MILLIMAN WHITE PAPER

Can voluntary POS rebates work for Medicare Part D?

Jennifer Carioto, FSA, MAAA
Gabriela Dieguez, FSA, MAAA
Bruce Pyenson, FSA, MAAA

Commissioned by *The Pharmaceutical Research and Manufacturers of America (PhRMA)*

Prominent proposals to improve the affordability of Medicare Part D prescription drug coverage would have pharmaceutical manufacturer rebates shared directly with the consumer at the point of sale (POS). While Part D plans can voluntarily offer this approach, premiums under a voluntary POS system will likely be rather high relative to market averages. This report explains why a requirement that all plans use POS rebates would produce much more modest premiums.

What causes higher premiums with voluntary POS rebates?

We modeled the 2019 financial impact of plans voluntarily sharing 50% of manufacturer rebates at the POS, using actuarial models calibrated to national averages. We find that voluntary POS rebates can result in premiums that are substantially higher than market rates, for the following reasons:

- **Currently, rebates reduce plans' premiums**: By offsetting a plan's projected liability, manufacturer rebates[1] (when retained by the plan) directly reduce the plan's bid amount and its resulting premium. When rebates are shared with beneficiaries the plan liability net of rebates increases, and therefore the plan's premium increases (assuming no offsetting changes in the plan).
- **Most plans prefer lower premiums and thus they do not offer POS rebates**. Plans, especially stand-alone Part D plans, compete on the basis of premium. Therefore, most plans would not voluntary offer POS rebates because this would make them less competitive. A single bid has limited impact on the overall Part D market, and therefore does not greatly influence the national average bid amount. But if all Part D plans were required to implement POS rebates, the national average bid amount would grow substantially, which would result in direct subsidy increases and a moderate impact to premiums. Formulary changes driven by lower values of rebates could reduce premiums.
- **Adverse selection**: Voluntary POS rebates create anti-selection risk to plans. Medicare Plan Finder[2] allows beneficiaries to estimate out-of-pocket costs for their current drugs, so plans with POS rebates would likely be attractive to beneficiaries with high drug spending. Beneficiaries have many plan options in most markets, including lower-premium products without POS rebates that would be more appealing to beneficiaries who expect lower drug spending. Therefore, POS rebate plans can expect higher spending per beneficiary and higher brand drug use than the average Part D plan in the market.

We describe these issues below, but note that other factors, such as the mix of members enrolled, benefit considerations, and plan behavior to address market demands, are also important.

The plan-specific bid amount is the plan's estimate of the cost to provide standard Part D benefits (net of federal reinsurance, low-income subsidies, coverage gap discount amounts, and member cost sharing) given the plan's specific experience, contract terms (including rebates), and demographics. The plan-specific bid amount is standardized to a risk score of 1.0 for purposes of the premium calculation

The National Average Bid Amount (NABA), determined by CMS, is a weighted average of the standardized bid amounts for all of the Medicare Advantage Part D (MA-PD) and stand-alone prescription drug plans (PDPs) submitted for the bid year. The NABA reflects the cost of average Part D standard coverage (excluding any supplemental coverage).

The National Average Member Premium (NAMP) is then determined as 25.5% of the NABA plus **the national average federal reinsurance**.

The direct subsidy (calculated as NABA minus NAMP) is subtracted from the standardized bid amount to develop the standard coverage premium charged to members of the plan.

[1] We assume that 100% of retail pharmacy price concessions would be passed to the consumer, which is a requirement proposed by CMS for 2020.

[2] Medicare Plan Finder is available at https://www.medicare.gov/find-a-plan/questions/home.aspx.

Rebates reduce a plan's premium rates

Figure 1 illustrates the strong impact rebates can have on premium levels if they are adopted by a plan on a voluntary basis. In this illustrative example, each dollar of rebate retained by the plan, on a per member per month (PMPM) basis, reduces premiums by almost one dollar.[3] Scenario A illustrates the premium calculation under current rules, where plans retain a portion of manufacturer rebates that directly reduce the bid amount. Scenario B shows what the resulting bid and premium amounts would be in the absence of rebates. Note that this example does not incorporate behavior changes that would likely occur if rebates were eliminated. Instead, we have assumed prices and formularies are identical in scenarios A and B.

Most plans will prefer low premiums over POS rebates

A plan-specific Part D premium is calculated as:

- The standardized plan-specific bid amount, minus
- The national average bid amount (NABA), plus
- The national average member premium (NAMP)

The difference between the NABA and the NAMP is also called the "direct subsidy," which is revenue from the Centers for Medicare and Medicaid Services (CMS). Therefore, the premium for a specific plan is equal to the standardized plan-specific bid amount minus the direct subsidy amount. Figure 2 illustrates the calculation of the 2019 direct subsidy amounts.

Because the direct subsidy is calculated based on national averages weighted by enrollment measured in the prior year, plans with larger enrollment have more influence than smaller plans. New plans do not influence the national averages, because their prior year enrollment is 0.

Therefore, a plan that voluntarily shares substantial rebates with its beneficiaries at the POS (as in our example) would experience higher premiums due to a combination of a higher plan-specific bid amount and a low direct subsidy. Figure 3 illustrates this dynamic. If all or a large portion of plans offered POS rebate sharing, this dynamic would be ameliorated.

FIGURE 1: ILLUSTRATION OF THE IMPACT OF REBATES ON PREMIUMS (PMPM)

		REBATES RETAINED BY PLAN (PMPM)	
		SCENARIO A $52 REBATES	SCENARIO B $0 REBATES
(a)	Plan Liability Before Rebates	$93	$93
(b)	Rebates (plan share)	$52	$0
(c)	Retention	$10	$10
(d)=(a)-(b)+(c)	Plan-Specific Bid Amount	$51	$103
(e)	Direct Subsidy	$18	$18
(f)=(d)-(e)	Premium Amount	$33	$85

FIGURE 2: CALCULATION OF THE 2019 PART D DIRECT SUBSIDY (2019 PMPM)

	(A)	(B)	(C) = (A) + (B)	(D) = 25.5% * (C)	(E) = (A) – (D)
	National Average Bid Amount	National Average Federal Reinsurance	Total Standard Part D	National Average Member Premium	Direct Subsidy
CY 2019	$51.27	$78.86	$130.13	$33.18	$18.09

FIGURE 3: POS REBATES IMPACT TO MEMBER PREMIUM (2019 PMPM)

		NO POS REBATES	VOLUNTARY 50% POS REBATES
(a)	Standardized Plan-Specific Bid Amount	$51	$72
(b)	Direct Subsidy	$18	$18
(c) = (a) – (b)	Plan-Specific Member Premium	$33	$54
	PMPM Change in Member Premium		*$21*

[3] This example uses a risk score of 1.00. Risk scores different from 1.00 will result in each dollar of rebate retained by the plan to reduce premiums changing by slightly more or less than one dollar.

Adverse selection: A disincentive to voluntary POS rebates

Part D beneficiaries can select from multiple plans with varying combinations of cost-sharing and premium levels. A plan that voluntarily offers POS rebates can experience what actuaries call "adverse selection," where beneficiaries who expect to benefit from the lower POS cost sharing are most likely to pay the higher premium. This dynamic is facilitated by Medicare Plan Finder, through which beneficiaries can estimate their total out-of-pocket costs, including premium and cost sharing for their drugs, with competing plans. Due to adverse selection, a POS rebate plan's bid would reflect a relatively higher portion of beneficiaries not eligible for low-income subsidies (LIS), as most LIS beneficiaries do not benefit from lower POS prices and are unwilling to pay a premium, and there are higher volumes of brand and specialty scripts, and lower generic dispensing rates (GDRs), as compared to other plans.

We modeled a voluntary POS rebate plan with a large proportion of non-LIS enrollment, enhanced benefits (vs. standard Part D), and adverse selection (in the form of higher use of brands and specialty tier drugs). Figure 4 illustrates the premium development of such a product.

FIGURE 4: DRIVERS OF $80 PREMIUM (2019 PMPM)

	$ INCREMENTAL CHANGE			
	MEMBER PREMIUM	PLAN LIABILITY	MEMBER PREMIUM	PLAN LIABILITY
Status Quo	$33	$41		
With Voluntary POS Rebates	$54	$58	$21	$17
With Greater Non-LIS (95%)	$47	$45	-$7	-$13
Enhanced Benefits	$66	$61	$19	$16
With Adverse Selection	$80	$73	$14	$12
Total Increase Over Status Quo			$47	$32

POS rebates: Mandatory vs. voluntary

The Part D premium-setting dynamics are important to understand when comparing the impact of mandatory versus voluntary POS rebates. If all plans are mandated to pass through rebates at the POS, the arithmetic would produce a modest premium increase as the direct subsidy will increase, offsetting plan liability increases. But, in reality, we expect plans to take actions to minimize any premium increases, such as negotiating greater price concessions and tightening formularies to encourage the use of lower-priced drugs. By contrast, as shown above in Figure 4, premiums for a voluntary POS rebate plan can increase by $47 ($80 - $33), a combination of a low direct subsidy, adverse selection, and other factors.

Conclusion

Voluntary POS rebates will result in a higher member premium than if POS rebates were mandatory, which will deter many members from enrolling in these plans. Most LIS members do not benefit from POS rebates and will not be attracted to a plan where the premium is set above the low-income benchmark (where CMS subsidizes the premium at this level). Higher member premiums for voluntary POS rebate plans are driven by the unaffected national benchmarks and adverse selection.

For POS rebates to be viable under the current Part D structures, they would need to be mandatory for all plans, so the national benchmarks are adjusted to reflect higher costs to the plans as they retain less rebates, resulting in higher bid amounts. This would benefit a larger subset of members with brand use and high spending, for whom total beneficiary costs would decrease.

Methodology

Our analysis used Milliman's Part D pricing model, calibrated to 2019 national average bid and premium amounts assuming a 70% non-LIS and 30% LIS enrollment mix. We assumed 2019 defined standard benefits except for the voluntary POS plan, where we assumed enhanced benefits with $0 deductible applied to all tiers, no supplemental gap or catastrophic coverage, and initial coverage phase copays for generics and coinsurance for brand and specialty drugs. Adverse selection was reflected through increases to unit cost (by decreasing the GDR by 2% and an additional unit cost increase of 5%) and utilization (increases by 9%, with about 5% correlating to a risk score increase). We assumed total price concessions (manufacturer rebates and pharmacy price concessions) equal to 27% of drug spending (15% of this attributable to pharmacy price concessions). Manufacturer rebates were modeled on specialty and brand prescriptions only, whereas pharmacy price concessions were applied to all retail prescription types.

Caveats

The examples in this report represent national averages. Results for any particular plan may vary substantially from those presented here due to enrollment demographics, cost structure, adverse selection, and other factors. Certain types of benefit programs, such as the employer group waiver plans (EGWPs), can create different dynamics. This report was commissioned by Pharmaceutical Research and Manufacturers of America (PhRMA). The findings reflect the research of the authors. Milliman does not endorse any product or organization. Jennifer Carioto, Gabriela Dieguez, and Bruce Pyenson are members of the American Academy of Actuaries and meet its qualification standards to issue this report.

Milliman

CONTACT

Jennifer Carioto
jennifer.carioto@milliman.com

Gabriela Dieguez
gabriela.dieguez@milliman.com

Bruce Pyenson
bruce.pyenson@milliman.com