Sibson Consulting

update

Compliance News for Plan Sponsors

June 12, 2018

2019 Medicare Part D Drug Benefit: Modest Increases from 2018

The Medicare Part D standard defined benefit will be slightly higher in 2019.[1] The Centers for Medicare & Medicaid Services (CMS) provides a Retiree Drug Subsidy (RDS) to sponsors of group health plans that provide prescription drug coverage to Medicare-eligible retirees. The RDS amounts for 2019 will be slightly higher than the 2018 amounts.

This *Update* features charts comparing the 2019 numbers to the 2018 numbers. It also reviews changes to the Part D benefit, which were made by the Affordable Care Act and the more recent Bipartisan Budget Act of 2018, and illustrates the impact of those changes on the 2019 benefit.

Health Compliance News Highlights:

- The Part D deductible, the Retiree Drug Subsidy (RDS) cost threshold and the RDS cost limit will increase by less than 2.5 percent.
- Seniors will pay less in 2019 than they do this year for brand and generic drugs in the “coverage gap.”

Standard Benefit Design Parameters

The table below compares the standard benefit design parameters for a Part D plan for 2019 to the amounts for 2018.

Part D Standard Benefit Design Parameters	2018	2019
Deductible	$405.00	$415.00
Initial Coverage Limit for Drug Expenses Paid by the Individual and the Part D Plan	$3,750.00	$3,820.00
Out-of-Pocket Threshold Paid by Individual	$5,000.00	$5,100.00
Total Covered Part D Drug Spending before Catastrophic Coverage*	$7,508.75	$7,653.75
Minimum Copayment in Catastrophic Coverage Portion of Benefit for Generic/Preferred Multi-Source Drugs**	$3.35	$3.40
Copayment in Catastrophic Coverage Portion of Benefit for Other Drugs	$8.35	$8.50

* In the catastrophic portion of the benefit, beneficiaries pay the greater of 5 percent coinsurance or fixed copayments set by CMS, which are shown in the last two rows of this table.

** Multi-source drugs are drugs that may be purchased from multiple manufacturers or distributors.

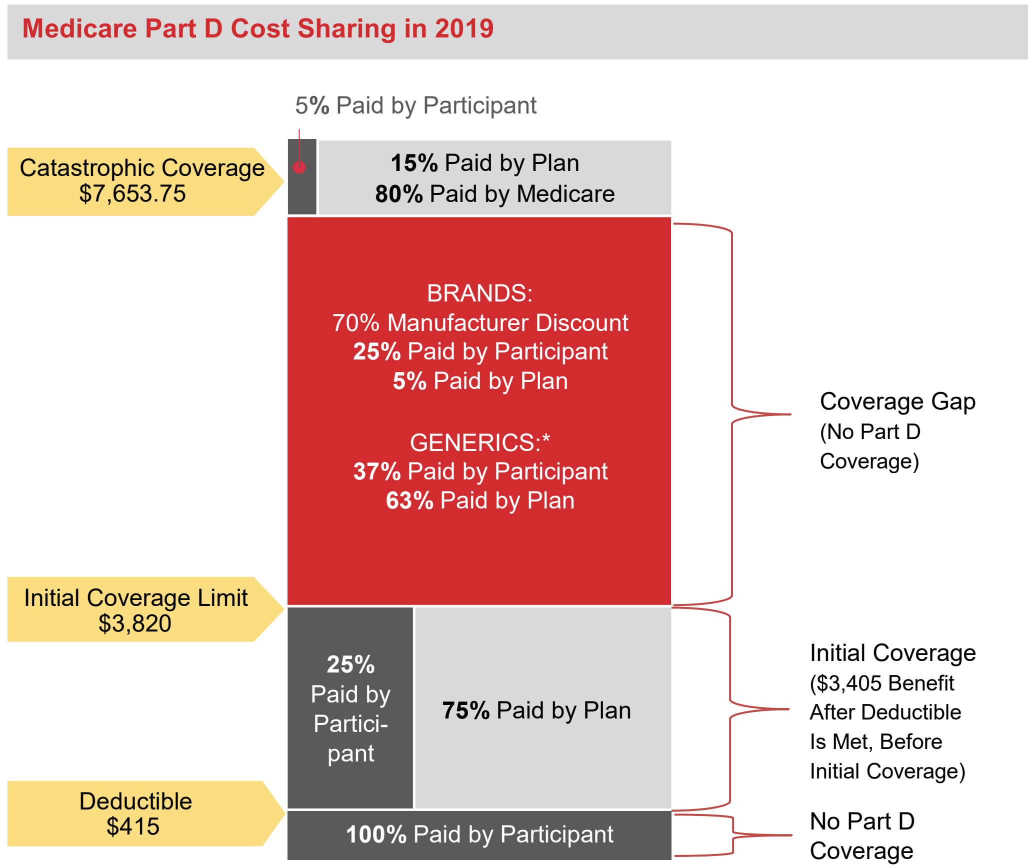
[1] An announcement known as a Call Letter is available on the CMS website.

The Bipartisan Budget Act of 2018 (the Act) increases the amount that manufacturers of brand-name drugs must pay during 2019 and beyond when Medicare beneficiaries are in the coverage gap (the period during which there is no Part D coverage until the out-of-pocket threshold is reached). Currently, manufacturers of brand-name drugs pay 50 percent of costs during the coverage gap. The Act increases that share to 70 percent starting in 2019.[2]

The Act also closes the coverage gap one year earlier, at the end of 2018 instead of the end of 2019. Starting in 2019 (instead of 2020), Medicare beneficiaries will be responsible for 25 percent of their brand drug costs during the coverage gap — the same percentage that they must pay now before they reach the coverage gap. The Act does *not* affect payment for generic drugs during the coverage gap.

The chart below shows 2019 cost sharing for individuals in a standard Medicare Part D prescription drug plan, starting with the deductible at the bottom of the chart and ending with catastrophic coverage at the top of the chart.

Medicare Part D Cost Sharing in 2019



* This breakdown is not affected by the Bipartisan Budget Act of 2018.

The Act increases Medicare Part D (and Part B) income-based premiums for individuals with adjusted gross income of at least $500,000 (or $750,000 for married couples filing jointly) starting in 2019. Before the Act, individuals at these income levels were treated the same as individuals with incomes of at least $160,000 (or $320,000 for couples). The Act will create a new income-based band. Individuals in this new income band (at least $500,000 for individuals or $750,000 for couples) will have to pay higher premiums. The base Medicare Part D premium for 2019 will be announced by August.

[2] For a summary of the benefits provisions in the Act, see Sibson Consulting's April 19, 2018 *Update*.

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. Based on these changes, coverage of brand and generic drugs in the coverage gap has been increasing annually, with seniors paying less out of pocket each year until the coverage gap is eliminated. The Affordable Care Act eliminated the coverage gap for brand and generic drugs in 2020. The Bipartisan Budget Act of 2018 eliminated it for brand-name drugs in 2019, by reducing the percentage individuals will pay in 2019 for brand-name drugs to 25 percent, as shown in the following table.

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

Year	Brand-Name Drugs	Generic Drugs*
2017	40%	51%
2018	35%	44%
2019	25%	37%
2020	25%	25%

* The Bipartisan Budget Act of 2018 did not change these percentages for generic drugs.

Retiree Drug Subsidy (RDS) Amounts

For 2019, plan sponsors claiming the RDS will receive 28 percent of Part D prescription drug expenses between $415 and $8,500. The table below compares the 2019 numbers to the numbers for 2018.

RDS Amounts	2018	2019
Cost Threshold*	$405.00	$415.00
Cost Limit**	$8,350.00	$8,500.00

* 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 2019 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 2019, plan sponsors may wish to analyze the benefits of contracting with an Employer Group Waiver Plan (EGWP)[3] as opposed to retaining the RDS. In some 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. However, the expansion of coverage for participants may increase future costs for plans. Plan sponsors that already have an EGWP prescription drug plan should review the plan annually to assure that its terms remain advantageous.

Contracting with an EGWP may produce greater cost savings than the RDS.

[3] As the name suggests, EGWPs are custom plans set up for the exclusive use of the group of participants and for which CMS has waived some Medicare requirements.

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

Review internal policies and controls to ensure that deadlines are met and only appropriate personnel have access to RDS information and the RDS website.

How Sibson Can Help

Sibson works with plan sponsors and their legal counsel to address issues related to Medicare Part D, including quantifying the savings associated with introducing an insured or self-insured 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.

The savings associated with introducing an insured or self-insured EGWP over the amount received from the RDS can be quantified.

In addition, we help plan sponsors select Medicare Advantage 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 these new rules may affect your plan, please contact your Sibson consultant or the Sibson office nearest you.

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