MILLIMAN REPORT

PEBB Uniform Medical Plan Medicare Analysis

Pharmacy and Medical Benefit Design Options

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Executive Summary

INTRODUCTION

In 2018, the Washington State Health Care Authority (HCA) first engaged Milliman to assess the quantitative and qualitative impacts of three potential options for providing pharmacy benefits to Medicare eligible retirees and their dependents in the UMP Classic Medicare plan. This analysis was updated in February 2023 and is now being updated again to reflect the 2024 bid rate development. This update also includes five options for providing the medical benefit in the UMP Classic Medicare plan. The goal of the analysis is to identify if there could be any premium relief to PEBB Medicare retirees enrolled in UMP without compromising health care quality or access.

HCA provides medical and pharmacy benefits to its Medicare-eligible public and school retirees under the same self-funded plan it offers to employees and non-Medicare retirees. UMP Classic Medicare coordinates medical benefits with the Centers for Medicare and Medicaid Services (CMS) for services covered by Original Medicare Part A and Part B. It also offers creditable drug coverage and allows the state to collect the retiree drug subsidy (RDS) from CMS. For the full year of 2023, HCA is projected to have over 105,000 total enrollees in the PEBB Medicare retiree plans, of which approximately 44,000 are in the UMP Classic Medicare plan.

The PEBB Medicare retiree plans also include plans of different types beyond UMP Classic Medicare. There are offerings from United Healthcare, Kaiser Permanente of Washington, Kaiser Permanente Northwest, and the Premera Medicare Supplement. The impacts of these other enrollment alternatives are beyond the scope of this report. The analysis assumes that only the current UMP Classic Medicare population would utilize one of the various proposed alternatives.

For all PEBB Medicare retiree plans, the retiree premium is calculated as the plan option premium less the State's contribution of the Medicare Explicit Subsidy and plus the HCA administrative fee. The Medicare Explicit Subsidy is limited to the legislated per adult unit per month amount or 50 percent of the plan option premium, whichever is less. The HCA Administrative fee conforms to the legislated budget for the HCA, and the same amount is charged to each subscriber account as an addition to the monthly premium. Retirees also pay the Medicare Part B premium.

The UMP Classic Medicare plan has had retiree premiums in excess of 50 percent of the plan option premium limit for a number of years. With this premium position it means that year to year the retiree premiums include the full amount of the projected increase in plan option premiums, as the State contribution is capped at the Medicare Explicit Subsidy. The main objective of this report is to identify alternatives that may lower the UMP Classic Medicare plan option premium.

OPTIONS

This report contains our results, methodology, and key assumptions from evaluating the following potential retiree pharmacy and medical options for members in the UMP Classic Medicare plan who are Medicare Part D eligible over the next four years (2024 – 2027). We understand any change(s) may not take place until 2025, so we included 2024 solely for illustrative purposes.

In total the main report includes fifteen unique combinations of results that model the current Status Quo offering of both medical and pharmacy benefits, along with two pharmacy alternatives, and four medical alternatives. In discussion with HCA we also illustrate two additional fully insured pharmacy alternatives as Appendix B. In modeling these alternatives, all of the pharmacy alternatives would lower the retiree premiums and keep the full Medicare Explicit Subsidy intact.

Under all alternative pharmacy options, the UMP Classic Medicare plan would continue to provide both medical and pharmacy benefits. Definitions of the key terms in this report are provided within Appendix A.

Pharmacy Options

- *Creditable Drug Coverage (Status Quo)* – Continue to offer non-Part D pharmacy coverage in the UMP Classic Medicare plan and obtain the RDS, assuming PEBB continues to qualify for the RDS. Note that it is likely that the

Medicare Explicit Subsidy[1] will need to be increased during the term of these projections in order for the UMP Classic Medicare plan to continue to qualify for the RDS. Any impacts from a legislated change in the amount of the Medicare Explicit Subsidy were beyond the scope of this report and would impact the results for all options. An Appendix includes a description of the methodology used to meet the requirements to receive the RDS.

- *Medicare Part D EGWP (EGWP), Standard Option* – Modify the UMP Classic Medicare plan pharmacy coverage to a Part D employer group waiver plan (EGWP) through an organization contracting with CMS, either on a self-funded or fully insured basis. This option reflects a prescription drug plan design consistent with the Medicare standard plan "Defined Standard", or "DS plan" along with medical benefits all provided under the UMP Classic Medicare option and purchased by HCA. Benefit coverage levels for pharmacy would be lower than the current UMP Classic Medicare pharmacy benefit. This option allows for additional Federal subsidies to help lower retiree premiums. These lower retiree premiums are then partially offset by higher out of pocket cost sharing on the pharmacy benefit.
- *Medicare Part D EGWP Plus Wrap, Enhanced Option* – Modify the UMP Classic Medicare plan pharmacy coverage to a Part D EGWP plus secondary wrap coverage, with a plan design consistent with the current UMP Classic Medicare pharmacy benefit along with medical benefits all provided under the UMP Classic Medicare option and purchased by HCA. The pharmacy coverage levels (cost-sharing and tiers) and formulary of the EGWP will be selected to match as closely as possible the current design. This option allows for additional Federal subsidies to help lower retiree premiums while aiming for minimal impacts to out-of-pocket cost sharing. It could also be offered on either a self-funded or fully insured basis.

For the EGWP Plus Wrap Standard Option and the EGWP Plus Wrap Enhanced Option, the main report is limited to only the comparison of self-funded (SF) options. Appendix B contains the results for these two options under a fully insured (FI) arrangement with an organization approved by CMS.

Medical Options

- *Coordination of Benefits (COB) with Savings Bank (Status Quo)* – Continue to offer the UMP Classic Medicare plan medical coverage with a COB Savings Bank for plan savings accrued as a result of Medicare primary payments for medical services covered by Medicare Part A and Part B. Members may use savings to cover member cost-share for services covered by Medicare or toward supplemental medical services which are not covered by Medicare, and the UMP Medicare deductible. The current COB Savings Bank is only applicable to the Medical Benefits.
- *COB with No Savings Bank* – Continue to offer the same medical coverage in the UMP Classic Medicare plan with coordination with Medicare for Medicare-covered services (Part A and Part B). Eliminate the COB Savings Bank without increasing the UMP Medicare medical deductible. Members would no longer be able to use savings to cover member cost share for supplemental medical services which are not covered by Medicare.
- *COB with No Savings Bank, Increase Deductible* – Continue to offer the same medical coverage in the UMP Classic Medicare plan with coordination with Medicare for Medicare-covered services (Part A and Part B). Eliminate the COB Savings Bank and increase the UMP Medicare medical deductible from $250 to $500 with a corresponding increase in the out-of-pocket maximum from $2,000 to $2,250.
- *Maintenance of Benefits* – Continue to offer the same medical coverage in the UMP Classic Medicare plan with coordination with Medicare for Medicare-covered services (Part A and Part B). Retiree cost-shares are determined by subtracting Medicare payments from total plan eligible charges, then applying the plan's benefit limits and cost sharing provisions to the remaining charges. The $250 deductible is not changed. For supplemental medical services which are not covered by Medicare, the full amount of UMP Classic Medicare plan cost sharing would be due, as this option by definition also does not have a COB Savings Bank and there is no Medicare payment for these services.

[1] The Washington state "Medicare Explicit Subsidy" is described in RCW 41.05.085 and is provided to retirees via a reduction to monthly PEBB Medicare health plan premiums. For 2024 the value of the subsidy is $183 or 50% of the plan's total premium, whichever is less.

Carve-out – Continue to offer the same medical coverage in the UMP Classic Medicare plan with coordination with Medicare for Medicare-covered services (Part A and Part B). Retiree cost-shares are determined based on total plan eligible charges assuming no Medicare payment, less the amount of the Medicare payment. The $250 deductible is not changed. For supplemental medical services which are not covered by Medicare, the full amount of UMP Classic Medicare plan cost sharing would be due, as this option by definition also does not have a COB Savings Bank and there is no Medicare payment for these services.

RESULTS

Tables 1 and 2 show total annual costs in 2025, comprised of projected plan option premiums, and the HCA administrative costs. Annual savings for UMP Classic Medicare under each pharmacy and medical coverage scenario are a comparison to the current creditable coverage for pharmacy and current medical structure or the Status Quo offering. These tables are organized in a matrix format with medical options along the vertical axis and pharmacy options along the horizontal axis. The impacts are additive across the options. These tables reflect only the SF EGWP options for both the Standard and Enhanced pharmacy alternatives and have been arranged from least to most savings for all alternatives. The EGWP fully insured options (enhanced and standard coverage) are offered in the Appendix.

TABLE 1: UMP CLASSIC MEDICARE TOTAL PROJECTED 2025 ANNUAL COSTS ($ MILLIONS)

		Pharmacy Benefits		
		Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP
Medical Benefits	Current	**$ 345.7**	$ 254.4	$ 240.0
	No COB Savings Bank	336.5	245.2	230.8
	$500 Deductible, no bank	334.4	243.1	228.7
	Maintenance of Benefits, no bank	321.0	229.7	215.3
	Carve-out, no bank	303.3	212.0	197.6

TABLE 2: UMP CLASSIC MEDICARE TOTAL PROJECTED 2025 ANNUAL SAVINGS ($ MILLIONS)

		Pharmacy Benefits		
		Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP
Medical Benefits	Current	$ -	$ (91.3)	$ (105.7)
	No COB Savings Bank	(9.2)	(100.5)	(114.9)
	$500 Deductible, no bank	(11.3)	(102.6)	(117.0)
	Maintenance of Benefits, no bank	(24.7)	(116.0)	(130.4)
	Carve-out, no bank	(42.4)	(133.7)	(148.1)

Savings shown are versus $345.7m projected Creditable Coverage costs in 2025 (see Table 1)

The projected retiree premiums and savings in 2025 are shown in Tables 3 and 4. Table 4 includes the savings to retirees on their monthly premium after the Medicare Explicit Subsidy is applied and with inclusion of the HCA Administrative Expense.

Please note that the premium rates are projections based on assumptions and methods outlined in this report. They are comprised of projected claims and administrative costs. The self-funded options do not include any profit margin. All projections in this report are subject to change based on actual experience.

TABLE 3: UMP CLASSIC MEDICARE PROJECTED 2025 RETIREE PREMIUMS PER ADULT UNIT PER MONTH (PAUPM)

		Pharmacy Benefits		
		Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP
Medical Benefits	Current Medical	**$ 618.18**	$ 408.22	$ 375.06
	No COB Savings Bank	591.01	381.05	347.89
	$500 Deductible, no bank	586.23	376.27	343.11
	Maintenance of Benefits, no bank	555.46	345.50	312.34
	Carve-out, no bank	514.64	304.68	271.52

TABLE 4: UMP CLASSIC MEDICARE PROJECTED 2025 RETIREE PREMIUM SAVINGS PER ADULT UNIT PER MONTH (PAUPM)

		Pharmacy Benefits		
		Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP
Medical Benefits	Current Medical	$ -	$ (209.96)	$ (243.12)
	No COB Savings Bank	(27.17)	(237.13)	(270.29)
	$500 Deductible, no bank	(31.95)	(241.91)	(275.07)
	Maintenance of Benefits, no bank	(62.72)	(272.68)	(305.84)
	Carve-out, no bank	(103.54)	(313.50)	(346.66)

It is important to note that different options may result in greater or lesser out-of-pocket costs (deductibles, coinsurance, copays) for some retirees based on how they use benefits, which could increase or diminish their total premium savings. All of the medical options result in greater retiree out-of-pocket cost-sharing, which in aggregate is equivalent to members' average monthly premium savings. The pharmacy and medical options are discussed more fully in the remainder of this report.

Additional details for the impacts to out-of-pocket costs (deductibles, coinsurance, copays) are provided but these summary tables are limited to the primary objective for identification of options that reduce retiree premiums. As Table 4 notes, the most premiums for HCA purchased coverage would be saved under a Standard SF EGWP pharmacy option and a Carve-out with no COB Savings Bank medical option. Under both of these structures while there are savings to retiree premiums, there are additional out of pocket costs for Medical that would be borne by the member, and Part D premiums would need to be paid directly for the plan selected.

Pharmacy Benefits

This report contains our results, methodology, and key assumptions from evaluating two potential pharmacy alternatives for retirees in the UMP Classic Medicare plan over the next four years (2024 – 2027), as described below. We understand any change(s) would not take place until 2025 at the earliest, so we included 2024 solely for illustrative purposes.

- Continue to offer non-Part D creditable pharmacy coverage in the UMP Classic Medicare plan. Note that it is likely that the Medicare Explicit Subsidy will need to be increased during the term of these projections for the UMP Classic Medicare plan to continue to qualify for the RDS. Any impacts from a legislated change in the amount of the Medicare Explicit Subsidy were beyond the scope of this report and would impact the results for all options.
- Modify the UMP Classic Medicare plan pharmacy coverage to utilize a Medicare Part D employer group waiver plus secondary wrap plan (EGWP) through an organization contracting with CMS, either on a self-funded (SF) or fully insured (FI) basis.

Financial Results

We provide a discussion for each of the alternative pharmacy options relative to the status quo.

- The Standard Part D self-funded EGWP option could potentially save retirees up to $105.7 million in UMP Classic Medicare prescription drug premiums in 2025. These savings are driven by federal subsidies relating to the Manufacturer Discount Program (MDP), federal reinsurance, and direct subsidy. In the case of the Part D EGWP Standard plan some of these premium savings would result in higher out of pocket cost sharing for the members.

The cost projections should be considered approximate due to the estimation techniques used and their potential to differ from vendor costs that would ultimately be obtained through a Request for Proposal (RFP) process. In addition, several changes relating to the Inflation Reduction Act of 2022 (IRA) are included in this analysis. The impact of these changes is uncertain, and it is subject to change pending further guidance from CMS.

Table 5 shows total projected annual premium cost for each of the four years and savings relative to the Creditable Coverage (Status Quo) for UMP Classic Medicare under each pharmacy coverage scenario. It does not include the savings (or cost) to retirees on their prescription drug cost-sharing. As mentioned earlier, these out-of-pocket costs are based on how each member uses their benefits, i.e., what prescriptions they fill and how they are covered by the plan. Members may experience greater or lesser prescription drug expenses, or no change to their out-of-pocket costs, depending on their personal utilization and the plan design for each coverage option. Compared to creditable drug coverage, EGWPs may offer equivalent prescription drug coverage (a “wrap”) with limited or no aggregate cost-shifting to members because they receive the Direct Subsidy, federal reinsurance, and Manufacturer Discounts only available to Part D plans.

TABLE 5: UMP CLASSIC MEDICARE TOTAL PROJECTED ANNUAL PHARMACY PREMIUM COSTS / (SAVINGS) ($ MILLIONS)

Annual Rx Costs	2024	2025	2026	2027
Creditable Coverage	$ 195.8	$ 223.7	$ 249.4	$ 280.8
Enhanced Self-Funded EGWP	98.5	132.4	147.7	164.6
Standard Self-Funded EGWP	62.0	118.0	133.1	149.8
Annual Rx Savings				
Enhanced Self-Funded EGWP	(97.3)	(91.3)	(101.7)	(116.2)
Standard Self-Funded EGWP	(133.8)	(105.7)	(116.3)	(131.0)
Assumed Enrollees	36,226	36,226	36,226	36,226

The projected annual premium costs for 2025 are shown in Table 6 on a per adult unit per month (PAUPM) basis. This table adds the PAUPM for the Current Medical and includes the savings relative to the Creditable Coverage (Status Quo) for retirees on the portion of their PAUPM premium attributed to prescription drug costs.

TABLE 6: UMP CLASSIC MEDICARE PROJECTED 2025 EMPLOYER AND RETIREE PHARMACY PREMIUM COSTS / (SAVINGS) PER ADULT UNIT PER MONTH (PAUPM)

Pricing Component	Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP
Medical Claims + Administration [1]	$ 280.59	$ 280.59	$ 280.59
Rx Claims + Administration	514.57	304.61	271.45
Total Claims + Administration	$ 795.16	$ 585.20	$ 552.04
HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00
HCA Administrative Fee	$ 6.02	$ 6.02	$ 6.02
Retiree Premium [2]	$ 618.18	$ 408.22	$ 375.06
Retiree Premium Costs / (Savings)		$ (209.96)	$ (243.12)
Annualized Retiree Premium Costs / (Savings) [3]		$ (91.3)	$ (105.7)

(1) We excluded the HCA Administrative fee from the Medical Claims + Administration line.
(2) Equals Total Claims + Administration less HCA Explicit Subsidy plus HCA Administrative Fee
(3) In $millions based on 36,226 enrollees

More detail of the cost buildup by year for each option is shown in the attached Tables 7-10.

The sections below discuss each option, along with the advantages and disadvantages.

CREDITABLE DRUG COVERAGE WITH RETIREE DRUG SUBSIDY (*STATUS QUO*)

The creditable drug coverage option is the status quo and is the baseline against which savings attributable to other options are measured. This option has several advantages and disadvantages.

Advantages

- Maintains current benefits, and current structure so there is no need to educate members on benefits and other plan changes.
- Provides HCA with formulary flexibility, and benefits administration (including coverage policies such as step therapy) aligns with UMP Classic for employees.
- The structure and administration of benefits also more closely aligns with the employee plan than that for an EGWP benefit plan.
- HCA retains the highest level of program control.

Disadvantages

- Prescription drug costs, and therefore plan premiums, are significantly higher. Non-Part D plans do not receive the same level of federal funding as Part D plans, including the risk-adjusted CMS direct subsidy, Manufacturer Discount Program (MDP), and federal reinsurance. The coverage gap discount program (CGDP), which will be replaced with the MDP in 2025, pays for approximately 70% of brand costs in the coverage gap for non-low-income members (who primarily comprise the UMP Medicare population).
- Does not protect against catastrophic costs above the RDS Cost Limit. In other words, the current UMP Classic Medicare structure does not receive subsidy for prescription drug spending above the RDS Cost Limit. This means that a large portion of total prescription drug spending is not eligible for a subsidy. The program will likely require increases in the Medicare Explicit Subsidy to continue receiving the RDS, since pharmacy costs continue to increase over time.
- Must obtain annual actuarial attestation from a certifying actuary to receive the RDS.
- Must provide annual creditable coverage notices to members.

PART D EMPLOYER GROUP WAIVER PLAN (BOTH ENHANCED AND STANDARD)

HCA may elect to enroll its UMP Classic Medicare population in a self-funded or fully insured Part D EGWP with an insurance company or pharmacy benefit manager that holds a contract with CMS to offer Part D coverage. This option also has several advantages and disadvantages.

Advantages

- Offers the lowest cost option to retirees that allows maintaining benefit levels similar to UMP Classic Medicare due to the combination of the direct subsidy, manufacturer or Pharma contributions through the CGDP or MDP, and federal reinsurance from CMS.
- Provides protection against very high ("catastrophic") prescription drug costs, which are rapidly increasing due to increasing specialty utilization and unit costs.
- Lowers the administrative burden in the long term after initial setup, relative to creditable drug coverage with the RDS.
- Lower average member cost sharing relative to UMP Medicare status quo, due to inclusion of the coverage gap discount in members' accumulation toward reaching the catastrophic phase (2024) and richer coverage because of the way claims accumulate to the MOOP in 2025 and beyond.
- Given the high enrollment in the UMP Classic Medicare plan, HCA should be able to customize the EGWP plan design and formulary.

Disadvantages

- Introduces members to disruption through changes to the benefit design and formularies. Highlights are outlined below, with a more thorough discussion following.
  - *Benefit Design:* Since EGWPs are a Medicare Part D product, the benefit design is subject to some of the Medicare Part D requirements applied to individual plans and therefore is likely to require at least minor structural differences from that of a creditable drug coverage plan. The complexity of the Part D benefit can require education to help the beneficiary understand the benefit (typically through Explanation of Benefits).
  - *Formularies:* The EGWP formularies offered to HCA will likely be different than the UMP Classic Medicare formulary. EGWP formularies could be richer (as drugs may need to be on formulary per CMS regulations), or leaner (e.g., if they only cover Part D drugs). HCA could likely add drugs if the EGWP formulary is leaner to minimize disruption; however, any non-Part D drugs would not be eligible for CMS subsidies. To keep the comparison consistent between the EGWP and status quo options, we did not model changes to the EGWP formulary.
- Subjects HCA to increased regulatory uncertainty. Recent regulation (CMS final rule on pharmacy rebates at the point of sale) and legislation (Inflation Reduction Act – IRA) began impacting plans in 2023, with the most significant changes taking place in 2024 and 2025. There will likely be more guidance forthcoming to implement the IRA, which resulted in a benefit redesign in 2025. This analysis reflects the provisions from the final rule, the IRA, and all CMS guidance to date. The provisions of the IRA legislation are summarized in a Milliman paper from August 2022.[2]
- Increases administrative costs and, potentially, taxation. HCA would outsource the administration of the EGWP to the contract holder. A fully insured EGWP would be subject to state premium taxes and margin for claim liability and profit.
- Creates change for retirees and HCA. Additional HCA Administrative resources will be needed to educate members about their new benefits. There will also be additional HCA Administrative resources needed to help implement the EGWP structure. A procurement would need to be developed to contract with the PBM or entity authorized by CMS. After implementation of the EGWP structure the HCA Administrative resources should lessen substantially.

[2] See this link: https://www.milliman.com/en/insight/weathering-the-reform-storm

In the following Tables we provide the line-by-line detail of the cost assumptions underlying the Total Cost for the Part D premium of each alternative benefit design.

Table 7
Projected 2024 Benefit Option Comparison (PAUPM)

Projected Cost Components	Creditable Coverage	Enhanced Self-Funded EGWP	Standard Self-Funded EGWP
1. Total Incurred Claims (net of rebates)	$ 496.98	$ 498.48	$ 484.15
2. Less: Retiree Out of Pocket Cost Sharing	(70.47)	(67.53)	(100.86)
3. Less: Pharma Discount (CGDP)	N/A	(95.53)	(75.33)
4. Less: Federal Reinsurance (net of rebates)	N/A	(129.09)	(185.57)
5. Less: Federal Subsidy	N/A	(11.62)	(11.62)
6. Plan Liability for Primary Coverage	$ 426.51	$ 194.71	$ 110.77
7. Plus: Carrier Administration	19.36	19.36	19.36
8. Plus: EGWP Administration + Profit	N/A	8.00	8.00
9. Plus: Premium Taxes	N/A	N/A	N/A
10. Plus: Rx Change in PSR	4.46	4.46	4.46
11. Total Cost/Part D Premium	$ 450.33	$ 226.53	$ 142.59
Total Cost			
12. Total Medical Cost	$ 270.14	$ 270.14	$ 270.14
13. Rx Cost	450.33	226.53	142.59
14. Medical + Drug Cost	$ 720.47	$ 496.67	$ 412.73
15. HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00
16. HCA Administrative Charge	$ 5.96	$ 5.96	$ 5.96
Total Retiree Cost			
17. Retiree Premium (Line 14 - Line 15 + Line 16)	$ 543.43	$ 319.63	$ 235.69
18. Total Retiree Premium Savings (from Line 17)		$ (223.80)	$ (307.74)

Table 8
Projected 2025 Benefit Option Comparison (PAUPM)

Projected Cost Components	Creditable Coverage	Enhanced Self-Funded EGWP	Standard Self-Funded EGWP
1. Total Incurred Claims (net of rebates)	$ 562.45	$ 559.20	$ 549.74
2. Less: Retiree Out of Pocket Cost Sharing	(72.36)	(53.58)	(80.92)
3. Less: Pharma Discount (MDP)	N/A	(101.90)	(100.02)
4. Less: Federal Reinsurance (net of rebates)	N/A	(78.44)	(76.68)
5. Less: Federal Subsidy	N/A	(53.52)	(53.52)
6. Plan Liability for Primary Coverage	$ 490.09	$ 271.76	$ 238.60
7. Plus: Carrier Administration	19.56	19.56	19.56
8. Plus: EGWP Administration + Profit	N/A	8.37	8.37
9. Plus: Premium Taxes	N/A	N/A	N/A
10. Plus: Rx Change in PSR	4.92	4.92	4.92
11. Total Cost/Part D Premium	$ 514.57	$ 304.61	$ 271.45
Total Cost			
12. Total Medical Cost	$ 280.59	$ 280.59	$ 280.59
13. Rx Cost	514.57	304.61	271.45
14. Medical + Drug Cost	$ 795.16	$ 585.20	$ 552.04
15. HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00
16. HCA Administrative Charge	$ 6.02	$ 6.02	$ 6.02
Total Retiree Cost			
17. Retiree Premium (Line 14 - Line 15 + Line 16)	$ 618.18	$ 408.22	$ 375.06
18. Total Retiree Premium Savings (from Line 17)		$ (209.96)	$ (243.12)

Table 9
Projected 2026 Benefit Option Comparison (PAUPM)

Projected Cost Components	Creditable Coverage	Enhanced Self-Funded EGWP	Standard Self-Funded EGWP
1. Total Incurred Claims (net of rebates)	$ 622.13	$ 619.12	$ 610.08
2. Less: Retiree Out of Pocket Cost Sharing	(73.60)	(54.02)	(82.13)
3. Less: Pharma Discount (MDP)	N/A	(115.66)	(113.82)
4. Less: Federal Reinsurance (net of rebates)	N/A	(90.12)	(88.41)
5. Less: Federal Subsidy	N/A	(53.52)	(53.52)
6. Plan Liability for Primary Coverage	$ 548.53	$ 305.80	$ 272.20
7. Plus: Carrier Administration	19.76	19.76	19.76
8. Plus: EGWP Administration + Profit	N/A	8.76	8.76
9. Plus: Premium Taxes	N/A	N/A	N/A
10. Plus: Rx Change in PSR	5.43	5.43	5.43
11. Total Cost/Part D Premium	$ 573.72	$ 339.75	$ 306.15
Total Cost			
12. Total Medical Cost	$ 291.45	$ 291.45	$ 291.45
13. Rx Cost	573.72	339.75	306.15
14. Medical + Drug Cost	$ 865.17	$ 631.20	$ 597.60
15. HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00
16. HCA Administrative Charge	$ 6.08	$ 6.08	$ 6.08
Total Retiree Cost			
17. Retiree Premium (Line 14 - Line 15 + Line 16)	$ 688.25	$ 454.28	$ 420.68
18. Total Retiree Premium Savings (from Line 17)		$ (233.97)	$ (267.57)

Table 10
Projected 2027 Benefit Option Comparison (PAUPM)

Projected Cost Components	Creditable Coverage	Enhanced Self-Funded EGWP	Standard Self-Funded EGWP
1. Total Incurred Claims (net of rebates)	$ 694.87	$ 685.50	$ 676.91
2. Less: Retiree Out of Pocket Cost Sharing	(74.91)	(54.38)	(83.27)
3. Less: Pharma Discount (MDP)	N/A	(131.00)	(129.23)
4. Less: Federal Reinsurance (net of rebates)	N/A	(103.14)	(101.50)
5. Less: Federal Subsidy	N/A	(53.52)	(53.52)
6. Plan Liability for Primary Coverage	$ 619.96	$ 343.46	$ 309.39
7. Plus: Carrier Administration	19.96	19.96	19.96
8. Plus: EGWP Administration + Profit	N/A	9.16	9.16
9. Plus: Premium Taxes	N/A	N/A	N/A
10. Plus: Rx Change in PSR	5.99	5.99	5.99
11. Total Cost/Part D Premium	$ 645.91	$ 378.57	$ 344.50
Total Cost			
12. Total Medical Cost	$ 302.74	$ 302.74	$ 302.74
13. Rx Cost	645.91	378.57	344.50
14. Medical + Drug Cost	$ 948.65	$ 681.31	$ 647.24
15. HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00
16. HCA Administrative Charge	$ 6.14	$ 6.14	$ 6.14
Total Retiree Cost			
17. Retiree Premium (Line 14 - Line 15 + Line 16)	$ 771.79	$ 504.45	$ 470.38
18. Total Retiree Premium Savings (from Line 17)		$ (267.34)	$ (301.41)

Additional Consideration of Part D Defined Standard Benefit

When transitioning from creditable drug coverage to an EGWP, the most significant concerns are member disruption through changes to benefits and formularies. However, an Enhanced EGWP benefit option can have a plan design that mimics non-Part D coverage such as UMP Classic Medicare. Relative to the Defined Standard EGWP benefit option member disruption will be less, and the premium savings are still significant.

For plan liability and premium costs associated with the EGWP plus wrap options, the Part D coverage phases still apply. While the member cost-sharing amounts under the Enhanced option may be lower (more generous) than the Part D Defined Standard benefit described below, the plan receives manufacturer discounts and federal reinsurance according to the initial coverage and out-of-pocket limits.

- *Initial Coverage Corridor (ICC)* – Members are generally responsible for no more than 25% of prescription medication costs incurred between the deductible and the initial coverage limit (ICL). For 2024, the ICL is $5,030 in allowed cost. A maximum deductible of $545 (in 2024) is allowed prior to the ICC.
- *Coverage Gap* – After the allowed cost for a member exceeds the ICL, the member enters the coverage gap. A member remains in the coverage gap until that member's out-of-pocket costs plus manufacturer discounts reach the true out-of-pocket limit (TrOOP), which is $8,000 in spend in 2024. In 2024, various payers are responsible for costs incurred while the member is in the coverage gap. For a non-low-income member using a brand medication, the member generally pays no more than 25%, the plan pays at least 5%, and the CGDP pays 70% of the brand costs on average. For all members using generic medications, the member generally pays no more than 25%, and the plan pays at least 75% on average. **This is the portion of the benefit where EGWPs have historically provided the largest benefit enhancements over individual Part D plans and is often cited as a key reason employers retain retiree pharmacy coverage under an EGWP structure.**

  Beginning in 2025, the coverage gap will be eliminated, resulting in a simpler benefit design for both EGWPs and individual plans. The benefit design will be comprised of the deductible, the ICC, and catastrophic phases. The CGDP will be replaced with the MDP, which will cover costs in the ICC and catastrophic phases and be applicable to both low and non-low-income individuals.
- *Catastrophic Phase* – Once the TrOOP limit has been reached, a member enters the catastrophic coverage phase. In this phase in 2024, the member has no liability, the plan is responsible for 20% of allowed costs, and the remaining 80% is paid by CMS.

  Beginning in 2025, the member liability will be limited to $2,000, which is where the catastrophic phase will begin. The plan will be responsible for approximately 60% of allowed cost in the catastrophic phase, the manufacturer will be responsible for approximately 20% of the brand allowed cost in this phase, and CMS will pay the remaining cost (approximately 20% of brand and 40% of generic costs). **While this benefit change will increase the plan liability, the CMS direct subsidy will also increase, offsetting much of the additional plan liability.**

Retirees may expect formulary coverage to be similar but not the same when transitioning from creditable drug coverage to an EGWP. Although disruption from formulary differences may be minimized through selection and customization of a richer EGWP formulary, some members will almost certainly be impacted.

Another consideration if HCA selects this option is whether to select a self-funded or fully insured EGWP. While a fully insured product has higher administrative fees and profit margins than the self-funded option, cash flows are more of a concern with the self-funded option (as noted in the bullet points below). With the self-funded option, plan sponsors may need to wait as long as nine months after the end of the plan year to fully reconcile subsidies / costs. In some cases, carriers may allow for self-funding for a portion of the benefit only (e.g., the "wrap" plan). Appendix B provides the estimated costs for the fully insured EGWP options of both a Defined Standard and Enhanced benefit structure.

There are other considerations for transitioning from creditable drug coverage to a Part D EGWP:

- *Low Income Cost Sharing Subsidy (LICS)* – The Part D EGWP product provides premium and cost sharing assistance to low income (LI) members (i.e., members with incomes below 150% of the federal poverty limit). CMS does not pay prospective LICS amounts to EGWPs. However, the payments are reconciled during the year-end reconciliation process (approximately nine months after year-end). Retiree populations generally have a low percentage of LI members, so the reconciliation amount is relatively small. We assumed no LICS for this study but could estimate it with more analysis.
- *Federal Reinsurance Subsidy* – The CMS federal reinsurance subsidy reimburses EGWPs for 80% of eligible pharmacy costs in the catastrophic phase of the Part D benefit in 2024 and prior. In 2024, CMS will pay monthly prospective payments for reinsurance to EGWPs. Similar to LICS, federal reinsurance payments are reconciled during the normal year-end reconciliation process. This prospective payment is likely to change significantly for 2025 due to changes in the catastrophic phase.
- *Direct Subsidy* – The direct subsidy is a risk-adjusted payment made by CMS to plan sponsors. The direct subsidy is not reconciled like other subsidies and has been decreasing substantially over the last several years. However, we expect that trend to reverse in 2024 and 2025, with an increase in the direct subsidy in 2024 followed by an even larger increase in 2025. The direct subsidy is based on the individual retiree market dynamics and will continue to be subject to sequestration.
- *CGDP / MDP* – The CGDP was introduced with the Affordable Care Act (ACA) and will be sunset by the IRA at the end of 2024. The IRA introduces the MDP starting in 2025, which will help offset costs to HCA under an EGWP. There is a year-end reconciliation for the coverage gap discount, which is prospectively paid to plans quarterly. There will likely be a reconciliation for the MDP structured similarly to that of the CGDP.
- *Timing* – The implementation of an EGWP can take several months. With an anticipated effective date of January 2025, the transition should begin in late 2023 to early 2024.

Medical Benefits

This analysis includes five options for providing the medical benefit in the UMP Classic Medicare plan. All options retain UMP's self-funded status and coordinate with Medicare as primary for Medicare-covered services.

- *COB with Savings Bank (Status Quo)* – Continue to offer medical coverage in the UMP Classic Medicare plan with a COB Savings Bank for plan savings accrued as a result of Medicare primary payments for services covered by Medicare Part A and Part B.
- *COB with No Savings Bank* – Continue to offer the same medical coverage in the UMP Classic Medicare plan with coordination with Medicare for Medicare-covered services (Part A and Part B). Eliminate the COB Savings Bank without increasing the medical deductible. Under this coordination approach the secondary plan payment is limited to the amount that would have been paid by the primary plan for claims.
- *COB with No Savings Bank, increase Deductible* – Continue to offer the same medical coverage in the UMP Classic Medicare plan with coordination with Medicare for Medicare-covered services (Part A and Part B). Eliminate the COB Savings Bank and increase the medical deductible from $250 to $500 with a corresponding increase in the out-of-pocket maximum from $2,000 to $2,250. Under this coordination approach the secondary plan payment is limited to the amount that would have been paid by the primary plan for claims.
- *Maintenance of Benefits* – Continue to offer the same medical coverage in the UMP Classic Medicare plan with coordination with Medicare for Medicare-covered services (Part A and Part B). Retiree cost-shares are determined by subtracting Medicare payments from total Medicare Allowed Amounts, then applying the plan's benefit limits and cost sharing provisions to the remaining amount after primary coverage. For supplemental services not covered by Medicare the Plan Allowed Amount is applied to the plan's benefit limits. The $250 deductible is not changed.
- *Carve-out* – Continue to offer the same medical coverage in the UMP Classic Medicare plan with coordination with Medicare for Medicare-covered services (Part A and Part B). Retiree cost-shares are determined based on total Medicare Allowed Amounts assuming no Medicare payment, less the amount of the Medicare payment. Under this coordination approach the UMP Classic Medicare plan would continue to protect against balance billing, and so the Plan Allowed Amounts would be used for all supplemental services not covered by Medicare. The $250 deductible is not changed.

An illustration of how the retiree cost-share is calculated under both COB alternatives, Carve-out, and Maintenance of Benefits can be found in Appendix B.

FINANCIAL RESULTS

We provide a discussion for each of the alternative options relative to the status quo.

- The COB with No Savings Bank option could save $9.2 million in medical premium in 2025. Savings could be increased to $11.3 million in 2025 if the deductible is also increased.
- The Maintenance of Benefits option is projected to save an estimated $24.7 million in 2025. This method of coordination increases member cost-share compared to status quo but less than the Carve-out method.
- The Carve-out option could save an estimated $42.4 million in 2025, driven by the change in method of coordination with Medicare Parts A and B. This coordination method has the greatest increase on member cost-share.

The cost projections should be considered approximate due to the high level estimation techniques used and their potential to differ from estimates that would ultimately be obtained through a more robust pricing approach.

Table 11 shows total projected claims and administrative costs and savings for UMP Classic Medicare in 2025 under each medical coverage scenario. It does not include the savings (or cost) to retirees on their out-of-pocket costs.

TABLE 11: UMP CLASSIC MEDICARE ESTIMATED ANNUAL MEDICAL COSTS / (SAVINGS) ($ MILLIONS)

Annual Medical Costs	2024	2025	2026	2027
Current	$ 117.4	$ 122.0	$ 126.7	$ 131.6
No COB Savings Bank	108.7	112.8	117.1	121.5
$500 Deductible, no bank	106.7	110.7	114.9	119.2
Maintenance of Benefits, no bank	93.4	97.3	101.4	105.7
Carve-out, no bank	76.1	79.6	83.4	87.4
Annual Medical Savings				
No bank	$ (8.7)	$ (9.2)	$ (9.6)	$ (10.1)
$500 Deductible, no bank	(10.7)	(11.3)	(11.8)	(12.4)
Maintenance of Benefits, no bank	(24.0)	(24.7)	(25.3)	(25.9)
Carve-out, no bank	(41.3)	(42.4)	(43.3)	(44.2)

The projected savings in 2025 is shown in Table 12 on a PAUPM basis. This table includes the savings (or additional cost) to retirees on their out-of-pocket costs.

TABLE 12: UMP CLASSIC MEDICARE PROJECTED 2025 RETIREE PREMIUM COST / (SAVINGS) PER ADULT UNIT PER MONTH (PAUPM)

	Calendar Year 2025				
Pricing Component	Current	No bank	$500 Ded no bank	MOB, no bank	Carve-out, no bank
Medical Claims + Administration [1]	$ 280.59	$ 253.42	$ 248.64	$ 217.87	$ 177.05
Rx Claims + Administration	514.57	514.57	514.57	514.57	514.57
Total Claims + Administration	$ 795.16	$ 767.99	$ 763.21	$ 732.44	$ 691.62
HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00	$ 183.00	$ 183.00
HCA Administrative Fee	$ 6.02	$ 6.02	$ 6.02	$ 6.02	$ 6.02
Retiree Premium [2]	$ 618.18	$ 591.01	$ 586.23	$ 555.46	$ 514.64
Retiree Premium Costs / (Savings)		$ (27.17)	$ (31.95)	$ (62.72)	$ (103.54)

(1) We excluded the HCA Administrative fee from the Medical Claims + Administration line.

(2) Equals Total Claims + Administration less HCA Explicit Subsidy plus HCA Administrative Fee

Note that we did not assume any additional claims cost savings from the decreased utilization that can potentially accompany higher out of pocket cost sharing. As a result, the medical options produce no aggregate savings to the retirees since premium savings are offset by out-of-pocket cost increases. Nevertheless, these changes would benefit the healthier participants with lower total out-of-pocket costs, while those participants with more utilization would have higher total out-of-pocket costs even with the lower premiums.

Please note that for all of these medical benefit options we used the 2024 Medicare Explicit Subsidy amount, which is capped by the legislature at $183 or 50 percent of the plan's premium, whichever is less. In addition, the medical benefit analysis assumes no change to the current UMP Classic Medicare pharmacy benefit.

Methodology and Assumptions

Our pharmacy projections are based on Milliman's Retiree Pharmacy Option Comparison Tool (RPOCT). We used underlying data and assumptions provided by HCA, CMS, and additional regulations to the Medicare Part D program introduced under the Affordable Care Act. We calibrated RPOCT to HCA's historical experience based on the memo from June 5, 2023 (Re: PEBB UMP Medicare 2024 Bid Development 2.1 – 3rd Pass – Updated 2024 Open Enrollment Adjustment) and projected the net pharmacy spend under the projected benefit option.

We made a number of key assumptions when developing our estimates.

We targeted 2024 prescription drug claims from the 2024 PEBB UMP Medicare Bid Rate Development by using calibration techniques in the RPOCT. The prescription drug claims are distributed by days' supply and channel (retail / mail) using the 2023 distribution from Milliman's pharmacy Health Cost Guidelines research. We trended the historical experience to the projection periods using the trends in Table 13. The trends in Table 13 result in a composite trend of approximately 10% to 11% per year (before cost sharing and federal funding).

TABLE 13: HCA ANNUAL TREND ASSUMPTIONS*

	RETAIL			MAIL		
TREND COMPONENTS	**GENERIC**	**BRAND**	**SPECIALTY**	**GENERIC**	**BRAND**	**SPECIALTY**
Utilization	3.1%	0.8%	12.5%	3.1%	0.8%	12.5%
Drug Mix	2.5%	-2.6%	0.0%	2.5%	-2.6%	0.0%
Inflation	0.0%	7.4%	6.5%	0.0%	7.4%	6.5%

*Trends do not include formulary shifts.

Our medical projections are based on Milliman's Retiree Medical Rating Model (RMRM). We used underlying data and assumptions provided by HCA. We calibrated RMRM to the PEBB UMP Medicare 2024 Bid Development 2.1 – 3rd Pass – Updated 2024 Open Enrollment Adjustment.

- We assumed the following additional annual trend rates:
  - Medical claims: 4.0%
  - RDS: 6.2% for 2024 to 2025, 3.3% for 2025 to 2026, and 3.4% for 2026 to 2027
  - Carrier and EGWP administrative expenses: 4.6%
  - Premium stabilization reserve trend based on projected costs
- We used the current plan design provided by HCA. Furthermore, we assumed HCA will continue to offer this plan design through the coverage gap in the EGWP scenario to resemble the current benefits.
- We assumed HCA would purchase EGWP options that do not cover non-Part D drugs.
- Pharmacy rebates are determined using HCA's experience and are assumed to increase slightly over time as brand and specialty trends outpace generic trends. We applied the same rebate percentage when projecting costs for all pharmacy plan options (EGWP SI and FI).
- Our projections assume HCA retirees will have an average risk score of 0.786, consistent with the 2024 nationwide non-institutionalized, non-Medicaid population based on Milliman research. We assumed this risk score would change to 0.681 in 2025 as a result of changes made by the Inflation Reduction Act of 2022.
- We assumed HCA PAUPM administrative fees of $5.96, $6.02, $6.08 and $6.14 in the years 2024, 2025, 2026 and 2027, respectively. The 2024 amount of $5.96 is consistent with the 2024 bid rate letter, and we then trend this amount to 2025 through 2027 at a 1% annual rate.
- We assumed vendor administrative costs would be $8.00 PAUPM higher in 2024 under the EGWP than the current RDS plan since administrative responsibilities are shifted from the plan sponsor to the carrier in that structure. This assumption is based on what we have observed from other clients. Actual results would need to be evaluated during a procurement.

- We assumed the fully insured EGWP is subject to estimated state premium taxes of roughly 2% of the premium associated with the wrap portion of the benefit.
- We assumed the fully insured EGWP would have profit margins of 5% of premium.
- We assumed sequestration would continue into 2024 through 2027, which decreases the Part D direct subsidy amount by 2%.
- We estimated the Part D Defined Standard benefit parameters based on the average historical trends of these values and modeling of the final rule and IRA. We also estimated direct subsidies based on these two items and our understanding of their implementation.
- Our modeling is limited to the UMP Classic Medicare plan. We have not included any other PEBB plans in this analysis and have not assumed any migration from UMP Classic Medicare to other options.
- We assume a constant retiree adult unit count of 36,226 in the UMP Classic Medicare plan based on the membership assumptions used in 2024 UMP Medicare rate development.

Caveats and Limitations on Use

VARIABILITY OF RESULTS

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate RDS and EGWP costs for calendar years 2024 through 2027. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information provided by HCA and Moda for this purpose and accepted it without audit. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are additional material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance include:

- Data used in our October 21, 2022 RDS projection letter
- 2024 PEBB UMP Medicare Bid Rate Development as described above
- Guidance from CMS on the Inflation Reduction Act of 2022

The models, including all input, calculations, and output may not be appropriate for any other purpose.

In addition, the actual RDS and EGWP costs will vary from the amounts presented in this analysis to the extent that actual experience differs from that projected by the actuarial assumptions and to the extent that final CMS guidance on the IRA does not match our assumptions. In addition, it is likely that the Medicare Explicit Subsidy will need to be increased during the projection years shown in this report in order for the UMP Classic Medicare plan to continue to qualify for the RDS. Actual experience should be monitored, and appropriate action taken as results emerge.

LIMITATIONS OF USE

The information contained in this letter has been prepared for the Washington State Health Care Authority (HCA). It is our understanding that the information contained in this memorandum may be utilized in a public document. To the extent that the information supports other documents, this letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for HCA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the assumptions and factors used for projection of future budgets.

Actual experience will vary from our estimates for many reasons, including differences in population health status, in reimbursement levels, and in the delivery of healthcare services, utilization patterns, as well as other non-random and random factors. It is important that actual experience be monitored, and action be taken as appropriate.

Our projected estimates are not predictions of the future; they are projections or estimates based on assumptions. If the underlying data or other listings are inaccurate or incomplete, this analysis may also be inaccurate or incomplete. Emerging results should be carefully monitored with assumptions adjusted as appropriate.

In performing this analysis, Milliman relied upon data ultimately provided by the Health Care Authority, as well as HCA's third-party administrators and fully insured carriers. We have also relied on incurred but not reported liability estimates supplied by our office. We performed a limited review of the data used directly in our analysis for

reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment. To the extent that there are errors contained within this data, the results of our analysis could produce erroneous results.

The consultants who worked on this assignment are health actuaries. Milliman's advice is not intended to be a substitute for qualified legal, investment, or accounting counsel. This is particularly relevant to the COB Savings Bank, which is subject to legal interpretation as to the covered benefits.

We are members of the American Academy of Actuaries, and we meet the qualification standards for performing the analyses in this report.

Appendix A - Definitions

COB Savings Bank

UMP Classic Medicare relies on a third-party administrator to calculate and monitor the COB Savings Bank for each member over the course of the plan year. The Medicare Allowed amounts are used to establish the COB Savings Bank as the savings from UMP Classic Medicare serving as a secondary coverage. The plan then pays all amounts not covered by Medicare up to the amount that would be paid in absence of Medicare as described, before calculating the COB Savings Bank. Once this secondary payment amount is determined, a second calculation is performed to compare all amounts not covered by Medicare and the amount that would be paid in absence of Medicare to determine if there was a secondary plan savings and that amount less the secondary payment then accumulates to the COB Savings Bank. This is always done under the primary plan's Medicare allowed.

Members can use their accrued savings in the COB Savings Bank to reimburse cost-sharing for services not covered by original Medicare. For services not covered by original Medicare, the UMP network allowed amount is used to determine the secondary plan coverage, and the amount of cost sharing for these services. Ultimately the current benefit structure leads to a 100% coverage for almost all of the members, with only a very small percentage of members who do not have enough COB Savings to cover either their original Medicare deductible or their UMP Secondary Deductible.

Coordination Methods

The coordination methods are described further below. Also included is a simplified illustration of the coordination methods and the COB Savings Bank and their impact on member cost sharing. The following assumptions are used for purposes of the illustration:

1. Provider billed charge: $1,200.
2. Medicare allowed amount: $1,000.
3. Amount payable by Medicare: $800 (item 2 times 80%)
4. Medicare eligible charges not paid by Medicare: $200 (item 2 less item 3)
5. Amount payable by the UMP Classic Medicare Plan in the absence of Medicare: $850
   (item 2 times 85%, which is the coinsurance percentage for the UMP Classic Medicare Plan)
6. The member is assumed to have already met their deductible.

Coordination of Benefits (COB) Plan

Under this method, Medicare is treated as the primary carrier and benefits are paid as described on the policy's coordination of benefits (COB) provision. Such plans pay all Medicare eligible charges not paid by Medicare up to the amount that would be paid in the absence of Medicare. Below is an illustration of how this method impacts member cost sharing. While the UMP Classic Medicare plan includes sufficient protections from balance billing, some COB Plans may also allow the provider to bill the member for the difference between the billed charges (item 1) and the Medicare allowed amount (item 2). For these illustrations we assume the member is not balanced billed.

a. Medicare eligible charges not paid by Medicare: $200 (item 4 above)
b. Amount UMP Classic Medicare Plan would pay in the absence of Medicare: $850 (item 5 above)
c. Amount paid by UMP Classic Medicare Plan under this method: **$200** (lesser of item a and item b)
d. Amount payable by the member: **$0** (item 1 above less item 3 above less item c)

Maintenance of Benefits (MOB) Plan

This approach subtracts Medicare Parts A and B payments from total plan eligible charges and then applies the plan's benefit limits and cost-sharing provisions to the remaining charges. This is also known as an Eligible Expense Offset Plan. Below is an illustration of how this method impacts member cost sharing.

a. Total plan eligible charges: $1,000 (item 2 above)

b. Amount of Medicare payments: $800 (item 3 above)

c. Amount paid by UMP Classic Medicare Plan under this method: **$170** ((item a less item b) times 85%)

d. Amount paid by the member: **$30** (item 2 above less item 3 above less item c)

Medicare Carve-out

Medical benefit costs are determined as the benefits payable based on the total plan eligible charges (assuming no Medicare payment) less the amount of Medicare Parts A and B payments. This approach is sometimes also referred to as a Benefit Offset approach. Below is an illustration of how this method impacts member cost sharing.

a. Amount payable by UMP based on the total plan eligible charges assuming no Medicare payment: $850 (item 5 above)

b. Amount of Medicare payments: $800 (item 3 above)

c. Amount paid by UMP Classic Medicare Plan under this method: **$50** (item a less item b)

d. Amount payable by the member: **$150** (item 2 above less item 3 above less item c)

Amounts payable by the UMP Classic Medicare Plan and the member are summarized for all the options below.

TABLE 14: AMOUNTS PAYABLE BY UMP CLASSIC MEDICARE AND MEMBERS – DIFFERENT COORDINATION METHODS

	Current	COB Plan	MOB	Carve-out
Allowed Amount	$1,000	$1,000	$1,000	$1,000
Paid by Medicare	$800	$800	$800	$800
Paid by UMP Classic Medicare Plan	$200	$200	$170	$50
Paid into COB Savings Bank	$600	-	-	-
Paid by Member	-	-	$30	$150
Total Secondary Plan Liability	$800	$200	$170	$50

Retiree Drug Subsidy Program

The RDS program was created to incentivize employers to continue to provide prescription drug coverage for their Medicare-eligible retirees by reimbursing a portion of retiree drug expenses. To qualify for the subsidy, a Plan Sponsor must show that its eligible plans' drug coverage is at least as generous as the Part D Defined Standard benefit.

Pursuant to RCW 41.05.068, HCA has participated in the RDS Program for its eligible PEBB Medicare plans since 2006. However, as pharmacy claims costs increase, particularly for UMP Classic Medicare, the HCA may eventually no longer meet the actuarial equivalence test to qualify for the RDS, based on the $183 PAUPM retiree subsidy. This report does not consider the impact of either keeping or losing the RDS on the $183 PAUPM retiree subsidy.

Medicare Part D EGWP

A Medicare Part D EGWP (Employer Group Waiver Plan) is a type of prescription drug plan offered by employers to Medicare-eligible retirees as part of their benefits package. EGWPs are offered by employers or unions who have obtained a waiver from the Centers for Medicare & Medicaid Services (CMS) to provide prescription drug coverage through a group plan instead of individuals enrolling in Medicare Part D plans.

Here's how Medicare Part D EGWPs typically work:

- Employer or Union Sponsorship: The EGWP is sponsored by an employer or union, which means it is offered to retirees affiliated with the plan sponsor who are eligible for Medicare and a retiree benefits package. The plan sponsor (employer or union) administers the plan and contracts with a private insurance company or pharmacy benefit manager to handle the claims processing and management.
- Comprehensive Prescription Drug Coverage: Medicare Part D EGWPs provide coverage for prescription drugs, including brand-name and generic medications, as well as specialty drugs. The specific drugs covered and the associated costs (such as copayments or coinsurance) depend on the plan's formulary, which is a list of covered medications.
- EGWPs may offer “wrap” coverage to enhance benefits above the Part D defined standard benefit, including lower member cost-sharing and coverage of non-Part D drugs.
- Premiums and Cost-Sharing: EGWPs may have different premium structures and cost-sharing arrangements. The plan sponsor typically subsidizes a portion of the premium costs, making it more affordable for enrollees. Cost-sharing, such as copayments or coinsurance, may be required when obtaining prescription drugs.
- Medicare Part D Standards: Although EGWPs operate differently from standalone (individual market) Medicare Part D plans, they still must meet certain standards set by Medicare. These standards include coverage requirements, formulary guidelines, and coordination with other Medicare benefits.
- Annual Enrollment: Like other Medicare Part D plans, EGWPs have an annual enrollment period when individuals can join, switch, or disenroll from the plan. This typically occurs during the fall Open Enrollment Period, which is usually from October 15 to December 7 of each year. The PEBB Program has its own Open Enrollment period during which retirees can elect any plan in the PEBB Medicare portfolio.

Appendix B -
Pharmacy Benefit Tables with Fully Insured EGWP Options

Table 15
UMP Classic Medicare
Total Projected 2025 Annual Costs ($ millions)

		Pharmacy Benefits				
		Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP	Enhanced FI EGWP	Standard FI EGWP
Medical Benefits	Current	**$ 345.7**	$ 254.4	$ 240.0	$ 261.6	$ 246.2
	No COB Savings Bank	336.5	245.2	230.8	252.4	237.0
	$500 Deductible, no bank	334.4	243.1	228.7	250.3	234.9
	Maintenance of Benefits, no bank	321.0	229.7	215.3	236.9	221.5
	Carve-out, no bank	303.3	212.0	197.6	219.2	203.8

Table 16
UMP Classic Medicare
Total Projected 2025 Annual Savings ($ millions)

		Pharmacy Benefits				
		Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP	Enhanced FI EGWP	Standard FI EGWP
Medical Benefits	Current	$ -	$ (91.3)	$ (105.7)	$ (84.1)	$ (99.5)
	No COB Savings Bank	(9.2)	(100.5)	(114.9)	(93.3)	(108.7)
	$500 Deductible, no bank	(11.3)	(102.6)	(117.0)	(95.4)	(110.8)
	Maintenance of Benefits, no bank	(24.7)	(116.0)	(130.4)	(108.8)	(124.2)
	Carve-out, no bank	(42.4)	(133.7)	(148.1)	(126.5)	(141.9)

Savings shown are versus $345.7m projected Creditable Coverage costs in 2025 (see Table 1)

Table 17
UMP Classic Medicare
PAUPM Projected 2025 Medical Plus Pharmacy Retiree Premiums

		Pharmacy Benefits				
		Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP	Enhanced FI EGWP	Standard FI EGWP
Medical Benefits	Current Medical	**$ 618.18**	$ 408.22	$ 375.06	$ 424.9	$ 389.4
	No COB Savings Bank	591.01	381.05	347.89	397.68	362.20
	$500 Deductible, no bank	586.23	376.27	343.11	392.90	357.42
	Maintenance of Benefits, no bank	555.46	345.50	312.34	362.1	326.65
	Carve-out, no bank	514.64	304.68	271.52	321.3	285.83

Table 18
UMP Classic Medicare
PAUPM Projected 2025 Medical Plus Pharmacy Retiree Premium Savings

		Pharmacy Benefits				
		Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP	Enhanced FI EGWP	Standard FI EGWP
Medical Benefits	Current Medical	$ -	$ (209.96)	$ (243.12)	$ (193.3)	$ (228.81)
	No COB Savings Bank	(27.17)	(237.13)	(270.29)	(220.5)	(255.98)
	$500 Deductible, no bank	(31.95)	(241.91)	(275.07)	(225.3)	(260.76)
	Maintenance of Benefits, no bank	(62.72)	(272.68)	(305.84)	(256.0)	(291.53)
	Carve-out, no bank	(103.54)	(313.50)	(346.66)	(296.9)	(332.35)

Table 19
UMP Classic Medicare
Estimated Annual Pharmacy Costs / (Savings)
($ millions)

Annual Rx Costs	2024	2025	2026	2027
Creditable Coverage	$ 195.8	$ 223.7	$ 249.4	$ 280.8
Enhanced Self-Funded EGWP	98.5	132.4	147.7	164.6
Standard Self-Funded EGWP	62.0	118.0	133.1	149.8
Enhanced Fully Insured EGWP	104.7	139.6	155.7	173.5
Standard Fully Insured EGWP	65.2	124.2	140.1	157.6
Annual Rx Savings				
Enhanced Self-Funded EGWP	$ (97.3)	$ (91.3)	$ (101.7)	$ (116.2)
Standard Self-Funded EGWP	(133.8)	(105.7)	(116.3)	(131.0)
Enhanced Fully Insured EGWP	(91.1)	(84.1)	(93.7)	(107.3)
Standard Fully Insured EGWP	(130.6)	(99.5)	(109.3)	(123.2)
Assumed Enrollees	36,226	36,226	36,226	36,226

Table 20
UMP Classic Medicare
Projected 2025 Employer and Retiree Cost
Per Adult Unit Per Month (PAUPM)

Pricing Component	Creditable Coverage	Enhanced SF EGWP	Standard SF EGWP	Enhanced FI EGWP	Standard FI EGWP
Medical Claims + Administration [1]	$ 280.59	$ 280.59	$ 280.59	$ 280.59	$ 280.59
Rx Claims + Administration	514.57	304.61	271.45	321.24	285.76
Total Claims + Administration	$ 795.16	$ 585.20	$ 552.04	$ 601.83	$ 566.35
HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00	$ 183.00	$ 183.00
HCA Administrative Fee	$ 6.02	$ 6.02	$ 6.02	$ 6.02	$ 6.02
Retiree Premium [2]	$ 618.18	$ 408.22	$ 375.06	$ 424.85	$ 389.37
Retiree Premium Costs / (Savings)		$ (209.96)	$ (243.12)	$ (193.33)	$ (228.81)
Annualized Retiree Premium Costs / (Savings) [3]		$ (91.3)	$ (105.7)	$ (84.0)	$ (99.5)

(1) We excluded the HCA Administrative fee from the Medical Claims + Administration line.
(2) Equals Total Claims + Administration less HCA Explicit Subsidy plus HCA Administrative Fee
(3) In $millions based on 36,226 enrollees

Table 21
Projected 2024 Benefit Option Comparison (PAUPM)

Projected Cost Components	Creditable Coverage	Enhanced Self-Funded EGWP	Standard Self-Funded EGWP	Enhanced Fully Insured EGWP	Standard Fully Insured EGWP
1. Total Incurred Claims (net of rebates)	$ 496.98	$ 498.48	$ 484.15	$ 498.48	$ 484.15
2. Less: Retiree Out of Pocket Cost Sharing	(70.47)	(67.53)	(100.86)	(67.53)	(100.86)
3. Less: Pharma Discount (CGDP)	N/A	(95.53)	(75.33)	(95.53)	(75.33)
4. Less: Federal Reinsurance (net of rebates)	N/A	(129.09)	(185.57)	(129.09)	(185.57)
5. Less: Federal Subsidy	N/A	(11.62)	(11.62)	(11.62)	(11.62)
6. Plan Liability for Primary Coverage	$ 426.51	$ 194.71	$ 110.77	$ 194.71	$ 110.77
7. Plus: Carrier Administration	19.36	19.36	19.36	19.36	19.36
8. Plus: EGWP Administration + Profit	N/A	8.00	8.00	20.04	15.50
9. Plus: Premium Taxes	N/A	N/A	N/A	2.28	-
10. Plus: Rx Change in PSR	4.46	4.46	4.46	4.46	4.46
11. Total Cost/Part D Premium	$ 450.33	$ 226.53	$ 142.59	$ 240.85	$ 150.09
Total Cost					
12. Total Medical Cost	$ 270.14	$ 270.14	$ 270.14	$ 270.14	$ 270.14
13. Rx Cost	450.33	226.53	142.59	240.85	150.09
14. Medical + Drug Cost	$ 720.47	$ 496.67	$ 412.73	$ 510.99	$ 420.24
15. HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00	$ 183.00	$ 183.00
16. HCA Administrative Charge	$ 5.96	$ 5.96	$ 5.96	$ 5.96	$ 5.96
Total Retiree Cost					
17. Retiree Premium (Line 14 - Line 15 + Line 16)	$ 543.43	$ 319.63	$ 235.69	$ 333.95	$ 243.20
18. Total Retiree Premium Savings (from Line 17)		$ (223.80)	$ (307.74)	$ (209.48)	$ (300.24)

Table 22
Projected 2025 Benefit Option Comparison (PAUPM)

Projected Cost Components	Creditable Coverage	Enhanced Self-Funded EGWP	Standard Self-Funded EGWP	Enhanced Fully Insured EGWP	Standard Fully Insured EGWP
1. Total Incurred Claims (net of rebates)	$ 562.45	$ 559.20	$ 549.74	$ 559.20	$ 549.74
2. Less: Retiree Out of Pocket Cost Sharing	(72.36)	(53.58)	(80.92)	(53.58)	(80.92)
3. Less: Pharma Discount (MDP)	N/A	(101.90)	(100.02)	(101.90)	(100.02)
4. Less: Federal Reinsurance (net of rebates)	N/A	(78.44)	(76.68)	(78.44)	(76.68)
5. Less: Federal Subsidy	N/A	(53.52)	(53.52)	(53.52)	(53.52)
6. Plan Liability for Primary Coverage	$ 490.09	$ 271.76	$ 238.60	$ 271.76	$ 238.60
7. Plus: Carrier Administration	19.56	19.56	19.56	19.56	19.56
8. Plus: EGWP Administration + Profit	N/A	8.37	8.37	24.43	22.66
9. Plus: Premium Taxes	N/A	N/A	N/A	0.57	0.02
10. Plus: Rx Change in PSR	4.92	4.92	4.92	4.92	4.92
11. Total Cost/Part D Premium	$ 514.57	$ 304.61	$ 271.45	$ 321.24	$ 285.76
Total Cost					
12. Total Medical Cost	$ 280.59	$ 280.59	$ 280.59	$ 280.59	$ 280.59
13. Rx Cost	514.57	304.61	271.45	321.24	285.76
14. Medical + Drug Cost	$ 795.16	$ 585.20	$ 552.04	$ 601.83	$ 566.35
15. HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00	$ 183.00	$ 183.00
16. HCA Administrative Charge	$ 6.02	$ 6.02	$ 6.02	$ 6.02	$ 6.02
Total Retiree Cost					
17. Retiree Premium (Line 14 - Line 15 + Line 16)	$ 618.18	$ 408.22	$ 375.06	$ 424.85	$ 389.37
18. Total Retiree Premium Savings (from Line 17)		$ (209.96)	$ (243.12)	$ (193.33)	$ (228.81)

Table 23
Projected 2026 Benefit Option Comparison (PAUPM)

Projected Cost Components	Creditable Coverage	Enhanced Self-Funded EGWP	Standard Self-Funded EGWP	Enhanced Fully Insured EGWP	Standard Fully Insured EGWP
1. Total Incurred Claims (net of rebates)	$ 622.13	$ 619.12	$ 610.08	$ 619.12	$ 610.08
2. Less: Retiree Out of Pocket Cost Sharing	(73.60)	(54.02)	(82.13)	(54.02)	(82.13)
3. Less: Pharma Discount (MDP)	N/A	(115.66)	(113.82)	(115.66)	(113.82)
4. Less: Federal Reinsurance (net of rebates)	N/A	(90.12)	(88.41)	(90.12)	(88.41)
5. Less: Federal Subsidy	N/A	(53.52)	(53.52)	(53.52)	(53.52)
6. Plan Liability for Primary Coverage	$ 548.53	$ 305.80	$ 272.20	$ 305.80	$ 272.20
7. Plus: Carrier Administration	19.76	19.76	19.76	19.76	19.76
8. Plus: EGWP Administration + Profit	N/A	8.76	8.76	26.67	24.87
9. Plus: Premium Taxes	N/A	N/A	N/A	0.59	0.02
10. Plus: Rx Change in PSR	5.43	5.43	5.43	5.43	5.43
11. Total Cost/Part D Premium	$ 573.72	$ 339.75	$ 306.15	$ 358.25	$ 322.28
Total Cost					
12. Total Medical Cost	$ 291.45	$ 291.45	$ 291.45	$ 291.45	$ 291.45
13. Rx Cost	573.72	339.75	306.15	358.25	322.28
14. Medical + Drug Cost	$ 865.17	$ 631.20	$ 597.60	$ 649.70	$ 613.73
15. HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00	$ 183.00	$ 183.00
16. HCA Administrative Charge	$ 6.08	$ 6.08	$ 6.08	$ 6.08	$ 6.08
Total Retiree Cost					
17. Retiree Premium (Line 14 - Line 15 + Line 16)	$ 688.25	$ 454.28	$ 420.68	$ 472.78	$ 436.81
18. Total Retiree Premium Savings (from Line 17)		$ (233.97)	$ (267.57)	$ (215.47)	$ (251.44)

Table 24
Projected 2027 Benefit Option Comparison (PAUPM)

Projected Cost Components	Creditable Coverage	Enhanced Self-Funded EGWP	Standard Self-Funded EGWP	Enhanced Fully Insured EGWP	Standard Fully Insured EGWP
1. Total Incurred Claims (net of rebates)	$ 694.87	$ 685.50	$ 676.91	$ 685.50	$ 676.91
2. Less: Retiree Out of Pocket Cost Sharing	(74.91)	(54.38)	(83.27)	(54.38)	(83.27)
3. Less: Pharma Discount (MDP)	N/A	(131.00)	(129.23)	(131.00)	(129.23)
4. Less: Federal Reinsurance (net of rebates)	N/A	(103.14)	(101.50)	(103.14)	(101.50)
5. Less: Federal Subsidy	N/A	(53.52)	(53.52)	(53.52)	(53.52)
6. Plan Liability for Primary Coverage	$ 619.96	$ 343.46	$ 309.39	$ 343.46	$ 309.39
7. Plus: Carrier Administration	19.96	19.96	19.96	19.96	19.96
8. Plus: EGWP Administration + Profit	N/A	9.16	9.16	29.12	27.29
9. Plus: Premium Taxes	N/A	N/A	N/A	0.60	0.02
10. Plus: Rx Change in PSR	5.99	5.99	5.99	5.99	5.99
11. Total Cost/Part D Premium	$ 645.91	$ 378.57	$ 344.50	$ 399.13	$ 362.65
Total Cost					
12. Total Medical Cost	$ 302.74	$ 302.74	$ 302.74	$ 302.74	$ 302.74
13. Rx Cost	645.91	378.57	344.50	399.13	362.65
14. Medical + Drug Cost	$ 948.65	$ 681.31	$ 647.24	$ 701.87	$ 665.39
15. HCA Explicit Subsidy	$ 183.00	$ 183.00	$ 183.00	$ 183.00	$ 183.00
16. HCA Administrative Charge	$ 6.14	$ 6.14	$ 6.14	$ 6.14	$ 6.14
Total Retiree Cost					
17. Retiree Premium (Line 14 - Line 15 + Line 16)	$ 771.79	$ 504.45	$ 470.38	$ 525.01	$ 488.53
18. Total Retiree Premium Savings (from Line 17)		$ (267.34)	$ (301.41)	$ (246.78)	$ (283.26)

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