Segal Consulting

update

Compliance News for Multiemployer Plans

May 4, 2016

Medicare Part D Amounts Will Increase in 2017

On April 4, 2016, the Centers for Medicare & Medicaid Services (CMS) announced the Medicare Part D standard defined benefit and Retiree Drug Subsidy (RDS) amounts for 2017, which will be higher than the 2016 amounts. (The press release and announcement known as a Call Letter are available on the CMS website.)

This *Update* features charts comparing the 2017 numbers to the 2016 numbers. It also reviews changes to the Part D benefit, which were made by the Affordable Care Act, and illustrates the impact of those changes on the 2017 benefit. Coverage for Medicare beneficiaries in the Part D prescription drug "coverage gap" between the initial coverage period, which begins after the deductible is paid, and the start of catastrophic coverage (often called the "donut hole"), will continue to increase in 2017.

Standard Benefit Design Parameters

The table below compares the standard benefit design parameters for a Part D plan for 2017 to the amounts for 2016.

Health Compliance News Highlights:

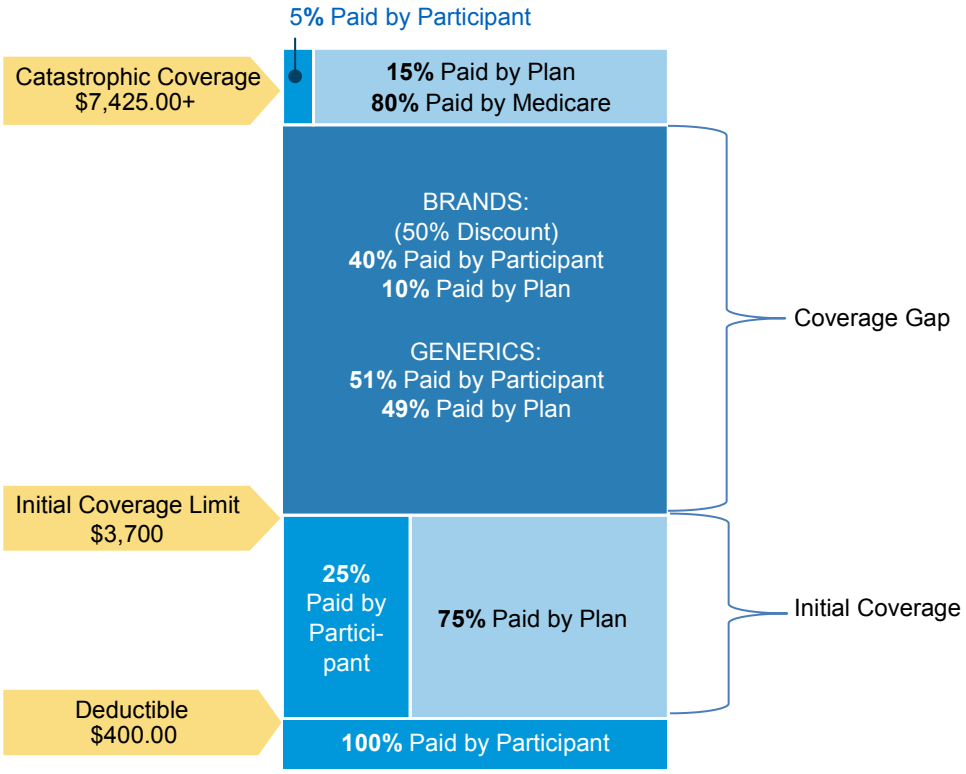
- The Part D deductible, the Retiree Drug Subsidy (RDS) cost threshold and the RDS cost limit will all increase by more than 11 percent.
- Seniors will pay less in 2017 than they do this year for brand and generic drugs in the "coverage gap."
- Medicare Advantage plan design for 2017 should be reviewed to address reductions in government funding.

Standard Benefit Design Parameters	2016	2017
Deductible	$360.00	$400.00
Initial Coverage Limit for Drug Expenses Paid by the Individual and the Part D Plan	$3,310.00	$3,700.00
Out-of-Pocket Threshold Paid by Individual	$4,850.00	$4,950.00
Total Covered Part D Drug Spending before Catastrophic Coverage*	$7,062.50	$7,425.00
Minimum Copayment in Catastrophic Coverage Portion of Benefit for Generic/Preferred Multi-Source Drugs	$2.95	$3.30
Copayment in Catastrophic Coverage Portion of Benefit for Other Drugs	$7.40	$8.25

* Cost sharing for the catastrophic portion of the benefit is set at the greater of 5 percent coinsurance or fixed copayments set by CMS, which are shown in the last two rows of this table.

The chart below shows 2017 cost sharing for individuals in a standard Medicare Part D PDP starting with the deductible at the bottom of the chart and ending with catastrophic coverage at the top of the chart.

Expected Medicare Part D Cost Sharing in 2017



Part D Changes Introduced by the Affordable Care Act

The Affordable Care Act made significant changes to the Medicare program, including for Medicare beneficiaries enrolled in a Part D Prescription Drug Plan (PDP). Based on these changes, coverage of brand and generic drugs in the coverage gap is increasing annually, as shown in the table below, with seniors paying less out of pocket each year until 2020 when the coverage gap will be eliminated.

Individual's Responsibility for Prescription Drug Costs in the Coverage Gap

Year	Brand-Name Drugs	Generic Drugs
2016	45%	58%
2017	40%	51%
2018	35%	44%
2019	30%	37%
2020	25%	25%

The 25 percent of drug costs that seniors will pay for both brand and generic drugs starting in 2020 is the same percentage of costs that seniors pay now during the initial coverage period.

Change in Frequency of CMS Payments to Part D Plans

In its April 4, 2016 announcement, CMS also modified a long-standing policy about how Part D plans that contract with plan sponsors are paid. Prior rules prohibited Part D plans (primarily insurance companies) from receiving reimbursement for catastrophic reinsurance during the year, and instead required plans to wait until final reconciliation for that reimbursement. CMS recognized that this presented a significant cash-flow problem for these plans, particularly in light of the ever-increasing costs of specialty drugs. Consequently, CMS announced that beginning in calendar year 2017 it will pay $26.50 per member per month in reinsurance payments to each Part D Calendar-Year Employer Group Waiver Plan (EGWP) as part of its monthly payment from CMS for prescription drug costs. The monthly amount will be adjusted in future years.

While this change in payment frequency does not increase the actual amount that the Part D plan will receive from CMS, it will provide a significant improvement in cash flow. That, in turn, could affect the amount that the EGWP will charge plan sponsors for Part D coverage.

Changes to Employer-Sponsored Medicare Advantage Plans

The April 4, 2016 CMS announcement also contained significant changes to Medicare Advantage (MA) plan reimbursement policy. (The press release is available on the CMS website.) MA plans that contract with employers or group health plans to provide benefits to Medicare-eligible retirees are known as MA EGWP. CMS announced that beginning in 2017, MA EGWP plans will receive less money from the federal government to provide benefits. However, initial assessments of the CMS funding changes suggest the financial impact will vary by region and most MA plans will see only modest cuts to MA plan funding.

This reduction in payments may mean that in order to provide the same level of Medicare supplemental benefits as currently offered, employers may need to pay a higher premium or retirees may face benefit cuts. The change in reimbursement, which will be phased in over a two-year period, has been widely criticized by employer groups and Congressional representatives. However, CMS argues that the amounts paid to MA EGWPs will now be standardized and known across competing plans.

Retiree Drug Subsidy (RDS) Amounts

For 2017, plan sponsors claiming the RDS will receive 28 percent of Part D prescription drug expenses between $400 and $8,250. However, CMS will apply a mandatory 2 percent payment reduction of the RDS (a change due to budget sequestration that went into effect beginning in April 2013). CMS will apply the payment reduction when calculating the final subsidy amount during reconciliation. (Information about the reduction is on the CMS website.)

The table below compares the 2017 numbers to the numbers for 2016.

RDS Amounts	2016	2017
Cost Threshold*	$360.00	$400.00
Cost Limit**	$7,400.00	$8,250.00

* The cost threshold is the minimum amount of covered Part D drug expenses that must be incurred by an individual before a plan sponsor is eligible to receive the RDS based on the individual's claims.

** The cost limit is the maximum amount of covered Part D drug expenses for which a plan sponsor may claim the RDS for each individual.

Implications for Plan Sponsors

Plan sponsors should note the 2017 amounts for planning purposes — both with respect to expected RDS income and to the design of any Medicare Part D prescription drug plan that is offered to retirees. Before deciding on benefit designs for 2017, plan sponsors may wish to analyze the benefits of contracting with an EGWP as opposed to retaining the RDS. In many instances, contracting with an EGWP will produce greater cost savings than the RDS because the reimbursement those insurers receive from CMS can be greater than what plan sponsors obtain in RDS subsidies. Plan sponsors that already have an EGWP prescription drug plan should review the plan annually to assure that its terms remain advantageous.

"Plan sponsors may wish to analyze the benefits of contracting with an EGWP."

Plan sponsors that continue to apply for the RDS should take several actions to make sure RDS income continues and that they are prepared for potential audits by the Department of Health and Human Services Office of Inspector General:

- Review RDS income and ensure it meets expectations,
- Ensure that the contract with the RDS administrator or pharmacy benefit manager accurately reflects charges for RDS and contains all language required by CMS, and
- Review internal policies and controls to ensure that deadlines are met and only appropriate personnel have access to RDS information and the RDS website. Ensure that the RDS website is accessed at least every 60 days so that access status is maintained.

Plan sponsors that contract with MA plans on behalf of their retirees may see larger than expected rate changes from these plans for 2017 due to the change in CMS funding for those plans. Plan design adjustments may be required to moderate the premium increase due to the change in funding by CMS.

"Plan sponsors that contract with MA plans…may see suggested rate changes from these plans for 2017."

[All text that follows will differ by market.]

How Segal Can Help

Segal works with trustees and their fund counsel to address issues related to Medicare Part D, including quantifying the savings associated with introducing an EGWP over the amount received from the RDS. If you decide to apply for the RDS, reach out to us for assistance with all of the recommended steps outlined above. In addition, we help plan sponsors select MA plans that offer the best fit based on their current and future objectives. With our guidance, you can make informed decisions about which vendors offer the best value and the most competitive premium rates or self-funded financial terms. If you are interested in measuring retiree access to providers and assessing which programs and vendors offer superior clinical and member services geared towards a retiree population, let us know.

Questions?

For more information about how the 2017 Medicare changes may affect your plan, please contact your Segal consultant or the Segal office nearest you.