RetireeFirst

BluePeak ADVISORS

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The Evolution of Employer Retiree Plans: Group Medicare Advantage & Part D in 2025

by RetireeFirst & BluePeak Advisors

INTERACTIVE MENU

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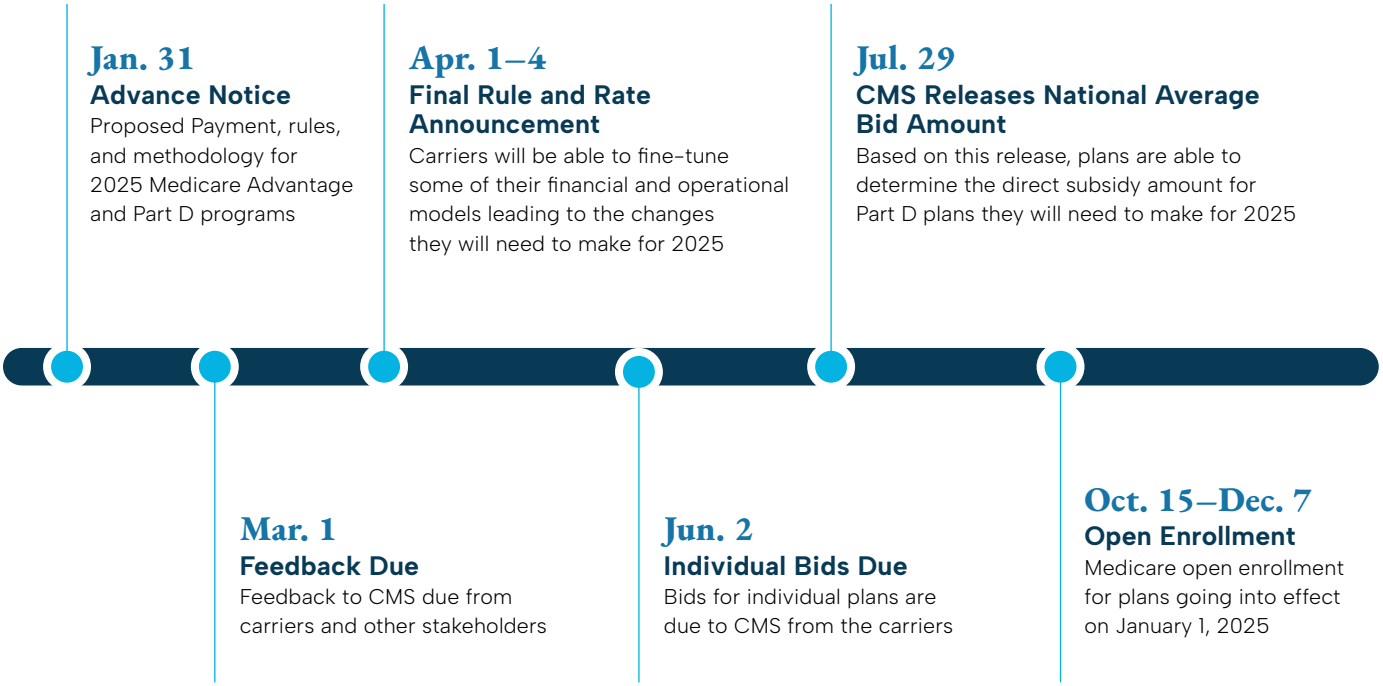
Introduction

At the start of April, the Centers for Medicare & Medicaid Services (CMS) released the 2025 Medicare Advantage and Part D Rate Announcement, Payment Updates, and Final Rule, along with the Part D Redesign Program Instructions. These releases finalized new payment methodologies and benefit structures for Medicare Advantage (MA) and Part D plans effective January 1, 2025. In parallel, the Inflation Reduction Act of 2022 (IRA) is a law that continues to impact Medicare Part D prescription drug benefits now and into the future.

Combined, the regulatory changes from the IRA and CMS will significantly shift the retiree healthcare landscape and affect a massive population of enrollees. As of May 2024, CMS reports approximately 57 million enrollees in a Medicare Advantage or Part D plan. Of which, 10.7 million—or approximately 19%—receive their Medicare Advantage or Part D plan coverage from an employer plan with 5.8 million covered by a Medicare Advantage or Medicare Advantage Prescription Drug plan and the remaining 4.9 million covered by a stand-alone Prescription Drug Plan (PDP).

Plan sponsors (employers, unions, or multiemployer plans) will want to prepare for these new dynamics and manage their impact. Education on the regulatory changes described in this white paper and their implications to the industry is paramount. The actionable information and list of recommendations within will help plan sponsors and their advisors strategize for 2025 and beyond.

EXHIBIT 1: TIMELINE & KEY DATES IN 2024



2025 Rate Announcement

At the core of the Medicare Advantage (MA) financial infrastructure, carriers are paid with risk-adjusted revenue using the Hierarchical Condition Category (HCC) coding model. It is critical for carriers to ensure their membership is appropriately and accurately risk-adjusted to represent disease burden and expected medical expenses.

In 2024, CMS introduced the three-year phase-in of an updated HCC risk adjustment model for calendar years 2024, 2025, and 2026. These risk model changes will significantly impact the 2025 payment methodology that affects the entire MA market.

Calendar year 2025 will begin the second year of the three-year phase-in of the updated 2024 CMS-HCC risk adjustment model (V28). In 2024, risk scores are calculated by blending 33% of the 2024 CMS-HCC risk adjustment model plus 67% of the 2020 CMS-HCC risk adjustment model (V24). In 202 5, this blend will shift to 33% of the 2020 model and 67% of the 2024 model. In 2026, there is an expectation of a full transition to a calculation using 100% of the new model.

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The new risk model has been recalibrated to include clinical updates using the ICD-10 classification system of codes, and is believed to have better predictive accuracy for all demographic segments of enrollees. ICD-10 is the tenth version of the international classification of disease conditions designed to capture diagnoses, symptoms, and procedures for claims processing. These changes added 29 new HCCs for a total of 115, but also removed approximately 2,000 diagnosis codes that map to these payment HCCs. The volume of changes was primarily driven by the transition from ICD-9 to ICD-10. However, some codes were removed if they had the potential to increase variance in coding activity because of broader, or more discretionary, interpretation of patient care, treatment, or management as required by ICD-10 coding guidelines. As one example of the new risk model's impact, a diabetic enrollee will have a lower overall risk score than the same diagnosis reported under the old model.

The 2025 Part D Defined Standard benefit is now more generous. As a result, employer plan sponsors who require a contribution from the retirees will see a reduction in their low-income subsidies because there is less of a standard benefit to subsidize. For example, after a $2,000 out-of-pocket (OOP) threshold, plan sponsors will no longer receive any low-income subsidies as there is no enrollee liability within the catastrophic phase. Starting in 2025, low-income enrollees will have a higher financial risk for plan sponsors. CMS can offset these plan costs by adjusting and increasing risk scores assigned to low-income enrollees, which would cause the plan to receive higher direct subsidy payments. Historically, Employer Group Waiver Plans (EGWPs) have a very low percentage

of low-income enrollees because their populations don't typically qualify for "extra help." An increase in risk adjustment for low-income enrollees may reduce risk adjustment factors for non-low-income enrollees, causing EGWPs to receive a risk adjustment in 2025, negatively impacting their direct subsidy payments.

In general, health plan insurance carriers will need to determine if the risk model changes will capture and generate sufficient payment to offset this risk and expense. Depending on the unique characteristics of a plan sponsor's membership, these risk model changes may have more or less impact. Contingent on the impact, positive or negative, plan sponsors and carriers will need to understand what options are available if expenses are not sufficiently covered by their risk revenue. The margin of impact can be addressed through alternative tools, such as formulary flexibility or utilization management changes.

The national average Effective Growth Rate for 2025 is 2.33%—an unexpected decrease from the originally published 2.44% reported in the 2025 Advance Notice.

One of the much-anticipated data points of the annual Rate Announcement is the growth rate that is used by CMS to determine the amount of additional payment to be made to Medicare Advantage plans each year. The baseline calculation looks at Medicare Fee-For-Service (FFS) payments from 2023 and estimates the impact on Medicare Advantage for 2025. The national average Effective Growth Rate for 2025 is 2.33%—an unexpected decrease from the originally published 2.44% reported in the 2025 Advance Notice. This decrease is especially surprising given the fourth quarter 2023 increase in utilization that many MA plans experienced but were not reported to be experienced similarly in FFS data.

CMS reports that the Effective Growth Rate will also continue to phase-in a technical adjustment of 52% for expenses related to indirect and direct medical education costs associated with care provided to MA enrollees with the intent to more closely align with FFS payment methodology. CMS's annual Effective Growth Rate calculation is always a contentious point of discussion. However, this year, the industry has heightened concern about increasing cost and utilization in medical trends that will be aggravated by this unanticipated reduction.

The cumulative net effect of the CMS payment changes for 2025 is creating headwinds and pressure on the financial risk tolerance of MA and Part D carriers. The impact of these many payment changes may delay the carrier's ability to provide 2025 rates. With increasing overall costs and higher individual market MA bids, the national average bid has significantly increased in 2024. This amount is a reflection of the direct subsidy that plan sponsors will need to rely on for both pricing and financial planning. The Part D direct subsidy is comprised of the national average monthly bid amount, multiplied by the projected risk score, minus the national average member premium.

On July 29th, CMS released the national average monthly bid amount at $179.45. This is a big increase from the calendar year 2024 amount of $64.28, mostly due to the significant changes in the Medicare Part D benefit design changes. This increase does not necessarily mean the same increases in premiums, but

instead shifts the money from reinsurance payments to upfront payments to the carriers. Additionally, CMS also announced the EGWP prospective reinsurance amounts as part of the same announcement for 2025 at $30.41. This is a reduction from prior years also due to the changes in risk share under the government's liabilities which previously covered 80% of allowed cost to 20% for applicable (brand) drugs and 40% for non-applicable (generic) drugs post-IRA. In the interim, this creates a valuable opportunity for employer group plan sponsors and carriers to work together to assess current supplemental benefit offerings, focusing on return on investment so that benefits deliver improved outcomes both by health and expense.

While the payment changes are not unexpected, the implications do give cause for carriers and employer group plan sponsors to evaluate their revenue understanding and strategies to assess the financial health of their plan offerings. Particularly, in the area of risk adjustment, a focused discussion on the specific implications of these model changes should be considered against the unique membership mix and demographics of the enrollees in the plans. Each EGWP may have a different financial impact as a result of these model changes and their unique attributes. Carriers and employer plan sponsors should work together to determine what strategies they can employ to mitigate potential losses and ensure ICD-10 coding practices align with the new model HCCs. Examples may include offering incentives for annual wellness visits to increase ICD-10 coding accuracy and ensure the full disease burden of the enrollee is documented properly and risk-adjusted by CMS. These incentives can pay dividends with both revenue, enrollee satisfaction, and even improved quality scores.

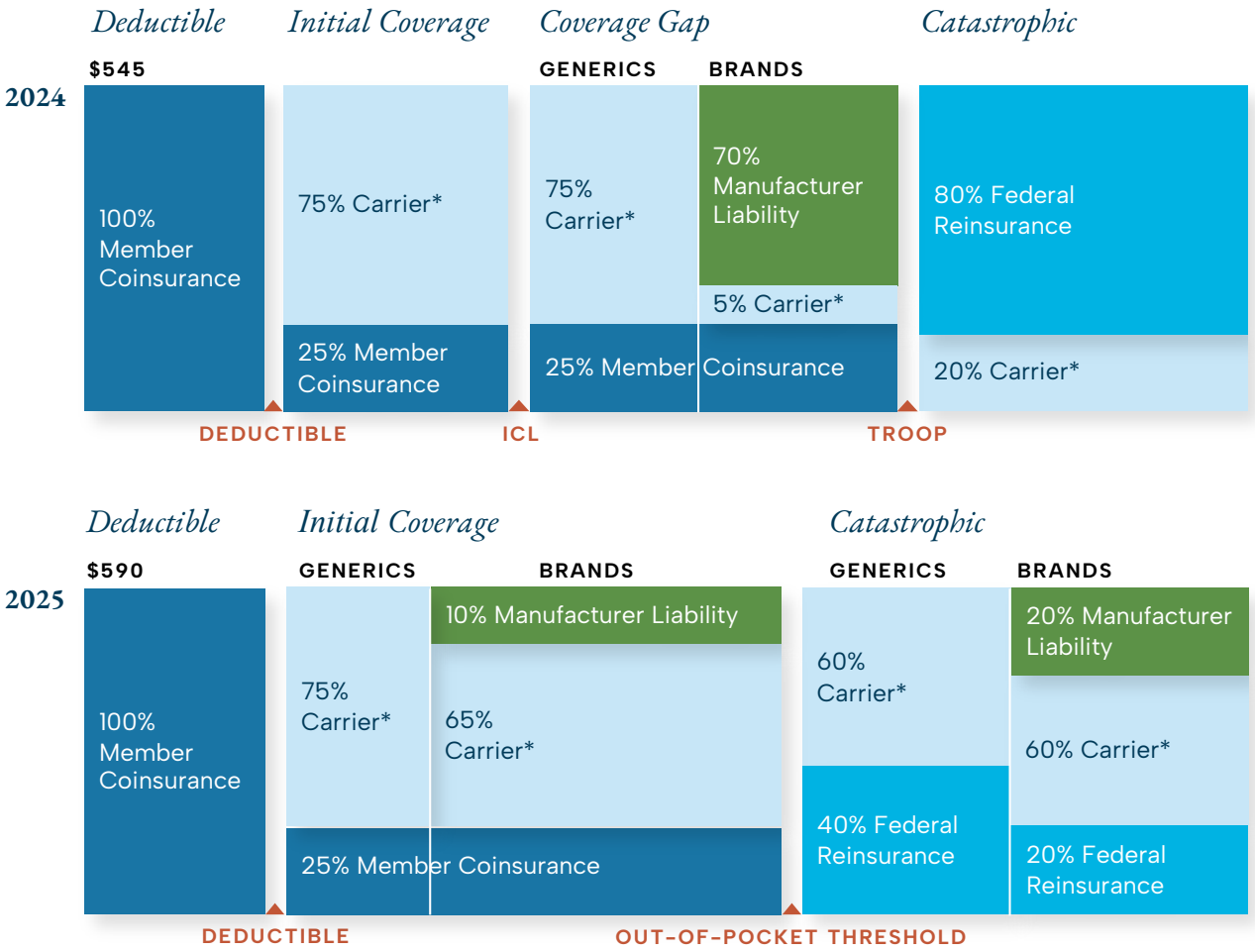
Each EGWP may also have regional variances based on its membership mix, service areas, and the cumulative impact of reduced benchmarks, growth rates, and the impacts of risk adjustment models. Carriers are likely to increase scrutiny against plan design and benefits as part of their 2025 bid filings in order to continue to maintain attractive supplemental benefits—such as gym membership and comprehensive dental coverage—that MA enrollees have come to rely on. Carriers can work with employer group plan sponsors to assess and share utilization data, ROI, and enrollee satisfaction scores (if available) to drive engagement and investment in high-value supplemental benefits. This exercise ensures that the most valuable benefits and services remain available for enrollees while sustaining the overall financial health of the plan and its enrollees. Carriers may already have certain supplemental benefits and cost-share recommendations as a result of this early-year individual MA plan bid work.

The periodic exercise of pressure-checking benefits and costs shares can be beneficial as it allows for adjustments to drive more cost-effective medical utilization and relieve increasing medical costs. An example could be using carrier-specific Centers of Excellence to enhance benefits and reduce copays. Adjusting benefits and cost shares will need to be a collaborative effort with the carrier to ensure regulatory requirements are met. Enrollees may also need to be included in the discussion to reduce impact.

Medicare Part D Redesign/Inflation Reduction Act (IRA)

While not part of the 2025 Medicare Advantage and Part D Rate Notice, CMS concurrently released the final Contract Year 2025 Part D Redesign Program Instructions. In 2025, the Defined Standard benefit will have a $2,000 OOP limit, as codified by the IRA. Additionally, CMS is applying supplemental benefits and other health insurance benefits towards the enrollee's OOP accumulation. As a result, group plan enrollees will reach the OOP limit at the same—or an accelerated—rate as an enrollee who has a Defined Standard benefit.

EXHIBIT 2: 2025 IRA CONTRIBUTION CHANGES TO PART D



If an employer group plan sponsor offers no deductible on their Part D coverage, the $590 that is otherwise charged in the Defined Standard benefit will be credited against the $2,000 OOP amount because it is being considered a supplemental benefit under Part D. Employer group plan sponsors may look to adjust their group copays to be less generous between the deductible and the OOP threshold to mitigate the additional amounts the plans would pay pharmacies next year. Employer group plan sponsors may consider offering less generous benefits prior to the OOP limit to mitigate the increase in premiums.

The IRA has made many changes to the payment and structure of Medicare Part D. Historically, the plan sponsor liability in the catastrophic phase was 15%, after the 5% enrollee payment and 80% CMS reimbursement. In 2024, the plan sponsor liability in the catastrophic phase increased to 20% due to the IRA

provision which eliminated the 5% enrollee liability. In 2025, the health plan liability in the catastrophic phase will significantly increase to 60% with CMS and pharma paying the remaining 40%. If the pharmaceutical manufacturer is eligible for a manufacturer phase-in discount, the plan liability could increase to 79% on applicable products.

With a reduction in CMS's reinsurance payments, plan sponsor premiums and bid amounts are expected to increase in 2025. The direct subsidy payment is based on the average bid and base enrollee premium which would cause plan sponsors to receive an increase in direct subsidy payments in 2025. Upon release of the national average monthly bid amounts, CMS also announced a voluntary Part D premium stabilization demonstration for stand-alone prescription drug plans. All PDP plans are eligible, including those that offer EGWPs. If a carrier participates, EGWP stand-alone PDP's will specifically benefit from the $15 uniform reduction to the base beneficiary premium that will be offset by a corresponding further increase to the PDP's direct subsidy payment. The demonstration may run up to 3 times and includes a number of eligibility requirements for carriers to consider for participation. The intent of the overall program is to stabilize the Part D premiums caused by the IRA benefit changes. Additionally, EGWPs typically have lower risk scores as they don't have a high volume of low-income enrollees. The lower risk scores will lower the increase in the direct subsidy payment. Plan sponsors may evaluate their formularies against competitors, and other data points, to mitigate any adverse selection in the market. They may also increase plan management using prior authorization, or other utilization management edits, to have more control over these costs. Employer group plan sponsors should be aware of these changes, which could cause disruption in their plans.

In 2025, the new Manufacturer Discount Program will begin.

In 2025, the new Manufacturer Discount Program will begin. Currently in 2024, the Coverage Gap Discount Program (CGDP) applies a 70% discount on brand drugs, in the coverage gap phase for non-low-income enrollees. The coverage gap applies to any drug costs above $5,030 and continues until the enrollee reaches the catastrophic phase. In 2025, the discount will begin after the enrollee has a TrOOP (True out-of-pocket) amount of $590 and will continue for the remainder of the plan year. The discount will extend a 10% discount on brand drugs to all enrollees until the $2,000 OOP limit, and 20% afterwards. However, if the pharmaceutical manufacturer qualifies for a phase-in discount, that discount would be reduced to 1% and would vary for low-income and non-low-income enrollees.

Phase-in discounts would apply to Specified Manufacturers and Specified Small Manufacturers, which CMS will identify based on multiple criteria. To qualify as a Specified Manufacturer, the manufacturer would need to have had a Coverage Gap Discount Program agreement in 2021, as well as having all drugs account for less than 1% of the total expenditure under Part B/D. Specific Small Manufacturers must meet the same criteria but must also have one drug that accounts for at least 80% of their total expenditures

within the program in 2021. Specified Manufacturers will have a phase-in discount on low-income enrollees. Specified Small Manufacturers will have a phase-in discount for all enrollees. A reduction in pharmaceutical manufacturer payments would increase the plan costs that may lead to an increase in enrollee premiums.

Medicare Prescription Payment Plan (M3P)

The Medicare Prescription Payment Plan (M3P) is another requirement of the IRA that stipulates all Medicare Advantage and Part D plans, including all EGWPs, allow enrollees to pay all OOP expenses in monthly payments, over 1 year, to the plan. By enrolling in the payment plan, retirees can break down high-cost shares into smaller monthly amounts paid to the health plan carrier instead of directly to the pharmacy at point of sale.

While the impacts of M3P are beneficial for enrollees overall in addressing the affordability of prescription drugs, it creates additional risk to the health plan carriers—in the case of participants not paying back their OOP amounts—and additional expense to administer the program and/or outsource to another entity. Plans are already building in bad debt assumptions as part of rate-setting and bid strategies. They will need to account for the additional administrative expense of implementing a complex program with plan sponsors collecting copays. This could be considered in the basis for premiums to further increase. Carriers may need to factor in the cost of supporting the M3P program within their premium calculation.

Retiree Drug Subsidy (RDS) & EGWPs

The Retiree Drug Subsidy (RDS) is a government-funded program established in 2003 to assist employers and unions in providing prescription drug coverage to their retired employees. CMS reimburses RDS plan sponsors the equivalent of 28% of all allowable enrollee drug expenses that fall between the federally designated cost threshold amount ($590 in 2025) and the cost limit ($12,150 in 2025), after the removal of actual cost adjustments. RDS plans must provide prescription drug coverage that equals or exceeds the actuarial value of the Defined Standard benefit, including the enrollee's OOP costs; a qualification known as creditable coverage.

The IRA will increase the actuarial value of the Defined Standard benefit by 5% to 14% (additive increase of 3% to 8%) from 2024 to 2025. With a richer reference plan, it will be more challenging for plans to qualify as creditable in 2025 compared to prior years, without moving to a more costly benefit design. RDS plan sponsors should work with an actuary to evaluate if their current plan will be credible and what the subsidy projections with RDS will be. Plan sponsors may need to enhance their commercial plan benefits to meet new qualification criteria, or consider alternatives to RDS, such as an EGWP.

Self-funded and fully insured Medicare Part D EGWPs provide creditable coverage and will continue to be financially favorable to RDS plans in 2025, while maintaining benefits. Transitioning from an RDS to an EGWP will offer financial gains due to subsidies. The monthly direct subsidy that premium plans will receive from CMS is expected to increase significantly, outmatching any changes to the projected RDS plan federal subsidy. EGWPs are also eligible for subsidies under the federal reinsurance program and the Manufacturer Discount Program. The discount program will apply earlier within the benefit during the initial coverage phase and will continue for the duration of the plan year, further buying down the plan's liability. Commercial plans, like those that apply for the RDS, are ineligible for these subsidies.

Overall, EGWP plans can offer additional financial support while providing more generous benefits and protections to their Medicare population. EGWP plan sponsors should be mindful of increased risk in the 2025 catastrophic phase where there will be lower federal reinsurance and a $2,000 OOP threshold. EGWP plan sponsors may look to reduce exposure through measures like improved pharmacy benefit manager (PBM) contracting.

2025 MA/Part D Final Rule Updates

Pivoting from the payment methodology changes and Part D redesign post-IRA, a number of other notable updates have been made through the 2025 MA and Part D Final Rule issued on April 4, 2024. As supported in their framework for health equity, CMS recognized that certain populations—low-income, dually eligible for Medicaid and Medicare, or those with disabilities—face unique challenges and barriers to accessing quality healthcare. Because of this, there are specific CMS initiatives in the Final Rule that will require plans to rethink how they currently function.

Effective January 1, 2025, all carriers who offer MA plans will be required to have a health equity expert on their Utilization Management Committee. These committees are responsible for overseeing the carriers' prior authorization and medical decision-making. Carriers will be required to conduct an annual health equity analysis of utilization management policies and procedures by July 1, 2025 and publicly post the results. The intent of the analysis is to identify prior authorization requirements that may delay or deny access to certain services and cause disparities among enrollees.

Carriers will need to evaluate their technology infrastructure to ensure that the high-risk population (e.g. socially isolated, food insecure, financially unstable, lacking transportation, socially isolated, etc.) can be identified, applicable Social Determinants of Health (SDOH) prior authorization measures are being tracked, and reporting capabilities are in place. Carriers can use the Mapping Medicare Disparities (MMD) Tool and the membership's SDOH data to identify underserved populations. Quick identification, rapid implementations to remedy disparities, along with continuous evaluations of outcomes, will be essential for carriers to meet the new health equity requirements set forth in 2025.

Tracking health equity data at this level may be new to many carriers and therefore may require outsourcing health equity and CMS data analytical expertise. It is essential that carriers begin to evaluate their current infrastructure, policies, and procedures to meet CMS regulatory requirements that are coming down the pike in the near future.

These efforts become even more important to carriers due to the finalization of the Health Equity Index (HEI) Reward Factor for the 2027 Star Rating that incentivizes improved care for enrollees with social risk factors. This rating will be based on data from 2024 and 2025 so carriers have already begun assessing the high-risk populations they serve (dually eligible, disabled, low-income defined as a "social risk factor" (SRF) population) for social disparity gaps. Carriers will only be eligible to earn the HEI reward if they have enough SRF members who qualify against the median of the national average SRF population. If plans do not have sufficient SRF membership, they will be ineligible to earn the HEI, regardless of their performance on individual measures.

Plans should keep in mind that care management and pharmacy benefit management interventions can often provide quick solutions to improve health outcomes. If the carrier has Health Risk Assessment (HRA) SDOH data at their fingertips, best practice would be to prioritize and identify this information today. As noted previously, employer group plan membership does not usually have many low-income subsidy enrollees, so carriers may focus on closing these gaps for enrollees with a disability status. Carriers may employ community-based resources like Meals on Wheels, Papa Pals, etc. HRA results should be auto-populated into Care Plans along with actionable goals to streamline Care Coordination efforts. Plans should evaluate their referral platform to ensure that applicable disciplines are tasked to complete SDOH needs. Healthcare Effectiveness Data and Information Set (HEDIS) changes have also looked to address this with the Social Need Screening and Intervention (SNS-E) measure looking to see the impacts of screening for SDOH needs and outcomes of interventions for positive screens. HEDIS data is a material driver of a carrier's star rating. Employer group enrollees may experience more personalized outreach strategies to screen and address any potential SDOH needs identified. This may improve overall satisfaction with the carrier and the employer group plan sponsor's coverage. The amount of data health plans will be expected to collect can also inform a carrier's supplemental benefit training to ensure they are well-versed in available plan benefits and how to coordinate SDOH care needs for enrollees.

Plans should keep in mind that care management and pharmacy benefit management interventions can often provide quick solutions to improve health outcomes.

Behavioral Health

While related but different to the framework for health equity, CMS has recognized a critical need for behavioral healthcare specifically to Medicare and Medicaid enrollees. The Final Rule adds a new facility-specialty type, "Outpatient Behavioral Health" (OBH) to the list of facility-specialty types evaluated as part of an MA plan's network adequacy review beginning January 1, 2025. An OBH may include any of the following:

- Marriage and family therapists
- Mental health counselors
- Opioid treatment programs
- Community mental health centers
- Any of the following providers that regularly furnishes behavioral health counseling, or therapy services, including psychotherapy or prescription of medication for substance abuse disorders:
  - Physician assistants, nurse practitioners, and clinical nurse specialists
  - Addiction medicine physicians
  - Outpatient mental health and substance use treatment facilities

Through the implementation, a concern for "ghost networks" of providers who do not regularly furnish behavioral health services, or lack the necessary expertise to address the BH needs of the enrollees, required CMS to clarify how this network type would be assessed. To be considered an OBH provider, Physician Assistants, Nurse Practitioners, and Certified Nurse Specialists must have furnished certain psychotherapy or medication prescription services to at least 20 patients within a 12-month period. Carriers will be annually required to independently verify that these providers meet this standard using "reliable information" such as claims data or electronic health records. Alternatively, if there is insufficient evidence of past practice (e.g., where the provider is new to independent practice), carriers must have a "reasonable and supportable" basis for concluding the standard will be met in the next 12 months.

CMS also noted that carriers are prohibited from submitting a single provider for purposes of meeting more than one provider network requirement (e.g., psychiatry and OBH facility). However, carriers may submit providers that hold multiple credentials for purposes of network adequacy evaluation under each applicable category.

The Final Rule includes base time and distance requirements for the OBH facility-specialty type, ranging from 20 minutes/10 miles for large metro areas to 110 minutes/100 miles for counties with extreme access considerations. Beginning on January 1, 2025, carriers will be able to receive a 10-percentage point credit toward the percentage of enrollees that reside within such time and distance standards if the plan includes a BH telehealth provider within its network. Carriers will be required to notify enrollees when their PCP or BH provider is dropped from their network and emergent BH services must not be subject to prior authorization. Codified standards for appointment wait times for PCP and BH services are also part of the Final Rule.

Health equity and behavioral health Final Rule implications are very much intertwined. Carriers offering MA plans will need to establish care coordination programs that include coordination of community, social, and BH services to help advance whole-person care.

Mid-Year Notification of Unused Supplemental Benefits

Beginning in January 2026, the Final Rule will also require carriers offering MA plans to provide a personalized report to each enrollee, between June 30th and July 31st of the given year, highlighting the supplemental benefits they have not yet utilized for the year. CMS observed that many of these unused supplemental benefits address food insecurity, access to public transportation, and other unmet social determinants of health needs. CMS is hopeful that notification will bridge the gap. Notification must include the scope of the benefit, any cost-sharing, how to access the benefit, network specificities, and a customer service number for assistance. The implications of these notification requirements may result in changes to supplemental benefit payment methodologies and utilization assumptions by plan sponsors. As plans build out this notification process, it may be advantageous to consider sending out additional notifications, perhaps quarterly, to give the enrollee more time during the year to use the benefit. Enrollees often have so many helpful benefits available through their MA coverage, it can be difficult to remember and recognize all that they have available to them.

Medication Therapy Management Program Updates

All carriers offering any type of Part D plan must have a Medication Therapy Management (MTM) program designed to assure, with respect to targeted enrollees, that covered Part D drugs are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions.

In the 2025 Final Rule, CMS made improvements to the MTM program to ensure more consistent, equitable, and expanded access to MTM services for enrollees with chronic conditions to help manage their medications. These improvements will have a substantial impact for carriers by increasing enrollment in the MTM program and thereby increasing staffing needs and administration costs. By some estimates, these costs will come with the added value of potentially increasing MTM program enrollment for some plans up to 60 percent of their Medicare Part D population. Currently, carriers see an average of only 7% participation in the program against their eligible membership.

Decreased Annual Cost Threshold

For 2025, the annual cost threshold is $1,623 compared to $5,330 in 2024. This change alone will dramatically increase the number of MTM-eligible enrollees, number of potential Comprehensive Medication Reviews (CMRs), and Targeted Medication Reviews (TMRs). Starting with and moving out from 2025, CMS will calculate the dollar amount of the annual cost threshold based on the average daily cost of eight generic drugs using Prescription Drug Event (PDE) data.

Part D Maintenance Drugs Inclusion

Carriers will be required to include all Part D maintenance drugs in their targeting criteria without limiting those included in MTM targeting criteria to specific Part D maintenance drugs or drug classes. Carriers must rely on information in a widely accepted, commercially or publicly available drug information database. This change increases the number of eligible Part D drugs for calculating the annual cost threshold for each enrollee, further increasing the volume of MTM-eligible enrollees.

Core Chronic Diseases Inclusion

Carriers must include all core chronic diseases in their targeting criteria for identifying enrollees who have multiple chronic diseases. HIV/AIDS was added for a total of ten core chronic diseases:

- Alzheimer's disease
- Bone disease-arthritis (including osteoporosis, osteoarthritis, and rheumatoid arthritis)
- Chronic congestive heart failure (CHF)
- Diabetes
- Dyslipidemia
- End-stage renal disease (ESRD)
- Human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS)
- Hypertension
- Mental health (including depression, schizophrenia, bipolar disorder, and other chronic/disabling mental health conditions)
- Respiratory disease (including asthma, chronic obstructive pulmonary disease (COPD), and other chronic lung disorders)

This change doubles the minimum number of five core chronic diseases in 2024 to ten in 2025. This will have an additive effect—combined with the decreased annual cost threshold and inclusion of all Part D maintenance medications—to increase the number of MTM-eligible enrollees.

Participation Requirement in Comprehensive Medication Reviews

Comprehensive Medication Reviews (CMRs) cannot be performed with a caregiver but without the enrollee unless the enrollee is 1) unable to accept the offer to participate due to cognitive impairment, and 2) the CMR includes an interactive consultation that is conducted in person or via synchronous telehealth. CMS provided additional commentary that the definition of "unable to participate" does not preclude enrollees from inviting other individuals to join them for the CMR. MTM enrollees may continue to include caregiver or family member participation during the MTM process. CMS codified the definition of "unable to participate," which is different from an enrollee requesting a CMR to be completed with another individual. CMS expects an enrollee being "unable to participate" due to cognitive impairment to be an uncommon designation.

Due to the substantial changes to the MTM program list above, CMS is moving the Star Rating MTM Program Completion Rate for CMR measure to the display page for at least two years before adding it back to the Star Ratings. Therefore, the 2025 and 2026 plan year data will be reported as a display measure for the 2027 and 2028 Star Ratings.

With these significant changes to the MTM Program starting January 1, 2025, plan sponsors should prepare for increased administrative costs in supporting increased MTM Program enrollment with additional staff and more efficient and streamlined systems and processes.

CMS finalized regulations permitting Part D plan sponsors to make mid-year formulary substitutions for biosimilar biological products on their approved formularies like non-biologic drugs.

Formulary Management Strategies

Current regulations permit Part D plan sponsors to immediately remove a brand name drug from their formularies and substitute its newly released generic equivalent. However, previous rules did not specify how plan sponsors could treat the substitution of biosimilar biological products other than interchangeable biological products. With the 2025 Final Rule, CMS finalized regulations permitting Part D plan sponsors to make mid-year formulary substitutions for biosimilar biological products on their approved formularies like non-biologic drugs.

For biosimilar drug products, plan sponsors can:

- Immediately substitute an interchangeable biological product for its reference product, a new unbranded biological product for its corresponding brand name biological product, and a new authorized generic for its brand name equivalent; and
- Substitute, upon 30 days' notice, any biosimilar biological product for its reference product.

Currently, plan sponsors must obtain approval prior to making a mid-year formulary change removing a reference product and replacing it with a biosimilar biological product (other than an interchangeable biological product) through the Negative Formulary Change Request process from CMS. After approval, the mid-year formulary change only applies to enrollees new to therapy with the reference product after the effective date of the change. Existing enrollees on the reference product will be able to continue with the reference product.

With the ability to interchange biological products on the formulary mid-year, any biosimilar may be substituted for its reference biologic upon 30 days' advance notice, and interchangeable biosimilars may be immediately substituted for their reference products. This allows plan sponsors more active management of their formularies and the ability to realize potential cost savings earlier with less expensive biologic products. However, it may create enrollee disruption and increase coverage determination exception requests (e.g., prior authorizations) from enrollees on reference products and interchangeable biologic products removed from the formulary. Plan sponsors should review their mid-year formulary change strategy and processes to address interchangeable biologic products.

CMS is affording plan sponsors additional formulary flexibility when it comes to managing biosimilar products. Starting in 2024, plans can immediately substitute biosimilar products for their formulary reference product, causing the landscape to become more competitive. It is not expected for plan sponsors to start covering biosimilar products once available. However, plan sponsors and PBMs should seek more in rebates from these manufacturers to keep the biosimilar product off the formulary. An increase in rebates would only help mitigate the increase in plan financial liability under the Part D benefit and reduce the enrollee premium.

Conclusion

The MA and Part D programs continue to be dynamic. It is crucial for group Medicare plans, whose enrollment represents almost 20% of the market, to stay informed and agile. While changes may feel overwhelming, there are several steps that employer group plan sponsors can take to prepare for the next evolution of MA and Part D. These are general guidelines based on currently available information as of July 31, 2024. Each plan should account for its own unique circumstances. Now, more than ever, employers may want to seek out advisors and solution partners with Medicare expertise to strategize and operationally execute in 2025.

Recommendations for Employer Group Plan Sponsors

- Employer group plan sponsors should discuss the aggregate impact of rate changes in the CMS payment methodology and expected medical trend to determine if premium and/or benefit changes may be needed.

- Employer group plan sponsors should seek to understand if the risk model changes will affect both Medical and Part D, and if they will materially impact their premium (either positive or negative). A substantially negative impact may warrant additional strategies or intervention. Strategies and/or tactics may look like incentives for participation in annual wellness visits to ensure accurate coding in medical records.

- Plan sponsors should review and understand the IRA impact on the Part D payment methodology. The $2000 OOP limit may be a significant advantage for enrollees with high drug costs. While the value of the Medicare Prescription Payment Plan may have a limited advantage for enrollees who do not have high-cost shares on their prescription drugs, there will be a lot of correspondence and communication in the market going into 2025. Employer group plan sponsors should be prepared to address any questions their enrollees may have, or refer to the carrier as appropriate.

- Required mid-year supplemental benefit notifications will improve communication and serve to remind enrollees of the value of their Medicare Advantage membership as well as the availability of any unused benefits by mid-year.

- Plan sponsors are reminded of both existing and improving formulary management strategies that are available to address cost and utilization concerns potentially impacting Part D premiums post-IRA. These tools should be reviewed with the health plan to determine what, if any, changes may be needed because of the 2025 rate changes.

- RDS plan sponsors should work with an actuary to evaluate if their current plan will be credible and what the subsidy projections with RDS will be. There are financially advantageous alternatives to RDS, such as Medicare Part D EGWPs, that should be explored.

- Carriers should already be actively pursuing health equity strategies to support their low-income and disabled membership in pursuit of quality rating goals. Enrollees, especially those who are disabled, may be contacted for additional support and care navigation to close gaps in care. Additionally, all enrollees of an employer group plan may be screened for SDOH needs and offered community or carrier resources if needed. These will be beneficial programs for enrollees that carriers will support. Strong enrollee participation rates will enable the carrier to support their quality strategies and meet health outcomes to ensure maximization of quality bonus payments that also impact EGWP payments to carriers.

- New outpatient behavioral health requirements will further improve the behavioral health network of health plans. These OBH providers serve an important role in the community to address the often underdiagnosed SDOH needs particularly related to social isolation and loneliness. Enrollees should be made aware of these services as appropriate, especially if access and scheduling had previously been identified as a barrier to care for certain communities. Updates such as these continue to drive the high value of membership in an MA plan.

- For enrollees on multiple chronic condition medications, the existing Medication Therapy Management (MTM) program is expanding to include more enrollees in its participation criteria. MTM offers an important MA service to ensure that covered Part D drugs are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions. Enrollees should be encouraged to take advantage of these programs when pharmacists call and inquire about participation.

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RetireeFirst

RetireeFirst is the premier Retiree Benefits Management provider, enhancing the experience and outcomes for group plan sponsors and their enrollees. The company partners with all major national health carriers and hundreds of labor unions, public sector entities, higher education, and commercial organizations, and serves over 325,000 Medical and Pharmacy lives across all 50 states. Its unparalleled Retiree Advocacy Services creates a seamless benefits experience and connects enrollees to programs to improve their health and wellness. RetireeFirst attained a HITRUST r2 certification for its Box and Salesforce platforms at its headquarters and data centers and has been awarded a full URAC Core Accreditation for its commitment to upholding federal regulatory requirements and improving business processes. Headquartered in Mount Laurel, NJ, with a recent expansion to include the RetireeFirst West facility in Scottsdale, AZ, the company's award-winning team and services have garnered industry acclaim. RetireeFirst consistently achieves world-class Net Promoter Scores (NPS), is regularly recognized as one of the Philadelphia Business Journal's "Best Places to Work," and won a 2024 Gold Stevie Award in the Front-Line Customer Service Team of the Year category.

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