

Approaches to lower Medicare Part D out-of-pocket costs for beneficiaries with limited income

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The discontinuation of two demonstration programs, the Medicare Advantage Value-Based Insurance Design Model and the Medicare-Medicaid Financial Alignment Initiative, impacts the ways in which health plans and states may reduce Part D cost sharing for dual-eligible Medicare beneficiaries who qualify for the Extra Help program.

KEY TAKEAWAYS

- Extra Help significantly reduces Part D out-of-pocket costs for Medicare beneficiaries with low incomes (at or below \$23,940 annually in 2026) relative to the Part D defined standard (DS) benefit design, but it does not eliminate cost sharing for many low-income beneficiaries.^{1 2}
- The Medicare Advantage (MA) Value Based Insurance Design (VBID) program and the Medicare-Medicaid Plans (MMPs) under the Financial Alignment Initiative's (FAI) both provided a pathway for Part D plans to offer prescription drug copays as low as \$0 for Medicare beneficiaries with low income. Both the VBID and FAI demonstrations ended in 2025.
 - Approximately 5.1 million out of 6.3 million total dual eligible beneficiaries who were enrolled in dual special needs plans (D-SNPs) were in plans that participated in VBID in 2025.
 - States and plans are eager for alternative methods to continue covering Part D cost sharing for Medicare beneficiaries with low incomes.
- Recent Medicare guidance clarified four potential options to keep Part D out-of-pocket costs low for beneficiaries with low incomes: alternative Part D benefit designs, Medicaid value-added services (VASs), state pharmacy assistance programs (SPAP), and state-only funds. The approaches vary in their financial impacts on plans and states, as well as operational complexity.

Background

MEDICARE PART D

The Medicare Part D program provides prescription drug coverage for 55 million Medicare beneficiaries. Part D coverage is available through both MA plans that include Part D (MA-PD) and through standalone Prescription Drug Plans (PDPs) for Medicare beneficiaries who have medical coverage through Medicare Fee for Service (FFS).²

1 Shapiro, J.L. (October 31, 2025). Calendar Year (CY) 2026 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS). Centers for Medicare & Medicaid Services. Retrieved March, 6, 2026, from <https://www.cms.gov/files/document/cy2026-lis-resource-limits-memo.pdf>.

2 For the purposes of this paper, the term "beneficiary" is used to describe an individual enrolled in Medicare, and the term "member" is used when referring to actions MA plans can take to lower Part D cost sharing.

DS BENEFIT

Under Part D, MA-PDs and PDPs have the option to either offer prescription drug coverage under what is referred to as the DS benefit or with an alternate design that is at least as rich as the DS benefit. A beneficiary's cost sharing varies throughout the calendar year (CY) based on the plan design and the beneficiary's accumulated out-of-pocket prescription drug costs, known as true out-of-pocket (TrOOP)-eligible costs.³ For CY 2026, the Part D DS benefit consists of three phases—note that beneficiary cost sharing displayed is prior to any low-income cost sharing subsidies

- **Phase 1: Deductible**—beneficiaries pay 100% of their prescription drug costs up to the annual deductible (\$615 in 2026).
- **Phase 2: Initial coverage**—beneficiaries pay 25% coinsurance. Depending on the medication type, the Part D sponsor covers 65%–75% of the cost and pharmaceutical manufacturers cover up to 10% of the cost. Additionally, CMS may pay a 10% subsidy for select medications. This phase continues until the enrollee reaches a true out-of-pocket cost (TrOOP) of \$2,100 in 2026.
- **Phase 3: Catastrophic**—beneficiaries pay 0% once they have reached this phase. The Part D sponsor covers 60% of costs, the pharmaceutical manufacturer pays a discount (generally 20%) for applicable medications, and CMS pays a reinsurance subsidy equal to 20% for applicable medications and a 40% reinsurance subsidy for all other covered drugs.

ALTERNATIVE BENEFIT DESIGNS

Part D plan sponsors have the option of structuring cost sharing differently than the DS benefit, for example using copays instead of coinsurance and/or lower deductibles. The alternative cost-sharing design must pass various actuarial tests, including ensuring the average cost sharing across all members is equal to or less than it would be under the DS benefit. There are three types of alternative benefit design: actuarial equivalent (AE), basic alternative (BA), and enhanced alternative (EA) benefit design. Many plans offer EA benefit designs with cost sharing that is meaningfully less than the Part D DS benefit in aggregate.

LOW-INCOME SUBSIDY PROGRAM OR “EXTRA HELP”

The Extra Help program lowers the costs of prescription drugs and provides other benefits to qualifying individuals with low annual incomes. Individuals are automatically enrolled in Extra Help if they are enrolled in Medicaid, a Medicare Savings Program (MSP) such as qualified Medicare beneficiaries (QMB), or receive Supplemental Security Income (SSI) from Social Security. The Extra Help program lowers the costs of prescription drugs through the low-income subsidy (LIS) program which federally subsidizes premium and cost-sharing support for eligible beneficiaries. LIS eligibility is determined annually based on the federal poverty level (FPL) and state Medicaid eligibility income requirements. As of 2025, nearly 14 million individuals enrolled in Part D are also enrolled in the LIS program.⁴

Those in the LIS program have reduced premiums and a \$0 Part D deductible and are responsible for copays ranging from \$0 to a maximum of \$12.65 per prescription in 2026, depending on the low-income level and medication type (i.e., generic or brand name) as shown in Figure 1. Plans also receive low-income cost sharing subsidies (LICs) to cover the increased costs to the plans from these beneficiaries having lower copays than those without Extra Help.⁵ Critically, the amount that the federal government subsidizes through LIS accumulates toward the beneficiaries' costs that are used to progress through the Part D benefit phases (i.e., TrOOP-eligible costs).

3 Centers for Medicare & Medicaid Services. (April 7, 2025). Final CY 2026 Part D Redesign Program Instructions. CMS.gov. Retrieved March 6, 2026, from <https://www.cms.gov/newsroom/fact-sheets/final-cy-2026-part-d-redesign-program-instructions>.

4 Cubanski, J. (October 7, 2025). A current snapshot of the Medicare Part D prescription drug benefit. KFF. Retrieved March 6, 2026, from <https://www.kff.org/medicare/a-current-snapshot-of-the-medicare-part-d-prescription-drug-benefit/>.

5 Shapiro, J.L. (October 31, 2025). Calendar Year (CY) 2026 Resource and Cost-Sharing Limits for Low-Income Subsidy (LIS). Centers for Medicare & Medicaid Services. Retrieved March, 6, 2026, from <https://www.cms.gov/files/document/cy2026-lis-resource-limits-memo.pdf>.

Note that under Section 6219 of the Consolidated Appropriations Act of 2026, Part D LIS generic copays will be \$0 beginning in plan year 2028 for dual-eligible beneficiaries with incomes at or below 100% of the FPL.⁶ This will help reduce copays for certain low-income individuals for a subset of drugs, but it will not reduce the need to consider other options for reducing copays for low-income individuals.

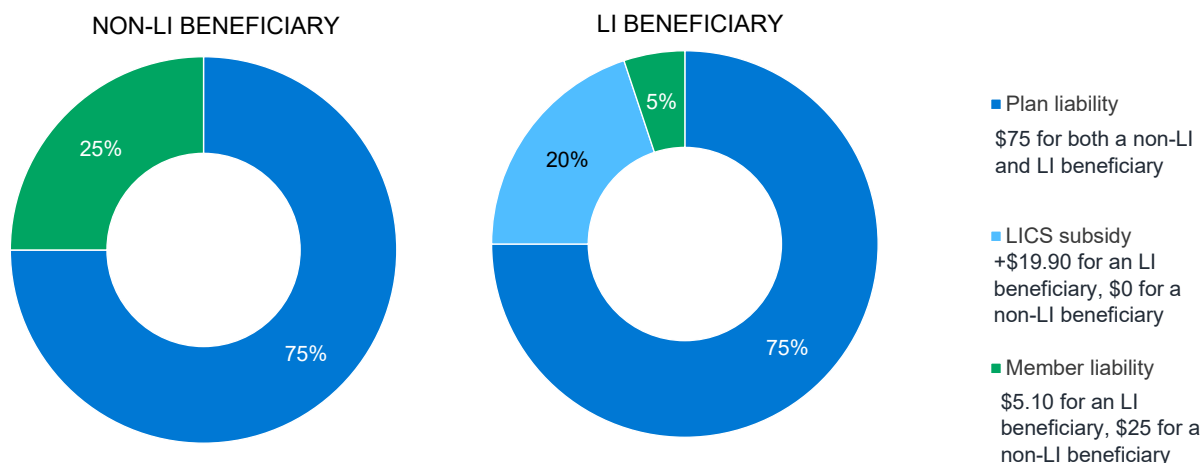
FIGURE 1: CY 2026 MAXIMUM PART D COST SHARING FOR LOW-INCOME BENEFICIARIES BY LOW-INCOME CATEGORY

LOW INCOME CATEGORY	GENERIC COPAY	BRAND COPAY
Full benefit dual eligible beneficiaries <i>institutionalized or receiving home and community-based services (HCBS)</i>	\$0.00	\$0.00
Full benefit dual eligible beneficiaries <i>with income ≤ 100% FPL</i>	\$1.60	\$4.90
Other dual eligible beneficiaries or Medicare beneficiaries <i>with income ≤ 150% FPL and resources ≤ \$18,090 (\$36,100 if married)</i>	\$5.10	\$12.65

Extra Help significantly reduces Part D out-of-pocket costs for low-income beneficiaries relative to the Part D DS benefit design, but it does not completely eliminate cost sharing for many low-income beneficiaries. The remaining copays can present financial hardship for beneficiaries and may be an impediment to drug adherence.

Figure 2 illustrates payments from the government, the Part D plan, and the beneficiary under a simple example showing LICS for a DS Part D plan where a dual eligible beneficiary is in the initial coverage phase and uses a generic drug that costs \$100. Note that while most generic drugs cost significantly less than \$100, this amount is used for illustrative purposes.

FIGURE 2: DISTRIBUTION OF COSTS FOR GENERIC DRUG IN INITIAL COVERAGE PHASE UNDER DS BENEFIT BY LOW-INCOME (LI) STATUS



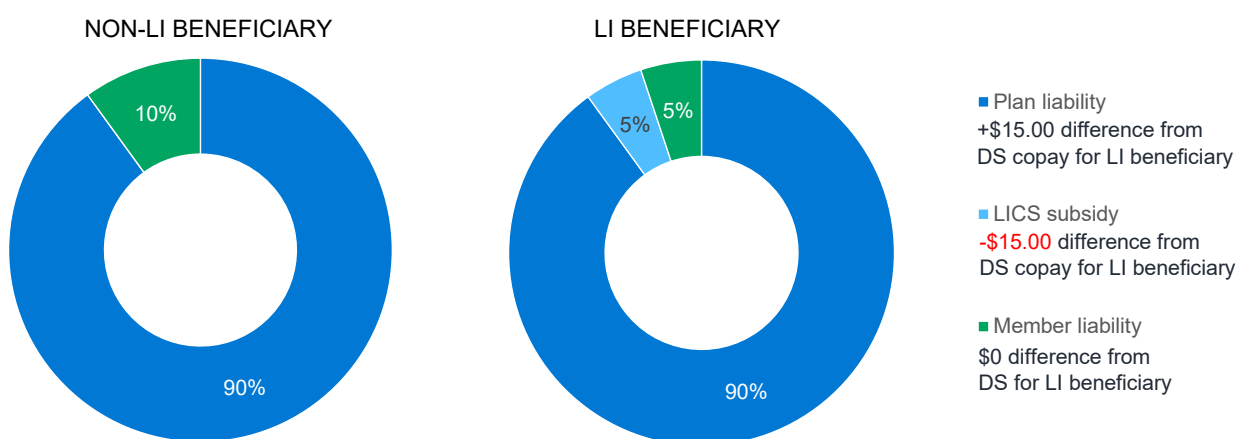
⁶ Consolidated Appropriations Act of 2026, U.S.C. § 12101 et seq. (2026). Retrieved March 6, 2026, from <https://www.congress.gov/119/bills/hr7148/BILLS-119hr7148enr.pdf>.

Under the example in Figure 2, a non-low-income (NLI or non-LI) Medicare beneficiary would be responsible for 25% cost sharing (or \$25). In 2026, the Extra Help program reduces out-of-pocket expense to \$5.10 (\$12.65 for brand drugs) for low-income beneficiaries.

Out-of-pocket costs that the government subsidizes through Extra Help are calculated after applying the plan's benefit structure. In other words, plan liability and beneficiary cost sharing are first calculated using the cost sharing that would apply for a Medicare beneficiary that is not enrolled in LIS. Then beneficiary cost sharing could be further reduced by Extra Help if the initially calculated cost sharing is greater than LIS copay amounts.

Figure 3 illustrates the scenario from Figure 2 under an alternative benefit design with a \$10 copay. It also compares amounts for beneficiaries with low incomes to the DS benefit.

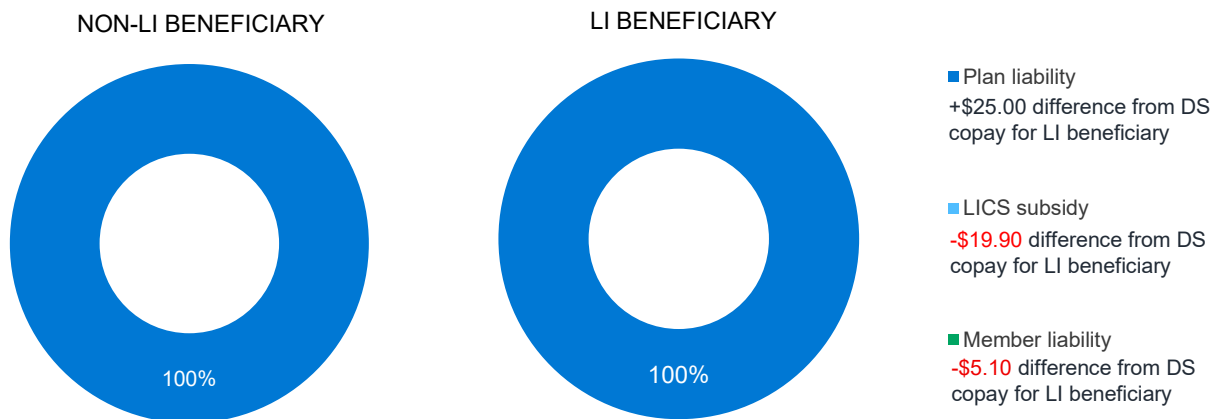
FIGURE 3: DISTRIBUTION OF COSTS FOR GENERIC DRUG IN INITIAL COVERAGE PHASE UNDER ALTERNATIVE BENEFIT DESIGN (\$10 COPAY) BY LOW-INCOME (LI) STATUS



In the scenario shown in Figure 4, a Medicare beneficiary with low income pays the same out-of-pocket costs as Figure 2 (DS benefit), but plan liability is higher, as the plan forgoes some of the federal LICS due to its EA benefit design.

Figure 4 illustrates the scenario from Figure 3 under another alternative benefit design with \$0 copays. It also compares cost-sharing amounts for beneficiaries with low incomes to the DS benefit shown in Figure 3.

FIGURE 4: DISTRIBUTION OF COSTS FOR GENERIC DRUG IN INITIAL COVERAGE PHASE UNDER ALTERNATIVE BENEFIT DESIGN (\$0 COPAY) BY LOW-INCOME (LI) STATUS



In the scenario in Figure 4, out-of-pocket costs for a Medicare beneficiary with low annual income are reduced by \$5.10 (from \$5.10 to \$0.00) compared to Figure 2 (under the DS benefit). However, plan liability is \$25 higher as the plan foregoes all of the federal LICS under this scenario.

Figure 5 shows a comparison of all three benefit design examples for a Medicare beneficiary with low income.

FIGURE 5: COMPARISON OF COST DISTRIBUTION FOR LOW-INCOME BENEFICIARY ACROSS DS AND EXAMPLE EA BENEFIT DESIGNS



As shown in Figure 5, the additional cost to the plan to reduce the copay to \$0 is equal to the combined cost of the LICS subsidy and the beneficiary's cost sharing.

Because plans have a limited budget to spend on benefit enhancements including supplemental benefits, these adjudication dynamics make it difficult for plans that focus on serving beneficiaries with low annual incomes, such as D-SNPs, to reduce Part D copays below the federally subsidized levels.

Historical approaches to reducing low-income Part D copays

The VBID and the Medicare-Medicaid FAI, two demonstration models that have historically offered plans a cost-effective means to reduce cost sharing for beneficiaries with low incomes, concluded at the end of 2025. Figure 6 details historical and current opportunities for plans and states to lower Medicare Part D out-of-pocket costs for beneficiaries enrolled in LIS.

FIGURE 6: APPROACHES TO REDUCE PART D COST SHARING FOR DUALELIGIBLE AND LOW-INCOME MEDICARE BENEFICIARIES

	RESPONSIBLE ENTITY	ELIGIBLE BENEFICIARIES	ADDITIONAL PLAN LIABILITY	ADDITIONAL STATE LIABILITY
NO LONGER AVAILABLE 2025				
VBID	D-SNP plan	Low-income (including dual-eligible) beneficiaries enrolled in participating MA plans	Low	None
FAI	State	Full dual beneficiaries enrolled in MMPs	Low	None
AVAILABLE AFTER 2025				
ENHANCED ALTERNATIVE PART D PLAN DESIGN	D-SNP plan	Low-income (including dual-eligible) beneficiaries enrolled in MA plans with enhanced Part D benefit	Low (select drugs to \$0) to very high (all drugs to \$0)	None
MEDICAID VAS	Medicaid plan, with state approval	Dual-eligible beneficiaries enrolled in Medicaid plan with VAS	Low	None
SPAP	State	At state discretion	None	Low
STATE BUYDOWN	State	At state discretion	Very high	Low

VBID

VBID allowed plans to test different service and payment designs tailored to specific populations based on chronic conditions: LIS eligibility, dual eligibility, or Area Deprivation Index (e.g., neighborhood ranking based on neighborhood socioeconomic ranking).⁷ Among VBID flexibilities was the ability for plan sponsors to reduce or waive Part D copayments for Medicare beneficiaries with low incomes without reducing the LICS.⁸

Figure 7 illustrates how VBID would have been applied for the same beneficiary in Figure 2 (under the DS benefit).

As shown in Figure 7, additional plan costs under VBID were equal to the cost sharing reduction for beneficiaries with low incomes. **Unlike alternative benefit design examples (Figures 3 and 4), plans that participated in VBID to reduce Part D copays did not forgo LICS and incur additional costs beyond the low-income copay reduction.**

VBID was widely adopted among D-SNPs. In 2025, about 80% of the 6.3 million D-SNP beneficiaries were enrolled in a plan that used VBID to reduce or eliminate Part D copays.⁹

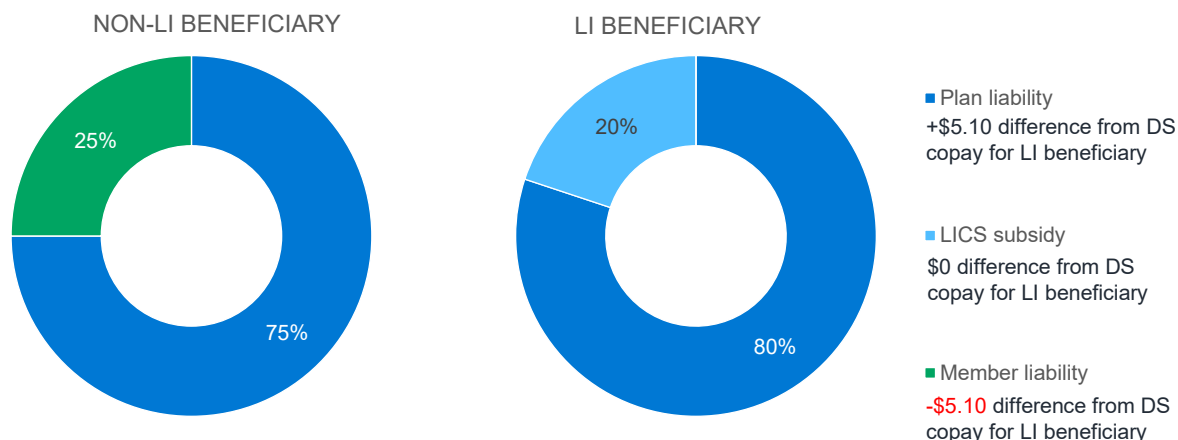
7 Centers for Medicare and Medicaid Services. (n.d.). Medicare Advantage Value-Based Insurance Design Model. CMS.gov. Retrieved March 6, 2026, from <https://www.cms.gov/priorities/innovation/innovation-models/vbid>.

8 McWright, L.T. (June 1, 2022). VBID Model Guidance on Treatment of Reductions in Part D Cost-Sharing. Centers for Medicare and Medicaid Services. Retrieved March 6, 2026, from <https://www.cms.gov/priorities/innovation/media/document/vbid-partd-buydown-guidance>.

9 Author's analysis of Milliman MACVAT.

In December 2024, CMS announced that CY 2025 would be the final year of VBID. CMS evaluations found costs needed to support VBID were “unprecedented” compared to any model the Center for Medicare and Medicaid Innovation (CMMI) has ever implemented.¹⁰

FIGURE 7: DISTRIBUTION OF COSTS FOR GENERIC DRUG IN INITIAL COVERAGE PHASE UNDER VBID FOR LOW-INCOME (LI) BENEFICIARIES



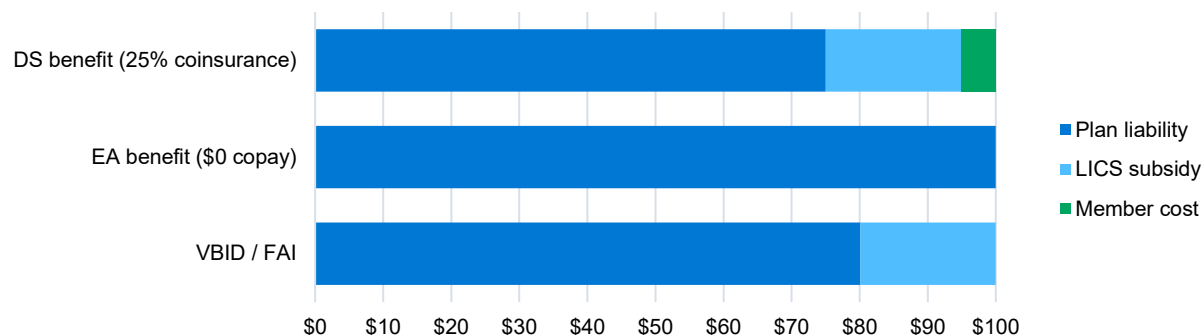
THE MEDICARE-MEDICAID FAI DEMONSTRATION

In 2012, the CMS Medicare-Medicaid Coordination Office launched the FAI demonstration that allowed participating states to seamlessly integrate Medicare and Medicaid coverage for individuals that are dually eligible under a single managed care plan referred to as a MMP. The demonstration nature of FAI allowed for both federal and state flexibility, including a three-way contract vehicle (between the state, CMS, and the plan) and state waivers (e.g., section 1115(a), 1915(b), 1915(c), 1932(a)) to waive other Medicare Advantage Prescription Drug, Medicaid Managed Care, or Part D requirements.

The FAI demonstration used a unique capitation rate-setting process that allowed participating states to require MMPs to reduce the Part D cost sharing for MMP enrollees without facing the same cost increases as a standard Part D plan. The financial dynamics were similar to those under the VBID, as illustrated in Figure 7. The CY 2023 MA Final Rule announced the end of the FAI demo and MMPs.

Figure 8 shows a comparison of VBID and the FAI demonstration to the DS benefit and \$0 cost sharing EA benefit design.

¹⁰ Centers for Medicare and Medicaid Services. (December 16, 2024). Medicare Advantage Value-Based Insurance Design (VBID) model to end after calendar year 2025: Excess costs associated with the model unable to be addressed by policy changes. CMS.gov. Retrieved March 6, 2026, from <https://www.cms.gov/blog/medicare-advantage-value-based-insurance-design-vbid-model-end-after-calendar-year-2025-excess-costs>.

FIGURE 8: COMPARISON OF LOW-INCOME COST DISTRIBUTION ACROSS DEMONSTRATION MODELS AND BENEFIT DESIGNS—DS BENEFIT, EA BENEFIT, VBID, AND FAI

As illustrated in Figure 8, the cost to the insurer varies significantly between the demonstration models (VBID, FAI) compared to an EA benefit design with \$0 copays. These approaches to eliminating cost sharing for beneficiaries with low incomes—VBID and FAI—are no longer available after 2025.

Currently available opportunities to lower Part D copays

Due to the sunset of VBID and the FAI demonstration, states and plans are eager for other opportunities to keep out-of-pocket pharmacy costs low for individuals with low annual income (see Figure 8).

EA PLAN DESIGN

As previously described, Part D plans can offer alternative benefit designs that enhance coverage (i.e., reduce member cost sharing) beyond the DS benefit structure. For example, a plan could choose to buy down all copays to \$0. In practice, this would be prohibitively expensive, as the plan would not only be responsible for the direct cost of reducing member copays (\$0–\$12.65 per prescription drug), it would also be responsible for the LICS amount that was previously funded by the federal government. An example of this option is illustrated in Figure 5. There are not any D-SNPs using an EA benefit design to **fully** eliminate member cost sharing in 2026, likely due to these financial dynamics.

While eliminating all cost sharing using an EA benefit design may not be financially viable, eliminating cost sharing for a more limited set of medications, particularly low-cost generic medications, may be feasible. For these lower-cost medications, the direct expense to the plan of removing cost sharing and the cost associated with the loss of LICS is significantly less than for higher-cost medications. **In 2026, approximately 90% of D-SNPs offer an EA benefit design in which beneficiary cost sharing is eliminated for at least some medication, typically generic medications.**¹¹

MEDICAID MANAGED CARE ORGANIZATION-FUNDED VASs

Medicaid managed care organizations (MCOs) can choose to offer services that are outside of their contract requirements with the state. Per 42 CFR 438.3(e)(1), these services, known as Medicaid value-added services (VASs), cannot be built into the managed care rates paid by the state to the MCO. A state cannot require an MCO to offer Medicaid VASs. However, a state can implement restrictions on a plan's ability to provide VASs, as well as encourage MCOs to offer Medicaid VASs.

Through a VAS, a Medicaid MCO could eliminate Part D cost sharing for members with low annual incomes. The Medicaid MCO spending would not impact federal subsidies to the Medicare plan and, critically, the beneficiary would progress through benefit phases consistent with typical plan adjudication, which makes this a financially viable option. Progression through the benefit phases ensures that federal subsidies which reduce plan liability continue to apply. Medicaid MCO value-added payments would replace the beneficiary payments in Figures 2 through 4.

¹¹ Author's analysis of Milliman MACVAT.

While the use of a Medicaid VAS offers a cost-efficient approach to reducing or eliminating Part D cost sharing, this option is not available to all MA plans. Specifically, only D-SNPs that also operate as Medicaid MCOs would be positioned to implement such an approach, and the cost-sharing reduction would only be applicable to fully dual-eligible beneficiaries who are enrolled in the companion Medicaid MCO. By contrast, the reduction may need to be offered to all dual-eligible beneficiaries enrolled in the Medicaid MCO, regardless of their MA Part D plan. Organizations considering this approach should carefully evaluate various operational, marketing, enrollment alignment, state Medicaid policy, and benefit uniformity factors before implementation.

SPAPs

SPAPs are state government-run programs that provide financial assistance or prescription drug coverage, including cost-sharing support (e.g., premiums, copays), supplemental prescription drug benefits, and retroactive claim adjustments for specified populations (e.g., income, age, disability status, health conditions, prescribed medications).¹² Eligibility criteria for SPAPs vary widely across states. Some states have a SPAP designed to provide wraparound coverage for Part D cost sharing for individuals enrolled in LIS in their state. Notably, this option **does not** impact the beneficiaries' advancement through the Part D benefit phases. By contrast, most other third-party payers **do** impact the beneficiaries' advancement through the benefit phases.

Section 1860D-23 of the Social Security Act as amended by the Medicare Modernization Act of 2003 (MMA) directed CMS to develop guidance on requirements for states to develop their SPAPs.¹³ The requirements for a SPAP to be qualified (i.e., receive federal funding) are outlined in 42 CFR 423.464(e), and include a requirement that a SPAP can be used by beneficiaries regardless of which Part D plan and associated benefit design the member is enrolled in. SPAP payments would replace the beneficiary payments in Figures 2 through 4.

While a SPAP can be a cost-effective approach to reducing or eliminating Part D out-of-pocket costs for beneficiaries with low incomes, it is at the discretion of the state government, and requires establishment, operation, and state funding. As a result, a SPAP is likely not a short-term solution for plans operating in states that do not currently operate a SPAP.

Furthermore, for a SPAP to serve as an effective replacement for the VBID and/or FAI demonstration, it must be sufficiently comprehensive to include all or most beneficiaries with low incomes. Many existing SPAPs are relatively limited in scope, for example providing cost-sharing assistance only to beneficiaries with specific conditions such as hemophilia.¹⁴

STATE-FUNDED BUYDOWN

States may also use state-only funds (i.e., not eligible for federal match/the Federal Medical Assistance Percentage (FMAP)) outside of a SPAP to buy down LIS Part D cost sharing. While this option can be effective at lowering Medicare Part D costs for beneficiaries with low income, for most states this is cost prohibitive.

Without a SPAP, there are significant impacts to TrOOP-eligible cost accumulation and advancement through the benefit phases for beneficiaries with low income. Specifically, a beneficiary with low income that had their cost sharing reduced to \$0 through a state-funded program other than a SPAP **would never reach the final phase of the Part D benefit**, which would significantly increase the Medicare plan's costs.

12 Public Health, 42 CFR § 423.466(a) (amended February 25, 2026). Retrieved March 6, 2026, from [https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-J/section-423.466#p-423.466\(a\)](https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-423/subpart-J/section-423.466#p-423.466(a)).

13 Social Security Administration. (n.d.). State Pharmaceutical Assistance Programs, Sec. 1860D-23. [42 U.S.C. 1395w-133]. Retrieved March 6, 2026, from https://www.ssa.gov/OP_Home/ssact/title18/1860D-23.htm.

14 National Conference of State Legislatures. (Updated October 26, 2022). State Pharmaceutical Assistance Programs. Retrieved March 6, 2026, from <https://www.ncsl.org/health/state-pharmaceutical-assistance-programs>.

Notably, while state payments would eliminate the beneficiary payments in Figures 2 through 4, it would be considered an outside payer that does not count toward the member's TrOOP accumulation. This would result in a reduction in federal reinsurance and/or LICs, and an increase in plan liability.

Summary

While the Extra Help program provides substantial relief for Part D cost sharing for Medicare beneficiaries with low incomes, it does not eliminate it. With the sunset of both VBID and the FAI demonstration, which provided plans the ability to eliminate Part D copays for beneficiaries with low incomes, states and Part D plans should evaluate alternative strategies to reduce cost sharing for these individuals. Several pathways remain, but each has distinct financial and operational considerations that should be carefully assessed for plan year 2027 and beyond.

Limitations

The opinions stated in this article are those of the authors and do not represent the viewpoint of Milliman.

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This information is intended to provide an overview of Part D low-income copay buydown opportunities and implications. The list of considerations outlined in this article is not exhaustive. This information may not be appropriate and should not be used for other purposes.

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