OLIVER WYMAN

PART D COVERAGE GAP - FINANCIAL IMPLICATIONS OF REDUCING DRUG MANUFACTURES' LIABILITY

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NOVEMBER 21, 2018

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1. Executive Summary

On February 9, 2018, President Trump signed into law the Bipartisan Budget Act of 2018 (BBA), which made changes to the Medicare Part D coverage gap (or "donut hole"). Specifically, it "closed" the donut hole one year earlier (reducing the beneficiary liability to 25%), and reduced the plan liability from 25% to 5% while increasing the manufacturer liability ("manufacturer discount") from 50% to 70%. Since the passage of the BBA, there have been subsequent discussions of changing the coverage gap liabilities again, for example by reducing the manufacturer discount from 70% to 63%.[1]

Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman") evaluated the effect of reducing the manufacturer discount in the donut hole from 70% to 63% (over a 10-year period). In our estimation, reducing the manufacturer discount to 63% would increase costs to the federal government by $4.45 billion over that period. Additionally, members would be expected to realize a $4.05 billion increase in cost through increased cost-sharing and premiums. Furthermore, manufacturers would benefit by $8.50 billion. In Table 1 below, we summarize the estimated cost impact to all stakeholders.

Table 1 – Estimated Cost Increase of Reducing Manufacturer Discount from 70% to 63% (billions)

Calendar Year	Member Premium	Member Cost-Sharing	CMS	Brand Manufacturers
2019	$0.13	$0.22	$0.39	($0.74)
2020	0.14	0.23	0.40	(0.77)
2021	0.14	0.24	0.42	(0.79)
2022	0.15	0.24	0.43	(0.82)
2023	0.15	0.25	0.44	(0.84)
2024	0.16	0.26	0.45	(0.87)
2025	0.16	0.26	0.47	(0.89)
2026	0.16	0.27	0.48	(0.91)
2027	0.17	0.28	0.49	(0.93)
2028	0.17	0.28	0.50	(0.95)
All Years	$1.53B	$2.52B	$4.45B	($8.50)B

As a result of reducing the manufacturer liability from 70% to 63%, the increase in drug cost to the health plan will be passed on through to members (premium increases) and CMS (direct subsidy payment increases.)

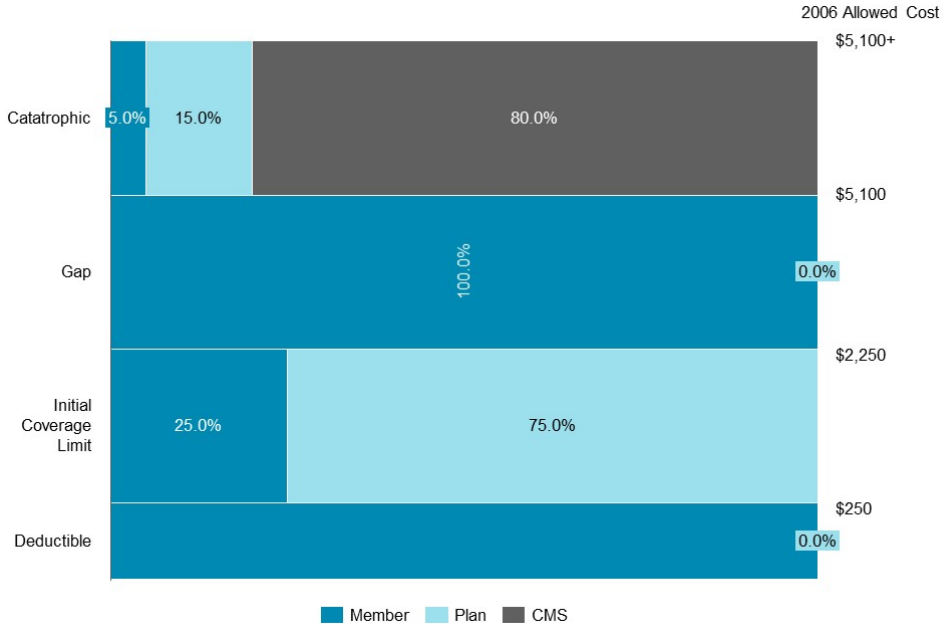
The remainder of this report provides background information on the closing of the coverage gap, outlines the analysis undertaken by Oliver Wyman, and presents the details of our results.

[1] https://www.ajmc.com/newsroom/phrma-tries-to-use-opioid-bill-to-shift-ldquodonut-holerdquo-costs-to-seniors

2. Background

With the passage of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA"), Congress authorized Medicare coverage of outpatient prescription drugs beginning in 2006. The MMA established the minimum standard benefit Part D plans must offer. The benefit structure adjusts each member's liability as their cumulative drug expenditures grow. Specifically, the standard Part D benefit included a phase known as the coverage gap (or "donut hole") where the member was responsible for 100% of their drug costs. The member reached the donut hole once their allowable drug costs hit a pre-determined limit, known as the initial coverage limit ("ICL" - $2,250 in 2006). At that allowable cost limit, members would have paid $750 in out-of-pocket expenses ("OOP"). The member would stay in the donut hole until their OOP costs reached the annual true out-of-pocket threshold, or "TrOOP," ($3,600 in 2006.) Once the member hit their TrOOP, their cost-sharing would be reduced to 5% and CMS would pay 80% of the drug cost. Exhibit 1 highlights the Part D benefit structures and stakeholder liability established by the MMA in 2006.

Exhibit 1 – 2006 Part D Benefit Design

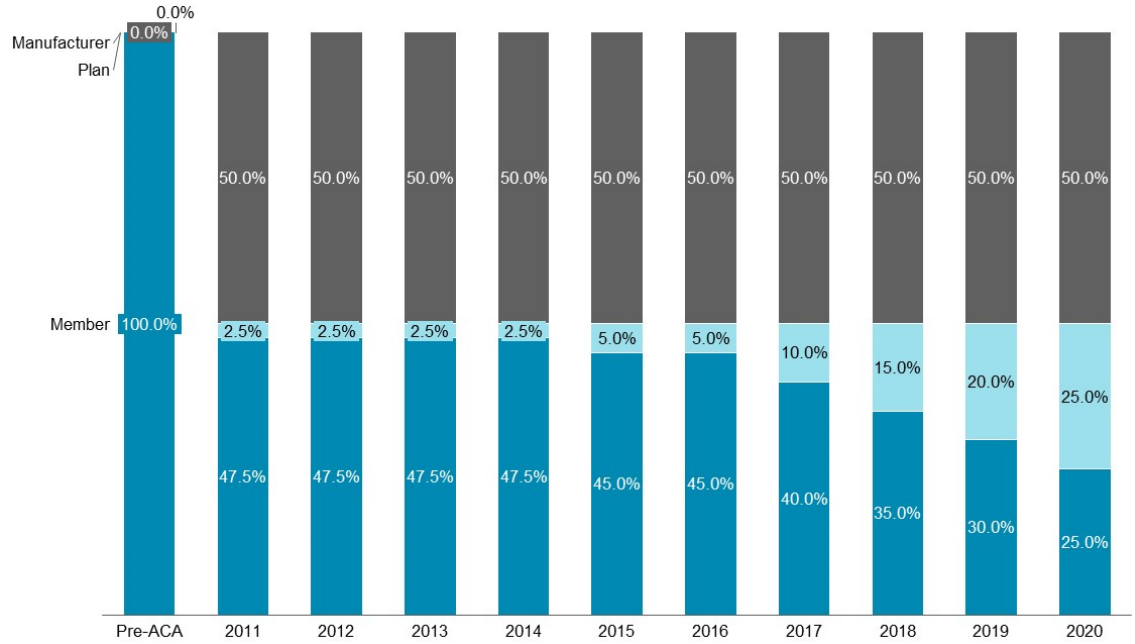


Some members qualify for Low-Income Subsidies ("LIS") to cover most of their OOP costs, including costs in the donut hole. But for a population that is largely on a fixed income, the donut hole created a financial barrier to accessing medications.

The Affordable Care Act ("ACA") introduced several significant changes to the Medicare Advantage Part C and Part D programs. One of these changes was to "close" the Part D donut hole, ultimately limiting the liability for non-LIS members in that benefit phase to 25% of the drug cost, consistent with what the member pays in the ICL. The ACA mandated a 10-year transition period from 2011 to 2020 to close the donut hole. For brand name drugs, the ACA required that

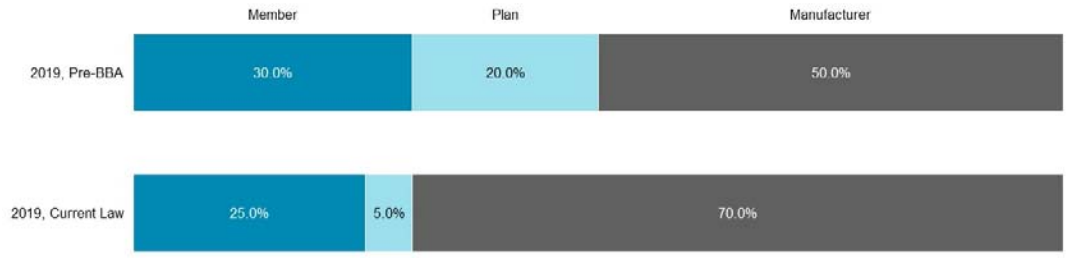
drug manufacturers cover 50% of the drug cost.[2] Exhibit 1 below shows the expected transition of the donut hole closure for brand name medications outlined in the ACA.

Exhibit 1 – ACA Transition of Donut Hole Closure for Brand Name Drugs



The passage of the BBA accelerated the closure of the donut hole for brand name medications in 2019 by increasing the manufacturer discount from 50% to 70%, as shown in Exhibit 2 below.

Exhibit 2 – BBA Impact on 2019 Liability for Brand Name Drugs in the Donut Hole



The Congressional Budget Office ("CBO") estimated that this change would decrease federal spending by $11.8 billion from 2018 to 2027, a one percent change in estimated spending over that period.[3]

The BBA's changes to the manufacturer discount considerably increases brand manufacturers' liability, while decreasing health plans' liability in the gap, both in perpetuity. Under the Part D program, CMS provides a premium subsidy for all members known as the direct subsidy. Absent the direct subsidy, the total net drug cost would be passed on to members in the form of premium. Consequently, reducing the net drug cost to health plans will lead to lower member

[2] The member and manufacturer costs both count toward the member's TrOOP threshold

[3] https://www.cbo.gov/system/files?file=2018-07/54192-PartD-letter.pdf

premiums and lower federal spending on direct subsidy payments. The decrease in federal spending on direct subsidy payments is somewhat offset by increases in federal reinsurance costs as members reach their TrOOP threshold more quickly, due the fact that the manufacturer discount counts towards the TrOOP.

3. Analysis

Using Oliver Wyman's internal claims dataset, we projected 2019 Part D costs, taking into consideration expected changes in utilization, drug costs and formulary. We then completed two separate pricing projections using Oliver Wyman's proprietary Part D pricing model. The first pricing projection reflects the 2019 defined standard plan. The second pricing projection modifies the first by shifting 7% of brand name drug costs from manufacturers to health plans for non-LIS enrollees.

Within our modeling, we captured the projected costs for all stakeholders (members, CMS and drug manufacturers). To estimate the impact on each stakeholder, we calculated what the adjusted 2019 standardized bid and federal reinsurances costs would be, assuming a 63% manufacturer discount. These values are the basis of the national base beneficiary premium and direct subsidy estimates. In Table 2 below, we have summarized the results of our analysis for CY2019.

Table 2 – 2019 Estimated PMPM Impact of Reducing Manufacturer Discount from 70% to 63%

		2019 Current Law(PMPM)	2019 @ 63% Manufacturer Discount (PMPM)	Change (PMPM)
A	Standardized Bid	$51.28	$53.20	$1.92
B	Federal Reinsurance	$78.88	$77.90	($0.98)
C = A + B	Gross Cost	$130.16	$131.10	$0.94
D = 25.5% x C	Base Premium	$33.19	$33.43	$0.24
E = A – D	Direct Subsidy	$18.09	$19.77	$1.68
F	Member Cost-Sharing	$61.28	$61.68	$0.40
G = D + F	Member Cost Increase			$0.64
H = B + E	CMS Cost Increase			$0.70
I = G + H	Manufacturer Savings			($1.34)

In the 2018 Medicare Trustees report, CMS estimates that Part D enrollment will increase from 48 million enrollees in 2019 to 58 million enrollees in 2027. Using these membership data, we projected that the Part D enrollment will reach 59 million enrollees in 2028. If we assume an annual cost impact of $1.34 PMPM, we estimate CMS and members will see an increase in cost of $8.50 billion from 2019 to 2028. In Table 3, we have summarized the cost impact by stakeholder and year.

Table 3 – Estimated Cost Increase of Reducing Manufacturer Discount from 70% to 63% (billions)

Calendar Year	Part D Enrollment (millions)	Member Premium	Member Cost-Sharing	CMS	Brand Manufacturers
2019	45.9	$0.13	$0.22	$0.39	($0.74)
2020	47.7	0.14	0.23	0.40	(0.77)
2021	49.5	0.14	0.24	0.42	(0.79)
2022	51.1	0.15	0.24	0.43	(0.82)
2023	52.5	0.15	0.25	0.44	(0.84)
2024	54.0	0.16	0.26	0.45	(0.87)
2025	55.5	0.16	0.26	0.47	(0.89)
2026	56.8	0.16	0.27	0.48	(0.91)
2027	58.0	0.17	0.28	0.49	(0.93)
2028	59.2	0.17	0.28	0.50	(0.95)
All Years		$1.53B	$2.52B	$4.45B	($8.50)B

Our estimate could be viewed as an upper limit in 2019, as plans could have included additional cost controls to offset the cost impact of this change to keep premiums competitive. Based on our review, the premium impact of this change is estimated to be less than $0.25 PMPM and may not induce a change in the health plans' cost control measures. In addition, we have not taken into consideration potential increases in drug costs in future years, which may result in a larger impact than what is shown in Table 3.

Within our review, we analyzed the cost impact of reducing the manufacturer discount in isolation and have not taken into consideration any additional regulatory changes. For example, we have not recognized the $1,250 increase in the member's TrOOP threshold that is scheduled to occur in 2020, which results from the expiration of an ACA provision that slowed the OOP threshold's growth rate from 2014 through 2019.

REPORT QUALIFICATIONS/ASSUMPTIONS AND LIMITING CONDITIONS

Oliver Wyman was commissioned by Blue Cross Blue Shield Association to analyze the impact of reducing the manufacturer gap discount would have on members, the federal government and drug manufacturers.

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 the results, advice or recommendations set forth herein.

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While this analysis complies with applicable Actuarial Standards of Practice, users of this analysis should recognize that our projections involve estimates of future events and are subject to economic and statistical variations from expected values.

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