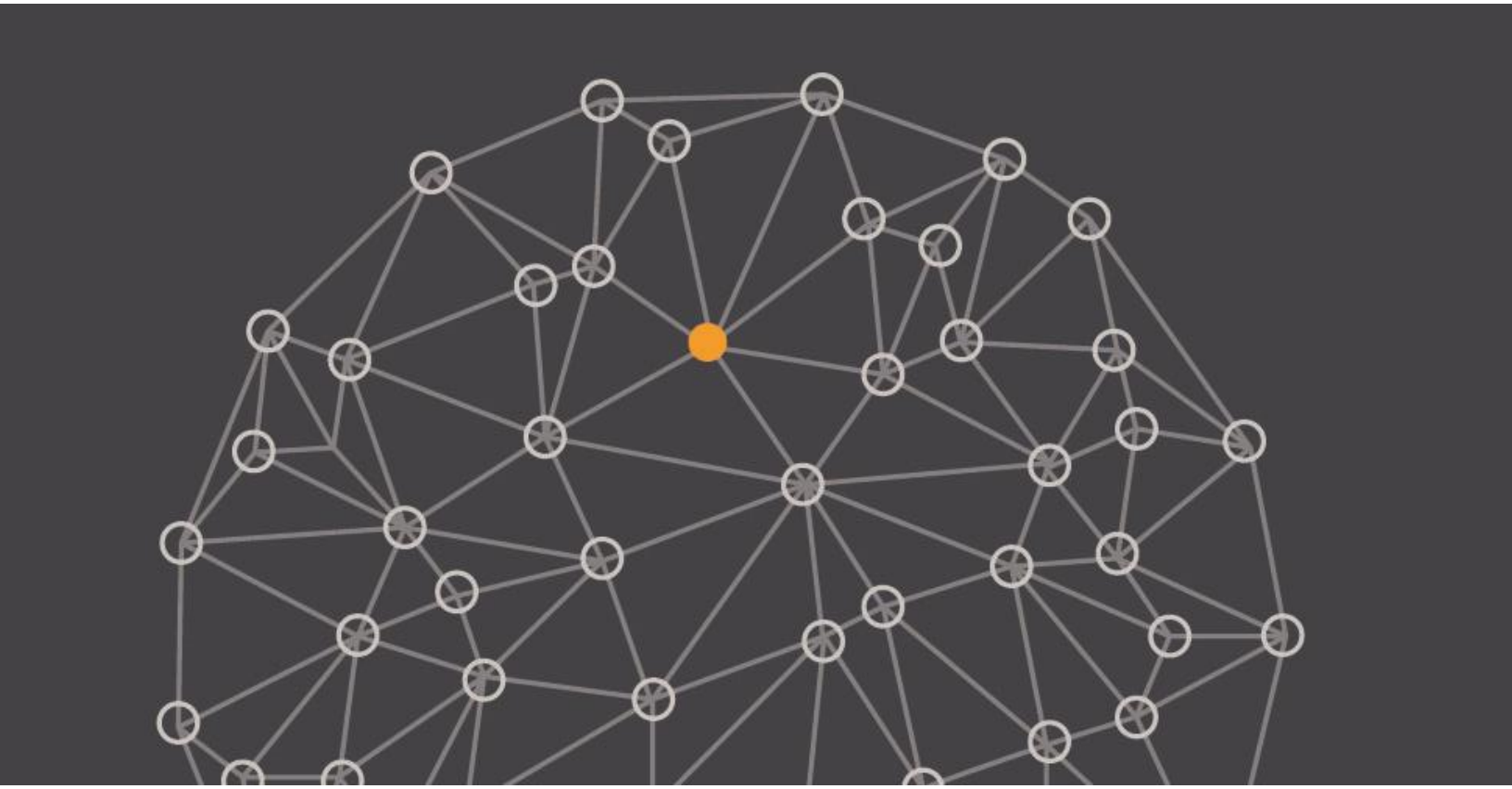
MILLIMAN REPORT

Value of Direct and Indirect Remuneration (DIR): Impact on Medicare Part D Prescription Drug Plan (PDP) Program Stakeholders

Commissioned by Pharmaceutical Care Management Association

July 2017



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Executive Summary

INTRODUCTION, SCOPE, & PURPOSE

The Pharmaceutical Care Management Association (PCMA) requested that Milliman estimate the value of direct and indirect remuneration (DIR) for Medicare Prescription Drug Plan (PDP) stakeholders. DIR includes manufacturer rebates, pharmacy performance-based price concessions, and any other subsidies or price concessions used to decrease the costs incurred by the Part D plan sponsor. This analysis estimates the historical, current, and projected value of DIR on individual prescription drug plan (PDP) program stakeholders, including the federal government, beneficiaries, and pharmaceutical manufacturers. Our analysis and 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.

The Part D program currently allows for a mix of price concessions that are determined either at the point-of-service (POS) or post-POS (after prescriptions have been dispensed). Post-POS price concessions are generally those that cannot reasonably be determined at the POS based on CMS guidance, and are reported to the Centers for Medicare and Medicaid Services (CMS) as DIR. This framework allows PDPs and pharmacy benefit managers (PBMs) to negotiate price concessions with both manufacturers and pharmacies based on metrics that can only be determined once trends and performance over time are known. Retail, mail, and specialty pharmacy performance-based price concessions are often referred to as "pharmacy DIR". By statute, all DIR must be reported to CMS.[1] The DIR a plan receives affects beneficiary premiums and federal government payments in the Part D program.

SUMMARY OF FINDINGS

We find substantial program cost reductions in the form of DIR price concessions based on actual historical experience from the inception of the Part D program in 2006 through 2016. We also project savings from 2017 to 2026 due to DIR price concessions based on current and expected PDP market dynamics.

- Total Value of DIR: In 2017, DIR negotiated by PDPs and their PBMs will save the Part D program and its beneficiaries a projected $20.4 billion or 24.0% of PDP POS drug costs.[2] The value of DIR has totaled approximately $87.8 billion from the inception of the program through 2016, and is projected to be approximately $308.2 billion from 2017 through 2026.
- Federal Savings from DIR: PDP DIR will reduce the federal government's costs for Part D by a projected $17.2 billion in 2017, a 26.6% savings compared to federal government costs without any price concessions similar to DIR. From 2006 to 2016, PDP DIR saved the federal government an estimated $75.4 billion, and from 2017 to 2026 PDP DIR will save the federal government a projected $259.6 billion.
- Premium Savings from DIR: Since the inception of the Part D program through 2016, PDP DIR has saved Part D beneficiaries an estimated 21.5% on their premiums, a $12.4 billion savings. From 2017 through 2026, that savings is projected to increase to an average 33.2% savings on premiums, a $48.7 billion savings.
- Manufacturer Rebates Account for Majority of DIR: In 2017, manufacturer price concessions in the form of rebates negotiated by PDPs and their PBMs are expected to account for most of the total DIR.
- Pharmacy DIR and Pay-for-Performance: Although pharmacy DIR accounts for a small portion of total DIR in 2017, its impact on Part D program costs may be larger in that it typically encourages pharmacies to meet contractual "pay-for-performance" standards based on measures such as the generic dispensing rate (GDR). While the exact impact of pharmacy DIR on generic dispensing is unknown, a one percentage point increase in the GDR for PDP plans would have saved the Part D program and its beneficiaries an estimated $15.3 billion since the inception of the program. Over the next ten years, that savings increases to an estimated $68.9 billion for a one percentage point improvement in the GDR.

[1] Centers for Medicare and Medicaid Services. Medicare Part D – Direct and Indirect Remuneration (DIR). January 19, 2017. Retrieved May 28, 2017 from https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2017-fact-sheet-items/2017-01-19-2.html.

[2] POS drug cost reflects point-of-service discounts negotiated between the PBM and pharmaceutical manufacturer, prior to the application of beneficiary cost sharing. This is also referred to as allowed drug cost or gross drug cost.

This report is intended to estimate the value of historical and future DIR for the Medicare PDP market. Our estimates do not represent the effect of removing DIR or reflecting the amount of DIR price concessions in a different form on PDP stakeholders. If price concessions were not negotiated as DIR, PDP sponsors may negotiate price concessions in other forms (for example, as POS discounts). Any amount of price concessions in a different form will have a different effect on PDP stakeholder costs.

In addition to DIR, PDPs and their PBMs also negotiate significant POS price concessions with their network pharmacies, typically in the form of a percentage discount off a known price benchmark such as the wholesale acquisition cost (WAC). Unlike post-POS price concessions, these discounts can be determined at the time a prescription is dispensed.

Beneficiary premium savings excludes reductions in government premium subsidies for low income members. Federal government savings includes the direct subsidy, federal reinsurance subsidy, and low income premium subsidy (LIPS).

Impact of DIR on PDP Costs

Direct and indirect remuneration (DIR) includes manufacturer rebates, retail, mail, and specialty pharmacy price concessions, and any other subsidies or price concessions used to decrease the costs incurred by the Part D plan sponsor. By statute, all DIR must be reported to CMS. The DIR a plan receives affects beneficiary premiums and federal government payments

The Part D program currently allows for a mix of price concessions that are determined either at the POS or post-POS (after prescriptions have been dispensed). Post-POS price concessions are generally those that cannot reasonably be determined at the POS based on CMS guidance, and are reported to CMS as DIR. This framework allows PDPs and PBMs to negotiate price concessions with both manufacturers and pharmacies based on metrics that can only be determined once trends and performance over time are known.

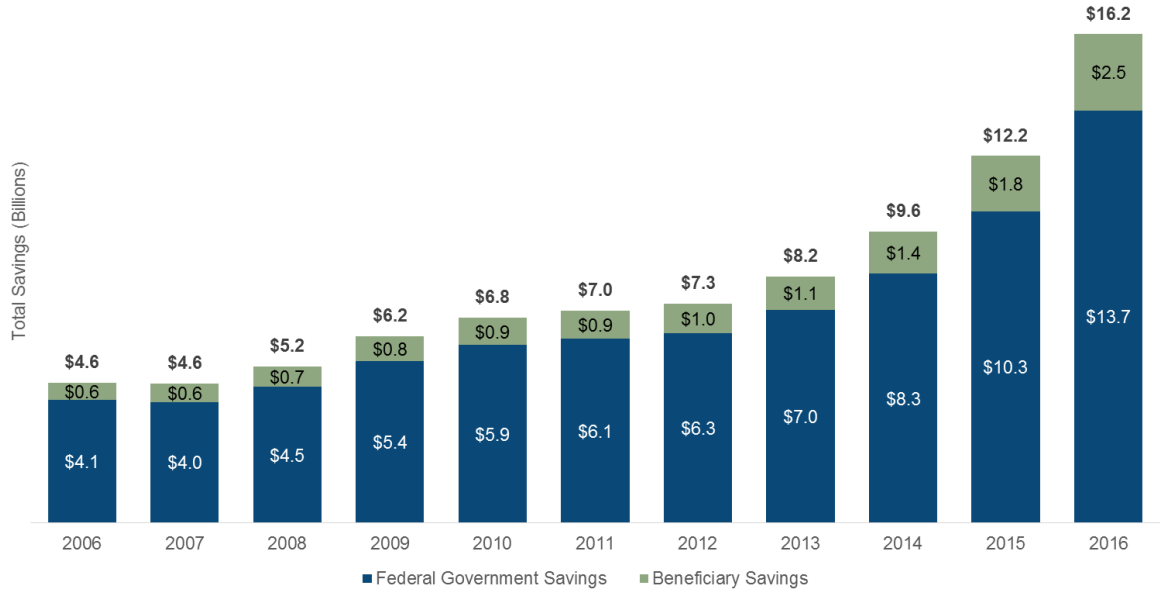
Price concessions determined at the POS are shared with all stakeholders involved in paying POS claims (i.e. they are used to reduce federal government costs, beneficiary cost sharing and premium, and pharmaceutical manufacturer CGDP payments). Post-POS price concessions are used to reduce federal government costs and beneficiary premiums.

This analysis estimates the historical, current, and projected value of post-POS DIR on PDP program stakeholders, including the federal government, beneficiaries, and pharmaceutical manufacturers. Our analysis and estimates pertain only to the PDP market, not the MA-PD or Part D EGWP markets.

VALUE OF PRICE CONCESSIONS REFLECTED AS DIR

The historical value of PDP price concessions reflected as DIR has totaled approximately $87.8 billion since the inception of the program in 2006 through 2016, including an estimated $75.4 billion for the federal government and $12.4 billion for beneficiaries (Figure 1, Figure 3).

Figure 1: Historical Estimated Value of PDP Price Concessions Reflected as DIR, 2006-2016



This translates to a 15.0% savings for the federal government and a 6.6% savings for beneficiaries.

In 2017, PDP price concessions reflected as DIR will save the Part D program and its beneficiaries a projected $20.4 billion, including $17.2 billion in savings for the federal government and $3.2 billion in savings for beneficiaries (Figure 2). This savings corresponds to lower revenue for pharmaceutical manufacturers and pharmacies that pay DIR. Since

DIR reflects retrospective price concessions, it does not directly reduce beneficiary cost sharing at the POS but instead results in lower beneficiary premiums and government payments.

Figure 2: Estimated Savings (Cost) from Price Concessions Reflected as DIR by PDP Stakeholder, 2017 ($ Billions)

	BENEFICIARY PREMIUM	FEDERAL GOVERNMENT	PHARMACEUTICAL MANUFACTURER & PHARMACY	TOTAL PROGRAM SAVINGS (COST)
2017 SAVINGS	3.2	17.2	(20.4)	20.4

Over the 2017-2026 period, DIR is projected to save $308.2 billion in total program costs, including $259.6 billion for the federal government and $48.7 billion in beneficiary premiums.

Figure 3: Historical and Projected Estimated Savings (Cost) from Price Concessions Reflected as DIR by PDP Stakeholder ($ Billions)

	BENEFICIARY PREMIUM	FEDERAL GOVERNMENT	PHARMACEUTICAL MANUFACTURER & PHARMACY	TOTAL PROGRAM SAVINGS (COST)
HISTORICAL (2006-2016)	12.4	75.4	(87.8)	87.8
PROJECTED (2017-2026)	48.7	259.6	(308.2)	308.2

Note: Values may not add precisely due to rounding.

Figures 1, 2, and 3 estimate the value of price concessions reflected as DIR. If price concessions were not negotiated as DIR, PDP sponsors may negotiate price concessions in other forms (for example, as POS discounts). Any amount of price concessions in a different form will have a different effect on PDP stakeholder costs.

Actual DIR amounts vary widely by PDP organization. In addition, not all PDP organizations contract pharmacy DIR.

WHY MANUFACTURER PRICE CONCESSIONS ARE CONSIDERED DIR

Several factors help to explain why manufacturer price concessions negotiated by plan sponsors and their PBMs are generally structured as rebates and reported as DIR. First, plan sponsors and PBMs do not directly purchase or take possession of drugs from manufacturers as do pharmacies. As a result, plan sponsors and PBMs often negotiate POS discounts with pharmacies and negotiate post-POS rebates with manufacturers as standard industry practice.

Secondly, part of the leverage that plan sponsors and their PBMs have in negotiations with manufacturers stems from their ability to use benefit design tools such as tiered cost sharing to encourage their enrollees to use “preferred” drugs over competing drugs in the same therapeutic class. Rebates allow manufacturers to base their price concessions on observed changes in their product’s market share based on “preferred” formulary status.

While manufacturer price concessions are typically reflected as DIR, it is possible to negotiate price concessions at the POS. Compared to DIR, price concessions at the POS would increase federal spending (including premium and cost sharing subsidies) and increase beneficiary premiums. However, certain high-cost beneficiaries would experience lower cost sharing due to lower POS costs, outweighing the premium increase. This is especially true for beneficiaries that take high cost, highly rebated drugs. The potential cost or savings to each individual beneficiary will vary based on an individual’s income, prescription drug usage, and benefit design.

PHARMACY DIR AND PAY-FOR-PERFORMANCE

Although pharmacy DIR accounts for a small portion of total DIR in 2017, its impact on program costs may be larger in that it may encourage pharmacies to meet contractual "pay-for-performance" standards based on measures such as GDR. These "pay-for-performance" standards have recently become more common in response to CMS guidance that DIR cannot be reasonably determined at the POS.

While the exact impact of pharmacy DIR on generic dispensing is unknown, a one percentage point increase in the GDR for PDP plans would have saved the Part D program and its beneficiaries an estimated $15.3 billion since the inception of the program through 2016. Over the next ten years, that savings increases to an estimated $68.9 billion for a one percentage point improvement in the GDR (Figure 4).

Figure 4: Estimated Savings (Cost) of One Percentage Point Increase in the Generic Dispensing Rate by PDP Stakeholder ($ Billions)

	BENEFICIARY PREMIUM AND COST SHARING	FEDERAL GOVERNMENT	PHARMACEUTICAL MANUFACTURER & PHARMACY	TOTAL PROGRAM SAVINGS (COST)
HISTORICAL (2011-2016)	3.3	10.9	(14.1)	**15.3**
PROJECTED (2017-2026)	14.9	50.1	(65.1)	**68.9**

Additionally, PDPs and their PBMs may use DIR payments to align incentives toward improving practice patterns at the pharmacy. This is analogous to the value-based payment incentives that Medicare uses with a wide range of providers, and is integral to forthcoming efforts to incorporate Part D into Accountable Care Organization (ACO) arrangements.

For example, some PDPs structure pharmacy DIR payments to be contingent on medication adherence metrics. When beneficiaries adhere to refilling prescribed medications, pharmacy revenue increases while plan sponsor costs (prior to DIR) increase. If pharmacies pay more in DIR with improved medication adherence, plan sponsors' financial incentives are better aligned with beneficiary quality of care.

Other examples of performance-based criteria that may be used to determine pharmacy DIR payments include:

- Increasing patient participation in Medicare medication therapy management consultations and comprehensive medication reviews;
- Reporting metrics related to diabetes disease management programs;
- Appropriately reducing high-risk medications in the senior population; and
- Actively engaging customer satisfaction and service programs.

While these and other criteria may be used to determine pharmacy DIR payments, performance-based criteria are often difficult to measure. This is because it is not always clear how to assign beneficiary experience to a given pharmacy, especially for specialty pharmacies that typically do not dispense the majority of a beneficiary's prescriptions. The provisions of DIR contracts between pharmacies and PDP plan sponsors vary widely and are often contingent on multiple criteria.

Conclusion

The Medicare Part D program currently allows for a mix of price concessions that are determined either at the POS or post-POS. Part D beneficiaries and the federal government realize savings resulting from reductions in Part D program costs due to both POS price concessions and post-POS DIR. In 2017, DIR negotiated by PDPs and their PBMs will save the Part D program and its beneficiaries a projected $20.4 billion, or 24.0% of PDP POS drug costs. PDP DIR will reduce the federal government's costs for Part D by a projected $17.2 billion in 2017, a 26.6% savings. This savings is largely driven by manufacturer rebates. While pharmacy performance-based price concessions represent a smaller portion of total DIR, the payments are typically structured to incentivize non-DIR cost or quality program improvements, such as increased GDR. Price concessions reflected as DIR have resulted in overall savings for Medicare Part D program beneficiaries and the federal government historically, and we expect this savings to continue going forward.

Methodology

We estimated nationwide average individual Medicare Part D pricing scenarios for eleven-year historical (2006-2016) and ten-year projected (2017-2026) time horizons. Our eleven-year historical estimate is based on a cost model calibrated to the Part D national averages for 2006-2016 published by the Centers for Medicare and Medicaid Services (CMS) using the defined standard benefit design. Our ten-year projection is based on the same 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 2006-2017 national average bid amount (NABA), national average member premium (NAMP), and national average federal reinsurance are shown in Figure 5. Restated CMS national averages are used for years in which they are available (2008-2016). After calibrating each year to market-wide national averages, we adjusted each pricing scenario to reflect the individual PDP population only.

Figure 5: Part D National Averages

	NABA	NAMP	FEDERAL REINSURANCE
2006	$92.30	$32.20	$33.97
2007	$80.43	$27.35	$26.82
2008	$79.54	$27.60	$28.70
2009	$82.57	$29.83	$34.41
2010	$86.96	$31.34	$35.94
2011	$85.36	$31.48	$38.09
2012	$82.96	$30.35	$36.06
2013	$77.95	$30.10	$40.09
2014	$74.36	$31.59	$49.52
2015	$68.63	$32.25	$57.84
2016	$63.11	$33.68	$68.97
2017	$61.08	$35.63	$78.65

This analysis uses Milliman's manual Part D data as a pricing basis. 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 (2006-2026) 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 2006-2016 PDP plans is based on publicly available enrollment data published by CMS. The income mix for 2017 PDP plans was assumed to be equal to 2016. To estimate individual PDP enrollment for 2018-2026 we computed PDP-specific growth factors for each year using publicly 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. Figure 6 summarizes the enrollment used in our analysis.

Figure 6: PDP Enrollment Assumptions (Millions)

	NON-LOW INCOME	LOW-INCOME
2006	7.4	8.1
2007	8.2	8.0
2008	8.5	8.0
2009	8.6	8.0
2010	8.7	8.0
2011	8.9	8.2
2012	9.3	8.3
2013	9.8	8.3
2014	10.4	8.2
2015	11.3	8.0
2016	12.1	7.9
2017	12.4	8.1
2018	13.0	8.3
2019	13.3	8.4
2020	13.6	8.6
2021	13.9	8.7
2022	14.2	8.9
2023	14.4	9.1
2024	14.6	9.1
2025	14.9	9.3
2026	15.1	9.5

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 DIR as a percent of total allowed cost, before sharing with federal reinsurance. 2017 DIR is based on Milliman's annual survey of Part D sponsors. Historical DIR (2006-2016) is based on publicly available CMS data. Projected DIR (2018-2026) as a percentage of allowed cost was assumed to be equal the 2017 projected DIR. Figure 7 shows modeled DIR as a percentage of total allowed cost for all years.

Figure 7: DIR Assumptions

	DIR AS PERCENTAGE OF ALLOWED COST
2006	9.0%
2007	9.6%
2008	10.2%
2009	10.8%
2010	11.3%
2011	11.5%
2012	11.7%
2013	12.9%
2014	14.3%
2015	17.2%
2016	20.6%
2017-2026	24.0%

DIR in this report includes manufacturer rebates, pharmacy performance-based price concessions, and any other DIR collected by Part D plan sponsors. This analysis estimates savings due to DIR alone, without reflecting the potential impact of changes in other contracting terms or stakeholder behavior over time or with changes in DIR levels. To estimate the impact of a one percentage point increase in GDR, we increased overall GDR by 1% and made no additional adjustments to allowed costs.

The intent of our analysis is to quantify the effect of DIR on the Medicare Part D program and its key stakeholders. Changes in stakeholder behavior are not explicitly modeled in this analysis. For example, we do not assume that beneficiaries utilize fewer prescriptions 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. 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.

Historical and projected estimates are on an undiscounted basis and do not reflect any time value of money adjustments.

Appendix: Medicare Part D Background

The Medicare Part D program was introduced in 2006 to subsidize prescription drug costs for Medicare beneficiaries. Part D plans are offered through private plan sponsors. The plan sponsors work with the CMS to administer the benefit.

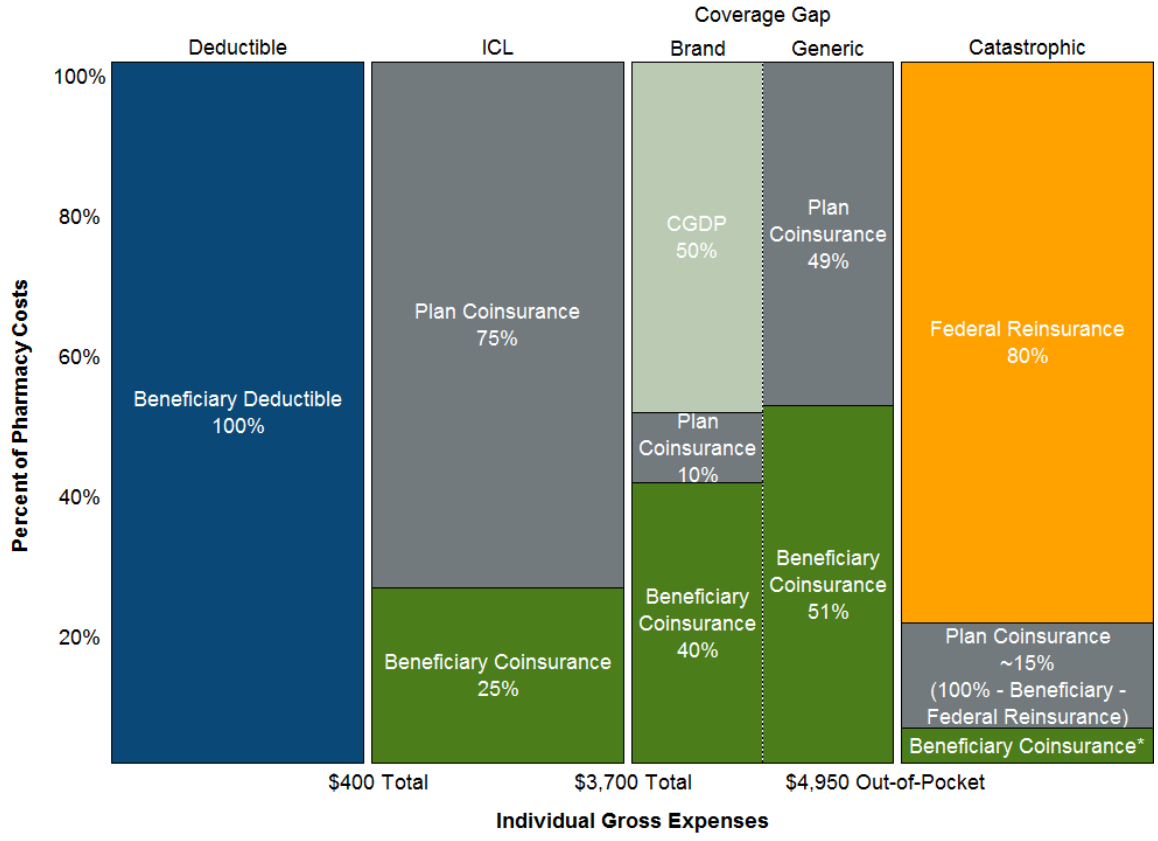
The Medicare Part D program is funded by beneficiaries, the federal government, and pharmaceutical manufacturers. Plan sponsors are risk-bearing entities that administer and sell subsidized plans to beneficiaries. Medicare Part D bids and margin are highly regulated by CMS. Therefore, plan sponsors are intermediaries within the program and not a primary source of funding for the program.

DEFINED STANDARD PART D BENEFIT

All Medicare Part D plan sponsors must offer a plan that is equivalent to the prescribed benefit, called the defined standard benefit. CMS updates the defined standard benefit parameters each year. Plan sponsors may alter the benefit within specified guidelines. The defined standard benefit is divided into four distinct cost sharing phases. Stakeholder liability changes throughout the year as the beneficiary moves through the different phases.

Figure 8 illustrates the 2017 defined standard Part D benefit for a non-low income beneficiary.

Figure 8: 2017 Medicare Part D Defined Standard Benefit, Non-Low Income Beneficiary



*Catastrophic beneficiary Coinsurance is 5%, subject to minimum of $3.30 copay for Generic/Preferred Multi-source drugs or $8.25 for other drugs.

Deductible

In the deductible phase, which is $400 in 2017, the beneficiary is responsible for 100% of drug costs. Drug costs are defined as allowed costs after POS discounts and prior to application of DIR.

Initial Coverage Limit (ICL)

After the deductible is met, the beneficiary pays 25% of drug costs until $3,700 in total drug costs is reached (the 2017 ICL). The plan sponsor pays the remaining 75% of drug costs.

Coverage Gap

Claim liability in the coverage gap phase is shared between the beneficiary and plan sponsor and varies for brand and generic drugs. Starting in 2011 under the Affordable Care Act (ACA), coverage gap beneficiary cost sharing decreases each year through 2020, at which point beneficiaries will pay 25% of drug costs.

Under the ACA, pharmaceutical manufacturers pay 50% of the cost of brand drugs in the coverage gap for non-low income beneficiaries. This is referred to as the CGDP payment.

Catastrophic

Beneficiaries reach the catastrophic phase when their annual out-of-pocket expenditures reach $4,950, the 2017 true out-of-pocket threshold (TrOOP). CGDP payments also contribute toward reaching the TrOOP.

In the catastrophic phase, the beneficiary pays approximately 5% of drug costs, the federal government subsidizes 80% of drug costs, and the plan sponsor pays the remaining cost.

The 80% of catastrophic drug costs covered by the government is referred to as the federal reinsurance subsidy. The drug cost used to calculate the federal reinsurance subsidy is net of DIR because DIR is typically collected for all claims (including catastrophic claims). The amount of DIR attributed to federal reinsurance is proportional to the amount of federal reinsurance as a percentage of annual drug costs. For example, if federal reinsurance accounts for 30% of total drug costs, the plan shares 30% of DIR with the federal government. Figure 9 illustrates this dynamic.

Figure 9: Federal Reinsurance Subsidy Calculation Example

	PER MEMBER PER MONTH (PMPM) COST	
ALLOWED COST	$100	[A]
FEDERAL REINSURANCE, GROSS OF DIR	$30	[B]
TOTAL DIR	$20	[C]
GOVERNMENT SHARE OF DIR	30%	[D] = [B] / [A]
FEDERAL REINSURANCE, NET OF DIR	$24	[E] = [B] - ([C] * [D])

FEDERAL MEDICARE PART D SUBSIDIES

In addition to the federal reinsurance subsidy, the federal government subsidizes Part D program costs through the direct subsidy, LIPS, and LICS.

Direct Subsidy

The direct subsidy is a risk-adjusted payment from CMS to the plan to cover the portion of a plan sponsor's costs related to the defined standard benefit. The national average direct subsidy is calculated as the difference between the national average monthly bid amount, which represents the average of all projected plan costs, and the average base beneficiary premium. The base beneficiary premium is calculated using the national average bid and estimated average federal reinsurance. Therefore, direct subsidy payments generally decrease if plan sponsors reduce the costs that are used to develop the national average bid.

The remaining portion of a plan sponsor's costs is covered through beneficiary premium.

Low Income Subsidies

CMS subsidizes premiums and cost sharing for low income beneficiaries through LIPS and LICS. Most beneficiaries with incomes below 135% of the federal poverty level (FPL) pay no premium or deductible and have minimal copays (typically $3.30 for generics and preferred multi-source drugs and $8.25 for other drugs in 2017) until they reach

TrOOP, after which they pay no cost sharing.[2] Most beneficiaries with incomes between 135% and 150% of the FPL pay a reduced premium that varies based on income, and have a reduced deductible and cost sharing defined by CMS. LICS subsidizes beneficiary cost sharing in all phases of the Part D benefit. Beneficiary premium and cost sharing in this report exclude LIPS and LICS; these amounts are reflected as a component of federal government costs.

RISK SHARING PROGRAMS

The Medicare Part D program includes three mechanisms to mitigate financial risk for Part D plan sponsors.

Risk Corridors

Risk corridors limit the gains and losses of individual Part D plans when actual claims differ from expected claims. Based on specific thresholds, the PDP sponsor pays CMS if performance is better than expected. CMS subsidizes the PDP sponsor if performance is worse than expected. No payments/ subsidies are made if actual experience is within plus or minus 5% of the target amount for a PDP. The payments/ subsidies cover 50% of claims in the 5% to 10% corridor and 80% of claims in excess of plus or minus 10% threshold.

In the risk corridor program, plan sponsors share large Part D gains and losses with CMS. Risk corridors are based on plan performance relative to expected levels. Therefore, reductions in risk corridor payments (either positive or negative) are the result of improvements in bid projection accuracy and claim projection stability from PDPs rather than reductions in the cost of prescription coverage.

Risk Adjustment

Plan sponsors' direct subsidy payments from the federal government are adjusted to reflect the health status of the enrolled beneficiaries. The risk adjustment mechanism model pays plan sponsors more for less healthy beneficiaries (those with higher risk scores).

Federal Reinsurance

The federal government covers 80% of beneficiaries' costs in the catastrophic phase of the Part D benefit, as described above. Federal reinsurance amounts in this report are net of DIR attributed to federal reinsurance.

[2] Centers for Medicare and Medicaid Services. Announcement of Calendar Year (CY) 2017 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter, p. 68-69. April 4, 2016. Retrieved March 27, from https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2017.pdf.

Caveats and Limitations

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.

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.

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.

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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