	Community, Non-Low Income, Age≥65	Community, Non-Low Income, Age<65	Community, Low Income, Age≥65	Community, Low Income, Age<65	Institutional
Entire sample	1.000	1.000	1.000	1.000	1.000
First (lowest) decile	0.627	1.087	0.858	0.984	0.559
Second decile	1.174	1.291	1.160	1.380	0.874
Third decile	1.353	1.036	1.112	1.179	1.030
Fourth decile	1.264	1.046	1.031	1.103	1.055
Fifth decile	0.998	1.020	1.026	1.056	1.072
Sixth decile	0.965	1.003	1.027	0.976	1.060
Seventh decile	0.978	0.981	0.981	0.952	1.043
Eighth decile	0.958	0.945	0.967	0.940	1.020
Ninth decile	0.944	0.971	0.980	0.972	0.998
Tenth (highest)	1.017	1.004	0.998	0.997	0.973
Top 5%	1.020	1.005	1.000	1.008	0.978
Top 1%	1.009	0.994	1.009	1.044	0.999
Top 0.1%	0.971	1.009	1.012	1.001	1.018

Non-PACE RxHCC Model Normalization Factor Updates

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Part D Normalization Factor

Background

Intent: Maintain an average 1.0 risk score across the entire Part D program.

Interpretation: The normalization factor is a projection of the underlying risk score trend to the payment year.

Application: Divide each individual risk score in the payment year by the relevant normalization factor.

https://www.cms.gov/files/document/2026-advance-notice.pdf

Part D Normalization Factor

Pre-2025

Single normalization factor for MA-PD and PDP markets

CMS Process:

1. Compute risk scores under selected RxHCC model for 5-6 year data period, generally lagged 3-4 years
2. Calculate slope based on most recent 5 years
3. Project to payment year from calibration year using (1 + slope) ^ N

Payment Year 2023 Example:

Table II-10. RxHCC Normalization Factor Risk Scores

Year	2023 RxHCC Model	2022 RxHCC Model	2020 RxHCC Model
2016	0.962	0.958	1.015
2017	0.972	0.972	1.023
2018	0.986	0.986	1.034
2019	1.000	1.000	1.043
2020	1.009	1.009	1.049

Calibration year: 2019

Slope based on 2016-2020: ~0.0122

2023 Normalization factor: 1.050 [≈ 1.0122 ^ 4]

https://www.cms.gov/files/document/2023-advance-notice.pdf

Part D Normalization Factor

2025

Separate normalization factors for MA-PD and PDP markets

CMS Process:

1. Compute risk scores under selected RxHCC model for 7 year data period
2. Calculate MA-PD and PDP specific slopes based on most recent 5 years, excluding 2021 due to COVID
3. Project to payment year from calibration year using (1 + slope) ^ N, normalizing total market to 1.0 risk score

Implicit assumption: differences in calibration year risk scores between markets reflect underlying population and morbidity differences in markets

Table III-11. Average MA-PD and PDP Risk Scores for the Proposed RxHCC Model for non-PACE Organizations

Year	Proposed 2025 RxHCC Model non-PACE MA-PD	Proposed 2025 RxHCC Model non-PACE PDP	Proposed 2025 RxHCC Model non-PACE Overall
2016	0.919	0.974	0.952
2017	0.940	0.973	0.959
2018	0.980	0.969	0.974
2019	1.020	0.964	0.989
2020	1.047	0.955	0.998
2021	1.029	0.898	0.965
2022	1.078	0.910	1.000

Calibration year: 2022

MA-PD slope based on 2018-2022 (excl. 2021): 0.0237

PDP slope based on 2018-2022 (excl. 2021): -0.0151

2025 MA-PD factor: 1.073 [≈ 1.0237 ^ 3]

2025 PDP factor: 0.955 [≈ 0.9849 ^ 3]

https://www.cms.gov/files/document/2025-advance-notice.pdf

Part D Normalization Factor

Proposed 2026

Separate normalization factors for MA-PD and PDP markets

CMS Process:

1. **Compute risk scores under selected RxHCC model for 5 year data period**
2. **Run multiple linear regression on MA-PD and PDP individually.**
   - 2019, 2020 – pre-COVID
   - 2021-2023 – post-COVID
3. **Project to payment year using results of regression, separately normalizing each market to 1.0 risk score**

Table III-12. Average Risk Scores for the Proposed 2026 RxHCC Model (2022/2023 Calibration, Reflects MFPs)

Year	Proposed 2026 RxHCC Model (2022/2023 calibration) MA-PD	Proposed 2026 RxHCC Model (2022/2023 calibration) PDP	Proposed 2026 RxHCC Model (2022/2023 calibration) Overall
2019	1.002	0.954	0.975
2020	1.030	0.941	0.983
2021	1.011	0.883	0.948
2022	1.062	0.892	0.983
2023	1.085	0.889	1.000

Table III-13. Proposed 2026 RxHCC Model (2022/2023 Calibration, Reflects MFPs) Normalization Factor Regression Coefficients

Coefficient	Proposed 2026 RxHCC Model (2022/2023 Calibration) MA-PD	Proposed 2026 RxHCC Model (2022/2023 Calibration) PDP	Proposed 2026 RxHCC Model (2022/2023 Calibration) Overall
Intercept (β_0)	-70.0704	1.3514	-44.2578
Average Change in Risk Scores (β_1)	0.0352	-0.0002	0.0224
COVID-19 Flag (β_2)	-0.0513	-0.0590	-0.0580

https://www.cms.gov/files/document/2026-advance-notice.pdf

Part D Normalization Factor

Proposed 2026

Separate normalization factors for MA-PD and PDP markets

MA-PD 2026 Factor: 1.194

≈ 70.0704 + 0.0352 * 2026 - 0.0513

PDP 2026 Factor: 0.887

≈ 1.3514 - 0.0002 * 2026 - 0.0590

Implicit assumption: 100% of difference in risk scores between MA-PD and PDP markets is due to coding differences

Comparison to 2025:

- **2025: apply market specific 3-year trend to composite baseline risk score, normalizing composite to 1.0**
- **2026: apply market specific regression parameters, normalizing each market to 1.0**

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Part D Normalization Factor

2026 Revenue Example Impact – 1.200 Risk Score

Year	Market	RxHCC & Demographic Based Risk Score	Normalization Factor	Normalized Risk Score	Revenue (2025 NABA & NAMP)	Gap (PDP / MA-PD - 1)	Gap (PDP - MA-PD)
2025	MA-PD PDP	1.200 1.200	1.073 0.955	1.118 1.257	$163.91 $188.71	15%	$24.80
2026	MA-PD PDP	1.200 1.200	1.194 0.887	1.005 1.353	$143.57 $205.99	43%	$62.42

150% Increase

PDP plan revenue 15% higher than MA-PD for member with same conditions and demographics in 2025, **43%** higher in 2026.

Part D Normalization Factor

2026 Revenue Example Impact – 0.800 Risk Score

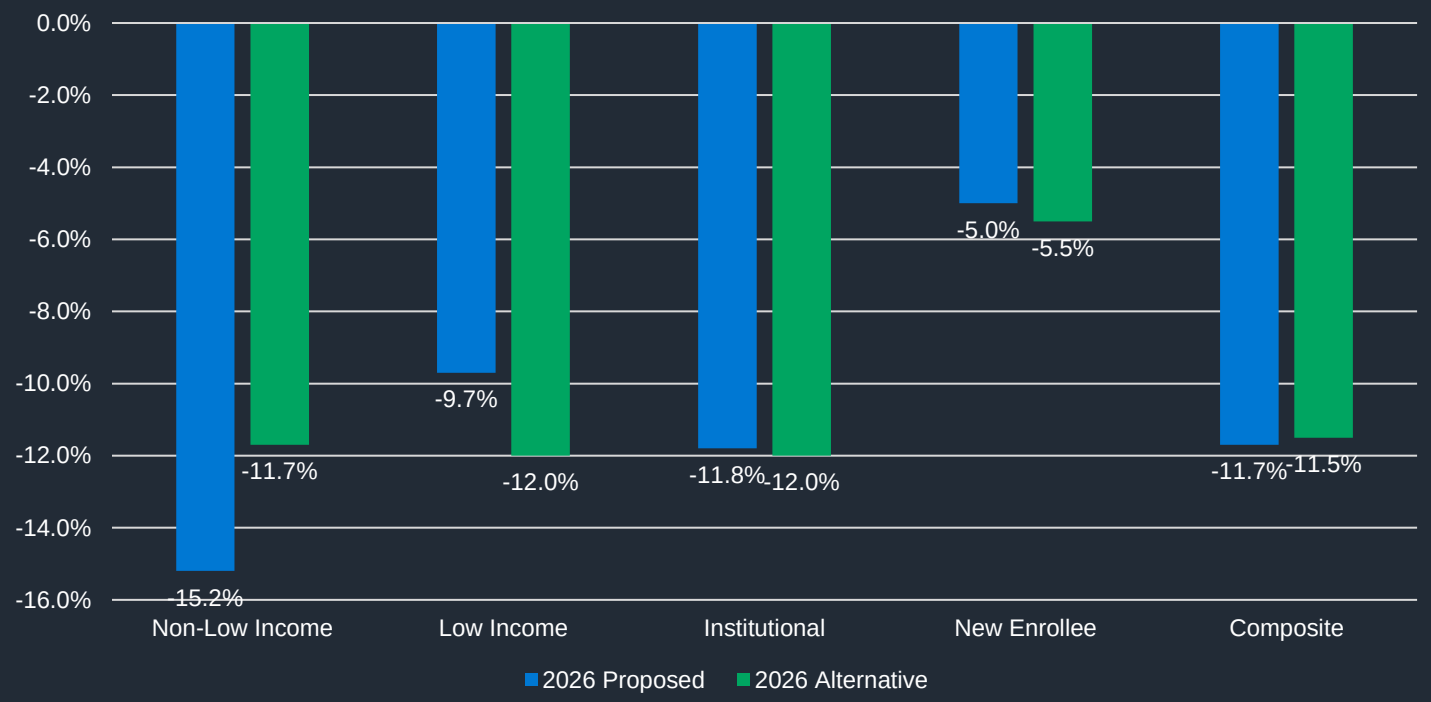
Year	Market	RxHCC & Demographic Based Risk Score	Normalization Factor	Normalized Risk Score	Revenue (2025 NABA & NAMP)	Gap (PDP / MA-PD - 1)	Gap (PDP - MA-PD)
2025	MA-PD PDP	0.800 0.800	1.073 0.955	0.746 0.838	$97.01 $113.54	17%	$26.53
2026	MA-PD PDP	0.800 0.800	1.194 0.887	0.670 0.902	$83.45 $125.07	50%	$41.61

150% Increase

PDP plan revenue 17% higher than MA-PD for member with same conditions and demographics in 2025, **50%** higher in 2026.

Part D Normalization Factor

2026 RxHCC Model Impact with Normalization by Member Status – MA-PD



Key Insights

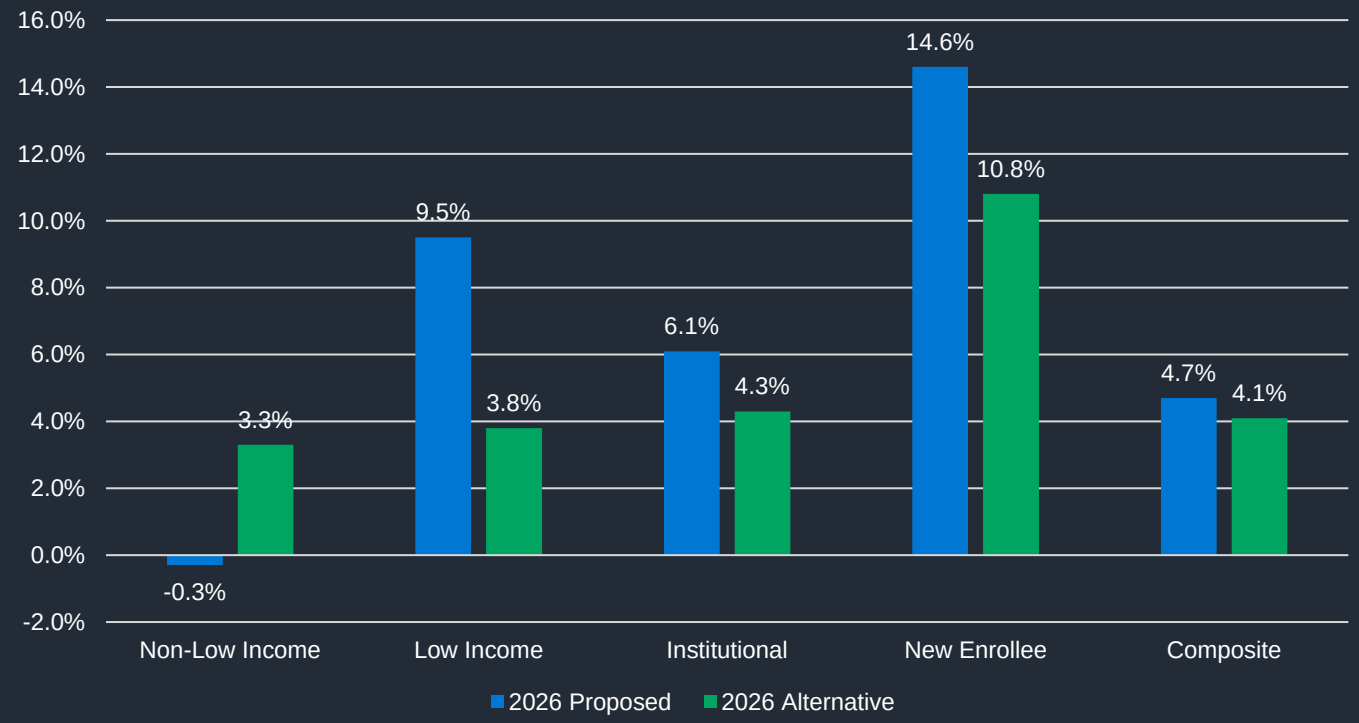
- Relative to the 2025 RxHCC model, both the proposed and alternative RxHCC models produce ***lower*** risk scores, largely driven by increased MA-PD normalization factors

**Impact relative to 2025 RxHCC model*
***Includes only adjustments for applicable normalization factors*

Source: Milliman Medicare Advantage and Part D study based on the CMS Research Identifiable Files (RIFs)

Part D Normalization Factor

2026 RxHCC Model Impact with Normalization by Member Status – PDP



**Impact relative to 2025 RxHCC model*
***Includes only adjustments for applicable normalization factors*

Key Insights

- Relative to the 2025 RxHCC model, both the proposed and alternative RxHCC models produce ***higher*** risk scores, largely driven by decreased PDP normalization factors

Source: Milliman Medicare Advantage and Part D study based on the CMS Research Identifiable Files (RIFs)

Overview of CY2026 Proposed MAPD Rule

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Background

On November 26, 2024, CMS issued a Proposed Rule that would revise the MA, Part D, Medicaid, Medicare Cost Plan Program, and PACE.

The Proposed Rule covers many topics including:

- MA and Part D benefits
- MA utilization management
- Inflation Reduction Act provisions
- Plan marketing
- Dual-eligible beneficiaries
- Star rating system
- Medical Loss Ratio reporting

For a complete copy of the Rule, please use the following link to the Federal Register, which hosts the authoritative text of the rule:

- https://www.federalregister.gov/d/2024-27939 *(page #s in this slide deck come from this link >> Public Inspection >> PDF)*

PD Benefits

Coverage of anti-obesity medications (AOMs)

CMS is proposing to reinterpret its longstanding broad exclusion of weight-loss drugs from coverage under Part D.

- Extends coverage of FDA-approved AOMs to be used for treatment of obesity
- Re-interprets AOM coverage exclusion – expanding coverage for both Medicare and Medicaid enrollees
- Enrollees would have access to AOMs for weight loss or chronic weight management
- Coverage is dependent on treatment of obesity as a disease
  - CMS is not proposing to extend coverage to individuals who are overweight but not classified as obese

Source: pages 5-6; 109-123

MA Benefits

Supplemental Benefit Debit Cards

- CMS has permitted MA plans to offer supplemental benefits through debit cards for several year.
- CMS proposing formalizing guidance on debit card usage.

Source: pages 8-9; 138-157

SSBCI

- CMS proposing to clarify which beneficiaries are eligible for these benefits.
- CMS also proposes to provide a non-exhaustive list of benefits that cannot be SSBCI
- Additionally, plans would have to demonstrate that they use an objective process (published on the plan's website) to determine SSBCI.

Source: pages 8-9; 138-157

Behavioral Health Cost Sharing

- CMS proposing changes to improve access to behavioral health care for enrollees who currently face higher cost-sharing than FFS beneficiaries
- CMS proposes plans will need to align cost-sharing for behavioral health services in MA and Cost Plans with those in FFS Medicare.
- The proposed rule includes analysis of in-network cost-sharing limits and potential impacts on service categories.

Source: pages 10-11; 197-206

PD Benefits

Formulary inclusion and placement of generics & biosimilars

- New step in formulary review process to ensure Part D sponsors provide broad access to generics, biosimilars, and other lower-cost drugs.
- This step stems from concerns that sponsors and PBMs favor more expensive branded products over cheaper alternatives.
- CMS will assess if a plan's formulary and utilization management (UM) practices are cost-effective, reasonable, appropriate, and incentivize cost reduction.

Source: pages 403-408

Pharmacy network transparency

- CMS proposing requirement for Part D sponsors to inform network pharmacies of their in-network status for specific plans by October 1 of the year prior to the plan year.
- Additionally, pharmacies can request a list of in-network pharmacies from October 1 onwards.
- This information may be provided in either hard copy or electronic form.

Source: pages 8; 124-126

MA Utilization Management

Use of artificial intelligence

- CMS proposing requirement to ensure services are delivered fairly – whether by humans or automated systems
- CMS to audit MA plans for compliance
- CMS is concerned about “algorithmic discrimination”

Source: pages 13-14; 178-185

Coverage Criteria

- CMS proposing to restrict MA plans from adopting their own medical coverage policies
- Aims to provide increase clarity around coverage criteria
- Internal coverage criteria cannot be utilized to introduce new, unrelated coverage criteria
- Plans will be required to provide data for every internal criterion that is used, including validating clinical relevance

Source: pages 9; 354-372

Plan Marketing

Provider Directory

- CMS proposing to require MA plans to expand their directories to include providers of supplemental benefits, in addition to medical providers
- The Proposed Rule would require a directory listing of each "direct furnishing entity"
- Plans would also need to identify which entities deliver in-home supplemental benefits and which are "community-based organizations“

Source: pages 14-15; 186-196

Provider Directory Formatting for Plan Finder

- MA provider directories on Plan Finder for the 2026 AEP by fall 2025, with initial network file submissions in summer 2025;
- MA organizations to confirm the accuracy of submitted provider directory data; and
- MA organizations to update provider directory data within 30 days of receiving network status changes.

Source: pages 6-7; 270-277

Supplemental Benefit Marketing

- CMS is proposing to prohibit MA plans from marketing the dollar value of a supplemental benefit or the method by which a supplemental benefit is administered
- For example, use of a debit card by the enrollee to provide the plan’s payment to the provider for the covered item or service.

Source: pages 7-9; 156-157

Review of Marketing Communications

- CMS is proposing to expand the number of materials filed for review
- Removal of the “content” requirement
- This change targets ads that lack benefit information about specific plans but still influence decisions

Source: pages 7-8; 278-296

Dual-Eligible Beneficiaries

Integrated Medicare and Medicaid ID Cards

- CMS plans to enhance Medicare and Medicaid integration by requiring plans to provide members with a single ID card for both benefits.
- Includes fully- and partially-integrated dual eligible special needs plans

Source: pages 11; 447-453

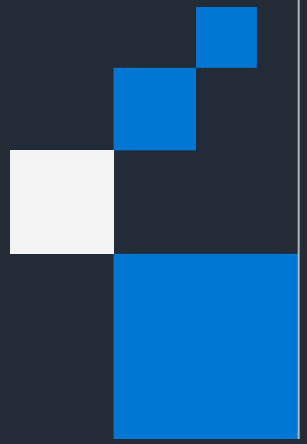
Integrated Medicare and Medicaid HRA

- CMS proposes specific standards for MA special needs plans (SNPs) to conduct initial and annual assessments of individuals' physical, psychosocial, and functional needs.
- CMS proposes to require dual eligible SNPs that are applicable integrated plans to perform a single integrated health risk assessment (HRA) for both Medicare and Medicaid enrollees.
- Additionally, CMS seeks to codify timeliness standards and enhance the organization of care planning requirements.

Source: pages 11; 453-457

Star Rating System

CY2026 Proposed Rule included multiple adjustments to 2027 - 2029 Star Rating Calculations



Initiation and Engagement of Substance Use Disorder Treatment (Part C)

- New measure for 2028 Star Ratings
  - Two distinct rates for Initiation and Engagement
  - Similar to data reporting process for QHPs on exchanges

Source: pages 414-423

Plan Makes Timely Decisions about Appeals (Part C) and Reviewing Appeals

- Updates for 2028 Star Ratings and retire legacy appeals with 2029 Star Ratings
  - Improve the timeliness of plan reviews

Source: pages 430-433

Initial Opioid Prescribing for Long Duration (Part D)

- New measure for 2028 Star Ratings
  - To address initial opioid prescriptions and reduce risk of long-term misuse and overdose

Source: pages 423-429

Breast Cancer Screening (Part C)

- Display for 2027-2028 Star Ratings, with potential inclusion in 2029 Star Ratings
  - Also proposed updating Breast Cancer Screening measure to reflect new guidance

Source: page 429

Rules Regarding Determination of Health Equity Index (HEI) Rewards

- HEI reward starting with 2027 Star Ratings
  - CMS proposes changes to how the HEI reward is determined, calculated, and set for the Star Ratings

Source: pages 436-444

Other Miscellaneous Items from the CY2026 MAPD Proposed Rule

- **M3P and Part D Coverage of Vaccines / Insulin** – CMS to formalize IRA program instructions related to M3P implementation and to codify Part D coverage of vaccines at $0 cost-sharing and insulin-products at $35 or 25%
- **M3P Grace Period** – CMS proposing simplifying the “grace period” calculation for payments, starting it from the first day of the month after an initial nonpayment notice is sent
- **M3P Point-of-Sale (POS)** – CMS not implementing a POS requirement for M3P, but seeking comment on real-time enrollment
- **Agent and Broker Requirements** – CMS proposing new topics agents must discuss with Medicare enrollees
- **MLR Reporting** – CMS proposing to more closely align with commercial and Medicaid MLR rules (and clarify treatment of various items such as M3P unsettled balances)

Source: pages 4-5; 6-7; 11-12; 40-108; 258-269; 319-353

Questions?

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Thank you

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