

LaborFirst

CMS CY 2026 Final Rule & Final Notice for Payment Policy Updates for MA & Part D

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Meet the Presenters



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Timeline & Key Dates in 2025

JANUARY 10

Advance Notice & Draft Part D Redesign

CMS released the Proposed Payment, rules, and methodology for CY 2026 MA and Part D Programs along with the draft for CY 2026 Part D Redesign Program Instructions

**FEBRUARY 10
Feedback Due**

Feedback to CMS from carriers and other stakeholders due

APRIL 4

Final Rule

Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly

APRIL 7

Final Notice & Final Part D Redesign

CMS will publish the Final Notice and Final CY 2026 Part D Redesign Program; carriers will be able to fine-tune their financial and operational models

LATE JULY–EARLY AUGUST

CMS releases National Average Bid Amount

This release is based on the average of all individual bids submitted on June 2. With this information, plans are then able to determine the direct subsidy amount for Part D plans.



Final Rule

Key Elements of the April 4 Final Rule

CMS Is NOT Finalizing Three Provisions from the Proposed Rule

- Part D Coverage of Anti-Obesity Medications (AOMs)
- Guardrails for AI
- Enhancing Health Equity Analyses: Annual Health Equity Analysis of Utilization Management Policies, Procedures and Ensuring Equitable Access to Medicare Advantage Services

Holding Plans to Approved Inpatient Admission Decisions

Restricts plans' ability to reopen and modify a previously approved inpatient hospital decision on the basis of information gathered after the approval

Closing MA Appeals Loopholes

- Clarification that MA appeals rules apply to adverse plan decisions, regardless of whether the decision is made before, after, or during the receipt of services
- Codifying provider and member notification of coverage decisions
- Clarification to ensure that an enrollee always has the right to appeal MA plan coverage denials that affect their ongoing course of treatment



Medicare Advantage Highlights

Highlights – Medical

- Growth rate of 9.04%
- CMS included FFS payment data through 4Q24
- MA risk score trend will be calculated based on 2 years of service instead of 3 (2022 to 2023)
 - CMS has not updated the data years for calculating the MA risk scores due to the impact of COVID 19 on risk score and calculated trend using average MA risk score from 2018 through 2020.
 - For CY2026, CMS wants to reflect MA experience since the pandemic and only has 2 years of risk score available after COVID
 - CMS plans to use the three most recently available years of MA risk scores for CY 2027
- Payment from CMS to the MA plans increased on average 5.06% from 2025 to 2026
- Includes year 3 of the phase-in of the MA risk model changes from ICD9 to ICD10
- Includes year 3 of the phase-in of the removal of medical education costs

Payment Year	Advance Notice MA Growth Rate	Final Notice MA Growth Rate
2026	+5.93%	+9.04%
2025	+2.44%	+2.33%
2024	+2.09%	+2.28%
2023	+4.75%	+4.88%
2022	+4.55%	+5.59%
2021	+2.99%	+4.07%
2020	+4.59%	+5.62%
2019	+4.35%	+5.28%
2018	+2.8%	+2.7%
2017	+3.0%	+3.1%
2016	+1.7%	+4.25%

What This Means for Plan Sponsors

This is a welcome relief from the CY 2026 Advance Notice!

MA payment methodologies drive the payment from CMS to the carriers.

Continues to position MA as an advantageous solution for group retiree plans.



Inflation Reduction Act: Part D Overview

2026 CMS Part D: New Key Changes



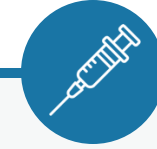
\$2,100 Annual Out-of-Pocket Spending Max

- Annual OOP Max will be capped at \$2,100 in 2026 up from \$2,000 2025
- Annual Deductible increases to \$615 from \$590
- Accumulation calculation of the out of pocket max will continue to be the greater of the plan copay vs the CMS defined standard of 25%



Additional Subsidy for Selected Drugs

- 10 drugs have been negotiated by CMS for 1/1/26 as part of the Medicare Price Negotiation Program
- These 10 drugs are also known as Selected Drugs
- CMS will pay plans 10% of the drug's negotiated price for the Selected drugs up until the out of pocket max of \$2100 is reached



Vaccine and Insulin Cost Sharing

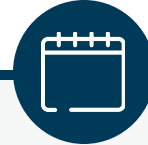
- For Part D covered vaccines, there continues to be no cost share and the Part D deductible does not apply.
- One month supply of covered insulin will now be the lesser of:
 - \$35
 - 25% of the Medicare Drug Price Negotiation Program price, if applicable
 - 25% of the plan's negotiated contract price

2026 CMS Part D: Continued Key Changes



Direct Subsidy Major Driver in Part D Pricing

- CMS calculates National Average Bid amount based on the Individual market bids submitted in June
- Carriers are more reliant on Direct Subsidy vs reinsurance putting more risk on plans
- Direct Subsidy determined by National Average Bid Amount which is released by CMS end of July/early August



Medicare Prescription Payment Plan (M3P)

- Option allowing members to spread their out-of-pocket drug cost out over a year (does not reduce out of pocket costs)
- Members pay nothing at the pharmacy and will be billed by their plan
- Addition of automatic election renewal process and failure to pay notifications resulting in termination from M3P



Risk Scores and Premium Stabilization

- CMS will continue to use separate Part D and MAPD normalization factors
- Difference in normalization factors may result in higher payment for PDP plans and lower payments for MAPD plans
- CMS will release details on the premium stabilization amounts after the National Average Bid Amount is released

Accumulation of OOP Costs

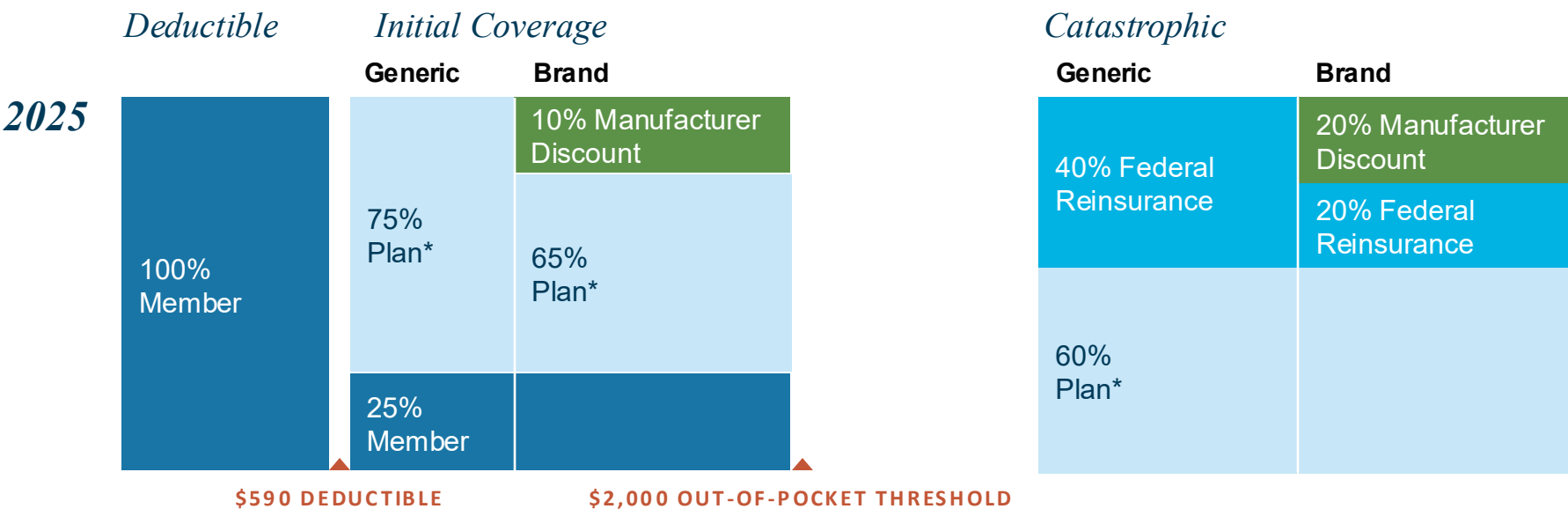
Group members are expected to have less than \$2,100 in annual out-of-pocket costs.

SCENARIO 1	
Average Gross Drug Cost	\$1000
CMS Defined Standard Benefit Copay	\$250
Group Member Actual Copay	\$50*
Out-of-Pocket Accumulation	\$250

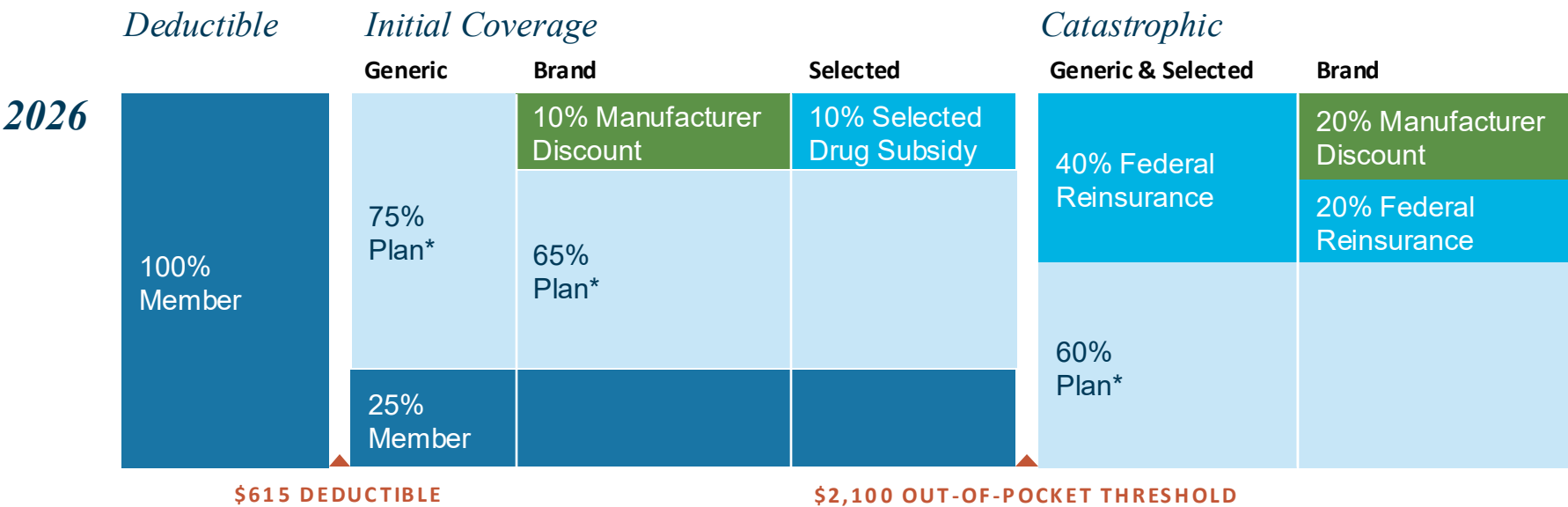
SCENARIO 2	
Gross Drug Cost	\$8,400
CMS Defined Standard Benefit Copay	\$2,100
Group Member Actual Copay	\$100*
Out-of-Pocket Accumulation	\$2,100

**Illustrative only*

Contribution Changes to Part D



- So What?**
- More movement into catastrophic placing more risk on plan
 - Most of plan funding from Direct Subsidy instead of Reinsurance
 - Additional funding from CMS on the Selected Drugs



- Key Contributors**
- Member
 - Plan*
 - Manufacturer
 - Federal (CMS)
- * Includes any plan sponsors directly contracted with CMS.

Medicare Drug Price Negotiation Program

Effective 1/1/26, the 10 drugs that CMS selected for the Medicare Drug Price Negotiation Program are:

1. Eliquis
2. Jardiance
3. Xarelto
4. Januvia
5. Farxiga
6. Entresto
7. Enbrel
8. Imbruvica
9. Stelara
10. Fiasp/NovoLog

These drugs are used to treat some of the most **common diseases**:

- Diabetes
- Heart disease
- Arthritis
- Psoriasis
- Blood clot prevention
- Cancers

In 2023 alone, around

9M seniors

and other Medicare
beneficiaries spent

\$3.9B+

out-of-pocket on the 10
drugs selected for
negotiation

Looking Ahead to 2027

Effective 1/1/27, the fifteen drugs that CMS selected for the Medicare Drug Price Negotiation Program are:

- | | |
|------------------------------|------------------|
| 1. Ozempic, Rybelsus, Wegovy | 9. Austedo |
| 2. Trelegy Ellipta | 10. Breo Ellipta |
| 3. Xtandi | 11. Tradjenta |
| 4. Pomalyst | 12. Xifaxan |
| 5. Ibrance | 13. Vraylar |
| 6. Ofev | 14. Janumet |
| 7. Linzess | 15. Otezla |
| 8. Calquence | |

These drugs are used to treat some of the more **common diseases** such as:

- Type 2 Diabetes
- Asthma/COPD
- Prostate Cancer
- Breast Cancer
- Bipolar/Major Depressive Disorder/Schizophrenia
- Psoriasis

In future years, CMS will select for negotiation:

- Up to 15 more drugs for 2028 (including drugs covered under Part B and Part D)
- Up to 20 more Part D and Part B drugs for each year after that, as outlined in the IRA

CMS will publish any agreed-upon negotiated prices for the selected drugs by November 30, 2025; those prices will come into effect starting January 1, 2027

Creditable Coverage for Active Plans

Final Rule Clarification

Creditable Coverage for Active Plans

- Employer group plans that 1) cover working retirees i.e., Medicare-eligible individuals who are employed and enrolled in the active employee plan, and 2) do not apply for RDS, have the option to:
 - Continue to use the simplified determination methodology for 2026, OR
 - Utilize the revised simplified determination methodology where coverage must be designed to pay at least 72% of participants' prescription drug expenses
- CMS felt the impact would be too extensive to make a complete change for 2026
- For 2027, CMS intends to have plans use actuarial equivalence testing or the revised simplified determination

So What?

- Active plans that cover working retirees, still need to issue creditable coverage
- Creditable coverage methodology is not required to change for 2026 for Active plans that do not file for RDS



Implications for Plan Sponsors to Consider

Implications for Plan Sponsors

Currently RDS

Evaluate and consider your current plan to **ensure you have creditable coverage and review subsidy projections** with your actuary. Consider **changes to your RDS plan** to meet requirements or **switching to an EGWP**.

Currently MA/MAPD, PDP

Understand the impact to your plan. **Evaluate and consider product (including Medicare Fee-for-Service and Medicare Coordination), benefit, and potentially formulary options and pricing** with your carrier and group Medicare plan advisors.

Educate Plan Participants

Q&A

Book a meeting with us!

**Book a Meeting
with one of our
advisors via QR code or
sales@LaborFirst.com**

