



Financial Impacts on Medicare Beneficiaries if Larger Part D Rebates Are Required for Medicare/Medicaid Dual Eligibles

Prepared for: Pharmaceutical Research and Manufacturers of America (PhRMA)

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Date: June 25, 2009

Introduction

When the Medicare Part D program was implemented in 2006, Medicare became the primary payer for prescription drugs for all persons enrolled in the program. For the nation's roughly 8 million persons who are enrolled in both Medicare and Medicaid (commonly referred to as "dual eligibles"), the creation of Medicare Part D shifted primary payer responsibility from Medicaid to Medicare. Prior to the implementation of Part D, state Medicaid programs were collectively paying approximately \$25 billion annually, pre-rebate, for medications on behalf of these dual eligibles.¹

Under the Omnibus Budget Reconciliation Act of 1990, manufacturers are required to pay a statutory rebate that was designed to help ensure that Medicaid programs received the "best price" that a drug manufacturer is offering to *any* commercial payer, and are required to pay an additional rebate if prices escalated more than inflation. Thus, by virtue of the "best price" provision, Medicaid rebates are intended to be at least as good as commercial rebates. Part D prices are exempt from best price.

The Medicare Part D program's design has not regulated price or rebate levels, although some policymakers are interested in creating rebate requirements for the Part D program. In particular, there is interest in applying Medicaid's rebate provisions to the dual eligible population. Such a policy would create differential rebate levels on the same drugs within the Part D program – with the net (post-rebate) prices for dual eligibles' medications becoming considerably lower than existing net prices for prescriptions used by Medicare only persons.

Financial Impacts on Beneficiaries

Within Medicare's 45 million covered persons, the 8 million dual eligibles themselves would not be financially affected by such a policy change, given that Medicare and Medicaid together provide these beneficiaries comprehensive coverage with no monthly premium charges and only nominal copayments involved at the point of accessing services. However, the creation of differential rebates could financially affect the remaining non-dual eligible Medicare population, whose monthly premium and cost-sharing levels are determined through a complex process centered around bids annually submitted to CMS by the participating Part D plans. Approximately 18.7 million non-dual eligibles participate in a Part D plan (not counting those Medicare beneficiaries with employer-sponsored coverage that is subsidized through the Part D Program).²

The Pharmaceutical Research and Manufacturers of America (PhRMA) has commissioned an evaluation of these "spillover" impacts that government-imposed changes to the rebate structure of drugs purchased for dual eligibles' would have on the 18.7 million Part D participants who are not dually eligible for Medicaid. Ingenix Consulting, which prepares more than 1,000 Medicare price bids each year, was selected to model these spillover impacts.

¹ Source for this figure is the CMS Medicaid Statistics Information System (MSIS) website. Prescription drug costs were tabulated for dual eligibles for Federal Fiscal Year 2005.

² Approximately 7 million Medicare beneficiaries are not participating in the Part D program.

Modeling Approach

The spillover cost dynamics are complex. Ingenix Consulting modeled dozens of scenarios addressing combinations of the following issues:

- a) Assumptions about the net prices for Part D prescriptions rendered to non-dual eligibles. One set of scenarios assumes that Part D is a “closed system,” meaning that in response to government-imposed rebates, drug manufacturers would negotiate with plans to provide lower rebates on medications for non-dual eligibles enrolled in Part D plans so that, in aggregate, total rebates in Part D would be the same before and after the policy change. Another set of scenarios assumes that half of manufacturers’ cost for government-imposed rebates would spill over to the non-dual population in Part D, so that the rebates negotiated between plans and manufacturers would be one-half of the aggregate rebates they currently provide.
- b) Assumptions about how differing rebates on drugs for dual-eligibles and non-dual eligibles would be administered. One scenario assumes that CMS will directly obtain from manufacturers all rebates for dual eligibles’ medications. Another scenario assumes that the Part D plans would collect the dual eligible rebates directly, with their monthly premium requirements in their price bids to CMS being reduced accordingly.
- c) Assumptions about the proportion of dual eligibles in a Part D plan’s population.
- d) Assumptions about the baseline and mandated rebate levels for dual eligibles’ medications. Scenarios are based on a baseline rebate estimate of 14.0% for all medications in the existing Part D program for duals, with the enhanced rebates modeled at 24.0% and 34.0% of initial (pre-rebate) expenditures. The rebate estimates used (14% for dual eligibles within Part D and 34% for dual eligibles using Medicaid pricing policies) are both from the Waxman report (Medicare Part D: Drug Pricing and Manufacturer Windfalls, July 2008). The 24% estimate is a scenario we created representing the midpoint of the two other data points.

The modeling effort primarily involved creating price bids for each combination of assumptions for 2009, using the CMS Bid Pricing Tool. Under each scenario, the National Average Bid (or “benchmark”) was estimated, such that the member premiums could be calculated. Note that all the initial modeling was performed using data from an Ingenix Consulting internal database consisting of national Part D data with more than several million Part D participants.

The results are presented below using one data set. As a data modeling check, an identical set of simulation modeling was conducted on a second data set. While the results from this second effort are not presented below, they closely match those shown in the simulation modeling effort.

Summary of Findings

The key finding is that under virtually all the scenarios modeled, there are adverse financial impacts for non-dual Part D participants. The magnitude of these impacts varies by scenario, but the consistent outcome is higher costs for the non-duals themselves. Table 1 illustrates the outcomes of various scenarios modeled and provides summary information as to the key assumptions underlying these scenarios. Premiums for non-duals increase because, with reduced rebates, the costs shown in the bids -- and hence basic member premiums for plans with non-duals -- will increase. CMS would capture the savings in lower dual eligibles' premiums through a reduced low-income premium subsidy (LIPS).

Summary of Key Scenarios and Financial Impact Estimates

Scenarios 1-3 depict situations assuming a “closed system” (i.e., full cost of government-imposed rebates is borne within Part D through lower rebates for other Part D participants). Under these scenarios, the Part D plans collect the all dual eligible rebates. These scenarios reflect a neutral shift in overall Part D spending and do not affect total Part D rebates. However, while these scenarios are not expected to impact the national benchmark average, they do shift some costs from dual eligibles to non-dual eligibles. This necessitates higher monthly premiums for the non-dual subgroup.

KEY ASSUMPTIONS			AMOUNT OF REBATE (% Allowed)		IMPACTS ON BIDS AND PREMIUMS			
Scenario Number	Spillover Outside of Medicare Part D?	Dual Rebates Collected By Treasury or Plans?	Assumed Mandated % Rebate Received For Dual-Eligibles	Assumed Mandated % Rebate Received For Non-Dual-Eligibles	National Benchmark Average Bid	Member Premium for Non-Dual Eligibles	Additional PMPM Cost Impact for Non-Dual Eligibles	Nationwide Annual Out-Of-Pocket Cost Impact for Non-Dual Eligibles
1	No	Plans	14%	10.4%	\$84.33	\$36.20	\$3.50	\$0.8 Billion
2	No	Plans	34%	1.0%	\$84.33	\$55.20	\$22.50	\$5.0 Billion
3	No	Plans	24%	5.7%	\$84.33	\$45.70	\$13.00	\$2.9 Billion

Scenarios 4-6 also assume a “closed system,” but assume that CMS (rather than the Part D health plans will collect all Part D rebates for duals. Because the rebates collected by CMS would be outside the bid process the costs experienced by the Part D plans are higher. This causes the national average bid to increase and in turn causes the basic member premium to increase.

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Scenario Number	Spillover Outside of Medicare Part D?	Dual Rebates Collected By Treasury or Plans?	Assumed Mandated % Rebate Received For Dual-Eligibles	Assumed Mandated % Rebate Received For Non-Dual-Eligibles	National Benchmark Average Bid	Member Premium for Non-Dual Eligibles)	Additional PMPM Cost Impact for Non-Dual Eligibles	Nationwide Annual Out-Of-Pocket Cost Impact for Non-Dual Eligibles
4	No	Treasury	14%	10.4%	\$88.60	\$33.50	\$0.80	\$0.2 Billion
5	No	Treasury	34%	1.0%	\$94.71	\$48.60	\$15.90	\$3.6 Billion
6	No	Treasury	24%	5.7%	\$91.65	\$41.00	\$8.30	\$1.9 Billion

The remaining scenarios (7-10) assume that increasing the mandated rebate amount in Medicare Part D will also impact rebates in the private sector. These scenarios continue to adversely impact the non-dual Part D beneficiaries because they still lower the rebates plans negotiate for the non-duals, thus increasing the plan bid amount, the national benchmark amount and/or the member premium. However, the projected premium increases for non-duals are not as great as in prior scenarios because half of the impact of the policy change either spills over into the private sector or reduces manufacturers’ revenues.

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7	Yes	Plans	34%	10.4%	\$78.22	\$40.10	\$7.40	\$1.7 Billion
8	Yes	Plans	34%	5.7%	\$81.27	\$47.70	\$15.00	\$3.4 Billion
9	Yes	Treasury	34%	10.4%	\$88.60	\$33.50	\$0.80	\$0.2 Billion
10	Yes	Treasury	34%	5.7%	\$91.65	\$41.00	\$8.30	\$1.9 Billion

Note that only the 34% rebate estimate was used in these four “open system” scenarios, as this is the Waxman report’s estimate of the duals’ rebate under Medicaid pricing policies.

Adverse financial impacts on non-dual beneficiaries across these ten scenarios vary from \$0.80 - \$22.50 PMPM or from approximately \$200 million - \$5.0 billion annually across the entire population of roughly 19 million non-dual and non-employer group Part D participants. While projecting which of the above ten scenarios have the greatest probability of materializing is a matter of conjecture, Ingenix Consulting staff feel that the scenarios demonstrating “middle ground” impacts are relatively likely to occur.

Thus, our best estimate is that the added costs to be imposed on the non-dual Part D participants would range from \$8 - \$16 PMPM or from approximately \$1.8 billion - \$3.6 billion in nationwide annual spending increases. In the context of existing Part D average monthly premiums, these additional costs would represent a significant additional outlay. Our best estimate range represents an increase of roughly 25% - 50% in the monthly premiums paid by non-dual eligibles participating in the Part D program.