Navigating Healthcare Cost Trends: Strategies for Michigan Counties

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Chadd Hodkinson and Jeff Nielson
Gallagher Benefit Services, Inc.

Gallagher

Insurance | Risk Management | Consulting

Today’s Speakers

Chadd Hodkinson

Senior Area Vice President

Market Leader, Michigan Public Sector

Gallagher Benefit Services, Inc.

Jeff Nielson

Area Vice President

Gallagher Benefit Services, Inc.

Agenda

1. Current state of the Michigan health insurance market
2. Health insurance funding strategies and savings opportunities
3. Trends in the pharmaceutical industry
4. Benefits-related legislation
5. Q & A

Current State of the Michigan Health Insurance Market

BCBS/BCN

Underwriting

September 2024 Trends by LOB					
	Cross	Shield	Drugs	Dental	Vision
BCBSM	4.0%	6.3%	12.0%	2.3%	1.2%
BCN	5.5%	6.9%	10.0%	2.3%	1.2%

BCBSM has a robust portfolio of solutions that is continually evaluated for enhancement and market innovation

Blue Cross Blue Shield Blue Care Network of Michigan

Market Solutions Portfolio

WELL-BEING

- Base, Plus well-being
- Well-being add-ons
- Virtual well-being
- Preventive screenings
- Resilience

CARE NAVIGATION/ ADVOCACY

- Blue Cross Coordinated Care℠:
  - Core
  - Enhanced
  - Advocate
  - Advocate+
- Travel concierge
- Treatment Decision Support (EMO)

NETWORK STEERAGE

- Blue Cross Rewards (Base)
- Specialty Care Rewards (BDC/BDC+ specialty areas)
- High-Performance and Select Networks

CARE DELIVERY/ ACCESS

- Virtual Care
- Virtual Primary Care - PPO
- BCN Virtual Primary Care HMO
- Employer-sponsored on-site clinics

PRECISION MEDICINE

- Blue Cross Personalized Medicine℠

COST CONTAINMENT

- Consumer-directed healthcare:
  - FSA
  - HRA
  - HSA
- Payment integrity enhanced services

Condition Specific Solutions

DIABETES CARE

- Diabetes Management Program
- Diabetes Remission Program (Pilot)

HYPERTENSION

- Hypertension Management Program

LIFESTYLE MANAGEMENT

- Diabetes Prevention Program
- Weight Management Program

FAMILY-BUILDING & WOMEN'S HEALTH

- Family-building program
- Maternity program
- Parenting & Pediatrics program
- Menopause program

CANCER CARE

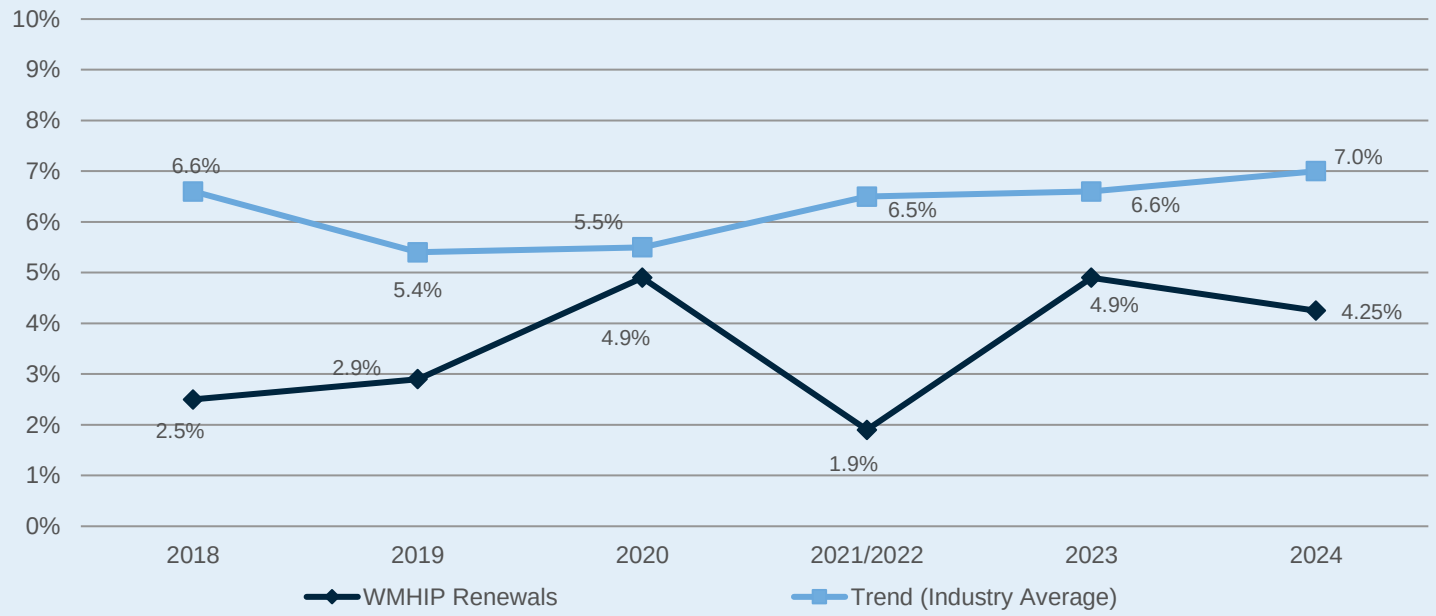
- Cancer Support program
- Oncology value management

MUSCULOSKELETAL CONDITIONS

- Spine and Joint Care program:
  - Clinical guidance with Blue Cross Rewards
  - COE designation

The Pool

Medical Renewal History for The Pool



The Pool

- Livongo/Omada/Virta - diabetes management/reversal
- Omada – chronic condition management
- Pregnancy assist – family building and maternity support
- myStrength – stress, depression, sleep, etc.
- Hinge Health – virtual PT
- 2ndMD – second opinion service
- Hearing coverage
- Voluntary/worksite benefit offerings

- 2nd largest health insurance carrier in Michigan with over 1.3 million total members
  - Largest integrated carrier in the state
- Nearly 600,000 commercial members
- Parent company – Corewell Health – is the largest employer in Michigan, and one of the largest hospital systems nationwide

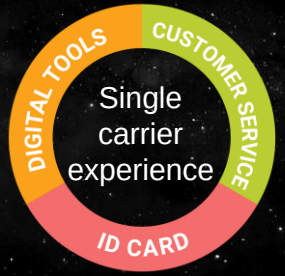
+

One of the strongest networks in Michigan

Includes all major hospital systems.

1 million

providers nationwide[3]

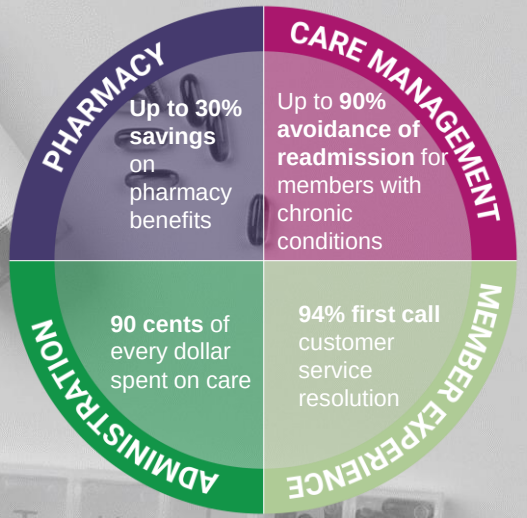


Statewide, worldwide, coverage. If your employees live work or travel this state, this planet — this dimension — they're covered.

PriorityHealth

- **Member centric, integrated approach**
- **Cost**
  - Industry leading cost-containment strategies: aggressive formulary management, care management, value-based care arrangements, and more
  - Competitive FF premiums, due in part to target loss ratio of 90% vs. industry standard of 85%
  - ASO – all inclusive admin fee
  - ASO – operate own Stop Loss pool, with aggressive and stable rates
  - Reliable renewals, outpacing national trend

	2024 Q3	2024 Q4	2025
Medical	6.30%	6.43%	6.57%
Rx	12.31%	12.60%	12.90%



Member focused, cost conscious.

PriorityHealth

SIMPLEPAY HEALTH

A happier way to healthcare.

Healthcare is complicated and confusing. SimplePay Health changes that. SimplePay delivers a different healthcare experience — one that is streamlined and simplified so members save time and money

Lower-cost care

Tiered providers and aligned copays encourage shopping on price as well as quality

Savings

10% - 20% average plan savings

Broad network

No need to narrow the network because tiered providers and aligned copays encourage members to access top quality and low-cost providers

Price assurance

No up-front-out-of-pocket costs, just one succinct monthly statement for the price shown

Simplified user interface

Drives higher engagement

Integrated health and wellbeing benefits

All employee benefits in one convenient location

A plan that leaves other plans behind

Quality Analytics	Providers are ranked based on new understandings for quality and efficiency
Plan design	Participants know their cost for all covered services
Monthly statement	Provider bills and EOB insurance forms eliminated
Zero % OOP financing	Line of credit for all participants to support financial wellbeing
App driven	Sleek member experienced powered by Virgin Pulse
Concierge support	Customer service replaced with a personal concierge
Enhanced care management	Ultra high-touch clinical support with a team of nurses and doctors
HDHP / HSA capabilities	Ability to leverage tax favorable benefits
Health and wellbeing suite	Robust integrated health and wellbeing from Virgin Pulse

Member journey

Price certainty

Use app, web or phone to search for provider

Select based on cost and quality

No bills or EOBs

Present ID card, owes $0 upon visit

Zero % financing

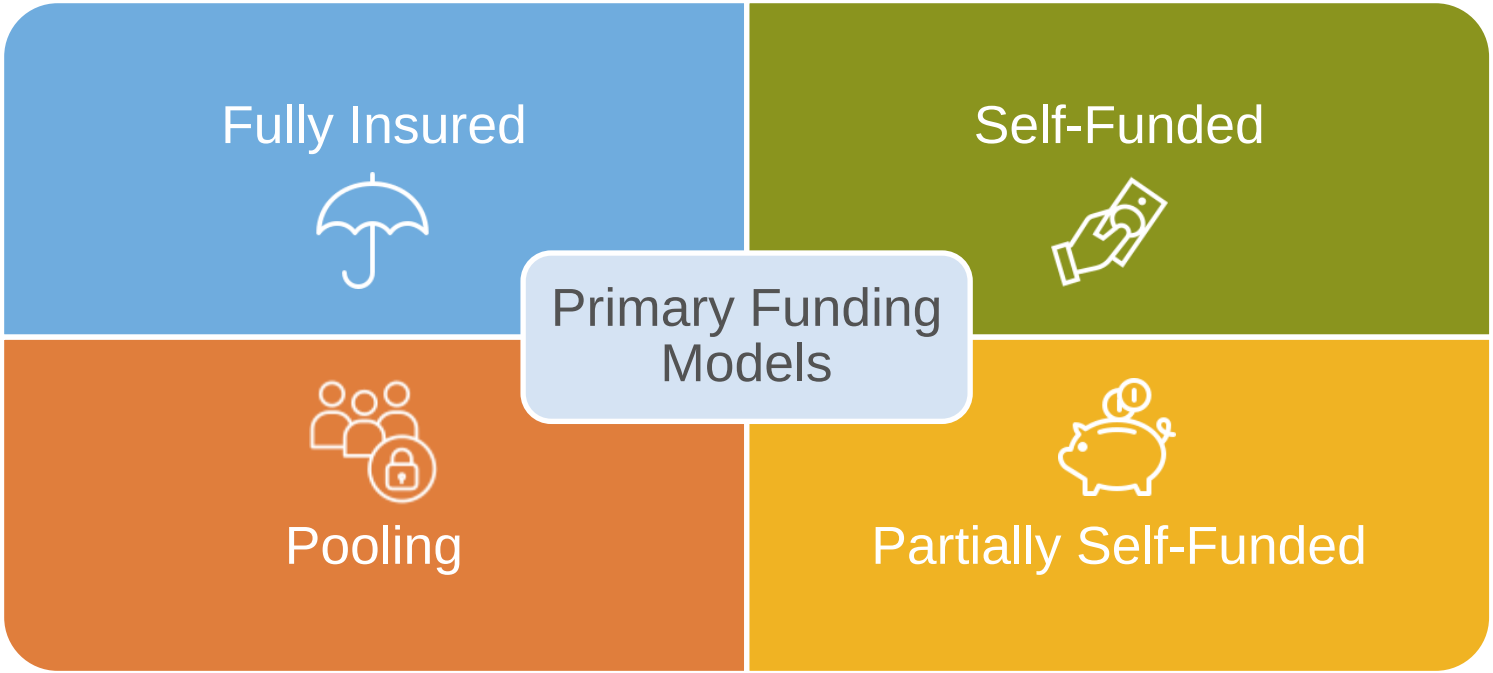
Receive one statement for the same price selected

Pay just like any other bill

Health Insurance Funding Strategies and Savings Opportunities

Funding Overview

Four primary funding models used by Michigan public sector

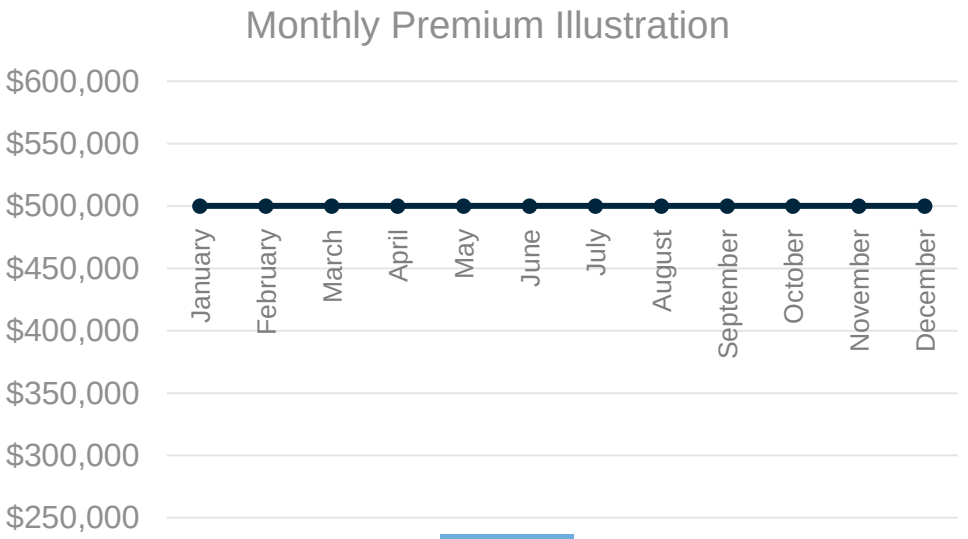


Funding Overview

Fully Insured

- Established single, two person and family rate for each plan offered
- Rates generally guaranteed for 12 months
- County pays the same rates for 12 months whether enrollees use more care than expected or less
- Claim data may or may not be considered when establishing rates (discussed later)

Enrollment Type8	Monthly Rate	Enrollment	Total Monthly Premium
Single	$600	100	$60,000
Two Person	$1,200	75	$90,000
Family	$1,750	200	$350,000
TOTAL MONTHLY PREMIUM			**$500,000**



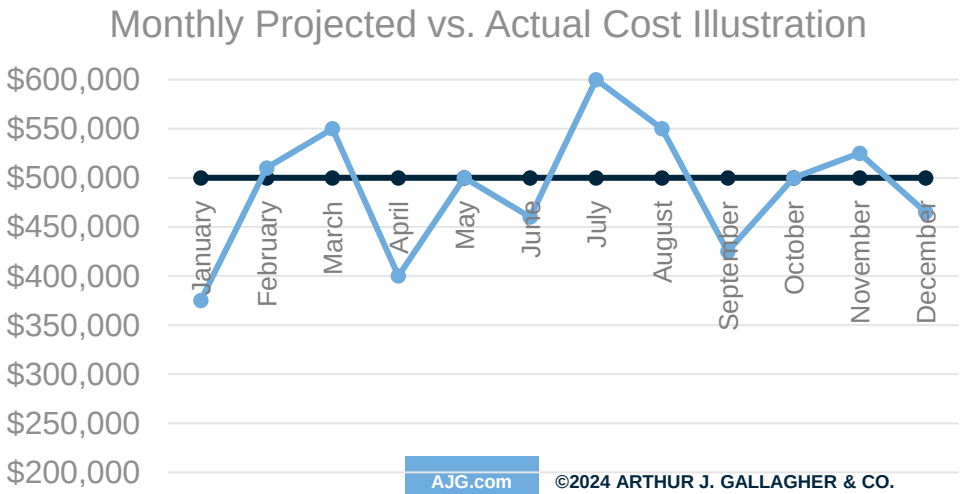
Assumes consistent enrollment all year for illustrative purposes

Funding Overview

Self Funded

- County pays for the cost of products and services as they are used by enrollees
- Rates are established based on projected costs expected for the 12 month plan year and are not guaranteed
- County pays more if enrollees use more care than expected and pays less if enrollees use less care than expected
- Insurance retained by county to protect against catastrophic losses called stop loss insurance

Cost Components	Monthly Rate	Enrollment	Total Monthly Projected Cost
Administrative Fee	$75.00	375	$28,125
Stoploss Insurance	$125.00	375	$46,875
Projected Claims	$1,133.33	375	$425,000
TOTAL			$500,000

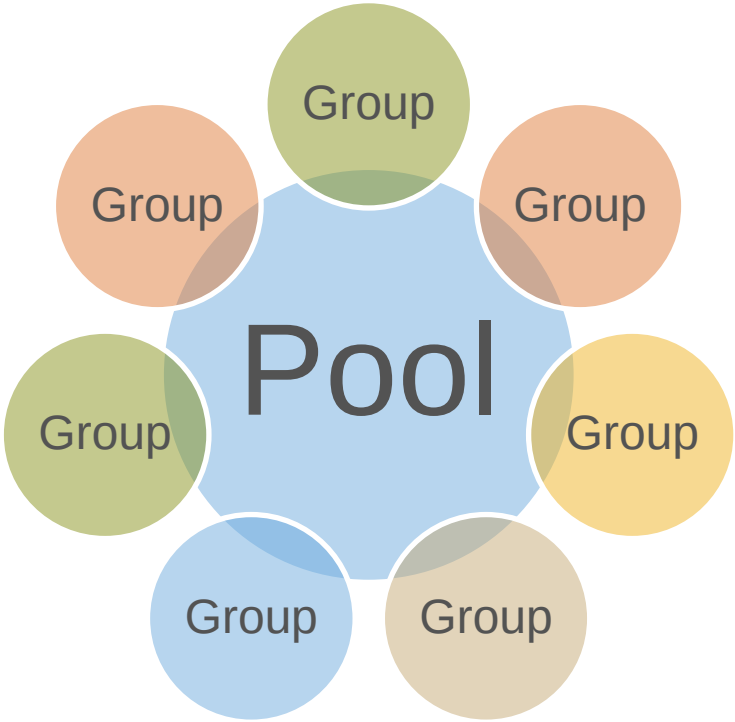


Assumes consistent enrollment all year for illustrative purposes

Funding Overview

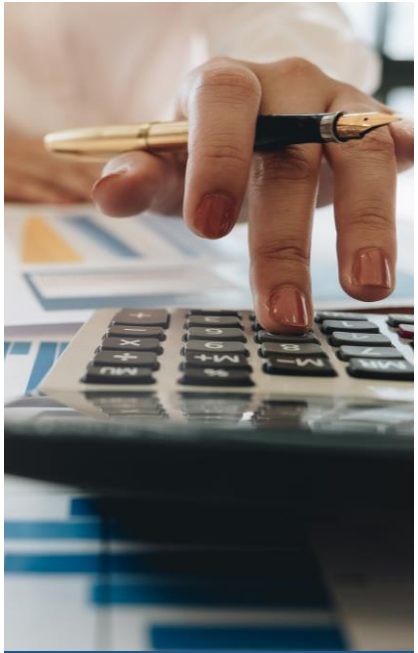
Pooling (example arrangement based on the Western Michigan Health Insurance Pool)

- Sharing claim risk with other employers and taking advantage of collective buying power
- Established single, two person and family rate for each plan offered
- Rates guaranteed for 12 months
- County pays the same rates for 12 months whether enrollees use more care than expected or less
- Pool members make program decisions with a view toward providing high quality coverage at a reasonable and stable cost



Basic Cost Avoidance Considerations

Utilization vs Cost



Are you paying what you should?

How do your benefit levels benchmark against similarly situated groups?

How is your next renewal shaping up?

Basic Cost Avoidance Considerations

Leveraging Data | Prevalence and Cost Stratification High Claim

High Cost Claimants

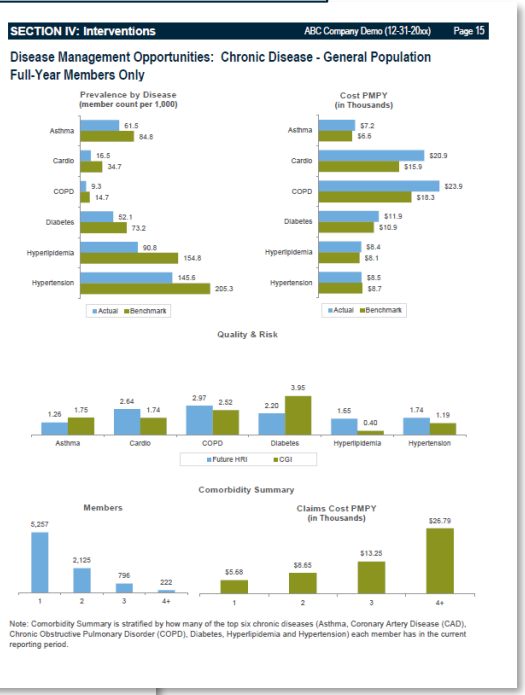

SECTION IV: Interventions ABC Comp

Case Management Opportunities: Group A Membe

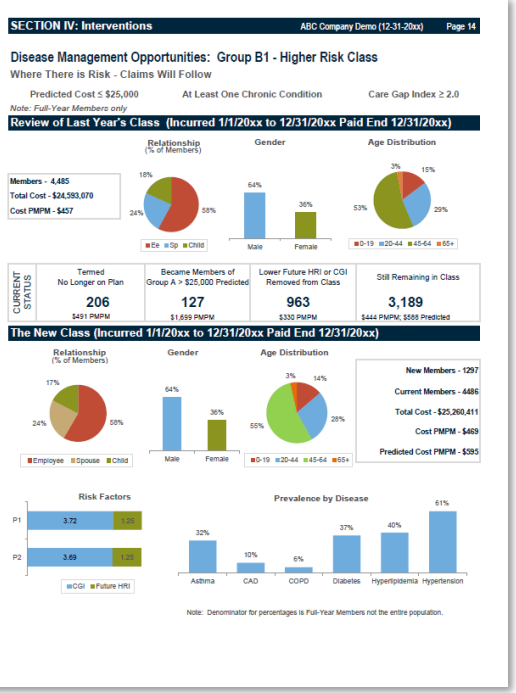
Predicted Paid Cost > $25,000

Full-Year Members	485	% Employee	50.3%	Future HRI	8.4
Average Age	46.5	% Spouse	37.7%	CGI	2.4
% Male	51.8%	% Dependent	12.0%		

Claimant 1	Future HRI	29	Total Paid	$156,430	Top Diag
	CGI	5	Predicted Cost	$164,294	Comorbi
Claimant 2	Future HRI	26	Total Paid	$96,943	Top Diag
	CGI	3	Predicted Cost	$146,855	Comorbi
Claimant 3	Future HRI	26	Total Paid	$120,545	Top Diag
	CGI	8	Predicted Cost	$146,855	Comorbi
Claimant 4	Future HRI	26	Total Paid	$28,308	Top Diag
	CGI	2	Predicted Cost	$146,189	Comorbi
Claimant 5	Future HRI	26	Total Paid	$136,295	Top Diag
	CGI	0	Predicted Cost	$146,189	Comorbi
Claimant 6	Future HRI	26	Total Paid	$153,555	Top Diag
	CGI	0	Predicted Cost	$146,189	Comorbi
Claimant 7	Future HRI	26	Total Paid	$68,395	Top Diag
	CGI	1	Predicted Cost	$146,189	Comorbi
Claimant 8	Future HRI	26	Total Paid	$163,973	Top Diag
	CGI	0	Predicted Cost	$146,189	Comorbi
Claimant 9	Future HRI	26	Total Paid	$11,878	Top Diag
	CGI	1	Predicted Cost	$146,189	Comorbi
Claimant 10	Future HRI	24	Total Paid	$216,686	Top Diag
	CGI	18	Predicted Cost	$138,696	Comorbi
Claimant 11	Future HRI	24	Total Paid	$98,183	Top Diag
	CGI	8	Predicted Cost	$138,597	Comorbi
Claimant 12	Future HRI	24	Total Paid	$52,300	Top Diag
	CGI	0	Predicted Cost	$136,386	Comorbi
Claimant 13	Future HRI	24	Total Paid	$10,251	Top Diag
	CGI	7	Predicted Cost	$135,744	Comorbi
Claimant 14	Future HRI	22	Total Paid	$72,424	Top Diag
	CGI	11	Predicted Cost	$127,725	Comorbi



Prevalent conditions



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Basic Cost Avoidance Considerations

Leveraging Data | Preventive Care Utilization and Risk Factors

SECTION II: Executive Overview ABC Company Demo (12-31-20xx) Page 8

Utilization

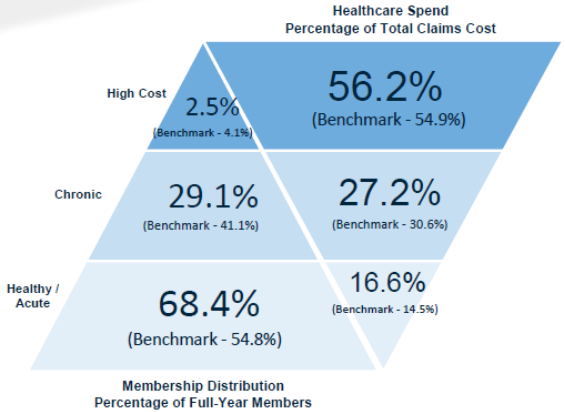
Metric					
ER Visit Utilization					
ER Visits					
Unique Patients with ER					
ER Visits per ER Claima					
ER Visits resulting in an					
ER Visit Paid per ER Vi					
Inpatient Utilization					
Inpatient Days					
Unique Patients with Ad					
Average Length of Stay	Average Days	4.3	4.4	-1.7%	
Total Admissions	Per 1000	39.9	38.1	4.8%	
Total Admission Paid per Admission	Average Paid	$ 19,242	$ 14,093	36.5%	✗
Total Admission Paid per Day	Paid per Day	$ 4,482	$ 3,247	38.0%	✗
Re-admissions	Per 1000	2.1	2.8	-23.2%	✓
Total Inpatient Re-admission Rate	Rate	0.057	0.079	-28.2%	✓
Imaging Utilization					
CT Scan	Per 1000	60.2	70.6	-14.8%	✓
MRI Scan	Per 1000	40.1	63.8	-37.1%	✓
Pharmacy Utilization					
Pharmacy Scripts	Per 1000	5,730.3	9,476.7	-39.5%	✓
Pharmacy Scripts(Generic)	Per 1000	5,061.3	7,947.0	-36.3%	✗
Pharmacy Scripts(Branded)	Per 1000	531.5	1,529.7	-65.3%	✓
Pharmacy Scripts Mail Order	% of Mail Order	6.3	-	-	
% Generic Drugs	% Generic Drugs	90.5	-	-	
Office Visit Utilization					
Total Office Visits*	Per 1000	3,825.1	3,854.3	-0.8%	
Primary Care Office Visits	Per 1000	960.6	1,043.6	-8.0%	
Specialty Office Visits	Per 1000	1,200.5	1,244.7	-3.6%	
Preventive Office Visits	Per 1000	1,286.8	1,139.8	12.9%	✓
Consultations	Per 1000	54.1	110.5	-51.1%	✓
Behavioral Health Office Visits	Per 1000	323.2	315.6	2.4%	
Other Utilization					
Chiropractic Visits	Per 1000	303.5	413.5	-26.6%	✓
Physical Therapy	Per 1000	1,104.2	1,297.5	-14.9%	✓
Maternity Inpatient Days	Per 1000	21.5	16.3	31.9%	✗
Dialysis Treatment Days	Per 1000	26.8	30.3	-11.7%	✓
Transplant Days	Per 1000	0.6	1.6	-64.6%	✓

Note: ✗ indicates relation to benchmark is worse by 10%. ✓ indicates Relation to benchmark is better by 10%.

** Urgent Care Visits fall under Specialty Office Visits*

Office Visit Utilization

Total Office Visits*	Per 1000	3,825.1	3,854.3	-0.8%
Primary Care Office Visits	Per 1000	960.6	1,043.6	-8.0%
Specialty Office Visits	Per 1000	1,200.5	1,244.7	-3.6%
Preventive Office Visits	Per 1000	1,286.8	1,139.8	12.9% ✓
Consultations	Per 1000	54.1	110.5	-51.1% ✓
Behavioral Health Office Visits	Per 1000	323.2	315.6	2.4%



Wellness Opportunities: Preventive Care Gaps

Full-Year Members only

Condition	Description	Members with Gap	Actual / Norm
All Individuals	Patients without long office visit in the last 12 months.	14770	43% / 48%
>=50 years old	Patients without any colorectal cancer screening in the last 24 months.	4206	79% / 84%
Women >20 y/o	Women without pap smear in the last two years.	8203	76% / 71%
Women >=49 y/o	Women without mammogram in last 12 months.	1587	55% / 51%
Men >50 years old	Men without PSA level in the last 2 years (controversial test).	3123	72% / 75%
Women between 40 and 49 y/o	Women without mammogram in the last 2 years.	1479	56% / 59%
Patients taking either SSRI/Bupropion/Effexor/Cymbalta and Neurontin in the last 6 months.	Patients without an office visit in the last 6 months.	409	17% / 15%

Note: Preventive Office Visits are 12.9% above norm.

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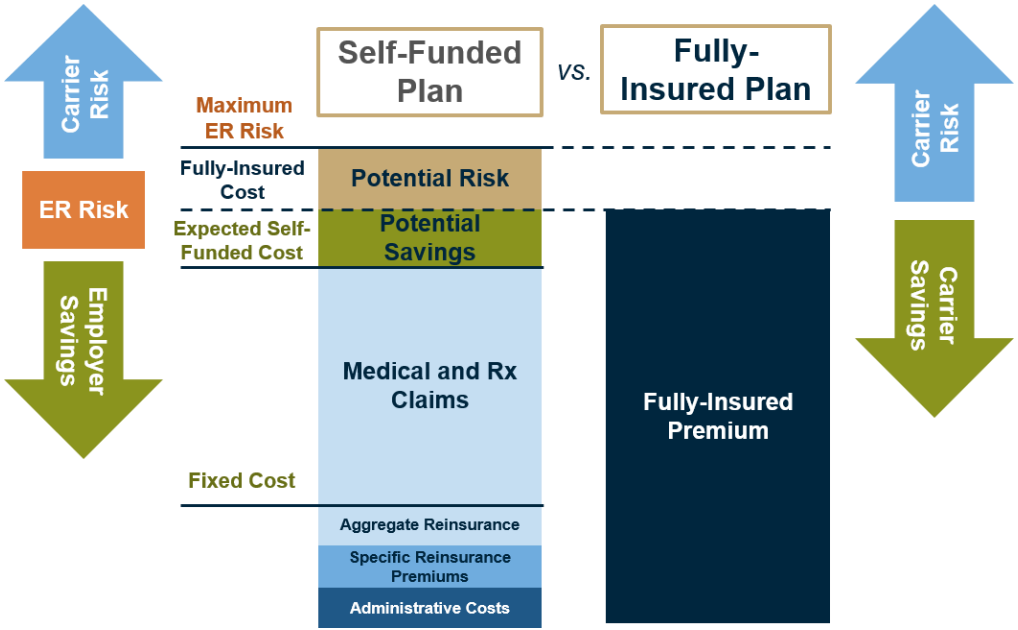
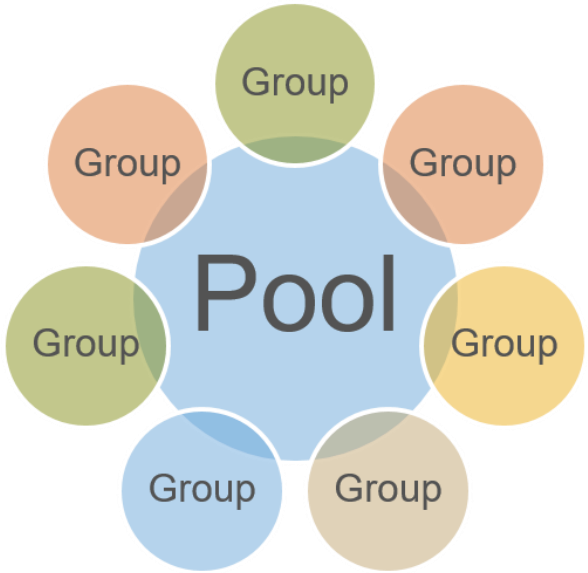
Basic Cost Avoidance Considerations

Evaluating Marketplace Alternatives | Funding Approaches





Basic Cost Avoidance Considerations

Evaluating Marketplace Alternatives

Plan Design Alternatives

Deductible
The amount you must pay out of pocket for covered expenses before the insurance company will cover the remaining costs.

Coinsurance
The percentage of costs you pay after you have met your deductible.

Copays
Set rate you pay for prescriptions, doctor visits and other types of care. Copays do not count towards your deductible.

Network Alternatives

HMO
- PCP required
- Specialist referrals required
- Low/no deductibles
- Low copays

PPO
- Larger network
- Access to network specialists
- Co-insurance paid after deductible

EPO
- No PCP required
- Access to network specialists
- Low/no deductibles/copays
- HMO feel/PPO access

Advanced Cost Avoidance Considerations

Evaluating Marketplace Alternatives | Innovative Strategies

Medical Benefit Strategies

- Digital health
- Virtual primary care
- Care navigation with data transparency
- Stop loss captives
- Mental health vendor partners
- Discount analysis
- On site/near site clinics

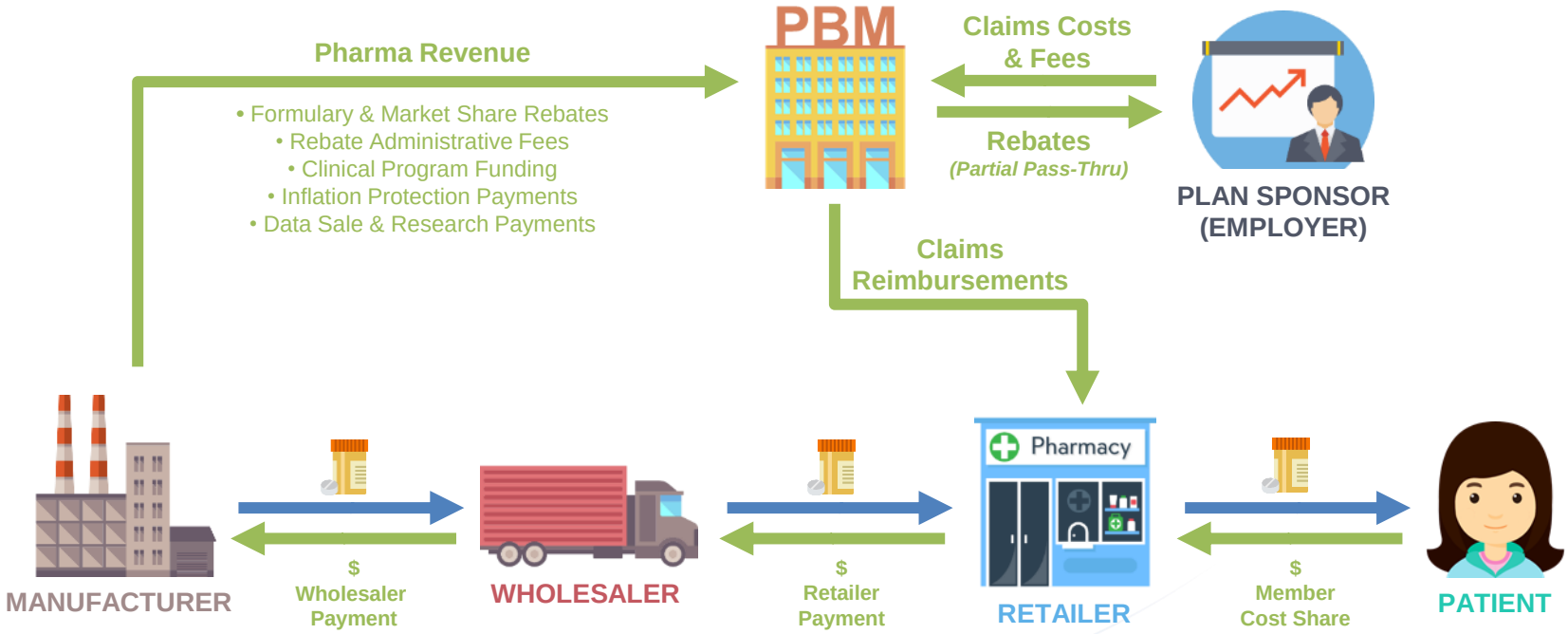
Case Study

Health Insurance Program Rebuild

Background / Business Challenge	Approach / Solutions	Results Achieved
• Client had a disjointed Medical/Rx program; with a leased network • Service issues were the norm • Employees had problems efficiently accessing care and getting their claims paid	• Evaluate the marketplace to find a streamlined solution • Keep plan design as is, but enhance network options	• Moved to an integrated program with a single administrator • Enhanced the participant experience by simplifying access to care • Eliminated service issues • Long-term financial stability (total projected cost increase of 3.5% over a 2-year period)

Trends in the Pharmaceutical Industry

Rx Ecosystem



General Pharmacy Terms

Average Wholesale Price [AWP]	An industry benchmark used to estimate the cost of a drug. AWP was reportedly created in the 1960s by the California Medicaid program as a means by which to standardize a basis for the pharmaceutical cost component of pharmacy reimbursement. Historically, AWP was the generally accepted drug payment benchmark for many payers because it was readily available. However, AWP is now thought of as a "sticker price," in that it rarely if ever reflects the average wholesale price actually paid after discounts have been subtracted. Payers base reimbursement on discount off of AWP for drugs.
Discounts	The reduction of cost of the baseline or benchmark price of a drug. The standard industry benchmark for discount evaluation is currently AWP.
Ingredient Cost	The actual cost of prescription drug claims.
Rebates	Broadly defined as a discount that occurs following a purchase wherein the manufacturer of the product returns some of the money that was paid for the product to the purchaser. When drugs are purchased by a managed care organization (MCO), a rebate is determined based upon volume, market share and other parameters0. Rebates are provided by a pharmaceutical manufacturer to MCOs, including health plans, pharmacy benefit managers (PBMs) or other type of MCOs.
Drug Type	Brand/Generic/Specialty. These drug type names are used to determine the appropriate discount and rebate that should be applied according to the PBM contract.
Drug Channel	Mail order and Retail. This is the method in which the drug is dispensed.

Pharmacy Hot Topics

- Legislative Activity
- Contracting Optics & Caveats
- Pass-through Pricing
- GPO's
- Formulary Design
- Insulin Pricing Changes
- Gene & Cell Therapy
- Discounts Card Programs
- Alternative Funding
- Weight Suppression Meds
- Hours 8am – 6pm
- Clinical Programs

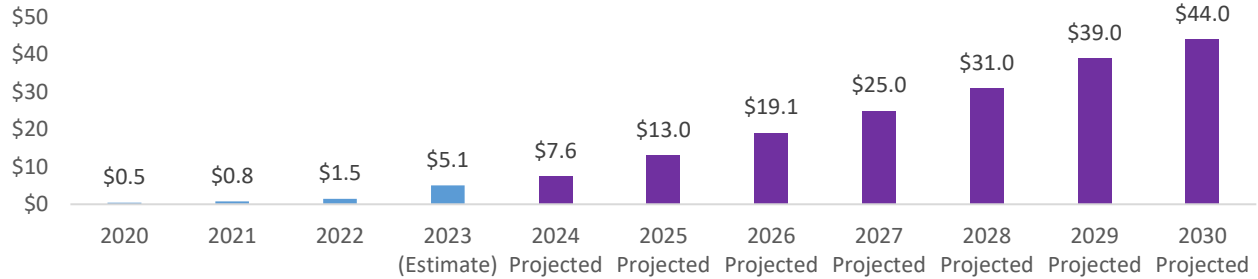
Green: Contracting issues; Blue: Strategic considerations

Emergence of Weight Loss GLP-1's

History and Present State of GLP-1 Market

- The prevalence of obesity in the U.S. has grown from 30.5% over 1999–2000 to 41.9% over 2017–2020[1]. Historically weight loss medications have not been both effective and safe and medical obesity treatments were typically surgical. However, advances in GLP-1 drugs, traditionally a diabetic treatment, have recently proven effective in weight loss management. As a result, the market for these drugs both for diabetes and weight loss has exploded in recent years.

Historical and Projected Obesity Drug Market (Billions)[2]



2023 Employer Coverage Trends and Costs

CVS: ~67% of employers cover GLP-1's for weight loss

Optum: ~50% of employers cover GLP-1's for weight loss

Prime: ~39% of employers cover GLP-1's for weight loss

$1,350 Average list price of Wegovy, most popular current weight loss GLP-1

$1,060 Average list price of Zepbound, a recently approved weight loss GLP-1

Sources:
1) Centers for Disease Control and Prevention - National Health and Nutrition Examination Survey (NHANES) 2021
2) J.P Morgan, *The increase in appetite for obesity drugs*, November 2023

Coverage of Weight Loss GLP's

Spectrum of Employer Options

Multiple vendors offer employers a solution in which the vendor administer a carve-out GLP-1 weight loss drug plan. Members must enroll in a weight loss management program in order to receive GLP-1's for weight loss. This alternative to PBM coverage has some advantages:

Removing PBM Incentives

PBM's incentive to overprescribe / not put appropriate PA's in place due to profit 1from spread pricing and rebates is replaced by prudent authorization of medication and ongoing monitoring for drug efficacy. Quantity limits can be set to 6 or 12 months to ensure constant efficacy evaluation

Clinical Focus

Programs includes clinically-driven selection criteria, constant health coach + pharmacist engagement and tangible goals (achieving 5 – 10% weight loss in 3 months initially and ongoing checkpoints)

Advanced Cost Avoidance Considerations

Evaluating Marketplace Alternatives | Innovative Strategies

Pharmacy Benefit Strategies

- **Patient assistance programs**
- **Stop loss carve out for gene/cell therapy drugs**
- **Third party expert opinion service**
- **Boutique PBM**
- **Pharmacogenomics**

Case Study

Pharmacy

Background / Business Challenge	Approach / Solutions	Results Achieved

• First year of partnership with a large public sector employer
• Employer in a cooperative purchasing arrangement
• Evaluated the employers' pharmacy contract and conducted a procurement for Pharmacy Benefit Manager (PBM)
• Deliver cost savings/containment without creating participant disruption
	• Go to market and secure offers from the incumbent and competing PBMs
	• Perform forensic review of contract terms associated with each offer
	• Negotiate best and final offers from leading respondents
		• Secured group-specific PBM contract guarantees, for example:
		  • Drug ingredient cost guarantees specific to scripts filled by the group
		  • Increased rebate share from 90% to 95%.
		  • PBM held accountable in each individual drug channel and delivery on each
		• $2.65M in cost avoidance over a three-year period
		• No impact to plan participants
		• PBM partner, list of approved drugs and copay structure stayed the same

Benefits-related Legislation

Inflation Reduction Act (IRA)

Impact on Health Care

The Inflation Reduction Act (IRA) was passed in 2022, with the most significant impact on health care since the 2010 passage of the Affordable Care Act (ACA)

The IRA will have the biggest impact for seniors enrolled in Medicare

- A monthly $35 cap on insulin effective in 2023
- A $2,000 out-of-pocket cap on prescription drug expenses beginning in 2025
- Significant changes to the manufacturers discount program and to catastrophic coverage take effect in 2025
- The Federal government will negotiate the price of certain high-cost prescription drugs, with the first impact in 2026

Other notable impacts

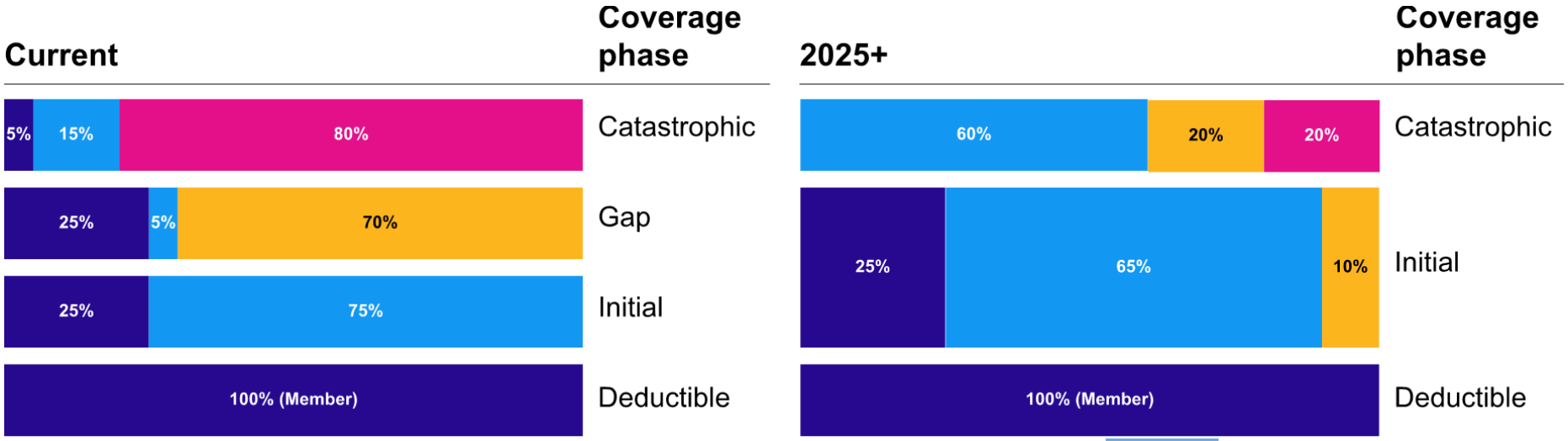
- The law extended subsidies through 2025 for approximately 13 million people who purchase individual coverage through the ACA (subsidies were set to expire at the end of 2022)

Inflation Reduction Act Impact on Future Retiree Coverage

The Inflation Reduction Act (IRA) is expected to have a significant impact on future retiree coverage

Changes Include:

- Changes to both Direct and Federal subsidies
- Standard Part D plan design changes, including $2,000 member maximum and elimination or retiree cost share in the catastrophic phase



Expected IRA Impacts on EGWP and MAPD Plan Costs

The IRA is expected to increase costs for Rx EGWPs and MAPD plans in 2025 due to lower federal subsidies and reduced member out-of-pocket costs

- Member out of pocket maximum will be reduced to $2,000
- Member cost sharing in the coverage gap phase will be eliminated in 2025
- Lower federal subsidies are expected to increase costs in 2025, but future price control measures could help moderate costs over the long-term through lower trends
- MAPD carriers are estimating premium increases of $30-$70 per member per month, with significant variance based on plan design and utilization
  - Final impact likely won't be known until July
  - Carriers will be finalizing rates and plan designs in August

Retiree Drug Subsidy (RDS)

Implemented as part of the Medicare Modernization Act of 2003, Retiree Drug Subsidy (RDS) was developed to encourage employers and unions to maintain retiree drug coverage for their Medicare-eligible retirees and their eligible dependents

- Requires no plan design changes
- Must go through Actuarial equivalence attestation process annually, placing significant compliance responsibility on employer
- Providing reimbursement (28%) for Medicare Part D eligible drugs within a certain corridor of claims spend, RDS was initially an ideal option for some employers
- Given the improvements in the Standard Part D plan design, it is expected to be more difficult to quality for RDS in the future
- RDS plans are commercial drug plans that are not expected to enjoy the price control measures enacted by IRA
- No direct impact to GASB costs/liabilities, as GASB does not allow expected RDS payments to be reflected
- If no longer eligible for RDS, Plan Sponsors should consider alternative strategies

Medicare Part D Creditable Coverage

Employer Notification Requirement

- Employers are required to provide Medicare-eligible employees a notice of whether the employer's prescription drug plan is creditable or non-creditable for Medicare Part D purposes
  - The Notice of Creditable coverage has to be provided annually prior to October 15
  - The due date aligns with the Medicare Part D open enrollment, which allows Medicare-eligible individuals that do not have creditable coverage to enroll in Medicare drug coverage and avoid a late enrollment penalty.
- To determine whether coverage is creditable, employers have two options
  - The simplified creditable coverage determination (available to employers that are not applying for a retiree drug subsidy ("RDS")) (available for 2025; CMS is evaluating whether this will be available after 2025)
  - The actuarial value test

Medicare Part D Creditable Coverage

Simplified Creditable Coverage Determination

- The requirements of the simplified creditable coverage determination vary according to whether the employer's plan is “integrated” (prescription drug benefits are combined with other benefits, such as medical, dental, or vision, with combined deductibles, and combined annual and lifetime benefit maximums) or whether prescription drug coverage is non-integrated (offered on a stand-alone basis)
- To be considered creditable coverage, a non-integrated plan must:
  - (1) provide coverage for brand-name and generic prescriptions;
  - (2) provide reasonable access to retail providers;
  - (3) be designed to pay on average at least 60% of participants' prescription drug expenses; and
  - (4) satisfy one of the following standards:
    - (a) the prescription drug coverage either has no annual benefit maximum or has a maximum annual benefit of at least $25,000; or
    - (b) the prescription drug coverage has an actuarial expectation that the amount payable by the plan will be at least $2,000 annually per Medicare eligible individual.
- An integrated plan must meet standards 1–3 above and the following three additional standards:
  - have no more than a $250 deductible per year;
  - have no annual benefit maximum or a maximum annual benefit payable by the plan of at least $25,000; and
  - have a lifetime combined benefit maximum limit of at least $1 million

Medicare Part D Creditable Coverage

Actuarial Valuation Creditable Coverage Determination

- Prescription drug coverage is considered to be creditable under this determination method if the actuarial value of that coverage equals or exceeds the actuarial value of "*defined standard prescription drug coverage*" using generally accepted actuarial principles and following CMS actuarial guidelines
  - Essentially, this means that creditable coverage must be at least as good as standard Medicare prescription drug coverage
  - The calculation must be done by an actuary

Medicare Part D Creditable Coverage

Medicare Part D - Out of Pocket Update

- Changes to Medicare Part D benefits may impact the creditable coverage status of plans using the actuarial valuation creditable coverage determination (but will not impact the status of plans using the simplified method in 2025)
- Medicare Part D Reduction in Out of Pocket Maximum
  - Annual out-of-pocket costs will be capped at $2,000 for people with Medicare Part D in 2025
  - Once the beneficiary meets the $2,000 limit, they move directly into the catastrophic phase since the gap coverage phase no longer exists.
- Implications for High Deductible Health Plans (HDHPs)
  - The reduction of the OOPM for prescription drug coverage may preclude the HDHP from qualifying as creditable coverage
    - For 2024, a HDHP must have an annual deductible of at least $3,200 for family coverage
  - Plan sponsors might consider earlier or additional communications with their non creditable coverage notices for the 2025 plan year (due by October 15, 2025) to ensure Medicare-eligible employees understand the effect of their HDHP election
    - Avoid a potential late enrollment penalty

Thank you!

Chadd Hodkinson
Chadd_Hodkinson@ajg.com
517-898-7752

Jeff Nielson
Jeff_Nielson@ajg.com
248-496-0912

Gallagher

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