

Impact of Moving Medications from Medicare Part B to Part D

Katie Holcomb, FSA, MAAA

Hillary Millican, FSA, MAAA



Medicare Part B provides limited coverage of certain types of medications, primarily those requiring administration by a physician or in a hospital outpatient setting. These include cancer treatments (both oral and infused chemotherapy treatments, as well as accompanying anti-nausea medications), many vaccinations, renal dialysis medications, transplant medications, and most injectable / infused medications provided by a medical professional. The Medicare Part D program provides coverage of most outpatient prescription medications not otherwise covered by Part B. The President's Fiscal Year 2019 Budget proposed moving certain Part B medications to the Part D benefit. Interest in this concept was elevated when HHS Secretary Alex Azar mentioned it as one of the most important provisions among the President's recently released *American Patients First: The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs*¹. Some believe

health plan / pharmacy benefit manager negotiations in Part D will help control Part B medication costs^{2,3}.

The Pharmaceutical Research and Manufacturers of America (PhRMA) engaged Milliman to analyze the potential impact of moving all medications currently covered by Medicare Part B into the Medicare Part D benefit. Specifically, this report discusses the impact of this change to the Part D program. Our analysis focuses on the impact of this change alone – analyzing downstream changes to Part D, such as corresponding changes to Part D risk scores or member behaviors, was outside the scope of this analysis.

Summary of Analysis

Table 1 includes the anticipated impact on Part D national average values and average cost sharing.

Table 1
Expected 2019 Impact to Part D of Moving All Medicare Part B Medications to Part D

	2019 Estimated Starting Bid Values	Percent-age Impact	PMPM Impact
National Average Bid Amount (NABA)	\$54.50	29.3%	\$16.00
National Average Member Premium (NAMP)	\$36.20	39.3%	\$14.20
National Average Direct Subsidy (NADS)	\$18.40	9.4%	\$1.70
National Average Reinsurance (NAR)	\$84.70	45.6%	\$38.70
Member Cost Sharing	\$43.60	6.7%	\$2.90
Low Income Cost Sharing (LICS)	\$47.40	6.9%	\$3.30

Shifting Part B pharmacy costs to the Part D benefit will increase the cost of the Part D benefit:

- Many Part B medications would be considered specialty products under Part D and would have costs high enough to push beneficiaries into the coverage gap and catastrophic phases (assuming no changes to the 2019 Part D benefit parameters). In these phases, plan liability is lower than in the earlier phases of the Part D benefit design. As a result, a significant portion of the added Part B medication costs would fall to the federal government through the federal reinsurance program, causing an increase in federal reinsurance of about \$39 per member per month (PMPM) on average.
- The national average bid amount is expected to increase around \$16 PMPM. The bid amount is funded through premiums and the direct subsidy. Part D beneficiary premiums would be expected to increase by over \$14 PMPM on average (gross of low income premium subsidies) due to the additional medications covered under Part D instead of Part B. An increase in the national average direct subsidy of about \$2 PMPM is also expected.

¹ Modern Healthcare. Senate pushes for stronger drug-pricing policy than Trump proposal. June 26, 2018. http://www.modernhealthcare.com/article/20180626/NEWS/180629934?utm_source=modernhealthcare&utm_medium=email&utm_content=20180626-NEWS-180629934&utm_campaign=dose

² U.S. Department of Health and Human Services. FY 2019 Budget in Brief. February 19, 2018. <https://www.hhs.gov/sites/default/files/fy-2019-budget-in-brief.pdf>

³ American Patients First – The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs. May 2018. <https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf>

The change to beneficiary cost sharing will vary significantly by beneficiary. Part D beneficiary cost sharing is expected to increase around \$3 PMPM (excluding any cost sharing paid by other stakeholders) when Part B medications are moved to Part D, as well as an additional \$3 PMPM increase in cost sharing subsidies, on average. However, the actual value of total cost sharing across Part B and Part D paid by the beneficiary will vary widely based on a number of factors.

For example, a beneficiary with a Medigap plan may see a large increase in cost sharing as most of their Part B costs are paid for by the Medigap plan, but the beneficiary must pay the cost sharing under the Part D benefit. However, an NLI beneficiary taking a Part B medication in Fee-for-Service (FFS) would likely save money since the reduction in Part B cost sharing would likely be greater than the increase in Part D cost sharing and premium. The increase in Part D cost sharing may be offset by a decrease in Part B cost sharing, but the extent to which it does depends on many factors including (but not limited to) income / Medicaid status, enrollment in an MA or Medigap plan, plan benefit design, and actual Part D / Part B pharmacy / medical spend.

The federal government would likely save if Part B medications move to Part D, since beneficiaries pay a higher percentage of the total revenue in Part D compared to Part B. While the government would pay more in Part D reinsurance, direct subsidy, and low income subsidy payments, these increases would likely be more than offset by the savings in Part B funding.

Generally speaking, this change would introduce a lot of volatility to Part D costs, premiums, and government risk sharing. Part D total costs are much smaller than Part A and Part B costs, so the effect of new pipeline products will have a bigger percentage impact under Part D than they would under Part B. As a result, prospective changes to the Part D risk model for new medications would be important to align Part D revenue with Part D expenditures. Plans could experience large changes in cost as a result of new medications and / or changes in population using Part B medications, so year over year premium changes could be less stable in the short term. This is particularly true for PDP plans, which will undoubtedly see a large increase in gross costs, while MAPD plans will experience a corresponding decrease in Part B gross costs, and will be less impacted.

Methodology and Assumptions

Part D Analysis Methodology

We used Milliman's Part D pricing model and nationwide assumptions to estimate the 2019 national averages under current law. We then estimated the allowed costs PMPM that would be removed from the Part B program (as described below) and added those costs to the allowed costs of the Part D program. We increased allowed costs to reach the new expected PMPM by increasing utilization and decreasing inflation trends for brand and specialty tiers. We used the average brand and specialty cost of the Part B medications from the Medicare 5%

sample. We assumed generics are not highly impactful in this analysis, given the majority of Part B costs are for brand or specialty medications. The changes from the national average assumptions represent the approximate change in the overall Part D market, while the impact to individual carriers, pharmaceutical manufacturers, and beneficiaries would certainly vary.

FFS and MA Payment Rate Analysis Methodology

We adjusted 2011 through 2015 FFS total Part B costs to remove the estimated cost of Part B medications, using the percentage of Part B medication claims from the 2011 through 2015 Medicare 5% sample data. Following CMS's calculation approach, we determined the adjusted 2018 FFS costs. CMS adjusts the FFS cost data to change all historical county claim costs to a program equivalent basis for that bid year (2018 in this case). We assumed the program adjustments would not affect the Part B data. We calculated the 2018 payment rates based on the adjusted 2018 FFS cost. We trended both the 2018 FFS cost and 2018 payments rates to 2019 at the preliminary 2019 FFS trend and payment trend released in the CMS 2019 Advance Notice, since county level FFS cost and benchmarks for 2019 had not yet been published by CMS at the time of this analysis. Quartile changes are phased into payment rates over a two-year period, so we also developed 2017 FFS costs and payment rates to calculate the full effect of quartile changes in the 2019 payment rates.

Other Notable Assumptions

In our analysis, we made several other important assumptions. These include:

National average assumptions: The Part D assumptions used to create the projected national average values largely came from Milliman's Part D PBM Contract survey. We used Milliman standard trends and manual rates, as well as the nationwide LI percentage from the 2017 Medicare Trustees report.

3.5 stars: We assumed all MA payment rates are for a plan carrier with 3.5 stars. A plan with 4 stars or above is eligible for a bonus, however, this bonus is the same percentage for all counties, so it will not materially affect our results. One could also adjust for FFS costs moving above or below the national average. However, since changes for adding Part B medications will impact all counties to some degree, the shift among counties and the impact of double bonus counties would also likely be small.

Payment rate trends: We assumed FFS costs will increase 4.08% and payment rates will increase 5.44% in 2019, based on the preliminary rate increases provided by CMS in the 2019 Advance Notice. Final payment rate increases were not available at the time of our quantitative analysis, but ended up being 0.5 to 1% higher than the Advance Notice values (which makes it unlikely to impact results materially). We also did not change the payment quartiles or adjust for county-level rate rebasing, which could impact the final results when viewed at a local level, but not materially when viewed in aggregate.

Pharmacy costs between Part B and Part D: Allowed costs are assumed to be the same under Part B and Part D. Medications are reimbursed based on Average Sales Price (ASP) in Part B and based on discounted Average Wholesale Price (AWP), which will vary by plan.

Rebates: There may be additional pressure on pharmaceutical manufacturers to provide rebates if Part B medications are moved to Part D. However, for simplicity, we assumed no rebates would be offered for these medications in our analysis. Many of the medications are high-cost specialty products with few or no therapeutic alternatives, so manufacturers may not offer a rebate on certain products, even in Part D. While some rebates exist on Part B medications, they are small in comparison to Part D rebates.

2019 Part B premium and deductible values: The premium and deductible values remained consistent from 2017 to 2018, so we assumed they would remain flat for 2019 also.

Non-benefit expense or gain / loss margin: Moving medications from Part B to D would involve significant implementation costs that are outside of the scope of this analysis. There could be some non benefit expense increases in the Part D program, with corresponding cost decreases in the medical benefit. However, we expect the two costs will offset for an MA organization, and the Part D changes would minimally affect the Part D national averages. For simplicity, we assumed Part D non-benefit expense and gain / loss margin did not change in this analysis.

No change to risk score models: We assumed no changes to risk score models. In reality, moving medications from Part B to Part D would require both the MA and Part D risk score models to be recalibrated with the new costs included in each program. We are assuming these changes will have offsetting effects, but there is a lot of uncertainty as to how this would play out and there would certainly be winners and losers.

No behavioral changes: We assumed beneficiary choices would not change if medications were covered under Part D instead of Part B. Similarly, we assumed no changes to Part D plan strategies which could impact costs.

Caveats, Limitations, and Qualifications

This report was developed to help PhRMA examine potential impacts of moving medications covered by the Medicare Part B benefit into the Part D benefit. This information may not be appropriate, and should not be used, for other purposes. The information presented in this report is provided for PhRMA. PhRMA may share this information with outside entities with Milliman's permission. Milliman does not intend this information to benefit, and assumes no duty or liability to, other parties who receive this work product. Any third party recipient of this work product who desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this report to a third party should be in its entirety.

In preparing our analysis, we relied upon public information on the Part B and Part D programs from CMS, Medicare 5% sample, and a Milliman claims database of nationwide Medicare claims. Actual results will vary for specific health plans due to differences in trends, discount and rebate arrangements, benefit designs, and formulary structures, among other differences.

We are not attorneys and do not intend to provide any legal advice or expertise related to the topics discussed here. Legislative changes should be discussed with legal personnel. We are not advocating for or against the proposed change discussed in this letter. The opinions included here are ours alone and not necessarily those of Milliman.

We are Consulting Actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. 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 information has been prepared under the terms of the consulting services agreement between Milliman and PhRMA, dated January 19, 2016.



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CONTACT

Katie Holcomb
katie.holcomb@milliman.com

Hillary Millican
hillary.millican@milliman.com