Estimating the Budgetary Impact of H.R. 4577, the "Ensuring Seniors Access to Local Pharmacies Act of 2014"

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THE MORAN COMPANY

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Since the enactment of the Medicare Modernization Act (MMA) in 2003, the Part D statute has required prescription drug plans to offer standard contracts to any pharmacy willing to enter into such a contract. Drug plan sponsors may, however, contract with pharmacies willing to offer additional pricing concessions to participate in a "preferred network," whose member pharmacies Part D beneficiaries are encouraged to use because of materially lower cost sharing at the point of sale. According to the Drug Channels Institute, approximately 75% of all Part D beneficiaries are enrolled in plans that offer beneficiaries access to preferred networks with discounted cost sharing.[1]

Advocates for pharmacies are presently promoting legislation that would permit any willing pharmacy to opt into the prevailing terms of preferred network contracts in areas designated as having a shortage of health professionals. The Moran Company was engaged by the Pharmaceutical Care Management Association, the trade association of pharmacy benefit management companies, to analyze the budgetary impact of legislation, introduced in the House of Representatives by Congressmen Griffith and Welch, to implement such a policy. Our findings are as follows:

- While the legislation might appear on its face to be limited in geographic scope, our analysis of data from the Health Resources & Services Administration (HRSA) indicates that 94.77% of all Medicare Part D enrollees reside in counties meeting at least one of the "underserved area" criteria established in this legislation.

- After offsets, we estimate that enactment of this legislation would increase Federal mandatory spending by $21.32 billion over the 2015-2024 scoring window.

Although the legislation indicates that willing pharmacies will need to match the "…terms and conditions…" applicable to preferred in-network pharmacies, our analysis suggests that present in-network pharmacies would, with a lag for recontracting, discontinue discounting, since such discounts would no longer be a requirement for preferred network participation. Within a few years, we would expect in-network discounts to decline toward the level implicit in the drug plans' standard "any willing provider" contracts. We would expect Part D drug plans to attempt to offset this discount erosion by lowering reimbursement rates in their "any willing provider" contracts, and by adjusting their program terms. We assume that such efforts might mitigate approximately half of the spending increase that would otherwise result from discount reductions.

The rationale for these findings is presented in the balance of this report.

[1] "For 2014, 3 out of 4 Seniors Choose a Narrow Network Medicare Drug Plan—and Humana, UnitedHealthcare Win Big". Pembroke Consulting analysis (January 2014). http://www.drugchannels.net/2014/01/for-2014-3-out-of-4-seniors-choose.html

The Program Dynamics of the "Ensuring Seniors Access to Local Pharmacies Act of 2014"

Under current law, prescription drug plans (PDPs) enter into contracts with pharmacies (either individually, or as chains of pharmacies) to provide both drug dispensing and administrative services under Part D. A PDP must offer a standard contract to any pharmacy that seeks one.

Pharmacies may also seek to enter into a "preferred" network relationship with the PDP, under which pharmacies willing to accept "lower than standard" reimbursements can attract beneficiaries with cost sharing requirements that are less than the standard cost sharing requirements applicable under the standard contract. In this sort of contracting arrangement, PDPs use the threat of exclusion from the PDP's preferred pharmacy network to motivate financial concessions from pharmacies. Thus, all pharmacies in the market must offer some form of discount in order to obtain access to preferred cost sharing for beneficiaries. As we understand the market, while preferred cost sharing arrangements are typically standardized by the PDP across all pharmacies in the preferred network within a local market (or region), contract pricing terms can vary from pharmacy to pharmacy (or chain to chain) to reflect company-specific deals with each PDP.

Market dynamics can also be affected by the extent to which PDPs use mail order delivery as a substitute for retail fulfillment of either branded or generic prescriptions.

The policy of the "Ensuring Seniors Access to Local Pharmacies Act of 2014" would make a simple but important change in these pharmacy contracting dynamics. It would make reduced cost sharing terms available to all patients in designated shortage areas who fill prescriptions at pharmacies that are willing to accept the "terms and conditions" of preferred network contracts.

On its face, this policy has some ambiguities, since there may be no standard "terms and conditions" for preferred networks in markets where PDPs and individual companies directly negotiate one-off deals. But the market impact is unambiguous: it would eliminate the need for pharmacies to propose company-specific discounts as a condition of offering their enrollees preferred cost sharing arrangements. As existing participating pharmacy network contracts expired, PDPs would be required to recontract their pharmacy networks in an environment where the threat of exclusion from the preferred network was not available to stimulate pharmacies to offer meaningful discounts relative to their competitors. In this environment, we would expect prevailing reimbursement rates to equilibrate, with a lag for recontracting, at levels meaningfully above prevailing preferred network discounts. As indicated below, our estimating methodology assumes that rates under this new regime would effectively equilibrate at the midpoint of the spread between preferred and non-preferred contracts presently observed in the Part D marketplace.

Geographic Scope of the Policy

On its face, the stated policy seems to imply that this legislation would only be applied in a limited number of areas that are medically underserved. As drafted, however, the geographic scope of the policy is very broad.

Our analysis used the Health Professional Shortage Area (HPSA) file, the Medically Underserved Areas (MUAs) and the Populations (MUPs) files downloaded from the HRSA website.[2] The Part D enrollment estimates are available through the most recent PDP State/County Penetration file and Medicare Advantage (MA) State/County Penetration file published by the Centers for Medicare & Medicaid Services (CMS).[3] We matched the Part D (PDP/MA) enrollment to health professional shortage/medically underserved area at the Federal Information Processing Standard (FIPS) county level. The results indicate that 94.77% of all Medicare Part D enrollees reside in counties meeting at least one of the "shortage/underserved" criteria. As a result, the legislation will apply quite broadly, regardless of the concentration of pharmacies in particular areas. We would also note that there is not necessarily a relationship between the underserved areas targeted in the legislation and pharmacy access. The targeted underserved areas are identified by primary medical care, dental or mental health providers, without regard to pharmacy access.

Estimating the Budgetary Implications of the Policy

To estimate the budgetary implications of this legislation, we built a spreadsheet model anchored to the CBO April 2014 Medicare baseline projections of spending and enrollment under Medicare Part D. Our assignment was to project how the change in market dynamics that would result under this policy would affect Federal mandatory spending during the FY 2015-2024 budget forecast horizon.

As noted above, approximately 75% of all Part D beneficiaries are enrolled in plans that offer beneficiaries access to preferred networks with discounted cost sharing. According to a study published by CMS,[4] the overall weighted unit costs for mail and retail (combined) was $1.39 at preferred pharmacies vs. $1.48 at non-preferred pharmacies, or a 6.1% overall savings at the preferred pharmacies. We assume that if the policy in question were enacted, the 6.1% overall

[2] The HRSA health professional shortage area data is available at: http://datawarehouse.hrsa.gov/Data/datadownload/hpsadownload.aspx

[3] These data are available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/PDP-State-County-Penetration-Items/PDP-State-County-Penetration-2014-06.html?DLPage=1&DLSort=1&DLSortDir=descending (PDPs) and http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration-Items/MA-State-County-Penetration-2014-06.html?DLPage=1&DLSort=1&DLSortDir=descending (MA)

[4]" Part D Claims Analysis: Negotiated Pricing Between General Mail Order and Retail Pharmacies." Centers for Medicare and Medicaid Services (December 2013). http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Negotiated-Pricing-Between-General-Mail-Order-and-Retail-PharmaciesDec92013.pdf

savings achieved by preferred pharmacies would erode from 2015 to 2017, and that pricing would remain at the level of non-preferred pharmacy for the balance for the scoring window.[5]

Under the proposed scenario, we calculated the total Part D payments for the shortage and underserved area as well for other areas. The net change is the difference between our estimate of the new total Part D spending as a result of the proposed policy and the total Part D spending projected by CBO in absence of this policy. We expect that Part D drug plans will attempt to offset this discount erosion by lowering reimbursement rates and by adjusting their program terms. We assume that such efforts will mitigate approximately half of the spending increase. Given that the LIS population accounts for 75% of total Part D payments[6] and Medicare pays 74% of the non-LIS Part D spending, the total change in mandatory spending is calculated as 75% of the total net change after offset (LIS mandatory spending) plus 25% of the total net change after offset multiplied by 74% (non-LIS mandatory spending).

Findings

As indicated in the table that follows, we project that the policy under evaluation would increase Federal mandatory spending by $151.89M in 2015, $7.06B over 2015-2019, and by $21.32B over 2015-2024.

[5] We modeled that 2.04% savings will erode for 2015, 4.07% savings will erode for 2016, and 6.10% savings will erode for 2017-2024.

[6] "Spending Patterns for Prescription Drugs Under Medicare Part D." Congressional Budget Office Economic and Budget Issue Brief (December 2011). http://cbo.gov/sites/default/files/cbofiles/attachments/12-01-MedicarePartD.pdf

Results

Table 1: Estimated Budgetary Impact of H.R. 4577 the "Ensuring Seniors Access to Local Pharmacies Act of 2014" (in Billions)

Year	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	5 Year Estimate	10 Year Estimate
Baseline Part D Payments Published by CBO	$ 76.00	$ 88.00	$ 88.00	$ 88.00	$ 102.00	$ 111.00	$ 122.00	$ 144.00	$ 147.00	$ 147.00		
Estimated Payments Under Proposed Policy	$ 76.32	$ 90.15	$ 92.00	$ 92.00	$ 106.63	$ 116.04	$ 127.54	$ 150.54	$ 153.68	$ 153.68		
Net Change	$ 0.32	$ 2.15	$ 4.00	$ 4.00	$ 4.63	$ 5.04	$ 5.54	$ 6.54	$ 6.68	$ 6.68	$ 15.11	$ 45.59
% Offset	50%	50%	50%	50%	50%	50%	50%	50%	50%	50%		
Net Change After Offset	$ 0.16	$ 1.07	$ 2.00	$ 2.00	$ 2.32	$ 2.52	$ 2.77	$ 3.27	$ 3.34	$ 3.34	$ 7.55	$ 22.80
Total Change in Mandatory Spending	$ 0.15	$ 1.00	$ 1.87	$ 1.87	$ 2.17	$ 2.36	$ 2.59	$ 3.06	$ 3.12	$ 3.12	$ 7.06	$ 21.32