PREMIUM IMPACT OF REMOVING MANUFACTURER REBATES FROM THE MEDICARE PART D PROGRAM

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Executive Summary

In 2018, more than 44 million seniors and people with disabilities are expected to be enrolled in Medicare Part D. The national average premium in 2018 is $35.02, only $2.60 higher than the national average premium in 2014 (representing less than 2% per year increase). One of the major contributors to holding premiums relatively flat over the last five years are manufacturer rebates. Manufacturer rebates are price concessions provided by drug manufacturers to health plans to promote use of their medications. These price concessions are distributed to all Part D enrollees indirectly through lower Part D cost-sharing at the point-of-sale and lower premiums.

Some policymakers and other stakeholders have raised questions about the use of rebates as a method for reducing prescription drug costs. Some have questioned whether the safe harbors from the federal Anti-kickback Statute (AKS) should be revised so that rebates no longer automatically avoid AKS scrutiny. Specifically, some policymakers have expressed support for ending rebates and devising another system for negotiating price concessions.

The Pharmaceutical Care Management Association (PCMA) engaged Oliver Wyman Actuarial Consulting, Inc. to estimate what Medicare Part D premiums would have been, absent manufacturer rebates. The major findings of the study are:

- Part D plan-negotiated manufacturer rebates have resulted in $34.9 billion in beneficiary premium savings for enrollees from 2014 to 2018.
- In 2017, the average Part D monthly premium of $35.63 would have been 45 percent, or $16.07, higher without rebates.
- In 2018, the average Part D monthly premium of $35.03 would have been 52 percent, or $18.36, higher without rebates.
- On an annual basis, the 2018 Part D premium would have increased from $420.24 to $640.56 without rebates.

Table 1 summarizes the estimated change in national average premium with and without manufacturer rebates for the most recent five years.

Table 1 – Premium Impact of Disallowing Manufacturer Rebates

	2014	2015	2016	2017	2018
National Base Beneficiary Premium (Actual)	$32.42	$33.13	$34.10	$35.63	$35.02
Manufacturer Rebate PMPM Estimate	$36.00	$49.00	$54.00	$63.00	$72.00
National Base Beneficiary Premium (Excluding Manufacturer Rebates)*	$41.60	$45.63	$47.87	$51.70	$53.38
Premium Increase (PMPM)	$9.18	$12.50	$13.77	$16.07	$18.36
Premium Increase (%)	28.3%	37.7%	40.4%	45.1%	52.4%
Part D Enrollment (millions)	37.8	39.5	41.3	42.8	44.3
Premium Increase (billions)	$4.2	$5.9	$6.8	$8.3	$9.8

*National Base Beneficiary Premium increases by 25.5% of manufacturer rebate estimate

The remainder of this report outlines the analysis and data utilized to draw this conclusion.

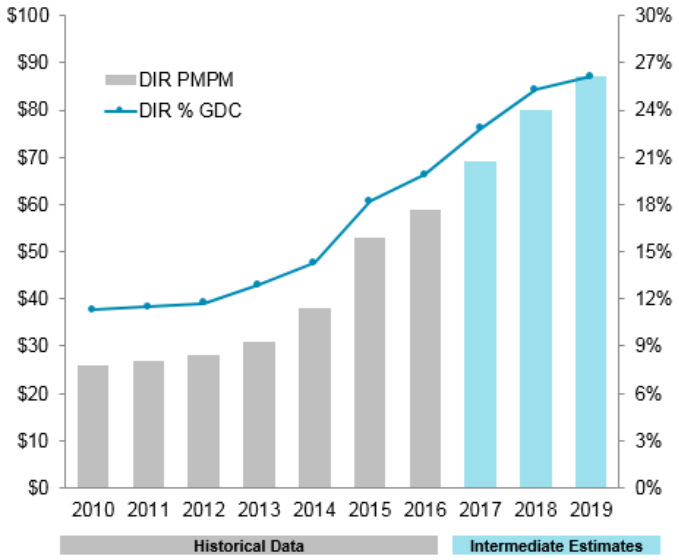
Data and Methodology

In early June preceding the calendar year of coverage, Part D sponsors submit one or more Part D bids that represents their best estimate of the cost to provide prescription drug coverage to members, including an estimation of direct and indirect remuneration (DIR). DIR is mostly comprised of negotiated rebates from manufacturers of brand name drugs and is passed on to members through improved drug coverage or lower premiums.

The purpose of this report is to estimate the premium increase enrollees in Part D may have realized if manufacturer rebates were not allowed assuming all else equal. We utilized readily available data published by the Centers for Medicare and Medicaid Services (CMS) to develop our estimates.

The first step in our analysis was to estimate manufacturer rebates by year. Within the Medicare Trustees report, CMS summarizes DIR as a percentage of gross drug cost, per capita Part D cost growth estimates and Part D enrollment. Using these data and the gross drug costs reported by CMS in their Medicare Part D – Direct and Indirect Remuneration (DIR) report published on January 19, 2017, we calculated the DIR PMPM estimates through 2019.[1] Table 1 below highlights the historical and intermediate DIR estimates for 2010 through 2019.

Table 1 – Historical DIR



DIR includes all price concessions received by health plans that are not reflected within the drug cost at the point-of-sale. The majority of DIR is from manufacturer rebates, but it also includes pharmacy price concessions. In 2014, manufacturer rebates accounted for $16.3 billion of the $17.3 billion of total DIR, or 94%.[2] While not specifically reported by CMS, we estimate that pharmacy price concessions have increased over the last several years (more members choosing to enroll in plans with preferred pharmacies and more plans offering preferred pharmacies). Without any additional information, we have assumed manufacturer rebates as a percentage of total DIR has decreased by one percentage point each year since 2014 e.g.,

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2017-Fact-Sheet-items/2017-01-19-2.html https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf

[2] https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Information-on-Prescription-Drugs/2014_PartD_Rebates.html

manufacturer rebates account for 90% of total DIR in 2018. In the event manufacturer rebates are a larger proportion of the total DIR, the premium increases would be larger than what is presented herein. Table 2 summarizes the DIR estimates utilized in our analysis.

Table 2 – DIR PMPM

Calendar Year	Total DIR	Manufacturer Rebates	Pharmacy Price Concessions
2014	$38.00	$36.00	$2.00
2015	$53.00	$49.00	$4.00
2016	$59.00	$54.00	$5.00
2017	$69.00	$63.00	$6.00
2018	$80.00	$72.00	$8.00

The next step in the process is to approximate the premium impact assuming manufacturer rebates were not allowed in Part D and assuming all else remains equal. Part D is a competitive bid whereby the member premium is calculated as the member weighted average bids across all health plans. Specifically, all health plans bid on their expected cost to provide Defined Standard Part D coverage at a 1.0 risk score. The expected cost is reduced for DIR. Each submitted bid is then weighted by membership from March of the prior year (i.e. March 2017 membership for 2018 bid) to determine the national average bid. Next, CMS adds the expected federal reinsurance cost to estimate the national average gross cost. The national base beneficiary premium is calculated as 25.5% of the national average gross cost. Lastly, the direct subsidy CMS provides plans at a 1.0 risk score is calculated as the difference between the standardized bid and base beneficiary premium. Table 3 summarizes the competitive bid results for the last five years.

Table 3 – Part D National Average Bid

		2014	2015	2016	2017	2018
A	National Average	$75.88	$70.18	$64.66	$61.08	$57.93
B	Federal Reinsurance	$51.26	$59.74	$69.07	$78.64	$79.40
C = A + B	Gross Cost	$127.14	$129.92	$133.73	$139.72	$137.33
D = 25.5% x C	Base Premium	$32.42	$33.13	$34.10	$35.63	$35.02
E = A - D	Direct Subsidy	$43.46	$37.05	$30.56	$25.45	$22.91

The removal of manufacturer rebates will result in a direct increase in the gross cost. As a result, the premium impact would equate to 25.5% of the change in gross cost. Oliver Wyman estimates premiums would be 28.3% higher in 2014 and 52.3% higher in 2018 if manufacturer rebates were not allowed in Part D all else equal. We would anticipate the loss of manufacturer rebates would result contracting changes to offset this increase, but have not modeled those changes in this analysis.

Table 4 – Premium Impact of Disallowing Manufacturer Rebates

	2014	2015	2016	2017	2018
National Base Beneficiary Premium (Actual)	$32.42	$33.13	$34.10	$35.63	$35.02
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*National Base Beneficiary Premium increases by 25.5% of manufacturer rebate estimate

Considerations and Limitations

The Actuarial Practice of Oliver Wyman was commissioned by the Pharmaceutical Care Management Association (PCMA) to estimate increase in premium Part D enrollees would realize if manufacturer rebates were not allowed. Oliver Wyman shall not have any liability to any third party in respect of this report or any actions taken or decisions made as a consequence of anything set forth herein. The opinions expressed herein are valid only for the purpose stated herein and as of the date hereof. Information furnished by others, upon which all or portions of this report are based, is believed to be reliable but has not been verified. No warranty is given as to the accuracy of this information. Public information and industry and statistical data are from sources Oliver Wyman deems to be reliable; however, Oliver Wyman makes no representation as to the accuracy or completeness of such information and has accepted the information without further verification. No responsibility is taken for changes in market conditions or laws or regulations and no obligation is assumed to revise this report to reflect changes, events or conditions, which occur subsequent to the date hereof.

For our analysis, we relied on data and information from CMS without independent audit. Though we have reviewed the data for reasonableness and consistency, we have not audited or otherwise verified this data. It should also be noted that our review of data may not always reveal imperfections. We have assumed that the data is both accurate and complete. The results of our analysis are dependent on this assumption. If this data or information is inaccurate or incomplete, our findings and conclusions may need to be revised.

The opinions and conclusions expressed herein reflect technical assessments and analyses and do not reflect statements or views with respect to public policy.