Federal Government costs could increase $24.4 billion over ten years if direct and indirect remuneration (DIR) were reflected at the point-of-service (POS), 2017-2026

2017-2026 Cost (Savings) of Reflecting DIR at the POS on Individual Medicare Prescription Drug Plan (PDP) Stakeholders (billions)

Scenario	Beneficiary Premium	Beneficiary Cost Sharing	Federal Government	Pharmaceutical Manufacturer-CGDP
Reflecting Manufacturer Rebates at POS	$8.1	($20.0)	$19.9	($8.0)
Reflecting Pharmacy DIR at POS	$2.0	($4.5)	$4.5	($2.0)
Reflecting All DIR at POS	**$10.1**	**($24.5)**	**$24.4**	**($10.0)**

Key Findings

- If DIR were reflected at the POS, we estimate federal spending would increase by $24.4 billion for 2017 through 2026.
- If DIR were reflected at the POS, we estimate beneficiary costs would decrease by $14.4 billion for 2017 through 2026. While some beneficiaries would experience lower cost sharing due to lower POS costs, all beneficiaries would pay higher premiums.
- If DIR were reflected at the POS, we estimate pharmaceutical manufacturer coverage gap discount program (CGDP) payments would decrease by approximately $10.0 billion for 2016 through 2026.

Notes

- The Pharmaceutical Care Management Association (PCMA) requested that Milliman estimate the impact of shifting price concessions reflected as DIR to price concessions at the POS over a ten-year projection period (2017-2026) on individual PDP stakeholders, including the federal government, beneficiaries, and pharmaceutical manufacturers.
- DIR includes manufacturer rebates, pharmacy performance-based price concessions, and any other subsidies or price concessions used to decrease the costs incurred by the PDP sponsor. Pharmacy DIR represents retail, mail, and specialty pharmacy performance-based price concessions. We assume pharmacy DIR represents 15% of total DIR in 2017 and remains a constant percentage of total DIR through 2026.
- The Medicare Part D program currently allows for a mix of price concessions determined either at the POS or post-POS (after prescriptions have been dispensed). POS price concessions are often referred to as discounts. Post-POS price concessions are generally those that cannot reasonably be determined at the POS based on guidance from the Centers for Medicare and Medicaid Services (CMS) and are reported to CMS as DIR.
- These estimates pertain only to the individual PDP market, not the Medicare Advantage prescription drug (MA-PD) or Part D employer group waiver plan (EGWP) markets. Approximately half of beneficiaries enrolled in Part D plans (PDP and MA-PD, including EGWP) are enrolled in individual PDP plans.
- Modeling uses the defined standard benefit design and is based on a hypothetical scenario where all DIR could be reflected at POS and where no system stakeholders or regulators change their behaviors or regulations as a result. The behavior of PDP stakeholders and regulators may change, as replacing DIR with equivalent POS price concessions may create different incentives for how to manage costs.
- In shifting price concessions reflected as DIR to price concessions at the POS, we assume no change to allowed drug costs gross of DIR, and assume no net change to pharmacy costs.
- Beneficiary Premium excludes the low income premium subsidy (LIPS). Beneficiary Cost Sharing excludes the low income cost sharing subsidy (LICS) and coverage gap discount program (CGDP) payments. Shifting price concessions reflected as DIR to price concessions at the POS would increase premiums for all beneficiaries. However, it would decease cost-sharing for certain non-low income high-cost beneficiaries, outweighing the premium increase. The potential cost or savings to each individual beneficiary will vary based on an individual's income, prescription drug usage, and benefit design.
- Federal Government includes the direct subsidy, federal reinsurance subsidy, LIPS, and LICS.
- Pharmaceutical manufacturer savings represents CGDP payments. The CGDP covers 50% of the cost of brand drugs in the coverage gap phase of the Part D benefit for non-low income beneficiaries. CGDP payments would decrease if DIR were reflected at the POS since fewer beneficiaries would reach the coverage gap phase of the Part D benefit.

David M. Liner, FSA, CERA, MAAA
Tracy A. Margiott, FSA, MAAA
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Commissioned by Pharmaceutical Care Management Association
See reverse side for methodology important to this analysis

Methodology: We estimated nationwide average individual Medicare Part D pricing scenarios over a ten-year projected (2017-2026) time period. Our estimates are based on a cost model calibrated to the 2017 Part D national averages published by CMS under the defined standard benefit design, trended to 2018-2026 using enrollment and trend projections developed from the 2016 Medicare Trustees report. The 2017 national average bid amount (NABA), national average member premium (NAMP), and national average federal reinsurance are $61.08, $35.63, and $78.65, respectively. After calibrating each year to market-wide national averages, we adjusted each pricing scenario to reflect the individual PDP population only.

This analysis relies on Milliman's manual Part D data. The manual rates, adjustment factors, assumed demographics, and risk scores are based on 2015 Part D experience. We scaled the cost and utilization data to each year by applying Part D trend assumptions and other pricing adjustments. The gross cost estimates reflect Milliman's unit cost and utilization trend and formulary research, including the impact of brand patent expirations. Our method relies on separate low income and non-low income claim probability distributions (CPDs) that provide allowed spend levels based on the average price by drug tier (generic, preferred brand, non-preferred brand, and specialty) and distribution method (retail and mail order).

The pricing projections for years 2018-2026 reflect allowed cost trends based on the Part D per capita cost trend from page 147 of the 2016 Medicare Trustees Report. Trends for 2026 were assumed to equal those for 2025. The projections are based on generic, brand, and specialty specific drug trends. We calibrated drug trends to the Trustees Report trends by scaling brand cost, specialty cost, and specialty utilization using Milliman's standard Part D 2017 trend assumptions. We assumed brand cost, specialty cost, and specialty utilization would be the primary drivers of changes in future trends. Benefit parameters for years 2018-2026 were projected using the same trends in Part D expenditures used for allowed costs, the consumer pricing index (CPI), or a combination of the two, in accordance with the 2017 CMS Medicare Part D Final Call Letter.

Enrollment assumptions were derived from the 2016 Medicare Trustees Report. Enrollment includes beneficiaries in individual PDP plans and excludes those in MA-PD and group Medicare Part D plans. Enrollment was assumed to be level throughout the year. The income mix for 2017 PDP plans was assumed to be equal to 2016 and is based on publically available CMS enrollment data. To estimate individual PDP enrollment for 2018-2026 we computed PDP-specific growth factors for each year using publically available CMS information. We applied these growth factors to total 2017 PDP enrollment from enrollment files published by CMS. To estimate income-specific PDP enrollment, we calculated low income percentage change factors from MA-PD and PDP enrollment data in the 2016 Medicare Trustees report and applied these factors to the assumed low income percentage for 2017. We did not apply a further adjustment to low income PDP enrollment, as the low income PDP enrollment percentage has been relatively constant since the program began, per CMS.

Discounts off average wholesale price (AWP), dispensing fees, margin and administrative fees were based on an annual survey of Part D sponsors conducted by Milliman and are representative of a typical PDP. We assume the LIPS program subsidizes 95% of the average premium for low income beneficiaries. We modeled 2017 DIR as 24% percent of total allowed cost, before sharing with federal reinsurance based on Milliman's annual survey of Part D sponsors. Projected DIR (2018-2026) was assumed to be equal the 2017 projected DIR. To estimate the impact of DIR on stakeholder costs, DIR was replaced with the same amount of price concessions offered at the POS.

Changes in stakeholder behavior are not explicitly modeled in this analysis. For example, we do not assume that beneficiaries change plans or prescriptions usage due to a different out-of-pocket cost at the POS. The results presented in this report assume no change to overall risk corridor payments, CMS payment parameters, or the risk adjustment model. We assume that CMS will not make any structural or regulatory changes to the Medicare Part D program, and that pharmaceutical manufacturers and pharmacies will not change the aggregate level of price concessions to plans. The behavior of PDP stakeholders and regulators may change if DIR were reflected at the POS. For example, beneficiaries may change plans or utilization, resulting in varying potential cost or savings to each individual beneficiary. Changes to pharmaceutical manufacturer Part D costs could affect pharmaceutical pricing in the commercial market. The value of DIR may change if stakeholders or regulators change their behavior in response to potential Part D program changes. Projected estimates are on an undiscounted basis and do not reflect any time value of money adjustments.

Important Disclosures: David M. Liner and Tracy A. Margiott are actuaries for Milliman. We are members of the American Academy of Actuaries and meet the Qualification Standards of the American Academy of Actuaries to render this opinion. To the best of our knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This Milliman report has been prepared for the specific purpose of summarizing the effect of direct and indirect remuneration (DIR) on Medicare Part D program costs. This information may not be appropriate, and should not be used, for any other purpose. Milliman does not endorse any public policy or advocacy position on matters discussed in this report. This report may be distributed publicly at the discretion of Pharmaceutical Care Management Association. If shared externally, the report should be shared in its entirety unless otherwise approved by Milliman. We do not intend this information to benefit, or create a legal liability to, any third party, even if we permit the distribution of our work product to such third party. This report must be read in its entirety and specialized knowledge of the industry is necessary to fully understand the report and its conclusions.

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience. In performing this analysis, we relied on data and other information from the Centers for Medicare and Medicaid Services (CMS). We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

This report outlines the review and opinions of the authors and not necessarily that of Milliman. Milliman does not provide legal advice, and recommends that Pharmaceutical Care Management Association consult with its legal advisors regarding legal matters. The terms of Milliman's Consulting Services Agreement with Pharmaceutical Care Management Association dated August 2, 2013 and the indemnification agreement in the engagement letter dated February 3, 2017 apply to this report and its use.