CAPITOL STREET

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2026 MA and Part D Rule Re-Cap

Our Take on Policies That May Be Finalized

Relevant Companies

Our Take & Next Up

The MA and Part D rule (published by CMS on November 26, 2024) contains some headwinds for plans. *We are re-sending due to technical difficulties last week; apologies if you receive this twice.* The outcome of the proposed changes are uncertain given that comments are due on January 27, 2025, which means the current administration will not finalize the policies. We believe that policies that are beneficiary focused are more likely to survive (e.g., provider directory data & supplemental benefit providers to CMS, agent/broker communication revisions, network pharmacy notifications by 10/1, marketing material review, and debit card usage for benefits) than those that increase regulatory burden on plans, such as Medical Loss Ratio (MLR) changes. Publication of the final rule will likely occur in April or May of 2025, so that policies can be taken into account in MA plan bids for 2026 that will be due by June 2, 2025.

Key Points

The proposed policies that are most detrimental to MA plans are below. We believe the policies below could increase operating costs for plans, with a varied impact by plan. These negative impacts could result in some combination of higher premiums, lower provider payments, and/or reduced benefits, are the following requirements that plans must:

- Cover Anti-Obesity Medications (AOMs)
- Offer Medicare FFS cost-sharing for behavioral health services
- Submit electronically formatted provider directory data to CMS
- Exclude administrative costs associated with quality improvement from numerator for Medical Loss Ratio
- Allow pharmacies to terminate their contracts without cause

The GLP-1 coverage loophole makes sense to us but it's expensive: $25 B for Medicare and $15 B for Medicaid. We discussed this here on Nov 26. Under Section 1860D-2(e)(2) of the Social Security Act, certain medications are excluded from the definition of a covered Part D drug. The list of medications excluded is based on the list of medications that Medicaid programs may exclude, which includes, among other drugs, “agents when used for anorexia, weight loss, or weight gain." CMS is reinterpreting this language such that the phrase

“agents when used for… weight loss” would no longer refer to AOMs when used to treat obesity. The estimated costs for Medicare and Medicaid of this proposal are substantial - $24.8 billion and $14.8 billion for Medicaid over 10 years.

Given conflicting views from HHS & CMS nominees, RFK Jr. and Dr. Oz, respectively (RFK Jr. has been critical of GLP-1s while Dr. Oz has been supportive), the policy could survive or Congress could approve a narrow patient population in 2025+. In addition, the most popular AOMs are likely to be negotiated by Medicare for 2027 (our take here), which means this policy could be meant to put pressure on Congress and the Trump Administration to not undo price negotiation in Medicare. With respect to the legality of this change, recent Supreme Court decisions such as *Loper Bright* suggest that CMS may be on somewhat shaky ground, but on the other hand, the agency has extended use of the AOMs to treat non-obesity related diseases.

Among dual eligible Special Needs Plans, CMS would require integrated dual eligible special needs plans (D-SNPs) to have an integrated membership card for both the Medicare and Medicaid plans and an integrated health risk assessment (HRA) for Medicare and Medicaid (HUM, UNH, CNC, others). The impact of this policy largely depends on how different duals plans operate. However, because D-SNPs that are integrated already have member IDs for both plans, and conduct HRAs for Medicaid, this alignment should not result in significant cost increases for D-SNPs.

The Biden Administration also continues to focus on mental health by requiring parity in mental health coverage in MA and FFS.

- CMS states in the proposed rule that about ¼ of MA plans charge in-network cost sharing that is higher than traditional Medicare for: mental health specialty services, psychiatric services, and partial hospitalization. MA plans would no longer be permitted to offer cost sharing for behavioral health services that exceed that offered by traditional Medicare. Under current rules, MA plans are permitted to offer higher cost sharing for these services than FFS, as long as the benefits in the MA plan are actuarially equivalent to FFS.
- CMS seeks comment on whether the policy should be in effect for 2026 or 2027. Given how many plans are not offering parity, this provision could result in material increases in medical costs for plans, because cost-sharing would be reduced and induced utilization could occur due to lower cost-sharing.

Under a new requirement, MA plans would be required to submit provider directory data to CMS that the agency could publish on Medicare Plan Finder, and plans must attest to the accuracy of the data submitted to CMS (likely for 2027). CMS has also been concerned that enrollees, when choosing a MA plan, are not able to easily identify whether or not a provider is in the plan’s network. Due to changes that occur in provider data (e.g., address changes), CMS will require that plans update the provider directory data within 30 days of receiving information that a provider’s contact information has changed. Given the operational challenges for creating these data files – CMS will likely not publish the file formatting requirements until after the publication of the final rule – plans will have challenges submitting the data for 2026 and are likely to push CMS for an extension of the due date for the 2027 plan year.

CMS also has concerns about the inclusion of activities in the numerator of the Medical Loss Ratio (MLR) for 2026. This particular change seems less likely to be finalized, as it could be viewed by the Trump CMS team as anti-competitive. By including these costs, plans are able to have an easier time meeting the 85% threshold for the MLR; if their MLR is less than 85 they must return the difference between 85% and their MLR

to the government. To calculate the Medical Loss Ratio the numerator is the sum of incurred claims and quality improvement activities, and the denominator is Medicare revenue minus certain taxes and fees.

CMS also notes that it has concerns about the impact of vertical integration on the Medicare MLR, but the agency will take ~2 years at a minimum to implement policy change and seeks comment on modifications to consider that would address these concerns, such as limits on the amount of transfer payments that can be included in the numerator. Finally, CMS would be collecting data on provider payment arrangements, which could be problematic for VBCs depending on how CMS chooses to use these data.

CMS would require that in pharmacy contracts, the timelines for termination without cause would be the same between pharmacies and Part D sponsors (and or their delegated pharmacy benefit managers). Because this provision could result in higher reimbursement from Part D sponsors to pharmacies, it could have a material impact on costs for Part D plans. That is, the Part D sponsor can terminate a contract without cause within 90 days but may require that a pharmacy provide 6 months of notice for termination without cause. This discrepancy from CMS' perspective means that pharmacies are less able to push back when they believe reimbursement is inadequate because they have limited ability to terminate their contracts.

The remaining policies from the rule would have a low-medium impact on plans:

- **Adult Vaccines**: Codify requirement from the IRA that (1) there is no cost sharing for adult vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and (2) the Part D deductible does not apply to these vaccines as of January 1, 2023
- **Insulin**: Codify requirement from the IRA that 1) Part D deductible does not apply to insulin and 2) cost sharing for one month supply limited to the lesser of a) $35, b) 25% of Maximum Fair Price (MFP) or c) 25% of negotiated price.
- **Health Equity of Prior Authorization:** Require plans to report on use of prior authorization by item and service, rather than at the aggregate level, as part of the annual health equity analysis report
- **Agent/Broker Communication:** Would require that agents/brokers inform enrollees of potential eligibility for low-income subsidies, Medicaid, and impact that enrolling in MA could have on ability to obtain Medigap after one year due to guaranteed issue.
- **Medicare Transaction Facilitator (MTF) Requirements for Network Pharmacies:** Would require that network pharmacies enroll in the MTF to ensure that pharmacies are paid for the difference in the drug acquisition cost and the maximum fair price (MFP).
- **Network Pharmacy Notifications:** Require Part D sponsors or delegated entity (e.g., pharmacy benefit manager) to inform pharmacies if they are in network by October 1 for the following plan year (e.g., October 1, 2025 for 2026 plan year).
- **Enhanced Marketing Review:** Propose to broaden definition of marketing materials to include any communication activity meant to influence a beneficiary's decision-making process regarding plan enrollment. This change would mean that the ads that are general in nature (e.g., "call now to find out about benefits you are missing") would require review and approval by CMS.
- **Medication Therapy Management (MTM) Program Eligibility Expansion:** Expands list of diseases that can be targeted for MTM to include dementia.
- **Guardrails for Use of Artificial Intelligence**: MA plans must ensure that AI is used in a non-discriminatory manner.
- **Debit card usage:** Codify existing guidance that requires MA plans allow debit cards to be used towards reduced cost sharing or spending on mandatory supplemental benefits.

- **Special Supplemental Benefits for the Chronically Ill:** Codify list of items that would not be allowed as SSBCI to include non-health related benefits such as hospital indemnity insurance and cosmetic procedures, and require enrollees receiving SSBCI to have multiple comorbidities, have a high risk of hospitalization or adverse events, and need care coordination.
- **Supplemental Benefit Providers:** MA plans must include any entity that provides services to an enrollee in their provider directory.
- **Medicare Prepayment Plan**: Codify existing guidance, with minor changes, implementing section 11202 of the IRA requiring Part D sponsors to provide enrollees with the option of 'smoothing' their out-of-pocket (OOP) costs during the plan year (e.g., monthly installment payments).
- **Enhanced Rules on Internal Coverage Criteria:** Define meaning of internal coverage criteria to mean those policies not expressly stated in any Medicare statutes, regulations or coverage decisions, and require plans to publish on their website the list of all items and services for which the plan uses internal coverage criteria.

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