PREFERRED PHARMACY NETWORKS AND THEIR IMPACT ON PART D PREMIUMS

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Executive Summary

The July 2017 Medicare Trustees Report estimated that in 2018 45 million beneficiaries will receive coverage for prescription drugs through the Medicare Part D program. Health plans and pharmacy benefit managers (PBMs) play a significant role in controlling costs in the Part D program. Specifically, PBMs serve these important functions in the delivery system:

- negotiate price concessions with drug manufacturers;
- create pharmacy networks and negotiate price discounts with pharmacies;
- create formularies that deliver effective clinical outcomes and incentivize a more affordable drug mix;
- encourage appropriate and clinically sound drug utilization; and
- deploy clinical programs that engage members and increase patient adherence.

This study first analyzes the growth in the number of individual stand-alone Part D plans (PDPs) offering preferred pharmacy networks. We then estimate 2018 premium increases absent preferred pharmacy networks and finally estimate 2018 increases in the Federal direct subsidy and the Federal reinsurance payments absent preferred pharmacy networks.

Between 2011 and 2018 the number of individual PDPs offering preferred pharmacy networks grew from 7 percent to over 98 percent. As of February 2018, over 99 percent of PDP beneficiaries are enrolled in an individual PDP that offered a preferred pharmacy network.

In this report, Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) estimates that preferred pharmacy networks result in:

- deeper pharmacy discounts on prescription drugs, which lead to reduced drug costs at the point-of-sale for members;
- pharmacy rebates, typically referred to as pharmacy price concessions, that are used to directly reduce member premiums; and
- Federal cost savings on direct subsidy, low-income premium subsidy and Federal reinsurance payments.

Oliver Wyman estimates 2018 Part D premiums would be $72 higher per member per year (PMPY) absent preferred pharmacy networks.[1] With a 2018 national average Part D basic premium of $420 PMPY, an increase of $72 equates to a 17 percent increase in Part D basic member premium. In addition, we estimate Federal spending would be $210 higher PMPY, or $4.5 billion higher, if preferred pharmacy networks were not an option for PDP plans.

Using the Part D membership growth published in the 2017 Medicare Trustees Report for CY2018 through CY2026, and $210 PMPY cost estimate from above, we estimate Federal spending would be $45.8 billion higher over the nine year period (CY2018 through CY2026) if preferred pharmacy networks were not an option for PDPs.

The remainder of this report describes the analysis undertaken by Oliver Wyman and presents the details of our results.

[1] CMS would realize part of the member premium savings for low-income members from low-income subsidy payments.

Introduction

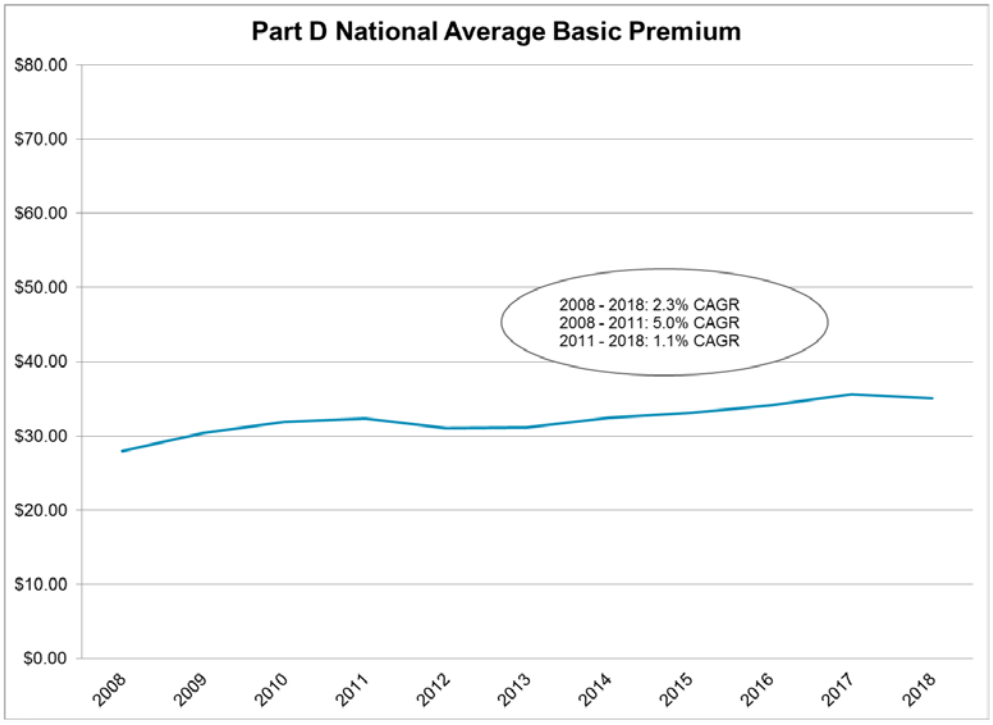
The passing of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA) brought on the biggest changes to the Medicare program in more than 35 years. Under the MMA, private health plans approved by Medicare became known as Medicare Advantage Plans. These plans are generally referred to as "Part C" or "Ma Plans." In addition, the MMA expanded Medicare to include an optional prescription drug benefit, "Part D," which went into effect in 2006. Since 2006, Part D plans have developed innovative concepts to provide beneficiaries with low cost plan options. One such concept was the development of preferred pharmacy networks. Preferred pharmacy networks allow health plans to negotiate larger discounts and price concessions on prescription drugs that wouldn't be realized from Part D plans that only use standard pharmacy networks.

The Coalition for Affordable Prescription Drugs (CAPD) engaged Oliver Wyman to analyze the use of preferred pharmacy networks in Part D and also to analyze any premium differences that exist between Part D plans that utilize preferred pharmacy networks and those Part D plans that do not utilize preferred pharmacy networks.

The popularity of preferred pharmacy networks has grown at a staggering rate in recent years. In 2011, only 7 percent of stand-alone Part D plans (PDPs) offered a preferred pharmacy network. In 2018, over 98 percent of PDPs utilize a preferred pharmacy network.

The increase in PDPs utilizing preferred pharmacy networks may also be responsible for slowing the trend in the Part D basic premium. Between 2008 and 2011, the national average Part D premium has increased by 5.0 percent per year, as shown in Table 1. The growth rate was only 1.1 percent from 2011 to 2018, coinciding with the significant increase in plans with preferred pharmacy networks.

Table 1

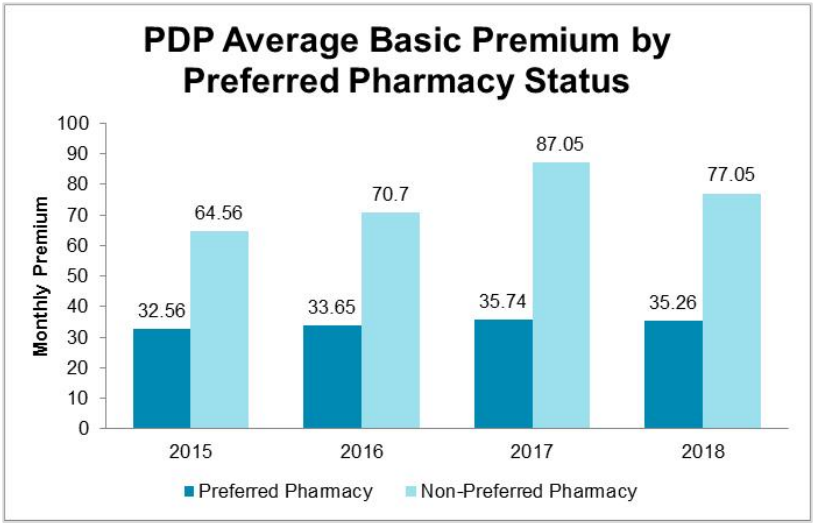


From 2015 to 2018, enrollment in PDPs has increased from 18.9 million to over 21.2 million. Over this period, membership in PDPs offering a preferred pharmacy network has grown to 99.9% (Table 2). We hypothesize that the expansion of preferred pharmacy networks is a result of market demand for lower cost options.

Table 2

For those PDPs that still do not offer members a preferred pharmacy network option, the premium charged is more than double what is charged by plans that do offer a preferred pharmacy network (Table 3).

Table 3



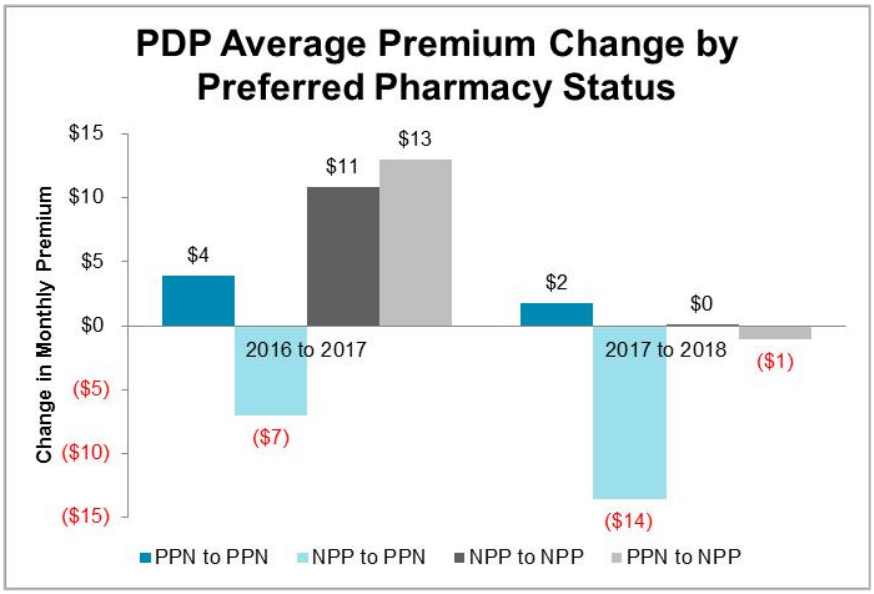
The vast number of beneficiaries in plans with preferred pharmacy networks has provided the Part D program with a number of positive benefits that should be highlighted:

- Improved pharmacy network discounts leading to reduced drug costs at the point-of-sale for members;
- Pharmacy rebates, typically referred to as preferred pharmacy price concessions, are used to directly reduce members' premiums;
- Federal cost savings as a direct result of preferred network discounts and pharmacy rebates.

The Part D market landscape shows that plans that switched from a standard pharmacy network to a preferred pharmacy network were able to lower premiums by $7 per member per month (PMPM) from 2016 to 2017, or $84 PMPY, and lowered premiums by $14 PMPM from 2017 to 2018, or $168 PMPY (Table 4). Please note, while PDP plans using a standard pharmacy network have premiums double what is charged by PDP plans with a preferred pharmacy network as shown in Table 3, we would not anticipate the change to a preferred pharmacy network would decrease premiums by 50%. The premium charged by PDP plans vary by region and will reflect the population expected to enroll in the plan. We do, however, anticipate premium savings moving to a preferred pharmacy network as a result of deeper pharmacy discounts and the addition of pharmacy rebates.

In addition, from 2016 to 2018, plans with preferred pharmacy networks have experienced the lowest collective premium increase when compared to those plans that maintain standard pharmacy networks and plans that go from having a preferred pharmacy network to a standard pharmacy network.

Table 4



Based on this information, we estimate that in 2018:

- Member premiums would be $72 higher PMPY absent preferred pharmacy networks. With a 2018 national average Part D basic premium of $420 PMPY, an increase of $72 would represent a 17 percent increase in premium.

- If preferred pharmacies did not exist, Federal government spending on direct subsidies would have been $47 higher PMPY, and Federal reinsurance costs would have been $163 higher PMPY, for a total increase of $210 PMPY. Assuming 21.2 million beneficiaries enrolled in individual PDPs in 2018, Federal spending would be roughly **$4.5 billion higher if preferred pharmacy networks were not an option for PDP plans.**

To project the increase in Federal spending for CY2018 through CY2026, we assumed Federal spending would by $210 PMPY higher for all years and projected membership growth in the individual PDP market. Under these assumptions, Federal spending would be roughly $45.8 billion higher for CY2018 through CY2026 if preferred pharmacy networks were not an option for PDPs.

Data and Methodology

Our analysis estimates the impact of the elimination of the use of preferred pharmacy networks by PDPs (a subset of all Part D plans). In our work, we relied on publicly available data. Specifically, we used data from CMS that includes formularies for each PDP and enrollment and enrollee premiums by plan made available by CMS. Using the CMS formulary data, we were able to identify which of the PDPs employ preferred pharmacy networks. Plans with preferred pharmacy networks were identified as those plans that offer retail, mail or both retail/mail preferred pharmacy options.

Once we were able to identify the PDPs that employ preferred pharmacy networks, we used enrollment data to calculate the total beneficiaries enrolled in these plans. The next step in our process was to determine the premium change assuming preferred pharmacy networks are eliminated. To accomplish this, we considered the average two-year premium increase for plans that changed from having a preferred pharmacy network to a standard pharmacy network and those plans that maintained a standard pharmacy network. The average premium change for these plans was roughly $6 PMPM.

The national average basic premium is calculated as 25.5 percent of the gross cost (national average bid amount plus Federal reinsurance). Using the $6 premium increase as our basis, we calculated the 2018 adjusted gross cost assuming the preferred pharmacy option was not available to PDPs. In our calculations, we assumed increases in the Federal reinsurance cost and the national average bid amount would be proportional to the increase that is expected in the gross cost. The direct subsidy is then calculated as the difference between the national average bid and the base beneficiary premium. The PMPM calculation is shown in Table 5. Note that our analysis assumes the average risk score nationwide is 1.00.

Table 5

		2018	2018 Adj.	PMPM Change
A	National Average Bid	$57.93	$67.86	$9.93
B	Federal Reinsurance	$79.40	$93.01	$13.60
C = A + B	Gross Cost	$137.33	$160.86	$23.53
D = 25.5% x C	Member Premium	$35.02	$41.02	$6.00
E = A - D	Direct Subsidy	$22.91	$26.84	$3.93

To project PDP enrollment for CY2018 through CY2026, we applied the same percentages as shown in the Part D enrollment projections published in the 2017 Medicare Trustees report to the current 2018 PDP enrollment of 21.2 million members.[2] In Table 6 below we have summarized the PDP enrollment estimates by calendar year.

Table 6

Calendar Year	Part D Enrollment	Growth Rate	PDP Enrollment
2018	44.8		21.2
2019	46.7	4.2%	22.1
2020	48.3	3.4%	22.9
2021	49.8	3.1%	23.6
2022	51.1	2.6%	24.2
2023	52.5	2.7%	24.9
2024	53.9	2.7%	25.6
2025	55.3	2.6%	26.3
2026	56.6	2.4%	26.9

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2017.pdf

Considerations and Limitations

The estimated savings of preferred pharmacy networks will vary considerably by health plan and region. The objective of this report is to estimate the cost increases that may be realized in the Part D program in the event preferred pharmacy networks were eliminated across the entire country.[3] The opinions and conclusions expressed herein reflect technical assessments and analyses, and do not reflect statements or views with respect to public policy.

Our projections involve estimates of future events and are subject to economic variations from expected values. We have not anticipated any changes to the regulatory or economic environment that might affect the results we show here. For these reasons, no assurance can be given that the emergence of actual results will correspond to the projections in this analysis.

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[3] The Actuarial Practice of Oliver Wyman was commissioned to prepare this report by the Glover Park Group on behalf of the Coalition for Affordable Prescription Drugs.