



THE AIDS INSTITUTE

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**MEDICARE PART D PROGRAM CAN INCENTIVIZE PLANS WITH
HIGH DRUG PRICES & REBATES**

*Milliman Report Examines Role of Drug Pricing & Rebates in Medicare Part D
Program*

WASHINGTON, D.C. - Today, The AIDS Institute released a [report](#) prepared by Milliman, Inc. titled "[Financial Incentives in Medicare Part D](#)" that explores how differing list prices and rebates for medications impact costs borne by beneficiaries, plans, pharmaceutical manufacturers, and the federal government.

In the report, the Milliman authors analyzed the point-of-sale (POS) costs and benefits for payers in the Medicare Part D system based on differing drug costs and rebate levels. The report compares the situation for a person who is taking a drug that costs \$50,000 and has no rebates with one for the same condition that costs \$100,000, but offers significant rebates. While the pharmaceutical company receives the same revenue in both cases, the cost to the federal government through the federal reinsurance subsidy would be over \$20,000 more for the higher priced drug. The beneficiary would pay an additional \$2,500 at POS for the higher priced drug. The plan sponsor would actually pay nearly \$23,000 less due to the rebates received. In fact, the plan sponsor would receive more than \$14,000 above what they pay for the medicine.[1]

According to Milliman authors Jason Gomberg and Adam Barnhart, "The unique nature of the Medicare Part D market and benefit design magnifies a plan's financial incentives to seek high rebates. As a result, 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."

"With the heightened focus on drug prices, rebates, spending in the Medicare Part D Program, and a desire for increased transparency, we hope this groundbreaking report will shed light on some of the perverse incentives in Medicare Part D and the federal government will take steps within its current authority to address the situation," commented Carl Schmid, Deputy Executive

Director, The AIDS Institute.

Based on their analysis, the Milliman authors concluded, "If the rebate on a high-cost medication is sufficient, the plan sponsor's portion of the claim may actually be negative, meaning that the beneficiary cost-sharing and federal reinsurance pay for more than 100% of the net cost of the medication."

In the report, the Milliman authors also analyzed two additional drug pricing and rebate scenarios.

In another scenario, the Milliman authors compared a generic drug that costs \$2,400 per year with a brand drug for the same condition that costs \$12,000 per year. Under this scenario, the revenue received by the pharmaceutical company would be nearly \$5,000 more per year with the higher-cost brand drug. The beneficiary POS cost share would be over \$2,000 more, and the federal government would pay nearly \$3,000 more in federal reinsurance subsidy payments. Due to rebates for the brand drug, the plan would gain about \$275 more per year if the beneficiary used the brand drug which may reduce beneficiary premium and federal payments through the direct subsidy.

In the last scenario, the Milliman authors compared a brand drug costing \$48,000 per year with a biosimilar for the same condition costing \$40,800 per year. Under this scenario, the revenue received by the pharmaceutical company would be nearly \$4,000 less for the biosimilar compared to the brand drug. The beneficiary POS cost sharing would be over \$1,300 more for the less-expensive biosimilar, while the federal reinsurance subsidy would be nearly \$6,400 less. The plan costs would be over \$1,000 more per year with the less-expensive biosimilar.

The Milliman authors explain these rather unexpected conclusions by stating, "most newly available biosimilar medications are expected to be treated like a generic product for beneficiary cost-sharing purposes within the Medicare benefit and not participate in the coverage gap discount program (CGDP). . . . If the plan will get both lower rebates and there is no CGDP, the biosimilar will likely be at a disadvantage from both the beneficiary and plan sponsor perspective, despite being priced 15% to 25% less than the branded medication."

It was assumed in all three scenarios studied that the beneficiaries were non-low income and used the standard benefit option.

"Over 57 million people on Medicare in the U.S. have the option to join the Medicare Part D prescription drug benefit; this includes those ages 65 and older and people with permanent disabilities. It's important that analysis like the Milliman report helps to protect patients that access the Part D drug benefit through private plans approved by the federal government," stated Michael Ruppel, Executive Director, The AIDS Institute.

The AIDS Institute looks forward to sharing the results of this study with policy makers, including the Center for Medicare and The Medicare Payment Advisory Commission (MedPAC), and with other patient groups as we all work to maintain a strong Medicare Part D Program.

Read the full report [here](#).

[1]The plan sponsor's payment is funded through beneficiary premium as well as the federal direct subsidy. As federal reinsurance and plan liability change, there are offsetting changes in beneficiary premium and the cost to the federal government through the direct subsidy that are not reflected in the values above.

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