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# The Impact of Preferred Pharmacy Networks on Federal Medicare Part D Costs, 2014-2023

Prepared for:  
**Pharmaceutical Care Management Association**

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## EXECUTIVE SUMMARY

The Pharmaceutical Care Management Association (PCMA) has retained Milliman to evaluate the effect of retail preferred pharmacy networks on the individual Medicare Part D market. In this report, we will: (1) Quantify the impact of preferred networks on 2014 federal spending using a representative Prescription Drug Plan (PDP) bid; (2) Estimate the effect of preferred networks on federal spending over a ten year period; and (3) Provide additional considerations regarding the methodology used in a recent CMS study on preferred networks.

In a preferred network plan, a PDP offers reduced member cost sharing at preferred pharmacies. Reduced member cost sharing is typically offered in the form of lower copays or coinsurance. The PDP is able to do this because it receives more competitive pharmacy contract terms on prescription drug prices. The preferential terms might be deeper drug discounts, lower dispensing fees and/or a post-point-of-sale (POS) price concession paid to the PDP sponsor. Post-POS price concessions are considered direct/indirect remuneration (DIR) under federal requirements. The objective of this report is to identify and quantify the financial impact of these terms on the federal Medicare Part D subsidies.

The analysis underlying this report uses a representative 2014 PDP bid developed from a comprehensive Medicare Part D claims database, survey data, and Milliman trend and formulary research. Publicly available data is also used in this report to estimate the effect of preferred networks on the entire PDP market. Assumptions used in the development of the representative bid are discussed in the *Representative Plan Bid Development Assumptions* subsection of this report.

### Major Findings

- Preferred pharmacy network plans are estimated to reduce federal Medicare spending by approximately \$870 million in 2014.
- Over the next ten years, preferred pharmacy network plans are estimated to reduce federal Medicare spending by \$7.9 to \$9.3 billion.
- The largest two-year decrease in federal direct subsidies in the history of the Medicare Part D program has coincided with the rapid adoption of preferred pharmacy network plans and the increased use of generic drugs.
- Post-POS price concessions cause a greater reduction in the federal Medicare spending than equivalent drug discounts reflected at POS.

### Effect of Preferred Pharmacy Networks on Federal Spending

PDPs must estimate the cost of providing Medicare Part D coverage in the bids they submit to the Centers for Medicare & Medicaid Services (CMS). This cost is affected by many factors including brand patent expirations, pharmacy contract changes and administrative cost changes. In this study we isolate the addition of a preferred network to a PDP bid to quantify the effect on federal spending.

The estimated annual cost impact of preferred networks on federal spending is presented in Table 1. The total effect is comprised of three distinct components. PDP bids typically decrease with pharmacy contracting improvements. This component is listed as “Pharmacy Contract Improvement” in Table 1. Each year, PDP members<sup>1</sup> move (and are reassigned) to lower cost plans.

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<sup>1</sup> In this report, we refer to Medicare Part D beneficiaries as “members”.

This membership movement decreases the average PDP cost and impacts the Direct Subsidy calculation. In addition, the migration to lower cost plans affects the amount that the federal government pays in premium payments for low income members. The effect of this movement is presented in Table 1 for each federal subsidy: Direct Subsidy and Low Income Premium Subsidy (LIPS).

<b>Table 1 Annual Federal Savings from Medicare PDP Preferred Pharmacy Networks, 2014</b>	
Pharmacy Contract Improvement Savings	\$750,000,000
Direct Subsidy Savings	\$80,000,000
LIPS Savings	\$40,000,000
<b>Federal Savings from Preferred Networks, 2014</b>	<b>\$870,000,000</b>

We estimate that the inclusion of preferred pharmacy networks will reduce federal Medicare Part D PDP spending by approximately \$870 million in 2014 based on the assumptions described in this report. There may also be additional federal savings associated with Medicare Advantage Prescription Drug Plans, which is outside the scope of this analysis.

- Pharmacy contract improvement savings:** This accounts for approximately 85% of total savings in Table 1. The improved contract terms may be in the form of (1) lower unit costs at the POS or (2) preferred network DIR. Lower POS unit costs may include more competitive discounts off Average Wholesale Price (AWP) or lower dispensing fees. Preferred network DIR may be in the form of a post-POS price concession or it could be an incentive payment for satisfying certain goals like preferred network drug volume, generic utilization rates, or other metrics designed to encourage cost savings.
- Direct Subsidy savings:** This accounts for approximately 10% of the total savings in Table 1. Each year, members move to lower cost PDPs. There are two primary drivers of this movement. First, certain low-income members are auto-assigned from high cost PDPs to low cost PDPs by CMS. Regional Low Income Benchmarks (LIB) affect this movement since low income members are auto-assigned to plans that submit bids below the LIB. Second, some members are attracted to lower cost plans and typically move to such plans when they are introduced. The market-wide Direct Subsidy funded by the federal government decreases as members enroll in lower cost plans.
- Low Income Premium Subsidy (LIPS) savings:** This accounts for approximately 5% of the total savings in Table 1. This savings is the result of members moving to lower cost plans. The government LIPS payment is smaller in aggregate when some of the low income members are reassigned to lower cost plans.

Based on marketplace conditions and trends, we assume that 30% of PDP membership will not enroll in a preferred network plan in 2014. We assume that 43% of the PDPs that have a preferred pharmacy network negotiate lower POS unit costs (30% of the overall PDP market). We assume that 57% of preferred network PDPs negotiate preferred network DIR (40% of all PDPs). In practice, PDPs may also use a hybrid preferred network approach, which relies on both improved POS costs and DIR.

### Estimated Impact on Federal Medicare Part D Costs, 2014-2023

In addition to the detailed analysis for 2014, we have developed a separate estimate of the impact of preferred networks on federal spending over a ten year period. We estimate that the total federal spending decreases by at least \$7.9 billion to \$9.3 billion from 2014 to 2023 with preferred network plans.

The range is developed using different population assumptions. The \$7.9 billion estimate is based on a closed-group population estimate. This includes all members currently enrolled in PDPs, which is 18.1 million as of March 2013. The \$9.3 billion estimate is based on an open-group population, which includes all members who are expected to enroll in PDPs during the projection period. Population definitions and the 2.9% annual population growth assumption are based on the 2013 Medicare Trustees Report<sup>2</sup>.

The 10-year estimated federal spending impact relies on improved POS unit costs at preferred network pharmacies included in a study published by CMS<sup>3</sup>. The ten year estimate is also based on representative plan assumptions and other assumptions related to pharmacy trends and preferred network plan enrollment in future years. Additional savings from DIR payments realized from members moving to lower cost plans are not included in this estimate.

## Methodological Considerations Related to CMS Study on Preferred Pharmacy Networks

CMS published a study dated April 30, 2013 to “determine if negotiated prices at preferred retail pharmacies are lower than the negotiated prices at non-preferred retail pharmacies for Part D sponsors with both preferred and non-preferred networks”. The CMS Study concludes that “negotiated prices are sometimes higher in certain preferred networks—contrary to our expectations.” We present additional considerations to supplement the methodology described in the CMS Study:

1. **DIR.** POS discounts and dispensing fees are not the only contractual terms used to reduce costs in preferred network plans. DIR appears to be acknowledged in the CMS Study but not included in the quantifiable results.
2. **Brand patent expirations.** The CMS Study is based on March 2012 Prescription Drug Event (PDE) data. This period falls within the six-month exclusivity period for Lipitor (the period where a limited free market and somewhat cheaper generic equivalent is available but at a cost not nearly reduced like it will be after exclusivity), which is the third-most-utilized brand drug in the study. A prescription drug's pricing during the exclusivity period is generally unstable as a new generic equivalent is introduced and PDP sponsors employ differing contracting strategies during this period. Dispensing a brand name drug could have a lower overall cost to the government when pharmaceutical company rebates are included in the analysis.
3. **Prescription drug mix.** The mix of drugs may vary by geographic region and between retail and mail order pharmacies. The CMS Study's Weighted Unit Cost metric appears to adjust for differences in total quantities dispensed for each drug. This metric does not appear to account for a varying mix of drugs by pharmacy, formulary, and geographic region.

The CMS Study recognizes the importance of preferred pharmacy networks in its conclusion: “between 2012 and 2013, the enrolled population in PDPs with a preferred network has doubled. Thus, we believe the impact of higher preferred network prices on the program as a whole is likely to be increasingly significant.”

Our analysis expands on the CMS analysis to examine the impact of preferred pharmacy networks on negotiated prices and all federal subsidies related to PDPs. We found that the addition of preferred pharmacy

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<sup>2</sup> Board of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, *2013 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*; May 31, 2013; available from <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2013.pdf>

<sup>3</sup> Centers for Medicare & Medicaid Services, *Part D Claims Analysis: Negotiated Pricing Between Preferred and Non-Preferred Pharmacy Networks*; April 30, 2013; available from <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/PharmacyNetwork.pdf>.

network plans decreases total federal PDP spending. We also show that the use of DIR can reduce federal PDP spending more than a comparable improvement with lower negotiated POS costs.

## INTRODUCTION

The 2013 Annual Report of the Social Security and Medicare Board of Trustees issues a stark warning about Medicare’s sustainability. Longer lifespans and increasing healthcare expenditures increase the financial cost of the Medicare program. The report states that “neither Medicare nor Social Security can sustain projected long-run programs in full under currently scheduled financing...”<sup>4</sup>.

With Medicare in a financially vulnerable position, it is encouraging to see cost-saving innovations from PDPs, including the use of preferred pharmacy networks. Medicare Part D has evolved into a highly competitive market where PDPs have been effective at controlling costs. This is supported by an eight year history of relatively modest cost increases for Part D. When Medicare Part D was introduced in 2006, typical commercial market pharmacy cost trends were in excess of 10%. Part D PDP federal spending has increased by less than 3% on average since Part D began<sup>5</sup>.

The number of members enrolled in plans with a preferred network is rapidly increasing. According to the CMS Study, the number of members enrolled in PDPs with a preferred network has doubled between 2012 and 2013. Some members are auto-assigned to lower cost plans with a preferred network. Other members voluntarily enroll in lower cost plans with a preferred network.

PDPs that introduce a preferred network typically decrease their bid amounts by a significant amount relative to the prior plan offered (see Table 2). While other market forces affect the PDP bid amounts, preferred network plans have provided lower premium options for Medicare Part D members. Low premium options appear to be popular since the four fastest growing basic PDP plans between December 2012 and February 2013 (offered by United, Humana, Aetna, and EnvisionRx) include preferred networks. Table 2 summarizes the year over year average change in member premium per member per month (PMPM) for plans that introduced a new preferred pharmacy network.

<b>Year</b>	<b>Plan Name</b>	<b>Premium Change</b>
2011	Humana Walmart-Preferred Rx Plan	-\$18.00
2012	Aetna CVS/pharmacy Prescription Drug Plan	-\$18.50
2013	AARP MedicareRx Saver Plus	-\$25.50
2013	First Health Part D Essentials	-\$10.50
2013	United American - Select	-\$3.50

With an increasing number of preferred network plans in the PDP market, CMS is considering additional rules related to preferred networks.

<sup>4</sup> Social Security and Medicare Boards of Trustees, *Status of the Social Security and Medicare Programs A Summary of the 2013 Annual Reports*; available from <http://www.ssa.gov/oact/TRSUM/tr13summary.pdf>.

<sup>5</sup> Federal government cost for PDP members includes the Direct Subsidy and the Federal Reinsurance subsidy less the member premium (ignoring the additional cost of low income subsidies). A comparison of 2006 to 2014 shows government costs to be essentially flat while a comparison on 2007 to 2014 reveals a 2.5% average annual increase in government costs based on CMS data published from bid submissions. We can compute the 2014 projected federal government PDP cost per member per month to be \$32.42/0.255 (since the member premium is 25.5% of the government’s cost by statute) minus \$32.42 which is \$94.72.

CMS expressed concern with preferred pharmacy networks in the 2014 Call Letter dated April 1, 2013<sup>6</sup>:

*We have begun to scrutinize Part D drug costs in PDPs with preferred networks, and comparing these to costs in the non-preferred networks, as well as to costs in PDPs without preferred networks. We are concerned because our initial results suggest that aggregate unit costs weighted by utilization (for the top 25 brand and top 25 generic drugs) may be higher in preferred networks than in non-preferred networks in some plans. Combined with lower cost sharing, we believe these higher unit costs may violate the requirement not to increase payments to such plans. We have contacted the plan sponsors identified in our analysis to initiate the validation of our findings.*

The CMS Study described in the excerpt was dated less than one month after the 2014 Call Letter on April 30, 2013. The study compares the March 2012 negotiated prices at the preferred and non-preferred pharmacies for thirteen PDP contracts. The analysis is based on PDE files and did not take into account post-POS price concessions reported as DIR. According to the CMS Study:

*In order to be compliant with requirements under §423.120(a)(9), sponsors must ensure the offering of lower cost sharing at preferred pharmacies does not result in increased payments to plans. Although CMS has not issued detailed guidance on what constitutes “increased payments to plans”, our general understanding has been this means preferred network pharmacies should be offering lower negotiated prices than are offered by non-preferred network pharmacies.*

While the CMS study concluded that “negotiated pricing for the top 25 brands and 25 generics in the Part D program at preferred retail pharmacies is lower than at non-preferred network pharmacies,” it also found that “some sponsors’ preferred network pharmacies are offering somewhat higher negotiated prices than are offered by their non-preferred network pharmacies.”

Our analysis expands on the CMS analysis to examine the impact of preferred pharmacy networks on negotiated prices and the full range of federal subsidies related to PDPs. We found that the addition of preferred pharmacy network plans decreases total federal PDP spending. Our analysis demonstrates that an increase in DIR can reduce federal PDP spending more than a comparable improvement with lower negotiated POS costs (from deeper discounts).

## PREFERRED PHARMACY NETWORK EFFECT ON FEDERAL SPENDING

Improved preferred network pharmacy contract terms may be in the form of (1) reduced POS costs such as better drug discounts and dispensing fees and/or (2) DIR as a post-POS pricing concession based on factors such as GDR or volume. PDP sponsors negotiate more competitive contract terms with pharmacies in exchange for inclusion in the plan’s preferred pharmacy network. We evaluate both forms of contracting in this analysis.

<sup>6</sup> Centers for Medicare and Medicaid Services, *Announcement of Calendar Year (CY) 2014 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies and Final Call Letter*, April 1, 2013; available from <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/RateNotice.pdf>.

The introduction of preferred network plans to the Medicare Part D market has had a significant financial effect on PDP bids starting in 2012. Average basic PDP plan bid amounts decreased 4% between 2012 and 2013. About half of this reduction is due to member movement to lower cost plans. Table 3 quantifies this effect by comparing average premiums weighted by July 2012 enrollment to premiums weighted by March 2013 enrollment.

<b>Table 3</b>			
<b>Effect of Member Migration on 2013 Basic PDP Member Premiums</b>			
<b>Plan Name</b>	<b>Average 2013 Premium</b>	<b>July 2012 Enrollment</b>	<b>March 2013 Enrollment</b>
SilverScript Basic	\$33.05	3,462,673	3,042,550
Humana Walmart-Preferred Rx Plan	\$18.50	1,472,324	1,757,244
Cigna Medicare Rx Plan One	\$35.71	586,216	693,150
First Health Part D Premier	\$38.32	943,892	680,103
WellCare Classic	\$33.52	888,767	636,012
AARP MedicareRx Saver Plus	\$15.00	0	545,758
AARP MedicareRx Preferred	\$38.58	504,200	465,442
Aetna CVS/pharmacy Prescription Drug Plan	\$30.93	340,780	458,057
EnvisionRxPlus Silver	\$33.14	325,836	445,192
Express Scripts Medicare - Value	\$39.72	438,071	377,268
All Other	\$40.38	1,984,379	1,895,139
<b>2013 Premium Weighted by Enrollment</b>		<b>\$33.61</b>	<b>\$31.99</b>
<b>Impact of Migration</b>			<b>(\$1.62)</b>

The market-wide average monthly premium decreased by \$1.62 PMPM due to member movement to lower cost plans. Premium and enrollment values in Table 3 are based on historical landscape files published by CMS. The “All Other” line item in Table 3 represents the average premium for all other plans not explicitly listed, weighted by March 2013 enrollment. The 2013 Premium Weighted by Enrollment presented in Table 1 above includes these plans in the “All Other” line item.

### Effect of Preferred Pharmacy Networks on Federal Medicare Part D Subsidies

Lower PDP bids generally correspond with a reduction in federal Medicare Part D spending. The remainder of this section describes the effect of preferred pharmacy networks on each component of federal Medicare Part D spending.

#### Direct Subsidy

The Direct Subsidy is a risk-adjusted payment from CMS to the plan to cover a portion of a PDP’s costs. The national average Direct Subsidy is calculated as the difference between the national average monthly bid amount and the base member premium. Member premium is a direct calculation based on bid submissions using the national average bid and estimated Federal Reinsurance. Therefore, Direct Subsidy payments generally decrease if PDP sponsors reduce bids.



Table 4 below demonstrates this relationship for 2013 and 2014. The national average bid amount (NABA) decreased by \$3.76 PMPM from 2013 to 2014. The Direct Subsidy decreased by \$5.01 PMPM from 2013 to 2014. This is determined by subtracting the national average member premium (NAMP) from the NABA.

<b>Table 4</b>			
<b>Comparison of Medicare Part D Bid Components</b>			
<b>Value</b>	<b>2013</b>	<b>2014</b>	<b>Difference</b>
National Average Bid Amount	\$79.64	\$75.88	(\$3.76)
Federal Reinsurance	\$42.60	\$51.26	\$8.66
Total Projected Cost (NABA + Fed. Reins.)	\$122.24	\$127.14	\$4.90
NAMP (25.5% * Total Projected Cost)	\$31.17	\$32.42	\$1.25
Direct Subsidy (NABA - NAMP)	\$48.47	\$43.46	(\$5.01)

Table 5 summarizes Direct Subsidy PMPM payments since the inception of the Medicare Part D program.

<b>Table 5</b>			
<b>Historical Direct Subsidy Payments</b>			
<b>Year</b>	<b>Direct Subsidy</b>	<b>Change (\$)</b>	<b>Change (%)</b>
2006	\$60.10		
2007	\$53.08	-\$7.02	-11.7%
2008	\$52.59	-\$0.49	-0.9%
2009	\$53.97	\$1.38	2.6%
2010	\$56.39	\$2.42	4.5%
2011	\$54.71	-\$1.68	-3.0%
2012	\$53.42	-\$1.29	-2.4%
2013	\$48.47	-\$4.95	-9.3%
2014	\$43.46	-\$5.01	-10.3%

There are many forces in addition to preferred pharmacy networks that affect bid amounts and Direct Subsidy amounts. These forces include brand patent expirations, contractual improvements, administrative cost improvements, and projected Federal Reinsurance amounts. Member movement to lower cost plans also reduces the national average Direct Subsidy<sup>7</sup>.

The Direct Subsidy has decreased by nearly \$5 per year from 2012 to 2014. While Direct Subsidy changes are due to several forces, the largest two-year decrease in the Direct Subsidy since program inception coincides with the rapid adoption of preferred pharmacy network plans and improving generic dispensing rates (GDR) from an increase in brand patent expirations. In addition, some pharmacy network contracting strategies seek to encourage generic dispensing by providing DIR incentive payments to pharmacies that increase their GDR. In short, both preferred networks and improved generic dispensing are critical factors that have contributed to the overall Part D program cost reductions observed.

### Federal Reinsurance Subsidy

The Federal Reinsurance subsidy covers a portion of drug costs for high cost members. The subsidy is equal to 80% of net PDP drug costs above the catastrophic threshold. In 2014, the catastrophic threshold is the claim amount at which members exceed \$4,550 in out-of-pocket spending. The PDP drug cost used to calculate the Federal Reinsurance subsidy is net of DIR because DIR is typically collected for all claims (including catastrophic claims). DIR includes manufacturer rebates, preferred network DIR, and any other DIR collected by the PDP sponsor. The Federal Reinsurance subsidy decreases with lower drug costs and

<sup>7</sup> The averages cited above are determined by using membership weights. As more members move to lower cost plans the averages decrease and drive a lower Direct Subsidy.

member cost sharing, which reduces the number of and total cost for members that exceed the catastrophic threshold.

We present sample bids in this report with two different preferred pharmacy network contracting strategies: (1) reduced POS costs and (2) improved DIR. Reduced POS costs reduce member cost sharing. This results in decreased Federal Reinsurance subsidy payments. Reduced POS costs also reduce the amount of claims that exceed the threshold, which further reduces Federal Reinsurance subsidy payments.

Improved DIR does not reduce member cost sharing at the POS. However, it may be reflected in lower plan premiums. However, DIR is allocated proportionally with the Federal Reinsurance subsidy and therefore lowers the Federal Reinsurance subsidy. For example, the net Federal Reinsurance subsidy is reduced by 25% of total DIR if the subsidy is equal to 25% of total claims. As a result, increases in DIR directly reduce the Federal Reinsurance subsidy. This allocation is presented in Table 6. DIR more directly reduces the Federal Reinsurance subsidy than reduced POS costs.

### **Low Income Subsidies**

CMS subsidizes premiums and cost sharing for low income members through LIPS and LICS. LIPS decreases with decreases in member premiums. LICS (cost sharing subsidies) make it harder to influence low income members' network choice since their copays are already generally lower than the preferred network copays. In some cases, preferred network plans incentivize preferred pharmacy utilization with even lower member cost sharing, typically on generic drugs.

Members from some plans who primarily use the preferred network receive a richer average benefit than if they used more non-preferred network pharmacies. For low income members the LICS payment is reduced since the cost sharing is less at preferred pharmacies. Members who primarily use the non-preferred pharmacy network could receive a less rich average benefit. Average LICS is typically higher for low income members using those pharmacies.

Low income members already have low copays because of LICS. As a result they do not have the same incentives to use preferred pharmacies as other members. In most instances low income members pay the same low copay amount whether they use a preferred or non-preferred pharmacy. The analysis presented in this report assumes different preferred pharmacy network utilization rates for low income members and non-low income members.

### **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. There will be no payments/subsidies 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.

Risk corridors are based on plan performance relative to expected levels. Therefore, reductions in risk corridor payments are the result of improvements in bid projection accuracy and claim projection stability from PDPs rather than reductions in the cost of prescription coverage.

This report focuses on the impact of reductions in the cost of prescription coverage rather than bid projection accuracy. We would not expect PDPs with preferred pharmacy networks to affect risk corridor payments unless their contractual terms introduce more volatility in results. In the short term, plans may find it difficult to accurately predict the gains (or losses) associated with a new preferred pharmacy network plan launch, actual preferred network use, and other demographics associated with a preferred plan offering. In either case, we would expect the impact to be unbiased (i.e., a similar number of PDPs generate better than expected and worse than expected experience).

## Preferred Pharmacy Network Bid Scenarios

We have developed representative Medicare Part D bids for three scenarios in this analysis:

1. **Baseline Scenario:** Represents a PDP basic bid with no preferred pharmacy network.
2. **Discount Improvement Scenario:** Represents a PDP basic bid with a preferred pharmacy network that uses an improved discount (or lower POS cost) contracting strategy.
3. **DIR Improvement Scenario.** A PDP basic bid with a preferred pharmacy network that uses an improved DIR contracting strategy.

We have estimated the amount of each federal Medicare Part D subsidy for each preferred contracting scenario using a representative plan holding all other factors constant. Table 6 summarizes the results of our analysis for a representative plan.

Federal Subsidy Component	Baseline	Discount	DIR
	Scenario	Improvement Scenario	Improvement Scenario
Direct Subsidy	\$49.38	\$48.20	\$45.66
Federal Reinsurance Subsidy	\$60.43	\$58.22	\$60.43
Share of Manufacturer DIR	-\$6.04	-\$5.99	-\$6.04
Share of Preferred Pharmacy DIR	\$0.00	\$0.00	-\$1.70
Low Income Cost Sharing Subsidy	\$60.00	\$59.29	\$60.92
Low Income Premium Subsidy	\$14.21	\$13.75	\$13.47
<b>Total Federal Subsidies</b>	<b>\$177.97</b>	<b>\$173.47</b>	<b>\$172.74</b>
<i>Total Change in Federal Subsidies</i>		<i>-\$4.50</i>	<i>-\$5.23</i>

Based on our analysis, federal subsidies decrease by \$4.50 PMPM when a PDP sponsor uses a discount improvement strategy. The federal subsidies decrease by \$5.23 PMPM when a PDP sponsor uses a DIR improvement strategy<sup>8</sup>. The price concessions from a preferred pharmacy are the same for both scenarios (whether through deeper discounts or DIR). This means that the DIR improvement contracting strategy is more efficient in terms of reducing federal subsidies.

This analysis is based on assumptions from Milliman's consulting experience and survey data. The representative plan is not specific to any particular PDP sponsor. The contracting terms are applied to a composite database of Medicare Part D claims experience to produce the subsidies estimates shown above.

Market-wide effects on federal PDP subsidies are estimated using the results of our representative plan analysis presented in Table 6. Table 7 estimates the composite federal PDP subsidy impact.

Preferred Network Strategy	Total Federal Subsidies	Weight
Baseline (No Preferred Network)	\$177.97	30%
Discount Improvement	\$173.47	30%
DIR Improvement	\$172.74	40%
<b>Market Average</b>	<b>\$174.53</b>	<b>100%</b>
<i>Market Average Less Baseline</i>	<i>-\$3.44</i>	

<sup>8</sup> A DIR contracting strategy is approximately 16% more effective in reducing the federal subsidies than a POS discount improvement (\$5.23/\$4.50 = 1.16).

The weights in Table 7 represent the estimated portion of the total PDP market that has currently adopted a preferred network strategy. As of March 2013, there are approximately 18 million enrolled in PDPs. Applying the \$3.44 PMPM federal subsidy decrease across all PDP enrollees produces the \$750 million estimate presented in Table 1.

In this analysis, we assume that 30% of PDP membership will not enroll in a preferred network plan in 2014. We assume that 43% of the PDPs that have a preferred pharmacy network negotiate lower POS unit costs (30% of the overall PDP market). We assume that 57% of preferred network PDPs negotiate preferred network DIR (40% of all PDPs). In practice, PDPs may also use a hybrid preferred network approach in practice, which relies on both improved POS costs and DIR.

**Additional Savings Due to Member Movement to Low Cost Plans**

There are two additional components to the savings estimates presented in Table 1. Each component is related to the effect of member movement to low cost plans. Member migration to lower cost plans decreases the effective Direct Subsidy. Total Direct Subsidy savings account for \$80 million of the total savings in Table 1. Table 8 summarizes original Direct Subsidy amounts and restated Direct Subsidy amounts by year from 2011 through 2013.

<b>Table 8 Original and Restated PMPM Direct Subsidy Amounts by Year</b>			
<b>Year</b>	<b>Original</b>	<b>Restated</b>	<b>Difference (\$)</b>
2011	\$54.71	\$53.88	\$0.83
2012	\$53.42	\$52.61	\$0.81
2013	\$48.47	\$47.85	\$0.62
<b>Average</b>	<b>\$52.20</b>	<b>\$51.45</b>	<b>\$0.75</b>

The average difference between original and restated Direct Subsidy from 2011 through 2013 is \$0.75 PMPM. This difference represents the impact of members moving from high cost plans to low cost plans. This movement is either by choice or auto-assignment. We estimate that the additional federal PDP spending on Direct Subsidy is approximately \$80,000,000 assuming that 50% of total bid reduction is attributable to preferred pharmacy networks and applied across 18 million PDP members. This assumption is representative of the savings that we have observed based on PDP and preferred network consulting experience.

Average member premiums decrease in a manner similar to the Direct Subsidy reductions summarized in Table 9. LIPS is a function of member premiums and decreases when low income members move to lower cost plans.

<b>Table 9 Original and Restated PMPM Member Premium Amounts by Year</b>			
<b>Year</b>	<b>Original</b>	<b>Restated</b>	<b>Difference (\$)</b>
2011	\$32.34	\$31.48	\$0.86
2012	\$31.08	\$30.35	\$0.73
2013	\$31.17	\$30.10	\$1.07
<b>Average</b>	<b>\$31.53</b>	<b>\$30.64</b>	<b>\$0.89</b>

The average difference between original and restated Direct Subsidy from 2011 through 2013 is \$0.89 PMPM. Again, this difference represents the impact of members moving from high cost plans to low cost plans. This movement is either by choice or auto-assignment. We estimate that the additional federal PDP spending on LIPS is approximately \$40,000,000 assuming that:

1. 50% of total bid reduction is attributable to preferred networks,
2. 18 million total PDP members,
3. 45% of total PDP market enrollment is classified as low income, and

- The LIPS program subsidizes 95% of average premium for low income members.

Migration and other estimates do not include the impact of additional potential reductions on MA-PD members. There are 29 million members who receive a Medicare Part D benefit based on March 2013 enrollment. This study is limited to the effect on the 18 million members enrolled in PDPs.

**Representative Plan Bid Development Assumptions**

Table 10 summarizes the assumptions used for preferred pharmacy network contractual terms for each scenario.

<b>Table 10 Preferred Pharmacy Network Contractual Terms by Scenario</b>			
<b>Assumption</b>	<b>Baseline Scenario</b>	<b>Discount Improvement Scenario</b>	<b>DIR Improvement Scenario</b>
Retail			
Generic Discount	78%	<b>80.5%</b>	78%
Brand Discount	14%	<b>16.5%</b>	14%
Dispensing Fee	\$1.00	\$1.00	\$1.00
Mail Order			
Generic Discount	80%	80%	80%
Brand Discount	25%	25%	25%
Dispensing Fee	\$0	\$0	\$0.00
Preferred Network DIR per script	\$0	\$0	<b>\$3.50</b>

Boldfaced values represent a change from the baseline scenario. Non-preferred network contract terms are equal to the baseline scenario in all scenarios. In the discount improvement scenario, we assume that PDP sponsors negotiate a 2.5% retail discount improvement with a preferred network. In the DIR improvement scenario, we assume that PDP sponsors negotiate a \$3.50 per script post-POS price concession with a preferred network. Improved pharmacy contract terms apply only to scripts filled at preferred network pharmacies. We assume a 55% overall preferred network utilization, which varies by income status. Table 11 presents preferred pharmacy network utilization assumptions by income status.

<b>Table 11 Preferred Network Utilization Assumptions by Scenario</b>			
<b>Scenario</b>	<b>Low Income</b>	<b>Non-Low Income</b>	<b>Total</b>
Baseline Scenario	0%	0%	0%
Discount Improvement	35%	72%	55%
DIR Improvement	35%	72%	55%

The effective PMPM value of preferred pharmacy network price concessions in each alternate scenario is the same. This relationship between scenarios gives us the ability to compare the bid dynamics and federal spending implications of each approach to preferred pharmacy network contracting.

A database comprised of 2012 Medicare Part D experience compiled by Milliman is used as the foundation for this analysis. We also rely on referenced published CMS files which itemize PDP and PD average utilization and allowed costs per member per month and overall generic use rates by region. Our pricing approach relies on separate low income and non-low income claim probability distributions 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).

Table 12 summarizes additional assumptions used to project 2012 claims experience to 2014.

<b>Table 12 Gross Claim Cost Projection Assumptions</b>		
<b>Assumption</b>	<b>Generic</b>	<b>Brand</b>
Utilization Trend (before patent expiration)	2%	2%
Unit Cost Trend	2%	8%
Utilization Brand Patent Expiration Impact	2%	-12%
Unit Cost Brand Patent Expiration Impact	2%	2%
Formulary Management Impact	-2%	-2%

We model three drivers of claim cost changes from 2012 to 2014. Secular trend represents annual increases in utilization and unit cost (AWP) inflation. Brand patent expirations increase GDR from 2012 to 2014 and do not affect specialty drugs. Formulary management savings are achieved by clinical decisions regarding coverage, tier placement, and drug utilization management that improve cost and/or DIR outcomes.

The representative plan’s bid is developed with 3% margin, \$11 PMPM non-benefit expenses, and gross pharmacy manufacturer rebates equal to 10% of gross drug costs (before sharing with Federal Reinsurance).

Low income members represent 45% of the representative plan’s enrolled population. The remaining 55% of enrollment is non-low income. This enrollment mix is based on the market-wide enrollment for all PDP plans. We assume that the average 2014 low income risk score is 1.31 and the average 2014 non-low income risk score is 0.83, based on the 2014 RxHCC model.

The representative bid is an Actuarial Equivalent (AE) basic Part D plan design with cost sharing that is equivalent to a 10% effective coinsurance differential (additive) between the preferred pharmacy network and non-preferred network.

Baseline scenario bid assumptions, including discounts, dispensing fees, manufacturer, non-benefit expense, and margin are based on an annual survey of PDP sponsors conducted by Milliman and are representative of a typical PDP. Gross cost projection factors are based on Milliman’s trend and formulary research.

## **ESTIMATED IMPACT ON FEDERAL MEDICARE PART D COSTS, 2014-2023**

In addition to our detailed actuarial analysis finding \$870 million in federal savings for 2014, we developed a separate estimate of the impact of preferred networks on federal spending over a ten year period. We estimate the total federal spending decreases by \$7.9 billion to \$9.3 billion from 2014 to 2023 with preferred network plans. Table 13 summarizes the results of this projection.

<b>Table 13 Ten Year Projected Federal Savings</b>	
Closed-Group Population	7,866,000,000
Open-Group Population	9,338,000,000

The range presented in Table 13 is developed using different population assumptions. The \$7.9 billion estimate is based on a closed-group population estimate. This includes all members currently enrolled in PDPs, which is 18.1 million as of March 2013. The \$9.3 billion estimate is based on an open-group population, which includes all members who are expected to enroll in PDPs during the projection period.

Population definitions and the 2.9% annual population growth assumption are based on the 2013 Medicare Trustees Report. Table 14 presents PDP enrollment assumed for each population scenario.

<b>Year</b>	<b>Closed-Group Population</b>	<b>Open-Group Population</b>
2014	18,100,000	18,600,000
2015	18,100,000	19,100,000
2016	18,100,000	19,700,000
2017	18,100,000	20,300,000
2018	18,100,000	20,800,000
2019	18,100,000	21,500,000
2020	18,100,000	22,100,000
2021	18,100,000	22,700,000
2022	18,100,000	23,400,000
2023	18,100,000	24,100,000

Federal spending under a baseline scenario and preferred network scenario is applied to the population estimates in Table 14 to estimate the savings in Table 13. The basis for the ten year projection matches the 2014 baseline scenario estimate in Table 6.

The ten year estimated federal spending impact relies on improved POS unit costs at preferred network pharmacies included in the CMS Study. The CMS Study shows that preferred network pharmacies have a 5.4% lower POS unit cost than non-preferred pharmacies overall<sup>9</sup>. We do not assume any DIR or additional POS unit cost improvements in the ten year projection. Additional savings realized from members moving to lower cost plans are not included in this estimate.

We assume that 70% of members enroll in a preferred network plan in 2014. This is similar to the assumption in the 2014 single-year analysis. This increases by 2% per year until 2019. We assume that 80% of members enrolled in a preferred network plan from 2019 through 2023.

Allowed pharmacy claims are trended 2.5% per year. This trend is applied uniformly across all drugs and represents net increases in unit cost and utilization. If a higher trend emerges over the next few years the actual savings may be greater than those shown in this report.

We assume the preferred network utilization remains at 55% throughout the entire ten year projection. This assumption is summarized in Table 11.

## **METHODOLOGICAL CONSIDERATIONS RELATED TO CMS STUDY ON PREFERRED PHARMACY NETWORKS**

The objective of the CMS Study was to “determine if negotiated prices at referred retail pharmacies are lower than the negotiated prices at non-preferred retail pharmacies for Part D sponsors with both preferred and non-preferred networks.” The study concludes that “aggregate unit costs weighted by utilization were lower in preferred networks for the majority of the PDPs studied” but that “negotiated prices are sometimes higher in certain preferred networks—contrary to our expectations.” We found that the PDPs with higher negotiated

<sup>9</sup> 5.4% savings based on Overall Retail Only Weighted Unit Cost from *Table 1: Weighted Unit Costs and Claim Counts For the Top 25 Brand and Top 25 Generic Drugs for PDP Sponsors with Preferred and Non-Preferred Pharmacy Networks for Retail Only and for Mail Order and Retail Prescriptions, (March 2012 PDE data for top 25 brand and top generic drugs only).*

prices represent 4% of total scripts included in the study. In this section, we present additional considerations to supplement the cost comparison methodology described in the CMS Study.

## Effect of DIR on Federal Spending

POS discounts and dispensing fees are not the only contractual terms utilized in preferred pharmacy network plans. This is acknowledged in the CMS Study conclusion but not included in the quantifiable results:

*One of the two sponsors that reported their own ratios to be less than 1.0 suggested in verbal communications that they relied upon price concessions other than negotiated prices at POS to meet the regulatory requirement not to increase payments to the plans.*

Preferred pharmacy network DIR may dramatically alter CMS Study conclusions if the study's scope is expanded to include both POS negotiated prices (discounts and dispensing fees) and all post-POS pricing concessions (DIR).

## Brand Patent Expirations During Study Period

The CMS Study is based on March 2012 Prescription Drug Event (PDE) data. This period falls within the six-month exclusivity period for Lipitor, which is the third most utilized brand drug in the study. Lipitor's manufacturer, Pfizer, lost its patent protection on November 30, 2011. The exclusivity period for Lipitor's generic equivalent, atorvastatin calcium, continued until May 2012.

We have observed atypical pricing trends during a drug's exclusivity period as PDP sponsors employ strategies during this unique time period that consider discounts, dispensing fees, manufacturer rebates, plan design and formulary placement, and the expected litigation environment. A prescription drug's pricing during the exclusivity period is generally unstable as a new generic equivalent is introduced. Pricing anomalies are present for both the brand drug (e.g. Lipitor) and its generic equivalent (e.g. atorvastatin calcium) during the exclusivity period.

An interesting expansion of the CMS Study may use more recent PDE claims data. Patent status for the fifty drugs may be verified during the selected experience period in an expanded study. Alternatively, brand drugs in their exclusivity period may be removed using the same March 2012 PDE data.

Also, timing issues for PBM contract negotiations can greatly influence a PDP sponsor's competitive position. Many PDP sponsors negotiate with their PBM every 2 or 3 years. The study only looks at one month of data (March 2012). For plans identified as outliers, CMS could consider reviewing a more recent time period and more than one month of data.

## Prescription Drug Mix

The CMS Study adjusts for differences in quantity dispensed with a weighted unit cost (WUC) metric. The WUC appears to be a reasonable metric to compare drug-specific unit costs as summarized in Table 2 of the CMS Study. Lipitor (in its exclusivity period) is the only drug in Table 2 with a preferred network WUC greater than its non-preferred network WUC.

The WUC metric appears to adjust for differences in total quantities dispensed for each product. The study does not appear to adjust for varying mix of drugs by pharmacy and geographic region in its approach.

For example, the WUC does not appear to adjust the average cost if preferred pharmacies are located in more costly locations. The WUC also does not appear to adjust the average cost if more expensive prescriptions are filled at preferred pharmacies.



It appears that mail order is classified as preferred network in the CMS study. The recent spread of preferred networks has primarily been driven by retail pharmacies. Mail order cost sharing incentives have been used by many PDPs before the wide adoption of preferred retail networks.

CMS Study results may not fully reflect retail/mail and geographic mix differences. An interesting expansion of the CMS Study may include either a normalization for drug mix or a fixed basket of goods.

## CAVEATS AND LIMITATIONS

Stephen Kaczmarek, Andrea Sheldon, and David Liner are actuaries for Milliman, 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 report has been prepared for the specific purpose of describing approaches to quantify the impact of Medicare Part D preferred pharmacy networks on federal spending. This information may not be appropriate, and should not be used, for any other purpose. Milliman does not endorse any policy.

This report has been prepared solely for the internal business use of, and is only to be relied upon by, the management of Pharmaceutical Care Management Association. While Milliman has agreed that this report can be shared by the Pharmaceutical Care Management Association, Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. This report must be read in its entirety.

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.

Milliman does not provide legal advice, and recommends that Pharmaceutical Care Management Association consult with its legal advisors regarding legal matters.