THE AIDS INSTITUTE

Milliman Medicare Part D Rx Pricing Report

November 4, 2016

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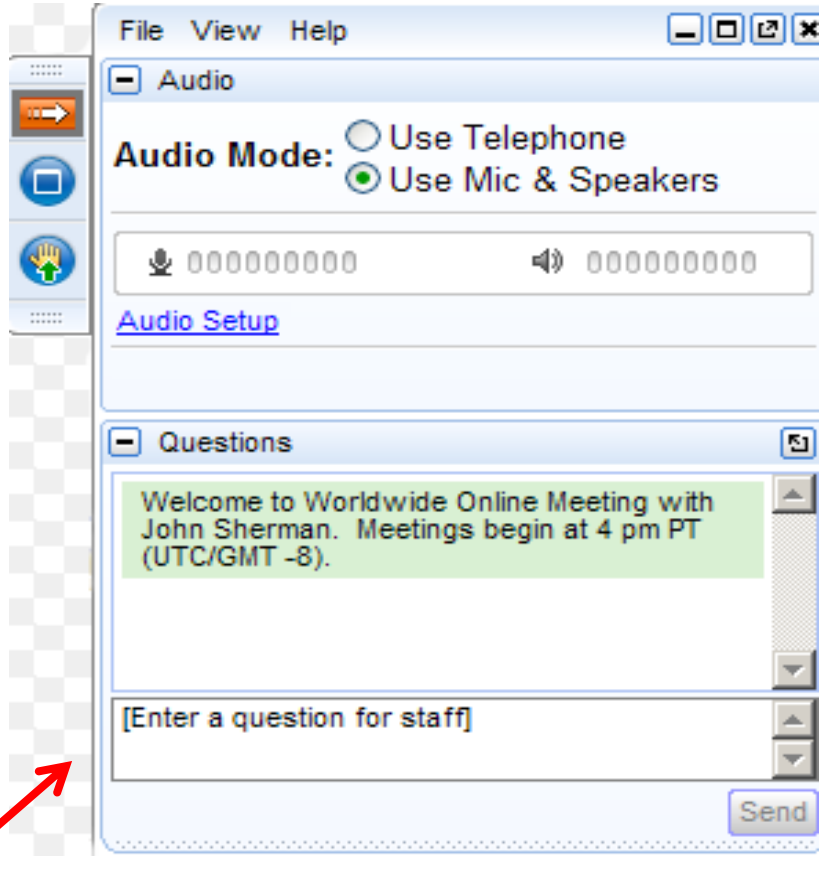

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Introductory Comments:

Carl Schmid, Deputy Executive Director

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Report Presenters:

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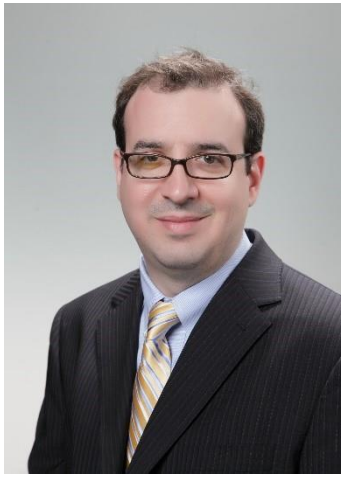

Adam Barnhart
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Financial Incentives in Medicare Part D

Adam J. Barnhart, FSA, MAAA
Jason Gomberg, FSA, MAAA

November 4, 2016

Executive Summary

The Medicare Part D market and benefit design magnifies a plan's financial incentives to seek high rebates. Many carriers seeking to target the lowest possible beneficiary premium have found that medications with higher point-of-sale (POS) prices and post POS rebates may actually be preferred financially relative to medications with lower POS prices.

In this report, we look at three Part D market scenarios to illustrate the trade-off between POS price and rebates:

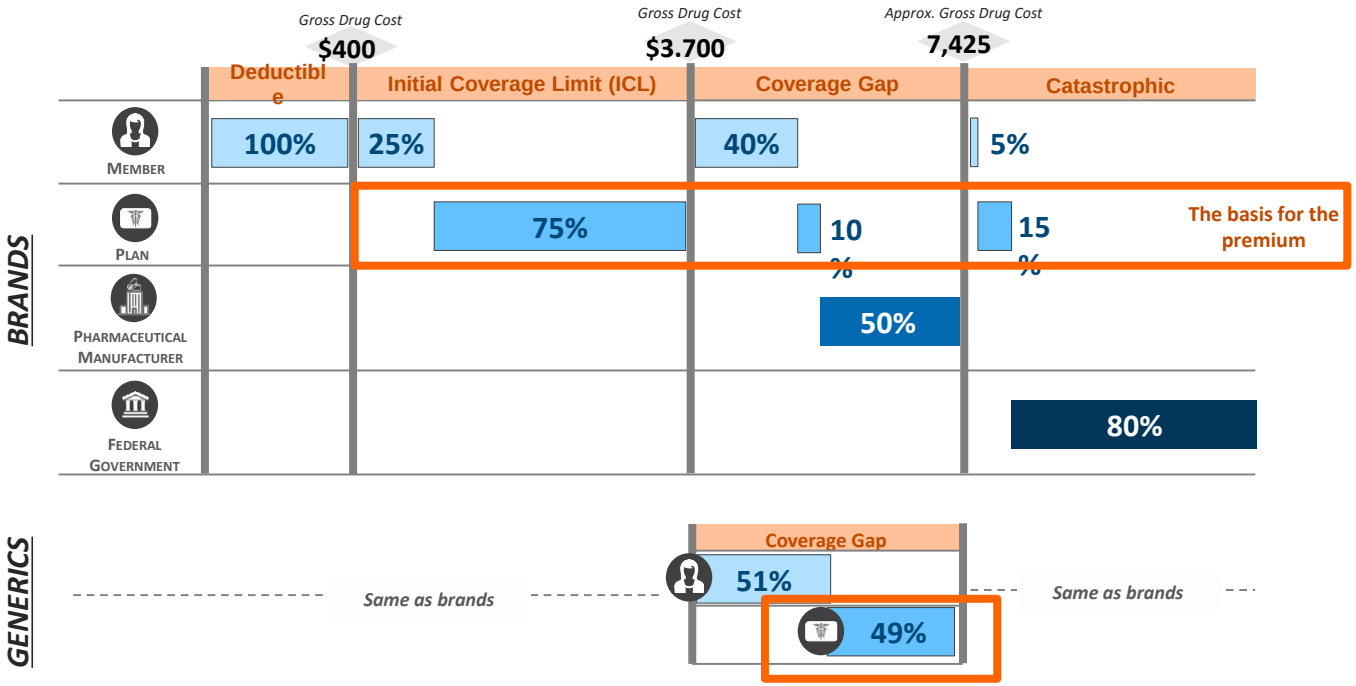
- **Scenario 1 – Brand Versus Generic Medications**
- **Scenario 2 – Specialty Medications**
- **Scenario 3 – Biosimilar Medications**

Each scenario illustrates how the lowest POS medication is not necessarily the preferred financial choice for a plan sponsor focused on having the lowest premiums.

Background

- Roughly 41 million enrollees in 2016
- Two means of receiving Part D benefits
  - Stand-alone prescription drug plans (PDPs) – roughly 25 million
  - Medicare Advantage plans (MA-PDs) – roughly 16 million
  - Can be individual or employer-based (i.e., 800-series) plans
- Low Income (LI) beneficiaries may qualify for "extra help" ranging from reduced cost sharing to fully subsidized premium
  - About 30% of Part D members qualify as LI
- Premiums, formulary, networks, cost sharing and other elements vary by plan

2017 Defined Standard Plan



Rebates in Part D

Changes in the contracted medication cost are shared with all parties, and changes in rebates are shared only with the government and plan sponsor. The government retains rebates equal to the ratio of the total amount of reinsurance over the total medication cost, with the plan retaining the remainder.

The amount of rebates shared is the same for all of a plan's claims. In other words, the rebates shared do not vary by medication based on the federal reinsurance and rebates associated with that particular medication).

Summary of Annual Cost Sharing by Payer for an Illustrative Beneficiary with Average Costs			
Item	**Cost Type**	**Formula**	**Annual Amount**
A	Medication Cost	N/A	3,000
B	Beneficiary Cost-Sharing	N/A	675
C	CGDP	N/A	300
D	Reinsurance Before Rebates	N/A	960
E	Plan Liability Before Rebates	A – B – C – D	1,065
F	Total Rebates	N/A	450
G	Rebates for Federal Reinsurance	F * D / A	144
H	Rebates for Plan Sponsor	F – G	306
I	Net Plan Sponsor Liability	E – H	759
	Total Paid by Payer		
	Pharma	C + F – A	-2,250
	Beneficiary	B	675
	Federal Reinsurance	D - G	816
	Plan Sponsor	I	759

Scenario 1 – Brand Versus Generic Medications

Generic Medication Example: A beneficiary exclusively taking $200 per month of generic medications for treatment of a certain condition.

Brand Medication Example: A beneficiary exclusively taking $1,000 per month of brand medications with a $250 per month rebate for treatment of the same condition.

Summary of Annual Cost by Stakeholder for Illustrative Beneficiary Taking Either Generic or High Cost Brand Medications			
Payer	**Generic Medications**	**Brand Medications**	**Difference**
Pharma	-2,400	-7,189	-4,783
Beneficiary	870	2,986	2,116
Federal Reinsurance	0	2,939	2,939
Plan Sponsor	1,530	1,258	-272

Scenario 2 – Specialty Medications

$50,000 No Rebate Example: A beneficiary exclusively taking a single $50,000 medication for treatment of a certain condition without any rebates.

$100,000 With Rebate Example: A beneficiary exclusively taking a single $100,000 medication with a $50,000 rebate for treatment of the same condition.

Summary of Annual Cost by Stakeholder for Illustrative Beneficiary Taking High Cost Specialty Medications			
Payer	**$50,000 No Rebate**	**$100,000 With Rebate**	**Difference**
Pharma	-48,183	-48,183	0
Beneficiary	4,886	7,386	2,500
Federal Reinsurance	34,445	54,566	20,393
Plan Sponsor	8,852	-13,769	-22,621

Scenario 3 – Biosimilar Medications

Brand Medication Example: A beneficiary exclusively taking $4,000 per month of brand medications with a 20% rebate for treatment of a certain condition.

Biosimilar Medication Example: A beneficiary exclusively taking $3,400 per month of biosimilar medications with a 20% rebate for treatment of the same condition.

Summary of Annual Cost by Stakeholder for Illustrative Beneficiary Taking Brand Versus Biosimilar Medications

Payer	Brand Medications	Biosimilar Medications	Difference
Pharma	-36,583	-32,640	3,943
Beneficiary	4,786	6,127	1,341
Federal Reinsurance	29,773	23,415	-6,358
Plan Sponsor	2,024	3,098	1,074

Caveats and Limitations

Adam J. Barnhart and Jason Gomberg are consulting actuaries with Milliman, Inc., 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 report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

The information in this report is intended for the use of The AIDS Institute to provide assessment better understanding of the financial incentives created by rebates and the benefit structure in Medicare Part D. It may not be appropriate and should not be used for other purposes.

This report may be distributed publicly at the discretion of The AIDS Institute. If shared externally, the report should be shared in its entirety unless otherwise approved by Milliman. We do not intend this information to benefit, or create a legal liability to, any third party, even if we permit the distribution of our work product to such third party.

Actual results may differ from those in this report due to several factors, including but not limited to different trends, changes in demographics, differences in benefit design, and changes to the Part D program. Results would be different using a different set of medications for each example, and will vary by year due to mandated changes to the standard Part D benefit design. The AIDS Institute may consider monitoring emerging results to better understand the cost difference between the intervention and control populations.

Our assessment is based on publicly available information from CMS. We accepted this information without audit, but reviewed the information for general reasonability and consistency. If the underlying data or information is inaccurate or incomplete, the contents of this report along with many of our conclusions, may likewise be inaccurate or incomplete.

This report outlines the review and opinions of the authors of this report and not necessarily that of Milliman. Neither Milliman nor the authors endorse any products or programs in general. The terms of Milliman's Consulting Services Agreement and Indemnification and Hold Harmless Agreement with The Aids Institute signed on August 1, 2016, apply to this engagement.

Concluding Comments:

Carl Schmid, Deputy Executive Director

The AIDS Institute

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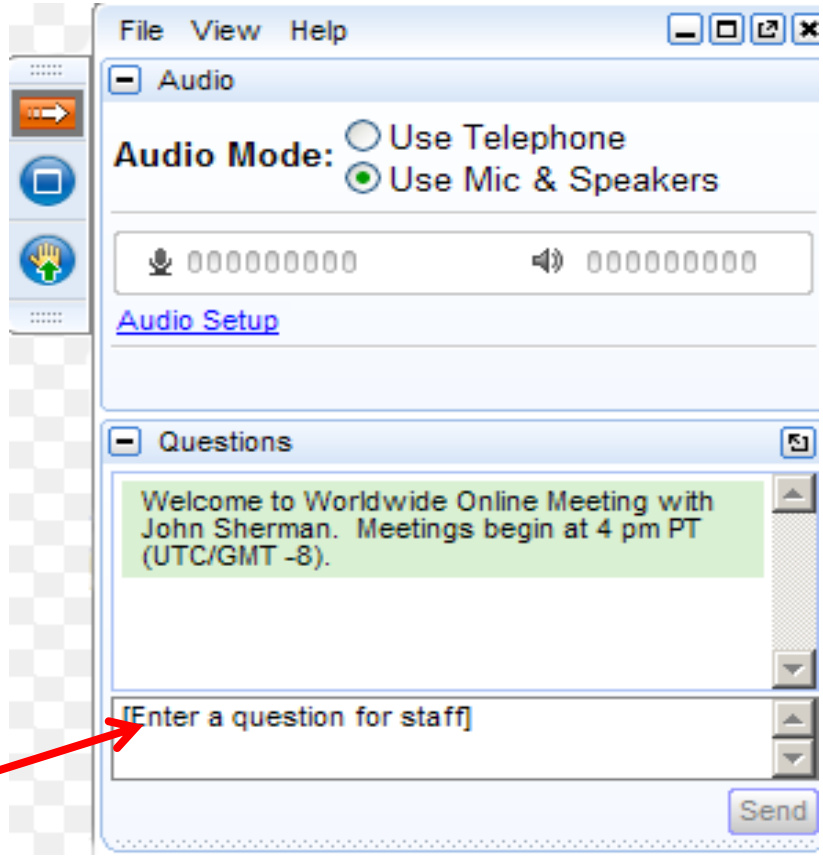

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