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What Will Be the Impact of the New Medicare Prescription Drug Benefit?

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Introduction

On Dec. 8, 2003, President Bush signed into law the "Medicare Prescription Drug, Improvement and Modernization Act of 2003." Two of the primary goals of this legislation were to offer a prescription drug discount card to Medicare recipients starting in 2004 and, more importantly, an insured prescription drug benefit to Medicare recipients starting in 2006. These new benefits, along with the restrictions imposed on the ability of Medigap policies to offer prescription drug coverage to new enrollees starting in 2006, will have a significant impact on prescription drug coverage for the Medicare population and could have an impact on coverage for the commercial population. The total annual cost to the federal government of this new prescription drug coverage was originally estimated at $400 billion, but those estimates have increased since the legislation was passed. For purposes of this article, our estimates are based on this $400 billion estimate. If the actual costs are higher, the distribution among recipients would likely be the same while the dollar amounts would increase.

The impact of this legislation on the entire pharmaceutical distribution chain, including pharmaceutical manufacturers, pharmacy benefit managers (PBMs), pharmacies, insurers, employers and insureds, is still unclear. For all of these entities, a number of questions will need to be answered in order to determine the impact:

- Who in the distribution chain will see the $400 billion estimated cost, and how much will each entity see? How much of the $400 billion is to cover additional utilization created by the drug card in 2004 and the insured benefit in 2006 versus just shifting costs to the federal government (i.e., does the pie grow or just get reallocated)?

- How will the Medicare prescription drug plan affect the commercial market? Will pharmacies reduce the discounts they offer to PBMs, insurers and employers in order to compensate for the loss of cash-paying customers, and will pharmaceutical manufacturers reduce their average rebates per prescription?

- What will potential prescription drug plans (PDPs) offer as benefits? Among those Medicare Advantage plans offering prescription drug plans (MA-PDs), what benefits will be offered? And will any offer supplemental benefits?

Who will see the $400 billion estimated cost?

Many published news stories indicate that the HMO/insurance industry and the pharmaceutical manufacturers are the big winners from the Medicare prescription drug benefit. Many of these news stories are based on quotes from detractors of the bills. In reality, neither of these industries may come out as huge winners from this legislation.

In fact, public sector and private sector *employers* who currently provide prescription drug benefits to their Medicare recipients appear to have the clearest-cut benefit. These employers will either receive a direct tax-free subsidy from the federal government for 28 percent of the gross cost of prescription drugs between $250 and $5,000 starting in 2006, or they could eliminate their prescription drug benefit and migrate their Medicare recipients into a Medicare prescription drug (Part D) plan. Original published estimates from several sources including the government's own estimates of the cost of this subsidy range from $71 to $86 billion out of the $400 billion, or about 20 percent of the total cost of the bill.

The impact on *HMOs/insurers* or any other entity that wants to be a PDP is less obvious. Clearly they will receive some of the $400 billion for providing administrative services for the prescription drug benefit. A rough estimate of the value of the administrative services is about $50 billion. Unlike the subsidies to the employers, however, this money will not go straight to the bottom line of PDPs. While some of this money could result in bottom-line profits, we would expect that a large percent of this revenue would cover real additional expenses.

Who will see the rest of the money? *Pharmaceutical manufacturers* will likely see some, although the increase in prescriptions filled (utilization) may be minimal. Studies have indicated that approximately 75 percent of Medicare beneficiaries currently have some level of coverage, either from employers, Medicare+Choice HMOs, Medigap plans, existing prescription drug plans, Medicaid or programs offered by the manufacturers. The level of coverage for these individuals is not clear and varies significantly depending on the coverage, but those with employer coverage, Medicaid, or some of the richer Medigap plans are likely to already utilize prescription drugs at the same level (or potentially an even higher level) than they would under the Medicare prescription drug plan, so they would be unlikely to increase their utilization. (In fact, if some of these people lose their current prescription drug coverage and move into the standard prescription drug plan, their utilization may actually decrease.)

In addition, analysis of Reden & Anders' internal prescription drug databases indicates that only about 10 percent of Medicare beneficiaries would have costs in excess of $5,100 and only 33 percent would have costs in excess of $2,250 in 2006. These are the two breakpoints in the formula for Medicare prescription benefits. Assuming a 10 percent increase in utilization from the introduction of the new coverage would mean additional revenue to the pharmaceutical manufacturers of about $50 billion in total from 2006 to 2013. Considering the industry had over $150 billion in revenues from the United States in 2004, a $50 billion increase in total from 2006 to 2013 would increase revenue by only 2-4 percent over that time period.

The remaining cost of the $400 billion, or about $200 billion (the largest part), would likely go to reimburse directly *Medicare beneficiaries* who currently pay for their drugs themselves by reducing the out-of-pocket costs for those beneficiaries.

How will the Medicare prescription drug plan affect the commercial market?

As mentioned previously, statistics show that about 75 percent of Medicare beneficiaries currently have some level of prescription drug coverage. For a majority of Medicare beneficiaries, however, the discounts available through that coverage are less

than the discounts currently available for commercial insureds. For example, for brand prescriptions most employers receive a discount of between 12 percent and 15 percent, before factoring in rebates, based on a survey performed by Reden & Anders. Most Medicare recipients not covered under an employer plan or a Medicare+Choice plan likely receive a discount of less than 10 percent on brand prescriptions, and those without any coverage most likely receive a discount of 5 percent or less, based on Reden & Anders' knowledge of those markets. If all Medicare recipients moved to a discount of 12 percent from their current estimated discounts, the reduction in revenue to the pharmacies could be as much as $2 billion. The net income of Walgreen's, CVS and Rite Aid combined for the trailing 12 months (as of 12/10/2003) was $1.8 billion based on filed financial statements. However, most Medicare members without insurance do not have the opportunity to receive prescription drugs from other sources, such as mail order. If these members were offered this option and chose to get mail order prescriptions, this would impact the revenue generated from other items sold by the retail prescription drug stores. The retail pharmacies will need to take this combination of factors into consideration when negotiating their contracts with the Part D carriers for Medicare insureds, which may impact their commercial contracts or result in entirely separate contracts for Medicare beneficiaries even though that would add additional administrative complexity.

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The same issue obviously applies to the pharmaceutical manufacturers. They currently provide rebates to the PBMs or employers based on market share and volume. These rebates are only paid, however, to entities that have a contract with the manufacturer. For Medicare beneficiaries that have limited or no insurance for their prescription drug coverage, the manufacturers do not pay a rebate. Once these beneficiaries start to enroll in an insured plan, however, the PBMs or insurers are likely to include these new prescriptions in the total volume they report to the manufacturers and request a rebate for these prescriptions.

The United States market for prescription drugs consisted of approximately 3.2 billion prescriptions in 2003 according to the NACDS Web site (accessed on 7/23/2004). Assuming that one third of that total is for Medicare, about 1.1 billion prescriptions are filled for Medicare recipients. If 40 percent of those prescriptions are filled by people that do not have any plan that would receive rebates, and 40 percent of those individuals' prescriptions would be eligible for an average rebate of $2, about 18 million prescriptions would receive rebates currently not paid. The additional rebates the manufacturers would have to pay would be $360 million in current dollars, (which may be applicable under the prescription drug card) and likely even more in 2006. As with the pharmacies, the manufacturers may face the same issue regarding the level of rebates they pay for Medicare beneficiaries compared to their current payments for commercial members, especially if the inclusion of Medicare members under insured coverage does not increase utilization.

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If the pharmacies and manufacturers refuse to extend their existing levels of discounts and rebates to new Medicare beneficiaries, the result will be either a two-tier level of discounts and rebates (one for commercial and one for Medicare) or new levels for discounts and rebates. Since most PBMs typically have a global contract with each pharmacy chain that covers all prescriptions filled by that chain for all members covered by the PBM, developing a split reimbursement schedule may be difficult, or, at a minimum, undesirable. Alternatively, developing new contracts with lower discounts and rebates that would maintain the current profit levels for the pharmacies and total payout for the manufacturers would result in lower discounts and rebates than what the commercial market currently receives. The result could be a spike in prescription drug costs for all entities currently providing prescription drug coverage that receive the higher discount over and above the trends we already see for pharmacy.

What will PDPs offer for benefits, and will any offer supplemental benefits?

The legislation defines a standard prescription drug benefit starting in 2006 as the following:

- From $0 to $250 in total costs (not including administration), the member pays 100 percent.
- From $250.01 to $2,250 in total costs (not including administration), the plan pays 75 percent of the cost and the member pays 25 percent.
- From $2,250.01 to $5,100 in total costs (not including administration), the member pays 100 percent.
- Above $5,100 in total costs (not including administration), the member pays the greater of 5 percent or $2 for generic or multi-source prescriptions and $5 for all other prescriptions and the plan pays the balance. The $5,100 in total costs is equal to an out-of-pocket expenditure for the member of $3,600.

The PDP must submit a bid for covering the cost of the standard prescription drug coverage (or an actuarially equivalent plan) that includes the cost of administration. This bid is called the "direct subsidy" and covers the 75 percent of costs between $250 and $2,250 and approximately 15 percent of the costs after the member's out-of-pocket expenses are greater than $3,600. The remaining 80 percent of costs above the out-of-pocket maximum are reimbursed directly by the government as part of a "reinsurance subsidy."

The legislation then requires that an "adjusted national average monthly bid amount" be calculated using all of the accepted bids. The "national average monthly premium" is then calculated as

approximately 25.5 percent of the total of this "adjusted national average monthly bid amount" plus an average of the expected reinsurance subsidy that all bidders must also include as part of their overall bid. Finally, the premium an individual member must pay will be the "national average monthly premium" plus or minus the difference between the PDP bid and the "adjusted national average monthly bid amount" (i.e. if the PDP bid is $10 above the "adjusted national average monthly bid amount," the entire additional $10 would be charged to the member.)

Since the "adjusted national average monthly bid amount" is not known when the bids are submitted, especially in 2006, there is clearly some risk in submitting a bid. One likely result from this mandatory adjustment in member premium in order to reflect the difference between the bid and the "adjusted national average monthly bid amount" is that in the first couple of years in which the Medicare prescription drug plans are offered, bids will likely be made conservatively, unless a PDP was looking to enroll a vast majority of the beneficiaries in their region or service area.

In addition to the *basic* prescription drug benefit, PDPs can offer supplemental coverage. Supplemental coverage is an enhancement to the basic prescription drug benefit, and has some additional aspects:

- The entire cost of the supplemental coverage must be paid for by the Medicare beneficiary.

- The supplemental coverage can take the form of a reduction in the deductible or coinsurance or an increase in the initial coverage threshold. There is no mention of a change in the annual out-of-pocket threshold and whether this can be reduced.

- The individual reinsurance provision that reimburses the PDP for 80 percent of their costs once a member hits the out-of-pocket maximum would be worth LESS since it would require more total claims for an individual to hit the out-of-pocket maximum of $3,600 if the member is paying less per prescription, on average, than they would under the basic benefit.

- The aggregate reinsurance provisions that apply when costs are in excess of 102.5 percent of expected costs do not apply to the portion of coverage that is for supplemental benefits.

- The cost for supplemental coverage can reflect an assumption for additional utilization due to selection.

These elements of the supplemental coverage may discourage plans from offering supplemental prescription drug coverage, even with the ability to adjust the bid to reflect additional utilization. Since members will have to pay the full cost of the additional benefit, and since prescription drug costs are among the most predictable of all medical costs, the individuals that will pay for the additional benefits are extremely likely to use it, and highly likely to use more services than the excess premium would cover. The lack of any additional reinsurance protection for this adverse selection means that if plans do offer supplemental coverage, they will likely price it very conservatively since they are at risk for all of the supplemental costs with minimal reinsurance from the federal government.

Conclusions

Clearly, this new Medicare prescription drug benefit will impact the pharmaceutical industry, many HMOs and insurers, employers sponsoring retiree prescription benefits and Medicare beneficiaries themselves. What remains to be seen is who the ultimate winners and losers will be, but identifying some likely repercussions and planning for them now can provide you with a competitive advantage under the new paradigm. 2006 will be here soon. So those who manage retiree prescription programs should start the review and planning soon.