City of Boston

Medicare Part D
Prescription Drugs

May 10, 2016

Segal Consulting

Educational Sessions Schedule
Medicare RFP and Prescription Drug Review

PEC Meeting Date	Discussion Topic
February 9	Medicare 101
March 8	Medicare Part C (Medicare Advantage)
April 12	Prescription Drug Carve-out
May 10	**Medicare Part D (Prescription Drugs)**
June 14	Review and Planning for RFPs

1. Background

2. Medicare Rx Options

3. Appendix

Background

- The City's Medicare eligible retirees receive prescription benefits through one of the following plan types depending on the plan in which they are enrolled:

Non-Part D Plan	Part D Plan *
Not subject to Medicare rules and restrictions	Subject to Medicare rules and restrictions
• City participates in the Retiree Drug Subsidy (RDS) Program	• PDP = Prescription Drug Plan • MA-PD = Medicare Advantage with PDP

- The majority of the City's retirees (82%) receive prescription benefits through a non-Part D Plan.

* An Employer Group Waiver Plan (EGWP) is a custom PDP offered to group plans. The City does not currently have an EGWP.

Background
Current City Medicare Plans

Plan Type	Plan Name	Network	Funding Arrangement	Drug Coverage[1]	January 2016 Enrollment
Medicare Supplement (Medigap)	HPHC Medicare Enhance	No	Self-Funded	**Non-Part D** *(RDS)*	4,563
	Tufts Preferred Supplement	No	Fully Insured	**Part D** *(PDP)*	1,693
Medicare Supplement	BCBS Managed Blue for Seniors[2]	Yes	Fully Insured	**Non-Part D** *(RDS)*	424
Medicare Advantage	Tufts Medicare Preferred HMO	Yes	Fully Insured	**Part D** *(MA-PD)*	218
	BCBS Medicare HMO Blue	Yes	Fully Insured	**Part D** *(MA-PD)*	49
Medicare Carve-out	BCBS Master Medical Carve-out[3]	No	Self-Funded	**Non-Part D** *(RDS)*	3,769

Membership Distribution	
Non-Part D	82%
Part D	18%

[1] Non-Part D RDS = Rx Benefit participating in Retiree Drug Subsidy program
Part D Plans: PDP = Medicare Prescription Drug Plan, MA-PD = Medicare Advantage with Prescription Drugs
[2] BCBS Managed Blue for Seniors is a network-based product, but is not filed as a Medicare Advantage plan
[3] BCBS Master Medical Carve-out plan will be discontinued effective July 1, 2017, per PEC Agreement

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Medicare Rx Options

1) Maintain existing benefits (majority non-Part D)
   - RDS subsidy continues
   - No member impact
   - No additional savings to the City and the member (via lower premium share)

2) Transition more (or all) plans to a Part D Plan
   - Increased savings
   - Some member impact and disruption

   2a) Commercial PDP – fully insured

   2b) EGWP – fully insured or self-funded

   2c) MA-PD – fully insured integrated with Medicare Advantage

3) Options 1 or 2 with carving-out prescription drugs to a Pharmacy Benefit Manager (PBM)

Part D – Pros and Cons

The key advantage of a Part D Plan is increased savings.

Advantages	Considerations

• Greater savings (shared by compared to RDS)
  o Base Subsidy
  o Incremental Manufacturer Discount
  o Federal Reinsurance
• Lower premium rates – savings shared by the City and retirees
• Benefit design can closely mirror existing plan
• Low-Income Subsidy available to Eligible Retirees
• Eliminate need for annual Actuarial Equivalence and Creditable Coverage Attestation and plan cost reporting to CMS (required under RDS)
	• Loss of some benefit control
	  o Benefit subject to Medicare (CMS) rules and regulations
	  o Calendar year basis required
	• Some degree of member disruption, differences in
	  o Formulary list
	  o Clinical programs/rules
	  o Network
	• Administration time/resources required to transition to a Medicare Part D Plan
	• Individuals may be subject to an income related additional monthly payment (IRMAA)

Part D Plan – Transition Issues

- City administrative resources required for member education and implementation
- Must follow CMS enrollment rules
- Membership transition issues:

Issues	How to Address
➢ Formulary and pharmacy network will change ➢ Clinical rule changes may apply ➢ Some plan design changes may apply	• Perform a disruption analysis to measure differences and plan to mitigate member impact • Effective member communication is essential

- Non-calendar year implementation is possible but has additional complexities and is not recommended
  - The City can opt for a non-calendar year start date BUT would lose out a portion of the subsidy received from CMS (catastrophic reinsurance) by starting mid-year.

Part D Plan – Requirements

- To the extent the current plan of benefits vary from the Part D Plan requirements indicated the below chart, membership disruption may exist.

Eligibility	Benefit Requirements	Coverage Rules	Clinical Requirements
• CMS required enrollment information includes member HIC number • Submit enroll/ disenrollment dates as 1st and last day each month	• Must allow 90-day supply at contracted retail maintenance pharmacies • Retail days supply limit must be between 31 and 34 days • Mail order days' supply must be a maximum of 90 • Exclusive specialty pharmacy arrangements must be changed to voluntary • Unit dose medications must be covered at Long-Term Care facilities	• Several drug category restrictions must be removed: – All contraceptives – Fertility regulators – Fluoride Products – OTC Equivalents • Restrictions on non-Part D eligible medications may continue • Potential removal/modification of mandatory generic rule(s)	• Formulary and clinical rules must be approved by CMS • Prior authorization, step therapy, and quantity limit rules may apply • Medication Therapy Management (MTM) • Fraud, Waste & Abuse Program

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Effect on Plan Participants – Income Related Monthly Adjustment Amount (IRMAA)

Beneficiary Income – Individual Filing	Beneficiary Income – Joint Filing	Part D Income-related monthly adjustment amount
Less than or equal to $85,000	Less than or equal to $170,000	$0.00
Greater than $85,000 and less than $107,000	Greater than $170,000 and less than $214,000	$11.60
Greater than $107,000 and less than $160,000	Greater than $214,000 and less than $320,000	$29.90
Greater than $160,000 and less than $214,000	Greater than $320,000 and less than $428,000	$48.10
Greater than $214,000	Greater than $428,000	$66.40

https://www.medicare.gov/part-d/costs/premiums/drug-plan-premiums.html

Note: IRMAA is directly assessed and billed by Social Security Administration.

Effect on Plan Participants – Low Income Cost (LIS) Sharing Subsidies

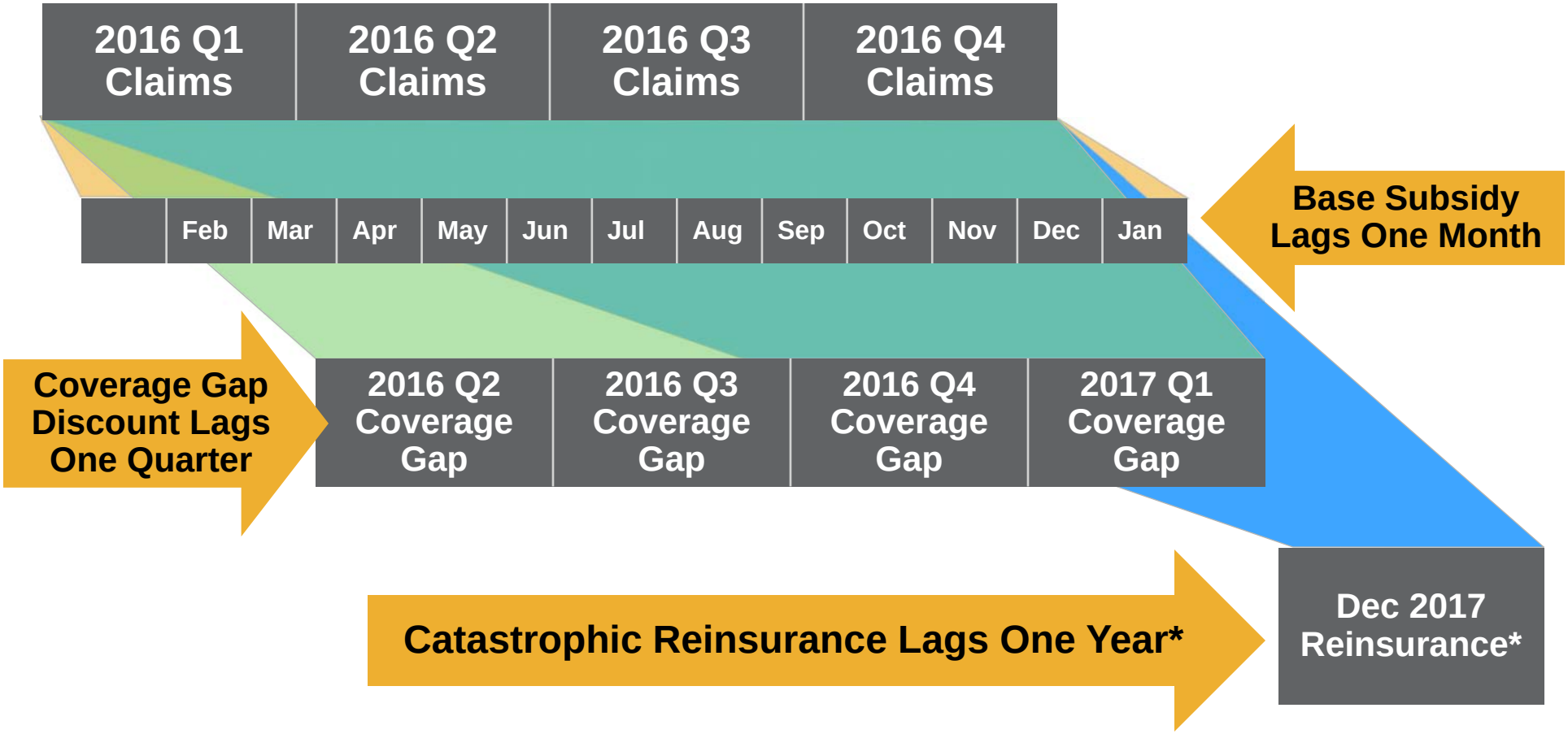
LIS Category	Income / Resource Thresholds	Co-Pays	Premium Subsidy
Non-LIS	Income >150% FPL	Standard Benefit Design	0%
Partial Benefit	Income >135% FPL Income <150% FPL Assets <$13,640	15% Copay	Sliding scale
Partial Benefit	Income <135% FPL Assets >$8,780 Assets <$13,640	15% Copay	100%
Partial Benefit	Income <135% FPL Assets <$8,780	Generic $2.60 Brand $6.50	100%
Full Benefit	Income >100% FPL Income <135% FPL	Generic $2.95 Brand $7.40	100%
Full Benefit	Income 100% FPL or below	Generic $1.20 Brand $3.60	100%

https://www.ncoa.org/economic-security/benefits/prescriptions/lis-extrahelp/

Notes:

- CMS determines eligibility and notifies the carrier or PDP
  - Co-pays – adjustments are administered at point-of-sale
  - Premium subsidy – the carrier notifies the City, the City reimburses retirees and/or waives the retiree premium share going forward as applicable
- FPL = Federal Poverty Level, asset amounts are based on filing status of “single” and are doubled for joint filing status.

Part D Plan Cashflow



Carriers for insured PDPs absorb the lag. Premiums are net of subsidies and savings are realized immediately.

* Per the CMS 2017 Call Letter, catastrophic reinsurance will be credited on a monthly basis to improve plan cash flows. An annual reconciliation or "true-up" will be performed after the plan year.