IMPACT OF THE ELIMINATION OF PREFERRED PHARMACY NETWORKS ON THE MEDICARE PART D PROGRAM

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Considerations and Limitations

The Actuarial Practice of Oliver Wyman was commissioned by the Pharmaceutical Care Management Association (PCMA) to prepare this report in response to the Centers for Medicare and Medicaid Services (CMS) Proposed Rules for Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs. Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of anything set forth herein. The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof. Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of this information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

For our analysis, we relied on data and information from CMS without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that our review of data may not always reveal imperfections. We have assumed that the data is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

The opinions and conclusions expressed herein reflect technical assessments and analyses and do not reflect statements or views with respect to public policy.

Executive Summary

On January 10, 2014, CMS published proposed rules to regulate the Medicare Advantage and Medicare Prescription Drug Benefit (Part D) programs. The health plans and pharmacy benefit managers (PBMs) that are responsible for designing and managing Part D plans have concerns that these rules will adversely affect the ability to develop preferred pharmacy networks. This is important to both Part D enrollees and CMS because the implementation of preferred pharmacy networks has had a significant impact on lowering the cost to provide prescription drug benefits delivered through Medicare Part D.

If the proposed rules are implemented as written, health plans and PBMs believe that the advantages that the preferred pharmacy networks offer may effectively disappear and the ability for plans to develop preferred pharmacy networks will be nearly impossible.

The Pharmaceutical Care Management Association (PCMA) engaged Oliver Wyman to prepare this report and provide an analysis of the impact of the elimination of preferred pharmacy networks on the Part D program. The plans that currently use preferred pharmacy networks are generally the lowest cost plans in the Part D program, and these lower costs are a result of Part D plans ability to negotiate better drug pricing in negotiations with these pharmacies. Therefore, the elimination of preferred pharmacy networks will increase the cost of Part D plans for enrollees, through higher premiums and cost-sharing, and will increase the cost to CMS, through higher direct subsidies.

Our analysis, which utilizes PDP data (a subset of Part D plans) has estimated the value of the increased costs for all parties and makes the following conclusions:

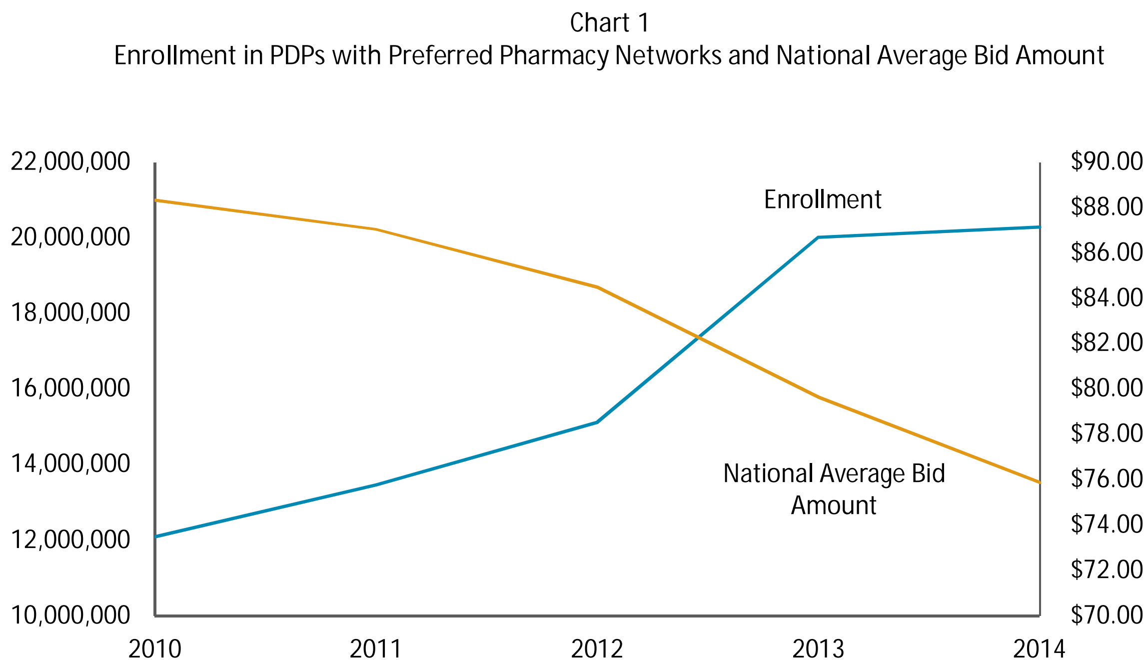
- As of February 2014, more than 75% of PDP enrollees are in plans with preferred pharmacy networks and these enrollees could be adversely affected by the elimination of plans utilizing preferred pharmacy networks.
- The estimated average increase in premiums for the affected population is $63 per year for the 2015 plan year.
- PDP enrollees may pay an average of $80 to $100 per year in additional cost-sharing in 2015.
- As a result of an expected increase in the national average benchmark for Part D plans, we estimate that CMS would pay an additional $64 in direct subsidies per beneficiary per year in 2015, for a total increased payment of nearly $1.5 billion in 2015 across all PDP enrollees, based on Part D enrollment of approximately 23 million beneficiaries.
- Over a 10-year period, we estimate the increased cost of eliminating preferred pharmacy networks to be approximately $990 per affected enrollee, and the cost would be approximately $24 billion to CMS in the form of higher direct subsidy payments.

Background

As the Medicare Part D program has evolved over time, health plans have found inventive ways to minimize the cost to provide pharmaceutical benefits and provide better service to enrollees. Since the beginning of the Medicare Part D program in 2006, per enrollee Part D costs have remained fairly flat or decreased slightly. This pattern has been accelerated in the last few years due to the introduction of Part D plans with preferred pharmacy networks. Enrollees benefit from plans that use preferred pharmacy networks because enrollees continue to have a wide network of pharmacies to choose from but also have the option of purchasing prescriptions with lower cost-sharing by acquiring their products at a narrower network of pharmacies. These preferred pharmacy networks are willing to negotiate lower pricing in anticipation of an expected increase in transactions.

The establishment of preferred pharmacy networks has resulted in reduced costs for both enrollees in the form of lower cost-sharing and premiums and for CMS through lower national averages and subsequently lower direct subsidies paid to Part D plans. Chart 1 below shows the growing membership in PDPs with preferred pharmacy networks compared to decreasing national averages.

Chart 1
Enrollment in PDPs with Preferred Pharmacy Networks and National Average Bid Amount



In January 2014, CMS published proposed changes to the rules governing Part D plans. It is our expectation that the proposed rules will be detrimental to PDPs offering preferred pharmacy networks, potentially eliminating plans with preferred pharmacy networks altogether.

There are two provisions in the proposed rule that specifically address preferred pharmacy

networks and that may cause disruption. First, Part D plans are currently allowed to offer lower cost-sharing to enrollees that utilize preferred pharmacy networks because these PDPs have been able to negotiate lower prices that more than offset the reduced cost-sharing, thus creating overall savings for the Part D plan. The proposed rule specifies that a Part D plan providing coverage other than defined standard coverage may reduce cost-sharing obtained through a subset of the network pharmacies as long as the preferred cost-sharing results, in all cases and for all drugs (brand and generic), in lower negotiated prices than the same drugs when obtained through the rest of the pharmacy network. The difficulty here lies in the requirement that this must be the case for all drugs. Negotiating the pricing of drug products is already complex and the proposed rule may make it overly burdensome such that negotiating a formulary to meet the new requirement becomes nearly impossible.

The second provision in the proposed rule that affects preferred pharmacy networks relates to the any willing provider requirements. CMS proposes to require Part D sponsors to have standard terms and conditions for network participation that list all combinations of cost-sharing and negotiated prices possible for retail settings under the plan. This would allow any willing provider the opportunity to participate in the preferred pharmacy network and offer preferred cost-sharing if the pharmacy can offer the requisite level of negotiated prices. This provision eliminates the ability of Part D plans to negotiate terms specific to a set of network pharmacies that will offer preferred pricing because PDP will no longer be able to provide any guarantees that the preferred pharmacies will have a pricing advantage over other network pharmacies.

If the CMS rules are implemented as currently proposed, it is expected that PDPs currently offering preferred pharmacy networks will no longer be able to maintain such networks and will need to revert to having cost-sharing and negotiated prices at similar levels for all contracted pharmacies. The result will be higher drug costs because the negotiated prices for prescription drugs dispensed by non-preferred pharmacies are generally higher than those from preferred pharmacies.

The PDP market is extremely competitive with multiple PDPs offering plans in all or nearly all regions. With this competitiveness, PDPs have managed their administrative costs to the lowest levels that they can with little margin for savings. Therefore, we expect that any increases in drug costs for PDPs will directly impact the overall cost (drug costs plus administrative costs) and subsequently will increase the premium members will pay.
Further, since the amount of the direct subsidies that are paid by CMS are dependent on the national average cost of all PDPs weighted by membership, moving members to higher cost plans will increase the amount of direct subsidies paid by CMS.

Data and Methodology

Our analysis estimates the impact of the elimination of PDPs (a subset of all Part D plans) utilizing preferred pharmacy networks. In our work we relied on publicly available data. Specifically, we used data from CMS that includes formularies for each plan and enrollment and enrollee premiums by plan made available by CMS. Using the formularies we were able to identify which of the PDPs employ preferred pharmacy networks.

Once we were able to identify the PDPs that employ preferred pharmacy networks, we used enrollment data to accumulate the total beneficiaries enrolled in these plans. The next step in our process was to determine the migration of members to new plans assuming that the plans with preferred pharmacy networks are eliminated. For this purpose, we assumed that beneficiaries will choose the nearest-cost plan that does not include a preferred pharmacy network.

The national average bid amounts which determine the level of payments that CMS makes to Part D plans and the premium amounts that beneficiaries pay are based on the weighted-average cost of all Part D plans. With the anticipated migration of membership to higher cost plans, CMS benchmarks will correspondingly increase. Therefore, once we modeled the migration of PDP enrollees from plans with preferred pharmacy networks to the nearest cost plan that does not include a preferred pharmacy network, we can recalculate the average cost of all plans.

The data available to us includes member premiums, but not direct subsidies, since these amounts are based on the average risk score for each plan. Therefore, we used beneficiary premiums to serve as a proxy for direct subsidies by assuming that the relationship between direct subsidies and premiums is consistent with the published national average.

Therefore, to estimate the change in the national averages, we first calculated the average premium to be paid by all members based on current membership. Next, we reassigned members to new plans as described above. Finally, we recalculated the average premium to be paid by beneficiaries after the migration. Based on the members enrolled in a PDP with preferred pharmacy networks as of February 2014, we estimated that the average basic premium is $32.88. After migration to new plans, we estimated the new average basic premium to be $38.15, an increase of $5.27 per month, or approximately $63 annually.

In order to determine the increase in CMS direct subsidies, we extrapolated these results to the direct subsidy. For 2014, the national average bid amount is $75.88 per month, and the average beneficiary premium is $32.42 per month. Using February 2014 data, we re-based these amounts and calculated an average direct subsidy amount of $44.99. After migrating the affected members to new plans, we recalculated a direct subsidy amount of $50.35, an increase of $5.36. On an annual basis, this amount is approximately $64 per beneficiary. Note that our analysis assumes the average risk score is 1.00.

In addition to the increased premiums, enrollees will also be subject to higher cost-sharing in plans without preferred pharmacy networks. We modeled the change in cost-sharing by using Oliver Wyman's proprietary Part D pricing model for the three most populated PDPs with preferred cost-sharing. We found that enrollees would pay between $38 and $47 in monthly cost-sharing, assuming the preferred cost-sharing amounts. Next, we modeled the same data but instead replacing preferred cost-sharing with non-preferred cost-sharing. Our results indicated that enrollees would pay monthly cost-sharing between $45 and $55. Annualized, the difference in the cost-sharing under the two scenarios is between $80 and $100.

The final step in our analysis was to estimate the long term impact over the next 10 years of eliminating preferred pharmacy networks from the Part D program. To forecast our results, we based the increase in enrollment in Part D plans and the annual trend in the cost per beneficiary on projections of the Part D portion of the Medicare program performed by the Congressional Budget Office. We assumed that the increased cost to the Part D program would be 2.1% of the total outlays for Medicare Part D.