Pharmaceutical Research and Manufacturers of America (PhRMA)

2016 Medicare Part D National Average Value Drivers

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

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I. SUMMARY AND RESULTS

The Pharmaceutical Research and Manufacturers of America (PhRMA) engaged Milliman to analyze the changes in Medicare Part D national average values from 2015 to 2016. PhRMA requested examination of the impact on the national average bid amount (NABA) and national average member premium (NAMP) per member per month (PMPM) as a result of various factors, including the impact of Hepatitis C Virus (HCV) treatments, new pipeline medications, AWP price increases, contractual improvements, and changes announced by the Centers for Medicare and Medicaid Services (CMS), among others. We summarized the impacts of each 2016 consideration and present the results in this letter.

The NAMP increased by about $1 PMPM from 2015 to 2016. The NABA decreased by over $5 PMPM, resulting in a total decrease in direct subsidy of $6.54 PMPM. The large increase in federal reinsurance dollars offsets the direct subsidy decrease to keep the NAMP fairly flat. Table 1 below shows our estimate of the driving forces behind how allowed costs and the NABA (along with the corresponding calculated NAMP, federal reinsurance, and direct subsidy) changed from the 2015 to 2016 bids. Note the impact of each component is an estimate only; CMS did not provide details to allow the actual impacts to be explicitly determined.

Table 1
PhRMA
2015 to 2016 Estimated Changes to Part D National Average Values PMPM

Consideration	Allowed PMPM [1]	NABA	NAMP	Fed Reins	Direct Sub
2015 National Averages [2]	$241	$70.18	$33.13	$59.70	$37.10
Restated 2015 Bid [3]	$241	$68.63	$32.25	$57.80	$36.40
Trend - Utilization and Unit Cost	$265 - $288	$73 - $79	$37 - $40	$71 - $78	$37 - $39
2016 Defined Standard Benefit	$265 - $288	$75 - $82	$37 - $40	$68 - $76	$39 - $42
2016 Projected Risk Score	$265 - $288	$74 - $80	$36 - $40	$68 - $76	$37 - $41
2016 Generic Pipeline	$235 - $278	$66 - $78	$32 - $38	$60 - $72	$34 - $40
New Heart Failure Treatments	$237 - $278	$67 - $78	$33 - $38	$61 - $72	$34 - $40
Hepatitis C Treatments	$239 - $284	$67 - $79	$33 - $39	$62 - $77	$34 - $39
PCSK9 Treatments	$239 - $285	$67 - $79	$33 - $40	$62 - $78	$34 - $39
Rebate & Contracting Improvements	$232 - $283	$56 - $72	$30 - $38	$60 - $77	$27 - $34
2016 National Averages [2]	**$257**	**$64.66**	**$34.10**	**$69.07**	**$30.56**

[1] Estimates based on Milliman Part D models
[2] Actual values other than allowed cost released by CMS
[3] Restated 2015 values using February 2015 membership from the final Part D bid form instructions

Table 2 shows the increase or decrease in costs associated with each step from Table 1:

Table 2
PhRMA
2015 to 2016 Estimated Incremental Impacts to Part D National Average Values PMPM

Consideration	Allowed PMPM [1]	NABA	NAMP	Fed Reins	Direct Sub
Restatement of 2015 [2]	$0	($2)	($1)	($2)	($1)
Trend - Utilization and Unit Cost	$24 - $47	$5 - $10	$4 - $8	$13 - $20	$1 - $3
2016 Defined Standard Benefit	$0	$2 - $3	$0	($3) - ($2)	$2 - $3
2016 Projected Risk Score	$0	($1) - ($2)	($1) - $0	$0	($1) - ($2)
2016 Generic Pipeline	($30) - ($10)	($8) - ($2)	($4) - ($2)	($8) - ($4)	($3) – ($1)
New Heart Failure Treatments	$2 - $0	$0 - $1	$1 - $0	$0 - $1	$0
Hepatitis C Treatments	$2 - $6	$0 - $1	$0 - $1	$1 - $5	($1) - $0
PCSK9 Treatments	$0 - $1	$0	$0 - $1	$0 - $1	$0
Rebate & Contracting Improvements	($7) - ($2)	($11) - ($7)	($3) - ($2)	($2) - ($1)	($7) - ($5)
Total Change - 2015 to 2016	**($9) - $42**	**($6)**	**$1**	**$9**	**($7)**

[1] Estimates based on Milliman Part D models
[2] Restated 2015 values using February 2015 membership from the final Part D bid form instructions

The impacts in Table 2 could vary significantly by plan. The ranges provided don't necessarily reflect results for all carriers, but are meant to indicate the average impacts.

II. KEY DRIVERS

NABA AND NAMP RESTATEMENT

The national average values announced in August 2014 are first adjusted to reflect enrollment weighting from February 2015. CMS publishes these restated values in the final Part D bid form instructions to help with projecting the 2016 NABA and NAMP values, since the 2016 values will be based on 2015 enrollment.

Trend

Utilization and AWP trends account for an increase in the NAMP from 2015 to 2016 of about $4 - $8 PMPM. The impact of trend in Table 2 excludes any increases in specialty utilization or costs specifically associated with new medications related to Hepatitis C virus (HCV), heart failure or hypercholesterolemia, the impact of which is estimated separately. Increases due to AWP trend accelerated compared to previous years, largely driven by increases in prices on brand medications, as well as an increase in specialty medications as a percentage of total pharmacy spend. Utilization trends, on the other hand, while still positive, have slowed compared to past years. Cost increases related to trends are partially offset by increases in rebates, as described later in this report.

Defined Standard Benefit

The defined standard benefit parameters change each year and are announced by CMS in the April Rate Announcement. In past years, changes to the defined standard deductible, initial coverage limit (ICL), and TrOOP have been modest; in 2014 the values actually decreased from the prior year. But in 2016, these limits increased significantly. The deductible increased from $320 to $360 and the ICL increased from $2,960 to $3,310. Defined standard gap coverage also changed in 2016 to 42% plan coverage of generic medications (35% previously), while brands remain at 5% coverage, per the Affordable Care Act. The 2016 benefit parameters cause members to remain in the ICL and gap benefit phases longer, which may increase the coverage gap discount program (CGDP) payments, and reduce federal reinsurance.

Risk Score

Each year, CMS announces the normalization factor used to calibrate the risk adjustment model and normalize the risk scores to 1.0. For 2016, the risk score normalization factor changed, causing an increase in risk scores of roughly 2% compared to 2015 with a minor reduction in both the NABA and direct subsidy. This impact tends to be neutral for plans since it applies higher risk scores to lower national average values.

Generic Pipeline

While the large influx of new generic launches seen in recent years due to brand patent losses slowed, there are still a few brand medications anticipated to lose patent protections prior to 2016. This accounts for a reduction in allowed costs and member premiums. One market-leading brand product had a generic launch in 2015, while another is expected in 2016. These products are expected to drive a majority of the generic pipeline savings.

New Pipeline Medications

There are three new therapeutic areas expected to have a large impact in 2016 (outside of oncology since oncology trends are included in the general trends) — heart failure, hypercholesterolemia and HCV. Though some HCV treatments have been available since late 2013, more are expected to be released, and further utilization of these new products is expected. HCV treatments have the largest impact among the three therapeutic classes considered here. Trend for HCV increased significantly in 2014 and 2015, and it is expected to continue into 2016. However, manufacturers have also significantly increased rebates for HCV drugs. The impact of offsetting rebates are included with contracting improvements below and should more than offset the additional HCV trend expected for 2016. New heart failure medications and new PCSK9 inhibitors are also expected to increase allowed costs, although these treatments may not have had a significant impact on 2016 bids due to their newness. The impact of PCSK9 inhibitors likely had some upward influence on NAMP, though some plans may have assumed minor utilization of these medications in their first year(s) since the potential covered population estimates for these medications are highly variable.

Contracting Improvements

Contracting improvements account for the most significant impact on the direct subsidy from 2015 to 2016. The impact on the national averages due to these provisions are dominated by the changes in manufacturer rebates. Competition in a few therapeutic classes, such as HCV, is assumed to have mitigated other increases in the NAMP as shown in Table 2. The increases in federal reinsurance also means the federal government will receive a larger portion of manufacturer rebates in 2016 than in previous years. Note that higher allowed costs lead to higher rebates, so high brand AWP trends are somewhat offset by increases in rebates. There are several other factors leading to an increase in manufacturer rebates. Price protection provisions were included in some rebate contracts, which arrange for additional rebates if price trends are higher than a specified amount. Given the increasing trend rates noted earlier, these price protections have become more prevalent and also are more likely to trigger. Increased demand from plans to manufacturers for brand medication formulary inclusion and increased competition in specialty product classes has also brought about increases in manufacturer rebates.

Other types of contracting improvements contributed to the reduction in direct subsidy as well. Preferred retail pharmacy network contracts, which typically provide price concessions that flow through the bid similar to a rebate, continued to improve in 2016. Negotiated discount rates, which determine the allowed costs at the point of sale, have also continued to improve for both brand and generic medications.

Other Factors

Other factors, such as administrative expenses, profit margin, benefit changes, and formulary changes, were not modeled explicitly, but also likely contributed to changes in national average values.

III. CAVEATS AND LIMITATIONS

This report was developed to illustrate the impact of various changes from 2015 to 2016 on the Medicare Part D program. This information may not be appropriate, and should not be used, for other purposes.

The information presented in this report is provided for PhRMA. PhRMA may share this information with outside entities with Milliman's permission. Milliman does not intend to benefit and assumes no duty of liability to other parties who receive this work product. Any third party recipient of this work product who desires professional guidance should not rely upon Milliman's work product, but should engage qualified professionals for advice appropriate to its own specific needs. Any releases of this report to a third party should be in its entirety.

Please note that in preparing our estimates, we relied upon a Milliman database of 2014 national Medicare Part D claims. Actual results will vary for specific plans due to differences in trends, discount arrangements, potential biases in the plans where data is available, and formulary structure, among other differences.

Katie Holcomb and Jason Gomberg are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. 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 information has been prepared under the terms of the consulting services agreement between Milliman and PhRMA, dated January 29, 2014.