



At the request of the National Community Pharmacists Association (NCPA), Wakely Consulting Group, LLC (Wakely) has estimated the financial impact of companion House and Senate bills H.R. 1038/S. 413 (“Improving Transparency and Accuracy in Medicare Part D Spending Act”) on the federal government over 2018 through 2027. The bills propose to prohibit retroactive reductions in claim payments by Part D sponsors.

The purpose of our analysis is to estimate the financial impact to the Centers for Medicare and Medicaid Services (CMS), considering only reductions in Part D payments made directly to pharmacies (i.e. manufacturer rebates are excluded). Use of these estimates may not be appropriate for other purposes.

Long-term projections over many years, such as those presented here, are inherently uncertain due to the length of the projection. In addition, our results are highly dependent on the assumptions made, so readers of this report should be familiar with the assumptions described below when evaluating results.

Below we describe the results of our analysis and describe the method and assumptions used.

Impact of H.R. 1038/S. 413 on CMS Payments Under Part D

Over 2018 through 2027, we estimate that the elimination of \$125.9B in Part D retrospective payment reductions (a portion of direct and indirect remuneration or “DIR”) will save the federal government \$3.4B in Part D payments made to plan sponsors if H.R. 1038/S. 413 is implemented beginning January 1, 2018. This excludes the estimated impact of risk corridor settlements. The primary driver of this savings is payments related to the Part D federal reinsurance program. Table 1 shows the changes in CMS Part D payments by year and by component of the Part D program.



**Table 1 - Impact of H.R. 1038/S. 413 on CMS Part D Payments
Assuming a Shift of Pharmacy DIR to POS**

2018 through 2027 Amounts in Billions					
Year	Direct Subsidy	Low-Income Premium Subsidy	Low-Income Cost-Sharing Subsidy	Federal Reinsurance	Total
2018	\$0.0	\$0.0	(\$0.6)	(\$0.8)	(\$1.4)
2019	\$1.7	\$0.3	(\$0.7)	(\$0.9)	\$0.4
2020	\$1.6	\$0.3	(\$0.7)	(\$1.0)	\$0.2
2021	\$1.6	\$0.4	(\$0.8)	(\$1.1)	\$0.1
2022	\$1.6	\$0.5	(\$0.9)	(\$1.3)	(\$0.0)
2023	\$1.7	\$0.6	(\$0.9)	(\$1.5)	(\$0.1)
2024	\$1.6	\$0.7	(\$1.0)	(\$1.6)	(\$0.3)
2025	\$1.6	\$0.8	(\$1.1)	(\$1.8)	(\$0.5)
2026	\$1.6	\$0.9	(\$1.2)	(\$2.1)	(\$0.8)
2027	\$1.5	\$1.0	(\$1.3)	(\$2.2)	(\$1.0)
Total	\$14.6	\$5.5	(\$9.1)	(\$14.3)	(\$3.4)

Table 1 shows that we expect CMS to spend less on federal reinsurance and low-income cost-sharing subsidies. In both cases, the presence of additional discounts contributes to lower total drug cost at the point-of-sale. This serves to decrease low-income cost-sharing subsidies as the amount of member cost-sharing as per the benefit plan decreases while low-income patient pay amounts remain relatively steady. The decrease in total drug cost at point-of-sale also lowers the amount of claim dollars in the catastrophic phase of the Part D benefit because accumulated claims and amounts accumulating towards the true out of pocket (TrOOP) catastrophic threshold are lower.

On the other hand, direct subsidy payments and low-income premium subsidy payments are both expected to be higher if H.R. 1038/S. 413 is implemented. This is primarily because Part D bids on average should increase slightly due to the way that the Part D bid form treats discounts less favorably than rebates from a plan pricing perspective.

The results in Table 1 are highly dependent on the assumptions underlying our calculations. These assumptions are described in detail in the “Method and Assumptions” section, below; however, highlights of key assumptions are listed below:

- Differences in federal spending are intended to reflect Part D program activity nationwide, with the exception of self-insured employer coverage of Part D benefits where retiree drug subsidies are paid.

- Only retrospective payments related to direct pharmacy payments are considered in relation to the shift towards point-of-sale price concessions, while manufacturer rebates are consistently treated on a retrospective basis, except where noted otherwise below (i.e. Table 2).
- Lost payment reductions for Part D plan sponsors are assumed to be replaced by increased discounts on a dollar-for-dollar basis in re-negotiated Pharmacy Benefit Manager contracts. This assumption was also applied to calendar year 2018, despite delays in PBM negotiations that may occur given an assumed effective date of 1/1/2018.
- Retrospective payment reductions are 24% total gross drug costs prior to any shift from retrospective to point-of-sale price concessions.
- Retrospective payment reductions to pharmacies are 15% of all retrospective payment reductions.
- Gross pharmacy claim costs increase at a rate of about 8.5%-10% annually.
- We assumed a Part D defined standard benefit, with adjustments for estimated increases in benefit parameters such as deductible, initial coverage limit, and TrOOP threshold.
- Low-income premium subsidy is about 24% of estimated national Part D basic premium.
- Many assumptions rely on projections from the 2017 Medicare Trustees report.
- The Wakely RxCalc model was used to price the impact of Part D claim components by year.

We would also note that we believe that the direction of our results is not likely to be impacted by fluctuations in some of our assumptions such as claim trend, Part D enrollment, and the percentage of total retrospective payment reductions shifting to point-of-sale. Fluctuations in these items will cause magnitude differences, however.

For example, if we were to consider a shift of 100% of total retrospective payment reductions to point-of-sale, then the magnitude of the results would increase significantly as shown in Table 2 below; however, the positive or negative direction for each component remains the same.

**Table 2 - Impact of H.R. 1038/S. 413 on CMS Part D Payments
Assuming a Shift of All DIR to POS
2018 through 2027
Amounts in Billions**

Year	Direct Subsidy	Low-Income Premium Subsidy	Low-Income Cost-Sharing Subsidy	Federal Reinsurance	Total
2018	\$0.0	\$0.0	(\$4.6)	(\$5.7)	(\$10.3)
2019	\$12.3	\$1.8	(\$4.9)	(\$6.5)	\$2.7
2020	\$11.7	\$2.4	(\$5.4)	(\$7.3)	\$1.4
2021	\$11.7	\$3.0	(\$5.7)	(\$8.3)	\$0.6
2022	\$11.7	\$3.6	(\$6.2)	(\$9.4)	(\$0.4)
2023	\$11.8	\$4.2	(\$6.7)	(\$10.7)	(\$1.4)
2024	\$11.7	\$4.9	(\$7.2)	(\$12.0)	(\$2.6)
2025	\$11.8	\$5.7	(\$7.8)	(\$13.5)	(\$3.9)
2026	\$11.6	\$6.5	(\$8.5)	(\$15.0)	(\$5.4)
2027	\$11.3	\$7.2	(\$9.0)	(\$16.3)	(\$6.9)
Total	\$105.5	\$39.3	(\$66.0)	(\$104.9)	(\$26.0)

Part D Risk Sharing Projection

The Part D program has maintained a risk sharing mechanism where results outside of specified risk corridors are shared between Managed Care Organizations (MCO) offering Part D and CMS. Beginning in 2012, CMS has the authority to widen these corridors or decrease the percentage share of risk borne by CMS; however, the parameters have not changed from 2012 through the 2018 contract year. Whether a Part D risk sharing payment is made (i.e. CMS pays the MCO or the MCO pays CMS) depends on the accuracy of the pricing submitted by the MCO in the original bid filing.

Due to the potential for CMS to alter risk corridors and risk sharing percentages as well as the significant uncertainty of projecting pricing accuracy, it is very challenging to project future risk sharing payments. For this reason, we have excluded risk sharing projections from the main results presented in the Impact section.

In considering the potential impact of the elimination of retroactive reductions to pharmacy payments on Part D risk sharing settlements, we examined historical risk sharing amounts released by CMS indicating that the program has typically resulted in payments to CMS from plan sponsors. Therefore, we developed estimates assuming that similar “favorable” plan experience in aggregate would to continue to occur. Please note that this is supported by

projections in the 2017 Medicare Trustees report, which projects net payables to CMS every year through 2026.

Our projection of the impact of H.R. 1038/S. 413 on risk sharing resulted in a reduction in the payable amounts to CMS from plan sponsors. This is shown in Table 3 as an increase in CMS expense.

**Table 3 - Impact of H.R. 1038/S. 413 on CMS Part D Payments
Assuming a Shift of Pharmacy DIR to POS**

2018 through 2027 Amounts in Billions Including Risk Sharing Payments			
Year	Total Excluding Risk Sharing	Risk Sharing	Total
2018	(\$1.4)	\$0.1	(\$1.3)
2019	\$0.4	\$0.1	\$0.6
2020	\$0.2	\$0.2	\$0.4
2021	\$0.1	\$0.2	\$0.3
2022	(\$0.0)	\$0.2	\$0.2
2023	(\$0.1)	\$0.2	\$0.1
2024	(\$0.3)	\$0.2	(\$0.1)
2025	(\$0.5)	\$0.3	(\$0.3)
2026	(\$0.8)	\$0.3	(\$0.5)
2027	(\$1.0)	\$0.3	(\$0.6)
Total	(\$3.4)	\$2.2	(\$1.2)

Method and Assumptions

In this section, we describe the process used and assumptions made in estimating impact of H.R. 1038/S. 413 on CMS Part D payments over 2018 through 2027. In general, we projected Part D claims and CMS payments under two scenarios – current conditions and an assumption that H.R. 1038/S. 413 is implemented and applies to only pharmacy-related price concessions.

Starting Base Data

It is our intent to model the aggregate Part D claims and CMS payments related to all Medicare Advantage and Prescription Drug Plan (PDP) sponsors nationwide. Part D claims related to self-insured employer sponsored coverage is excluded.

We developed starting costs for 2016 as follows:

- We began with 2015 nationwide drug costs of \$137.4B and total direct and indirect remuneration (DIR) of \$23.6B as reported in the January 19, 2017 CMS news release “Medicare Part D – Direct and Indirect Remuneration (DIR)”.
 - We calculated an allowed drug cost PMPM (i.e. before cost-sharing) using Part D enrollment from the 2017 Trustees report.
 - We trended this 2015 allowed drug cost PMPM to 2016 based on the observed change in gross drug costs from 2014 to 2015 from the January 19, 2017 CMS news release.
 - We fit this estimated 2016 national allowed drug cost PMPM to detailed Wakely Part D claim data for calendar year 2016.
 - In the Wakely data, we identified drugs as specialty, brand, and generic based on Wakely studies and external data sources.
 - We assumed that the beginning costs reflected the same distribution of low-income and non-low-income members as found in the 2017 Medicare Trustees report. The distributions by specific low-income category was developed from three sources:
 - Enrollment projections in the 2017 Medicare Trustees report – used to develop the percentage of low-income members that are partial duals
 - 2015 Medicare Limited Data Set (LDS) data – used to develop an estimated percentage of members with an institutional status
 - Wakely internal data – was used to develop the percentage of low-income members that are above or below the federal poverty limit

Appendix A provides a summary of starting 2016 utilization, costs per script, and allowed costs PMPM by generic, brand, and specialty drug type.

Our starting cost model also required other assumptions in addition to claim costs. These included the following:

- RxHCC Risk score of 1.00. We believe an assumption of 1.00 is an accurate representation of nationwide Part D plan sponsors because publicly available data from 2014 and 2015 showed a nationwide average very close to 1.00 in both years.
- Non-benefit expenses (excluding health insurance provider fees) equal to 9% of required revenue, prior to the shift towards point-of-sale price concessions. This is based on publicly available minimum loss ratio filings.
- Health insurance provider fees equal to 1.6% of required revenue, prior to the shift towards point-of-sale price concessions, in 2018 and 1.5% in 2019 onwards.
- Profit margin equal to 5% of required revenue on a pre-sequestration basis, prior to the shift towards point-of-sale price concessions. This is based on a nationwide post-sequestration average of about 3% profit, as reported in minimum loss ratio filings.

- The 2018 national average bid of \$57.93 and base beneficiary premium of \$35.02, as reported by CMS in the July 31, 2017 rebate reallocation announcement.

Projection by Year through 2027

Numerous assumptions were needed in order project CMS Part D payments and claim amounts by year through 2027.

The following projection assumptions were used:

- **Enrollment.** Total enrollment was based on projections in the 2017 Medicare Trustees report. Our analysis includes individual and employer group waiver program (EGWP) enrollees, but excludes retiree drug subsidy beneficiaries. The distribution of non-low-income and low-income members was assumed to vary based on the enrollment projections through 2026 in the 2017 Medicare Trustees report. This includes amounts used to determine the distribution of enrollment by low-income category from the 2017 Medicare Trustees report. Enrollment amounts for 2027 were assumed to be the same as those for 2026.
- **Allowed Cost Trend.** Total drug costs (before cost-sharing) were trended based on several components. First, we estimated the impact of patent expirations based on Wakely analysis of 2017-2018 anticipated expirations. This trend was held the same by year. Second, we trended brand, generic, and specialty drugs at annual rates based on Wakely drug trend studies that excluded the impact of brand patent expirations. We separated costs for high-cost Hepatitis C drugs from other specialty drugs, and applied a flat 1.0 trend factor to these drugs. Induced utilization adjustments were not made in the projections. Trend factors by drug type and year are shown in Appendix B. These trend factors include the impact of projected brand patent expirations by year.

Overall, the annual allowed drug trend was about 8.5%-10%. The generic dispensing rate (GDR) increased marginally each year. Table 4 shows the projected GDR by year.

Table 4 - Generic Dispensing Rate

2018 through 2027	
Year	Generic Dispensing Rate
2018	84.0%
2019	84.6%
2020	85.2%
2021	85.8%
2022	86.4%
2023	86.9%
2024	87.4%
2025	87.9%
2026	88.4%
2027	88.8%

- Part D Benefit Parameters.** The Part D Defined Standard benefit design was used for all years. Pricing in 2019 and 2020 reflects the incremental reduction in beneficiary cost-sharing as specified in the Affordable Care Act. Values for the Part D deductible, initial coverage limit, and attachment point for the maximum out-of-pocket threshold were trended at an annual rate of 4%. Catastrophic and low-income copayment amounts were also trended at 4% annually, with the exception of copayments amounts for the low-income category of members with annual spend below the federal poverty limit, which were trended at 2% annually. The national average bid amount (NABA) and base beneficiary premium (BBP) were projected assuming decreasing marginal reductions each year. In addition, we adjusted the NABA and BBP to recognize the impact of increased discounts if H.R. 1038/S. 413 is implemented, and only pharmacy DIR is affected. Table 5 shows the NABA and BBP by year.

Table 5 - National Average Bid and Base Beneficiary Premium Assumptions

Year	2018 through 2027			
	Current Conditions		H.R. 1038/S. 413 Implemented	
	NABA	BBP	NABA	BBP
2018	\$57.93	\$35.02	\$57.93	\$35.02
2019	\$55.29	\$36.02	\$58.94	\$36.61
2020	\$53.01	\$37.11	\$56.33	\$37.61
2021	\$51.07	\$38.28	\$54.26	\$38.74
2022	\$49.41	\$39.53	\$52.48	\$39.95
2023	\$48.00	\$40.84	\$50.94	\$41.22
2024	\$46.81	\$42.21	\$49.67	\$42.57
2025	\$45.83	\$43.63	\$48.61	\$43.97
2026	\$45.03	\$45.10	\$47.71	\$45.40
2027	\$44.40	\$46.61	\$46.99	\$46.90

The low-income premium subsidy amount by year was calculated as 24% of the estimated Part D basic premium amount projected for each year. This assumption is based on data in the publicly available 2015 minimum loss ratio filings. Note that the 24% factor considers both the relationship of the LIPSA to the national average BBP as well as the percentage of Part D beneficiaries nationwide who are low income.

- Retroactive Payment Reductions.** We projected the retroactive payment reductions by year as 24% of projected allowed drug costs. For scenarios where we modeled the impact of H.R. 1038/S. 413, we assumed that PBM discounts would increase by the same dollar amount as the eliminated retroactive reductions to pharmacies. As discussed earlier, reductions related only to direct pharmacy payments were assumed to be 15% of total reductions. In other words, the increased discount under H.R. 1038/S. 413 was equal to:

$$(total\ allowed\ cost) \times 24\% \times 15\%$$

We relied on the July 2017 Milliman report, “Value of Direct and Indirect Remuneration (DIR): Impact on Medicare Part D Prescription Drug Plan (PDP) Program Stakeholders”, for assumptions regarding payment reductions as a percentage of allowed drug costs as well as the assumed percentage attributable to pharmacies.

- **Part D Risk Sharing.** We examined historical net risk sharing payments released by CMS and observed that in aggregate across all organizations, the risk sharing program typically results in a payable to CMS from plan sponsors. Therefore, we developed estimates assuming that similar “favorable” plan experience in aggregate would continue to occur. The estimated risk sharing amount is highly speculative given that we do not know if this pattern will continue or what specifically was driving it in the past (i.e. lower-than-expected claims costs, higher-than-expected rebates or other DIR, some combination of the two, population shifts among plans, or other factors).

In order to develop factors to estimate this favorable plan experience, we relied on the following:

- Aggregate risk corridor amounts from the 2015 CMS plan payment data
- The CMS re-release of the 2015 national average bid amount weighted by concurrent year February 2015 enrollment
- An assumed target loss ratio of 84% based on publicly available minimum loss ratio filings

In using this information, we estimated that a risk corridor ratio (actual / expected) of 0.85 would have produced the aggregate risk sharing transfer across all carriers in 2015. This ratio was then used to develop the three scenarios of risk sharing estimates shown in Table 6, which vary depending on the assumed driver of plan sponsors’ overall favorable experience. Scenario 3 represents our best estimate and is therefore included in the Table 3 summary results, above.

Table 6 - Part D Risk Sharing Scenarios by Driver

Year	Favorable Experience Due to:		
	Scenario 1: Lower-than-Expected Claims	Scenario 2: Higher-than-Expected DIR	Scenario 3: An Equal Combination of Lower Claims and Higher DIR
2018	\$0.0	\$0.2	\$0.1
2019	\$0.1	\$0.2	\$0.1
2020	\$0.1	\$0.3	\$0.2
2021	\$0.1	\$0.3	\$0.2
2022	\$0.1	\$0.3	\$0.2
2023	\$0.1	\$0.4	\$0.2
2024	\$0.1	\$0.4	\$0.2
2025	\$0.1	\$0.5	\$0.3
2026	\$0.1	\$0.5	\$0.3
2027	\$0.2	\$0.5	\$0.3
Total	\$0.9	\$3.7	\$2.2

Disclosures

Tim Courtney and Drew McStanley are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent from NCPA.

The assumptions and resulting estimates included in this report are inherently uncertain. Users of the results should be qualified to use and understand the results their inherent uncertainty. Actual results may vary, potentially materially, from our estimates. Wakely does not warrant or guarantee that projected results in this report will be realized. It is the responsibility of the organization receiving this output to review the assumptions carefully and notify Wakely of any potential concerns.

We have relied on others for data and assumptions used in this report. We have reviewed the data for reasonableness, but have not performed any independent audit or otherwise verified the accuracy of the data/information. If the underlying information is incomplete or inaccurate, our estimates may be impacted, potentially significantly.

Our work on this report conforms to the following Actuarial Standards of Practice (ASOP) issued by the Actuarial Standards Board:

- ASOP #5, “Incurred Health and Disability Claims”
- ASOP #23, “Data Quality”
- ASOP #41, “Actuarial Communications”

Appendix A
2016 Base Utilization and Costs

	Utilization per 1000	Allowed PMPM	Unit Cost
<i>Low-Income</i>			
Brand	3,019.7	\$77.06	\$306
Generic	21,061.4	\$39.29	\$22
Specialty			
High-Cost Hepatitis C Drugs	5.1	\$12.35	\$28,830
All Other Specialty	367.9	\$54.86	\$1,789
Total Specialty	373.1	\$67.21	\$2,162
All Drug Types	24,454.2	\$183.57	\$90
<i>Non Low-Income</i>			
Brand	2,175.8	\$56.27	\$310
Generic	21,461.0	\$40.85	\$23
Specialty			
High-Cost Hepatitis C Drugs	1.9	\$4.63	\$29,655
All Other Specialty	121.7	\$34.68	\$3,419
Total Specialty	123.6	\$39.31	\$3,816
All Drug Types	23,760.4	\$136.43	\$69
<i>Total Population</i>			
Brand	5,195.5	\$133.34	\$308
Generic	42,522.4	\$80.14	\$23
Specialty			
High-Cost Hepatitis C Drugs	7.0	\$16.99	\$29,050
All Other Specialty	489.7	\$89.54	\$2,194
Total Specialty	496.7	\$106.53	\$2,574
All Drug Types	48,214.6	\$320.00	\$80

**Appendix B
Assumed Trend Factors by Member Type and Drug Type**

	Utilization Trend Factor				Unit Cost Trend Factor			
	Brand	Generic	Specialty		Brand	Generic	Specialty	
			High-Cost Hepatitis C Drugs	All Other Specialty			High-Cost Hepatitis C Drugs	All Other Specialty
Low-Income								
2016 to 2018	1.069	0.824	1.000	0.919	1.131	1.119	1.000	1.000
2016 to 2019	1.093	0.843	1.000	0.940	1.155	1.142	1.000	1.021
2016 to 2020	1.118	0.862	1.000	0.961	1.179	1.167	1.000	1.043
2016 to 2021	1.143	0.882	1.000	0.983	1.204	1.191	1.000	1.065
2016 to 2022	1.169	0.902	1.000	1.005	1.230	1.216	1.000	1.088
2016 to 2023	1.196	0.922	1.000	1.028	1.256	1.242	1.000	1.111
2016 to 2024	1.223	0.943	1.000	1.052	1.282	1.268	1.000	1.134
2016 to 2025	1.251	0.965	1.000	1.076	1.309	1.295	1.000	1.158
2016 to 2026	1.279	0.987	1.000	1.100	1.337	1.322	1.000	1.182
2016 to 2027	1.308	1.009	1.000	1.125	1.365	1.350	1.000	1.207
Non-Low-Income								
2016 to 2018	1.036	0.830	1.000	0.908	1.083	1.058	1.000	1.011
2016 to 2019	1.046	0.839	1.000	0.918	1.098	1.072	1.000	1.026
2016 to 2020	1.057	0.848	1.000	0.927	1.113	1.087	1.000	1.040
2016 to 2021	1.069	0.857	1.000	0.937	1.129	1.103	1.000	1.054
2016 to 2022	1.080	0.866	1.000	0.947	1.144	1.118	1.000	1.069
2016 to 2023	1.091	0.875	1.000	0.957	1.160	1.134	1.000	1.084
2016 to 2024	1.103	0.884	1.000	0.967	1.176	1.149	1.000	1.099
2016 to 2025	1.114	0.893	1.000	0.977	1.193	1.165	1.000	1.115
2016 to 2026	1.126	0.902	1.000	0.987	1.210	1.182	1.000	1.130
2016 to 2027	1.138	0.912	1.000	0.997	1.226	1.198	1.000	1.146