Medicare Advantage and Part D Trend Discussion

Milliman

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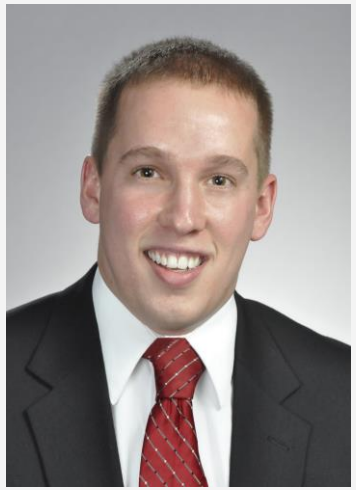
March 2022

Presenters



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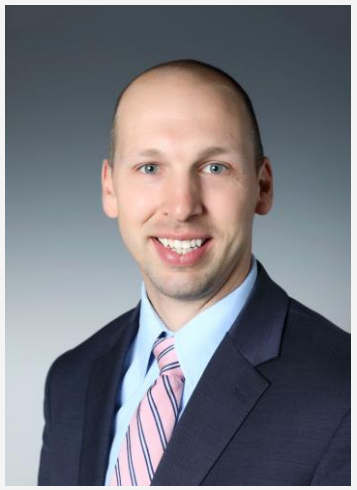

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Drug Spend Trends in Medicare Part D

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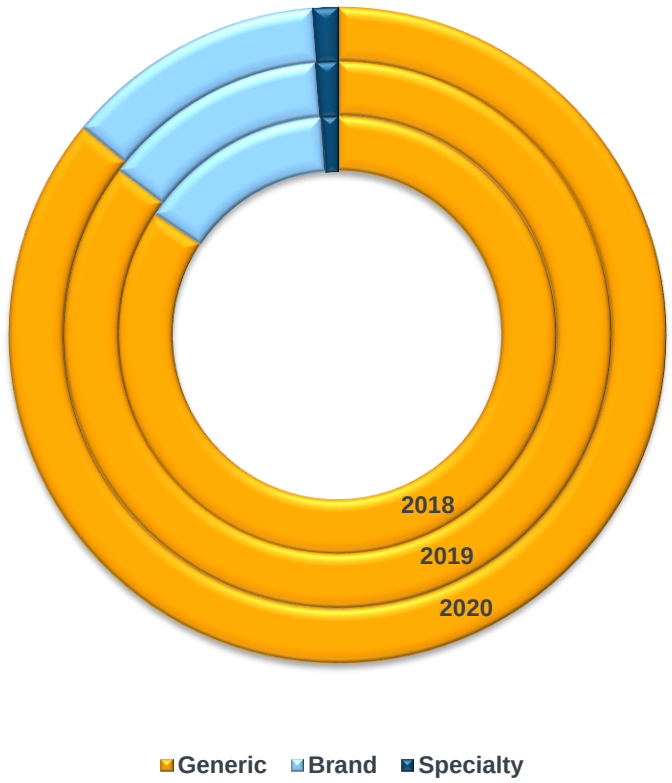
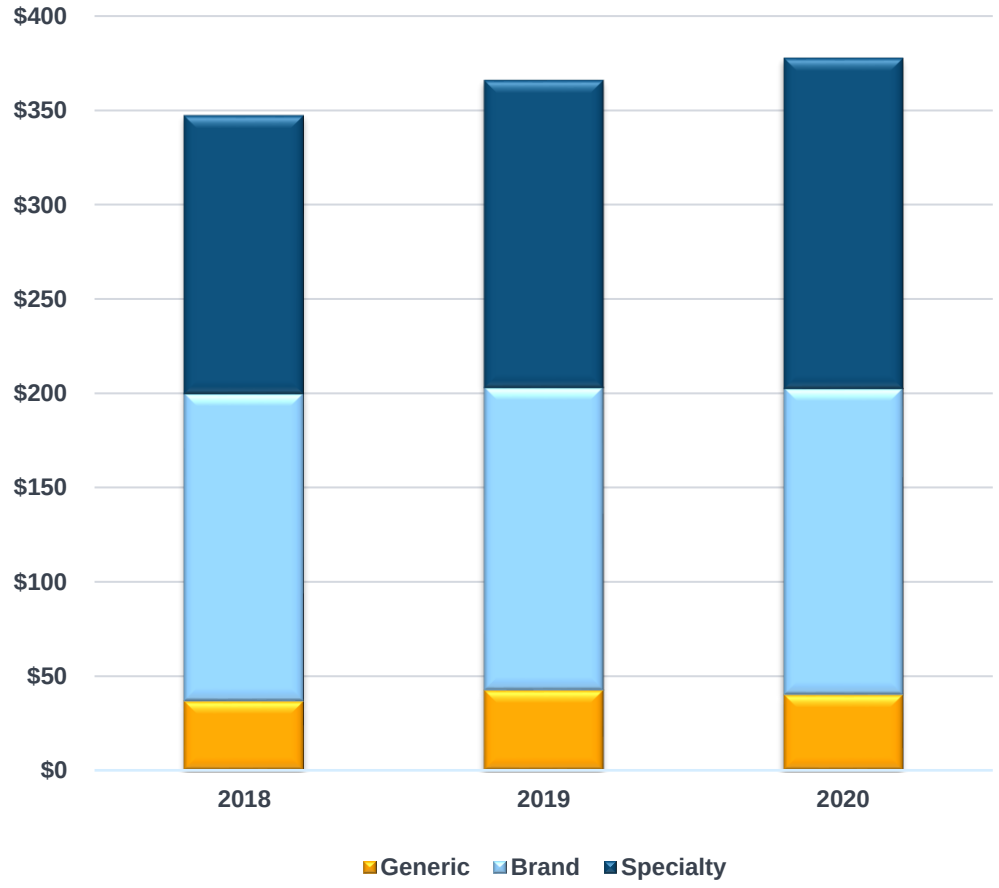
Trend Lookback: Drug Spend by Drug Type

Utilization Distribution

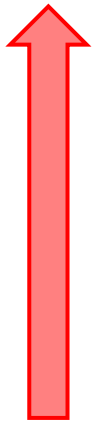


Gross Cost PMPM



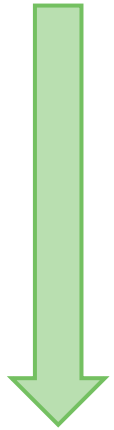
*Assumes 67% non-low income (NLI) and 33% low income (LI) population
**Specialty reflects CMS definition of greater than $670 per 30-day supply.

Trend Lookback: Drug Spend Trend Drivers

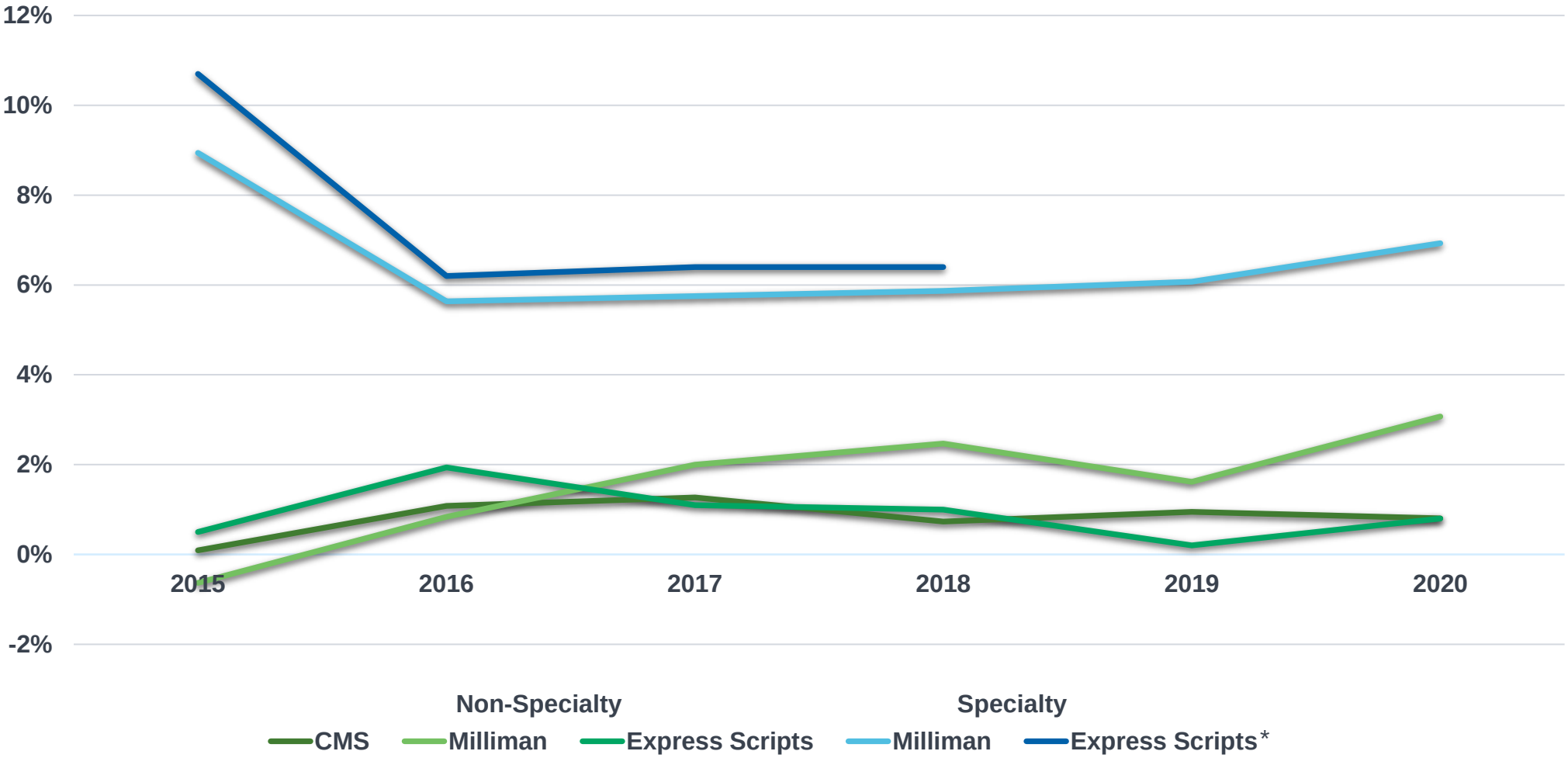


- List Price Growth
- New-to-Market / High-Cost Drugs
- Utilization Growth

- Improved PBM Contracting
- Brands Losing Patents

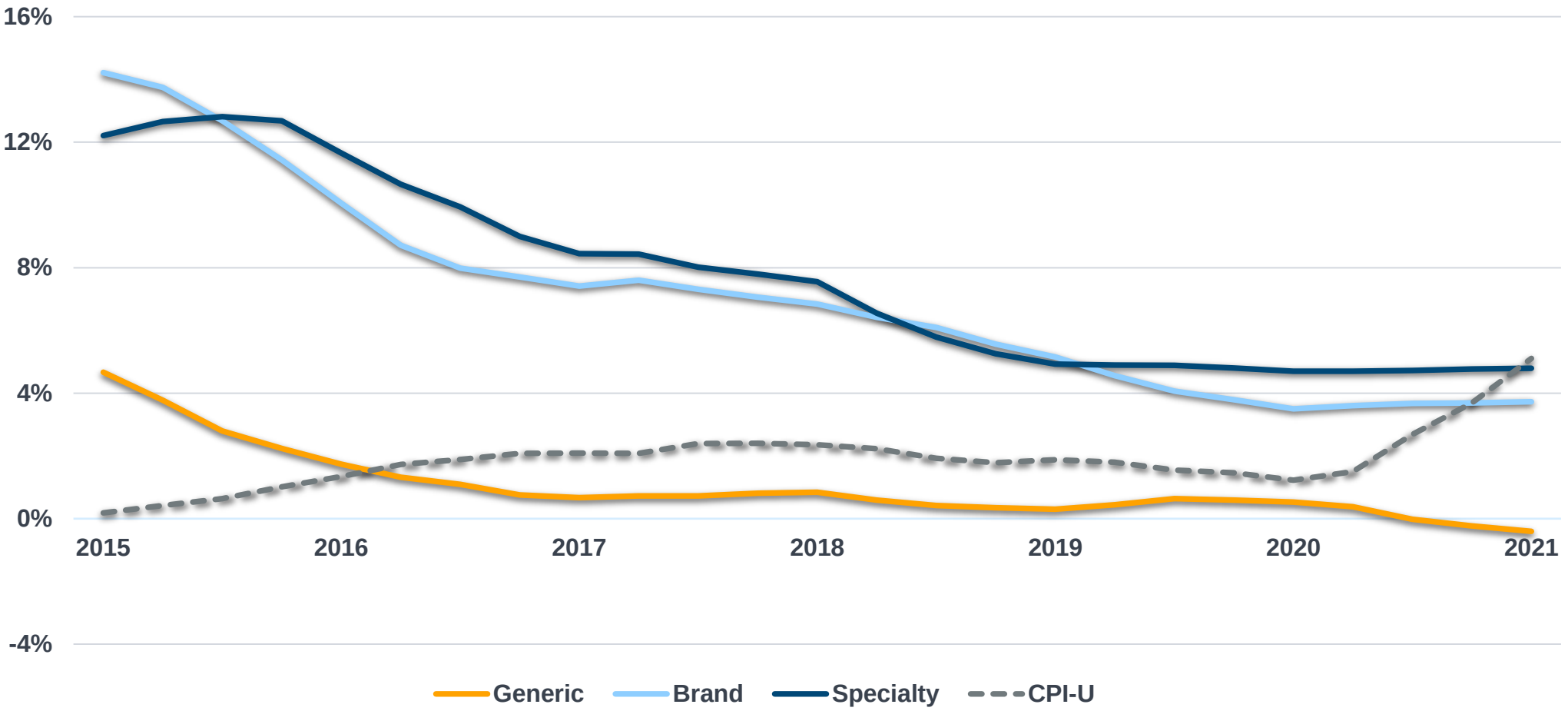


Trend Lookback: Utilization Growth



Results from Milliman Part D trend development
**Express Scripts trend reports did not provide Medicare specialty utilization starting in 2019.*

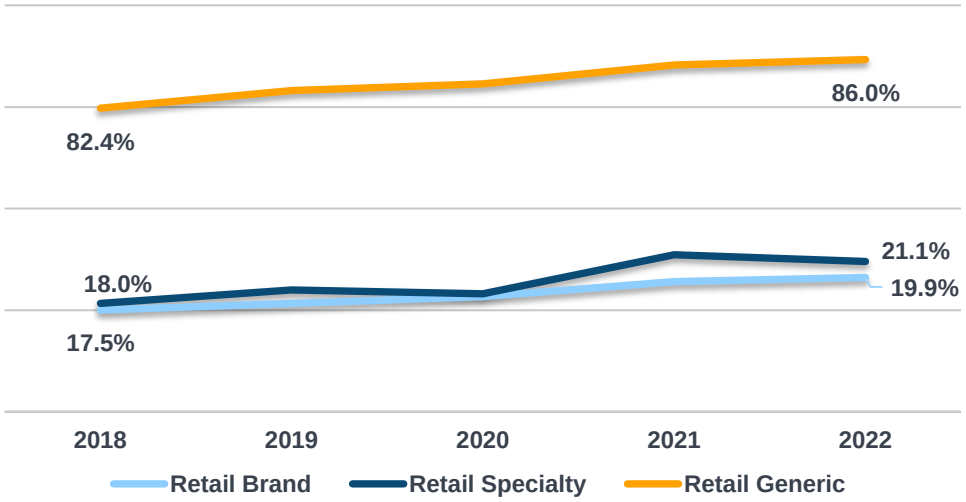
Trend Lookback: List Price Growth



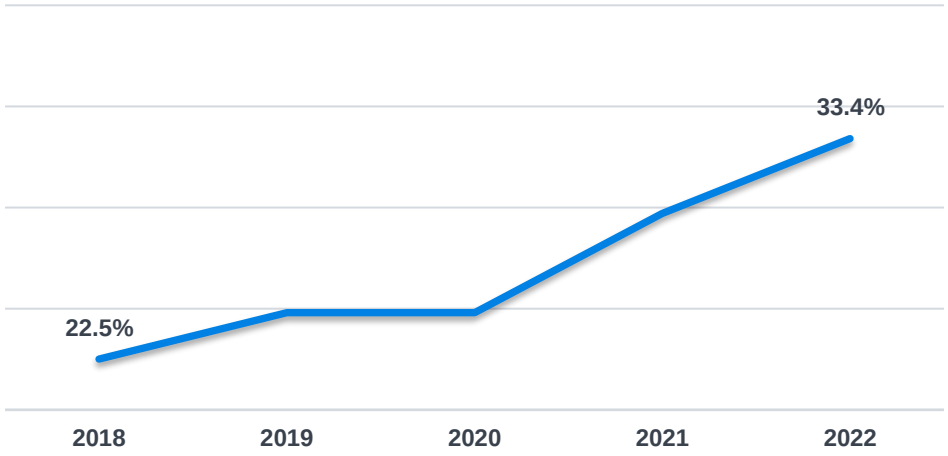
**Results from Milliman Part D trend development*

Trend Lookback: Offsets to List Price Increases

Discount from AWP



Rebate % of Brand Allowed



**Graphs reflect median contracting value based on Milliman PBM survey*

Example: $500 AWP Brand Drug

	AWP	AWP Trend	Discount	Rebate	Net Cost	Net Trend
2018	$500		$88	$93	$320	
2019	$525	***4.9%***	$94	$107	$324	***1.2%***
2020	$549	***4.7%***	$102	$111	$337	***4.1%***

Trend Lookback – New-to-Market / High-Cost Drugs

Hepatitis C

- Significant cost in 2014 and 2015
- Effectively curative
- Treatment costs from $40,000 to $90,000

Oncology

- 50+ new drug approvals in past several years, many orally administered
- Some are firsts for their indication
- Annual costs from $100,000 to $200,000+

Heart Failure

- Entresto introduced in 2015, replaced previously generic utilization
- Recent approval of diabetes drugs, Farxiga and Jardiance, for heart failure indication

Anticoagulants

- Eliquis and Xarelto: #1 and #3 in total gross spending
- 20% of overall non-specialty brand spend

Looking Forward: Potential Part D Drug Spend Trend Drivers

Upward Pressure

- List Price Growth
- Drug Pipeline
- Inflation
- Part D Benefit Redesign

Downward Relief

- Brands Losing Patents
- Drug Price Negotiation
- Inflation Rebates
- Biosimilars

Looking Forward: Pipeline Considerations

Nonalcoholic Steatohepatitis (NASH)

- No current drug treatment exists
- Product approvals expected in 2022-2023
- Potential large undiagnosed population

Chronic Inflammatory Disease

- Utilization for treatments in this space expected to continue to rise
- Newer drugs, as well as the launch of Humira biosimilars in 2023, may compete for market share

Oncology

- Trend in recent approvals expected to continue
- New generics for renal cell cancer and multiple myeloma in next few years

Other Specialty Products

- Several high-cost medications in the pipeline for hemophilia, sickle cell disease, and other rare conditions.

Looking Forward: Themes from Proposed Legislation

Drug Price Negotiation

- Allow federal government to negotiate prices for subset of drugs
- Minimum discounts to average manufacturer price or index to international prices

Price Increase Cap

- Manufacturers pay rebates if drug prices increase faster than inflation rate
- SSB and biologic Part D (and Part B) drugs

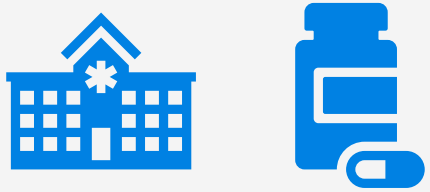
Benefit Redesign

- Aimed at savings for government and member
- Increase to manufacturer liability
- Increased adherence = Higher gross costs

Looking Forward: Other Potential Contributors

Inflation

Shift between Part B and Part D



Biosimilars

Pharmacy Point of Sale Rebates

COVID-19 Trends

Brent Jensen FSA, MAAA
Principal & Consulting Actuary

Milliman

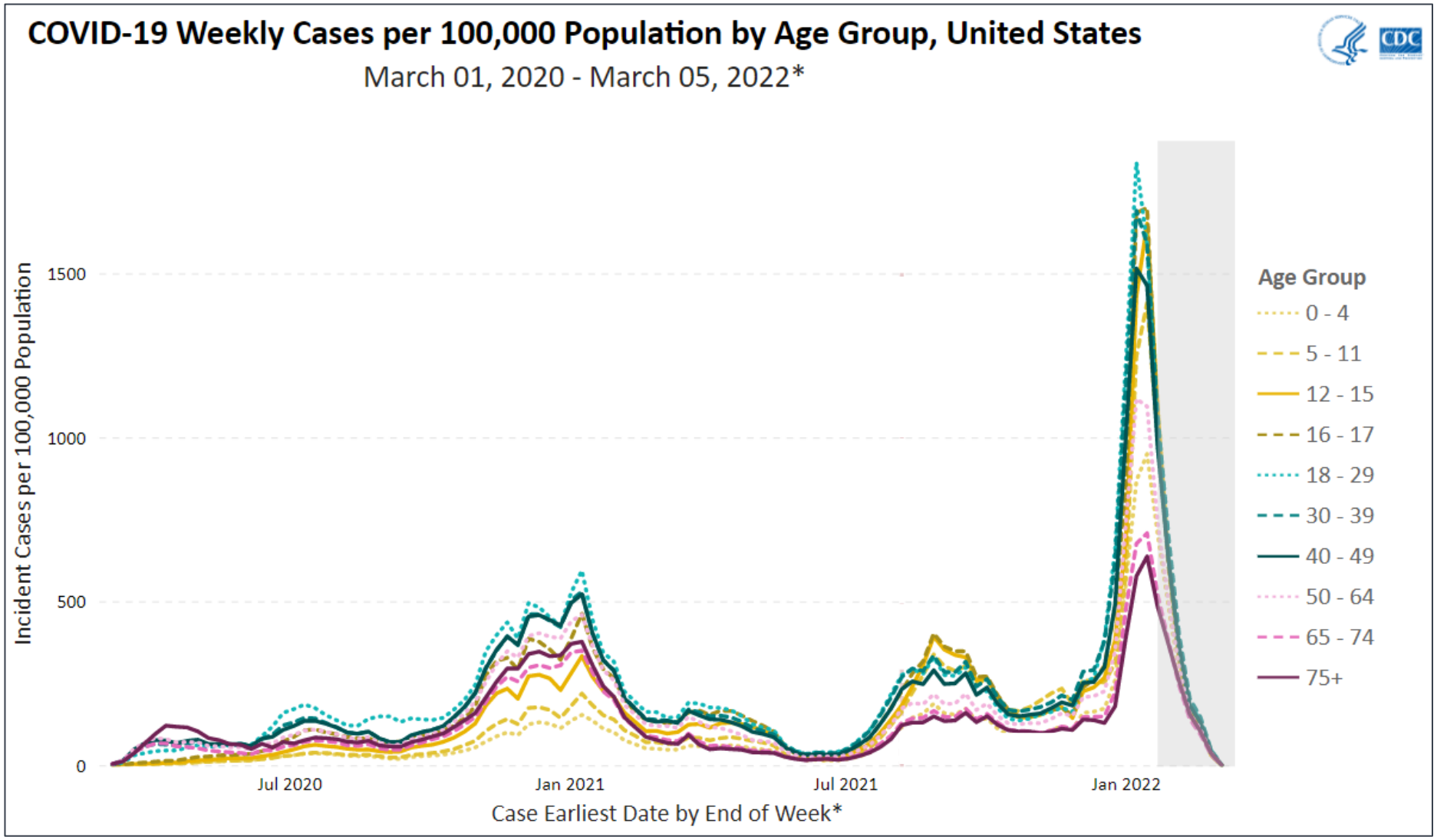
Overall Costs Trends

- **Two key factors impacting COVID-19 trends:**
- **1) Cost per case**
- **2) Frequency of severe cases**

Estimated COVID-19 Treatment Cost by Severity Level

COVID-19 Treatment Severity Level	*100% Medicare Per Case - January 2022*
Inpatient Severe	$17,000
Inpatient Critical - No Ventilator	$21,000
Inpatient Critical - Ventilator	$51,000

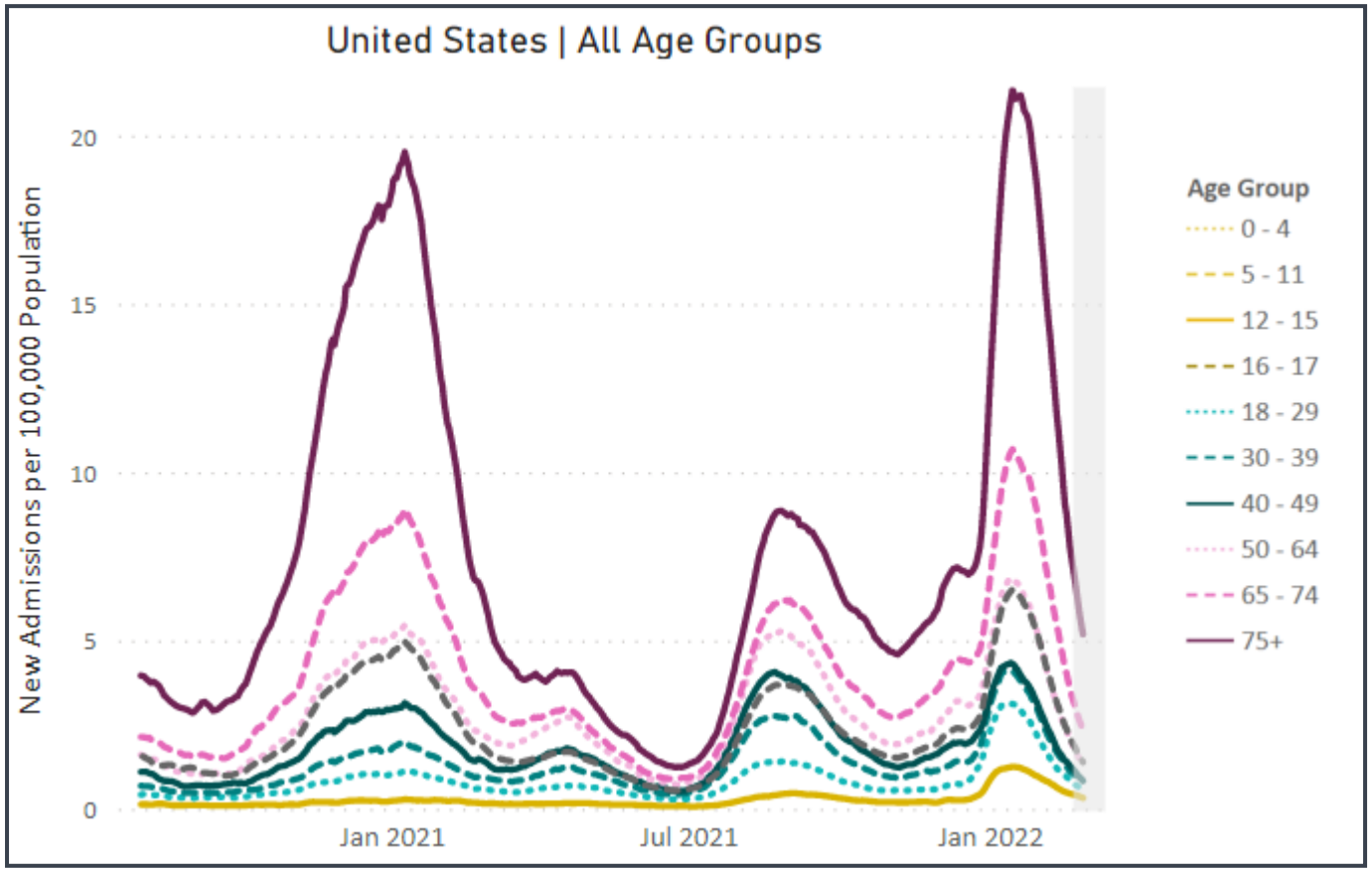
Cases vs Admits vs Deaths



Source: CDC, *covid.cdc.gov/covid-data-tracker*

Cases vs Admits vs Deaths

- New Admissions of Patients with Confirmed COVID-19
- August1, 2020 to Feb 27, 2022
- By Age Bucket



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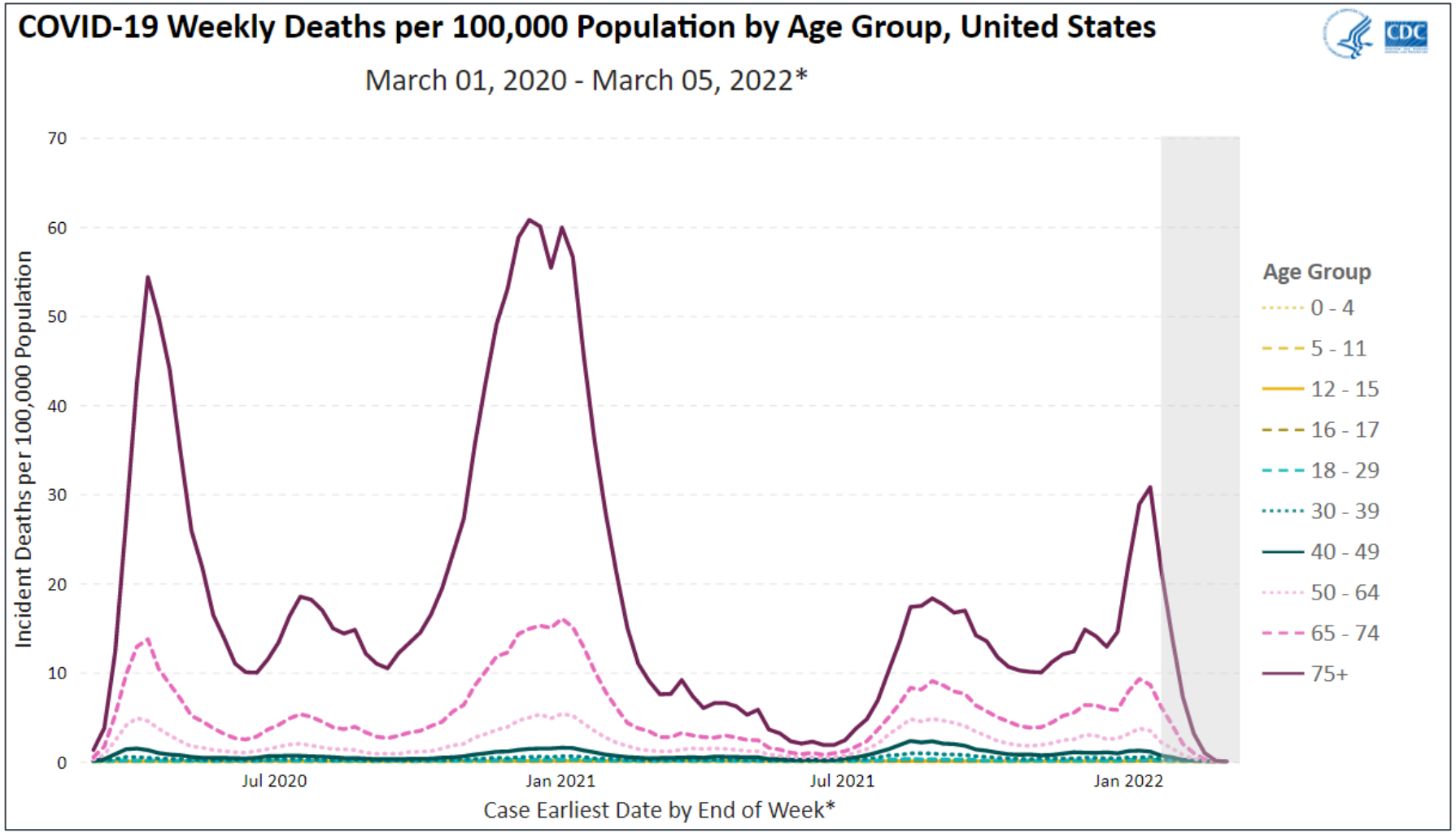
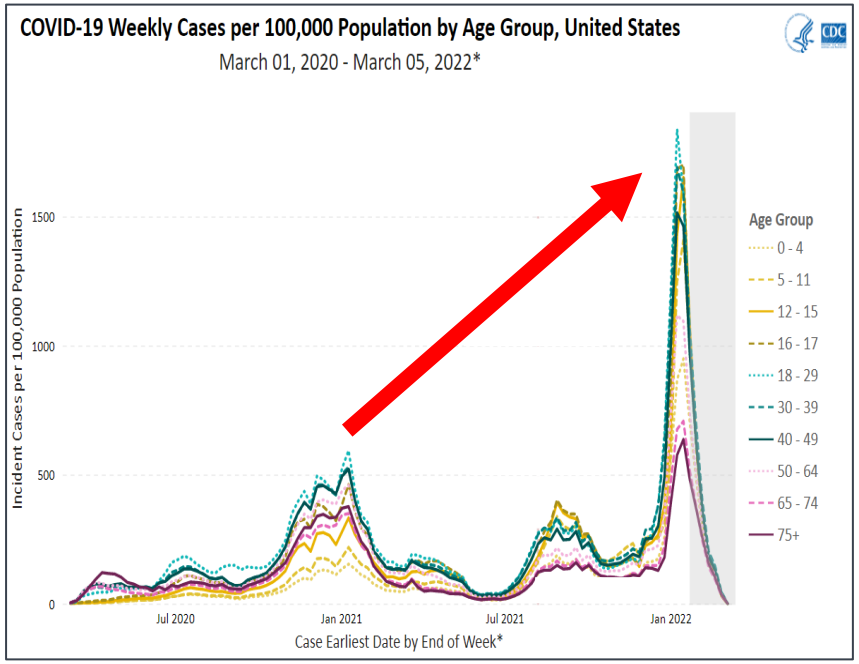
Cases vs Admits vs Deaths

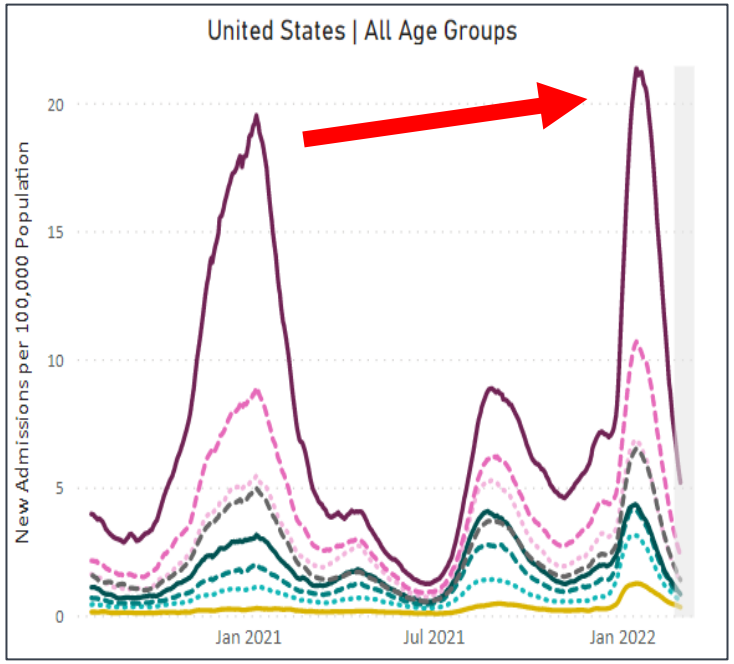


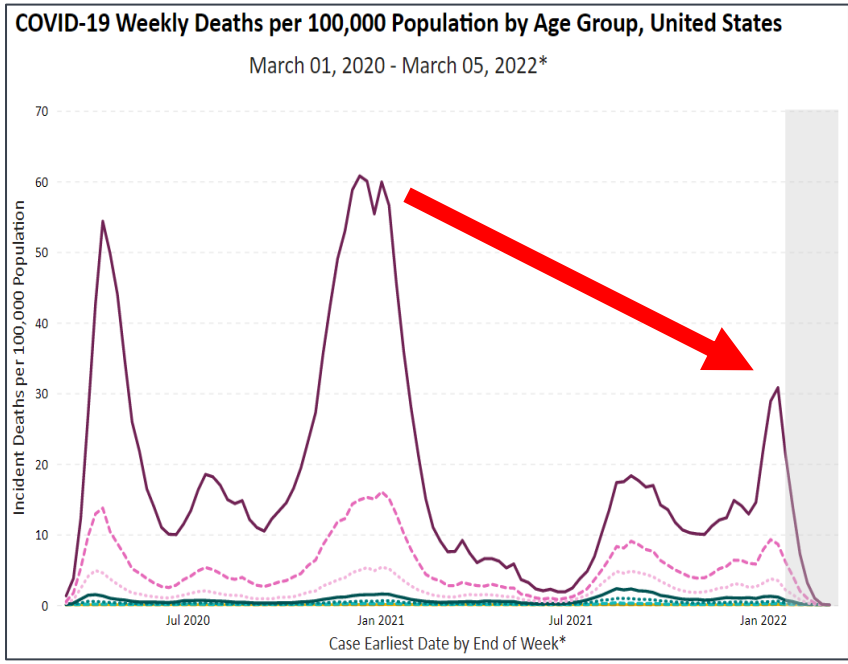
Source: CDC, *covid.cdc.gov/covid-data-tracker*

Cases vs Admits vs Deaths

- Important to understand the underlying data when setting COVID-19 trend assumptions







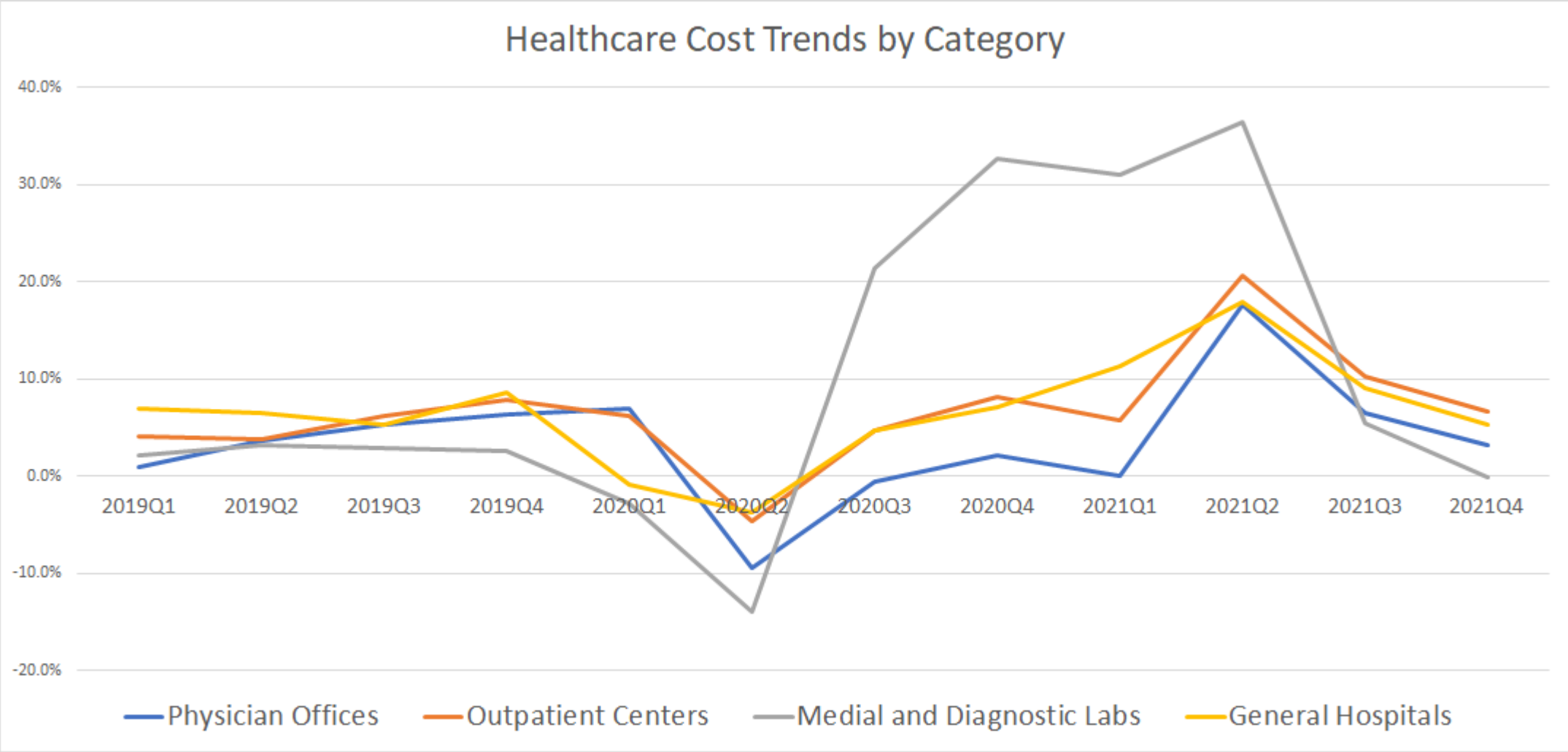
Source: CDC, *covid.cdc.gov/covid-data-tracker*

Cases vs Admits vs Deaths

- Key considerations when estimating COVID-19 trends
  - Demographics
  - Comorbidities (health risk scores)
  - Vaccination rates
  - Geography
  - Reimbursement
  - Network

COVID-19 Historical Trend

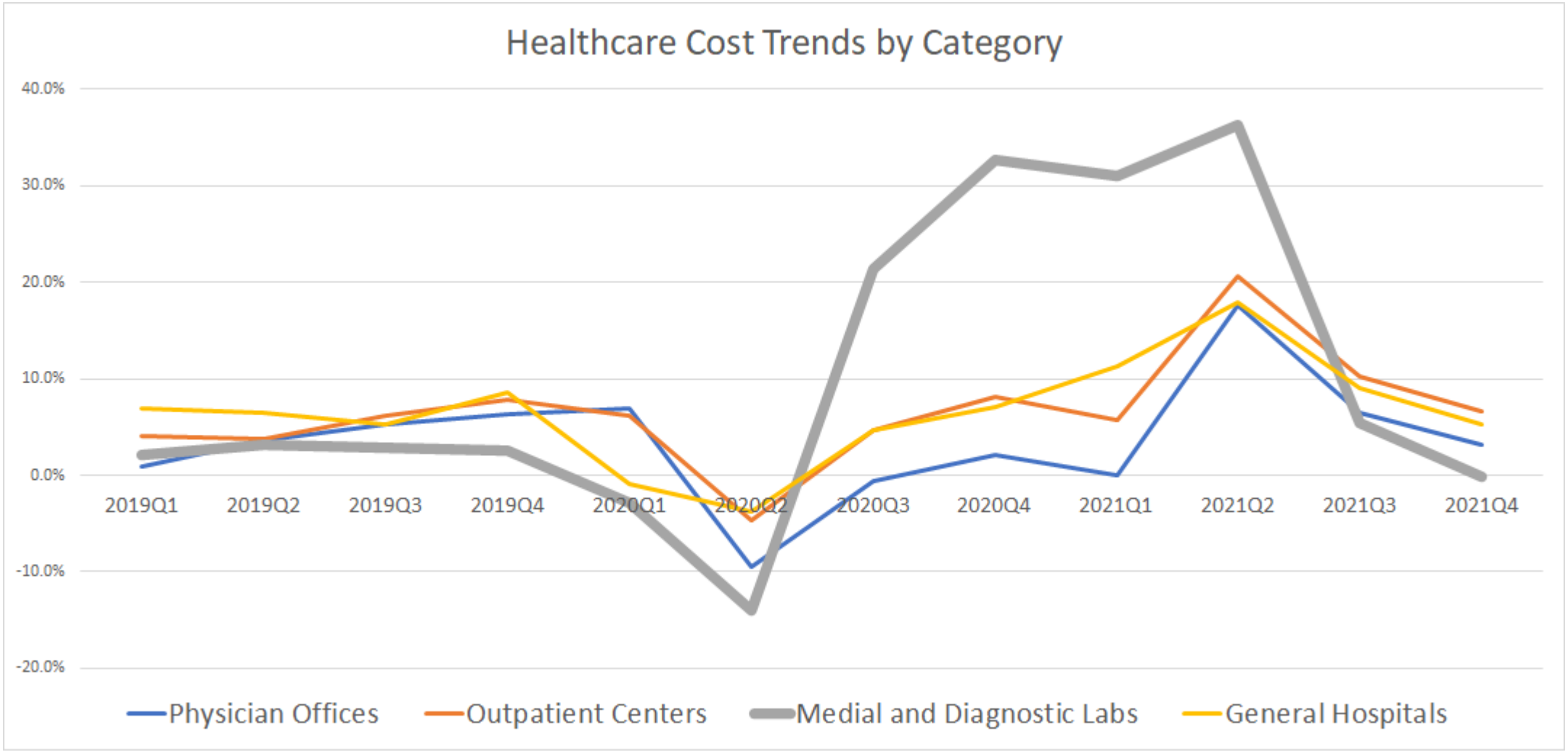
Declining Utilization and Return of Deferred Care



Source: Census Bureau Quarterly Services Survey, *https://www.census.gov/services/index.html*

COVID-19 Historical Trend

Declining Utilization and Return of Deferred Care



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COVID-19 Historical Trend

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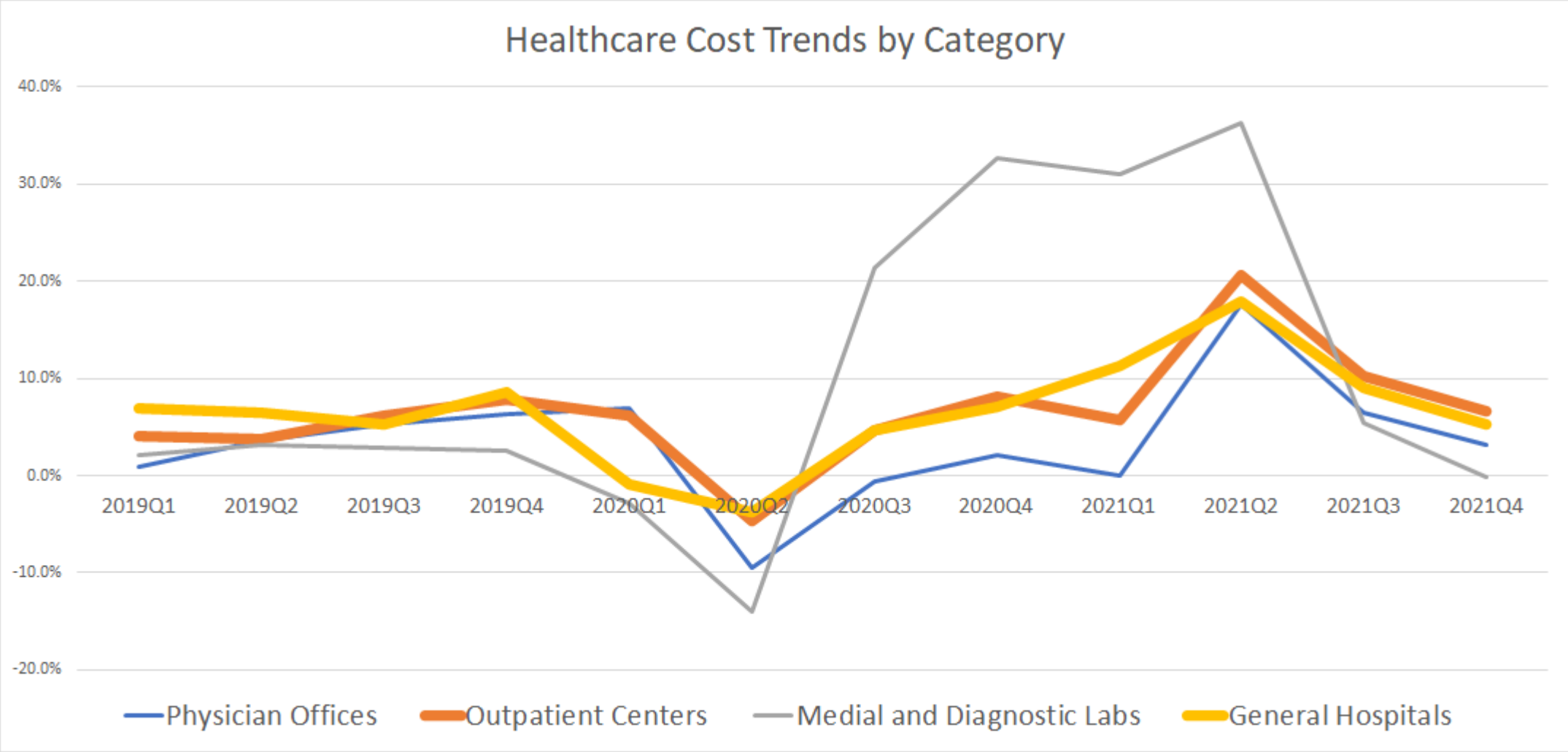

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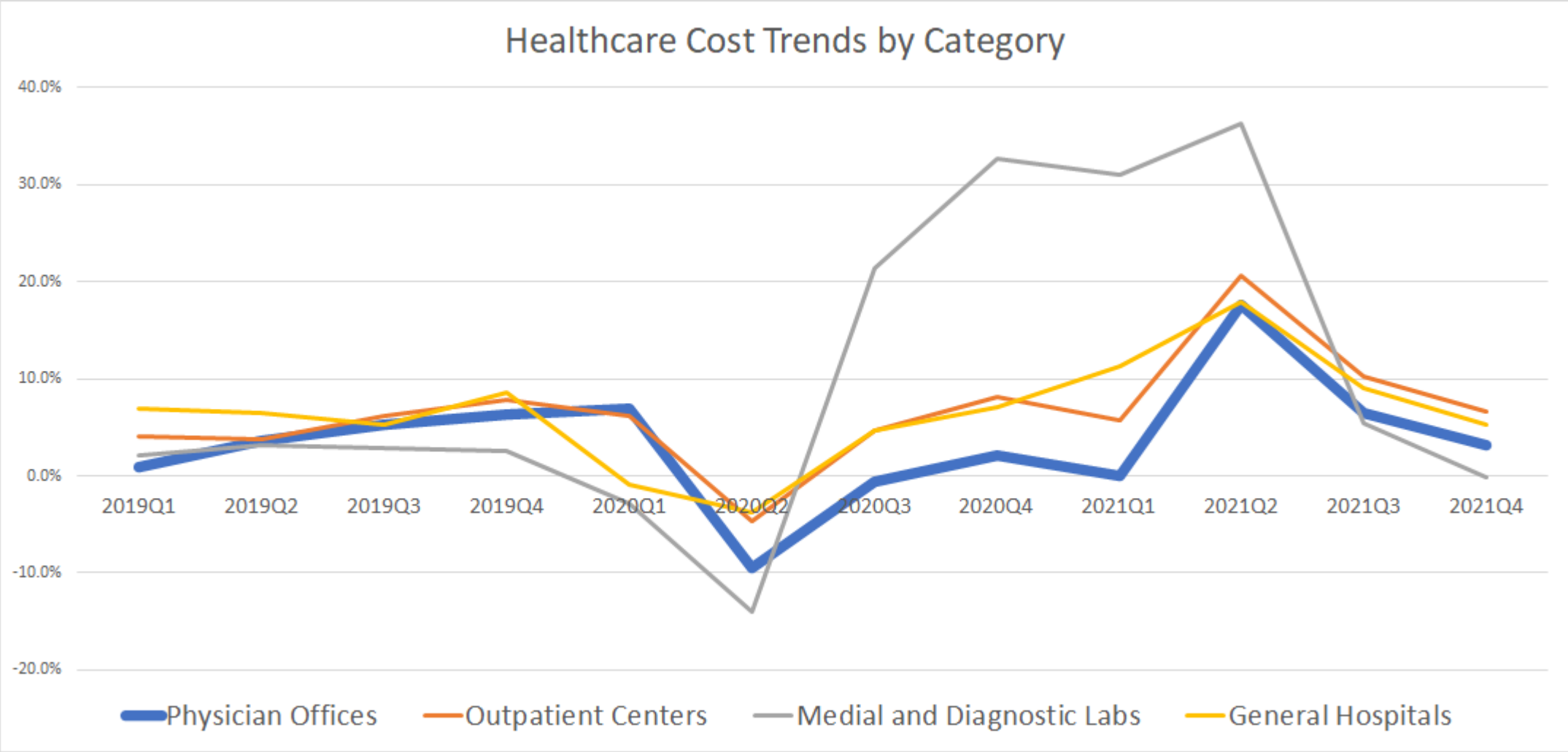
COVID-19 Historical Trend

Declining Utilization and Return of Deferred Care



Source: Census Bureau Quarterly Services Survey, *https://www.census.gov/services/index.html*

Part C reimbursement and contracting trends

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Part C FFS Unit Cost Trends

Medicare Advantage fee for service (FFS) contracts are typically set as a percentage of the Medicare FFS fee schedule.

This makes the CMS updates to the various FFS fee schedules the main driver of Part C unit cost increases.

Most Part C FFS unit cost increases are driven by three fee schedule updates

Inpatient Prospective Payment System (IPPS)

Outpatient Prospective Payment System (OPPS)

Physician Fee Schedule (PFS)

Inpatient Prospective Payment System (IPPS)

IPPS Overview

IPPS is the CMS fee schedule for short term acute care facilities

Accounts for 88% of total IP Medicare Allowed charges[1]

Pays discharges using a DRG weight multiplied by a conversion factor, with some additional adjustments

Payment is based on some nationwide amounts, adjusted for wage index and some facility specific adjustment

Some examples of facility specific adjustments:

Disproportionate Share Hospitals (DSH)

Uncompensated Care Payments (UCP)

Hospital Specific Payments (HSP)

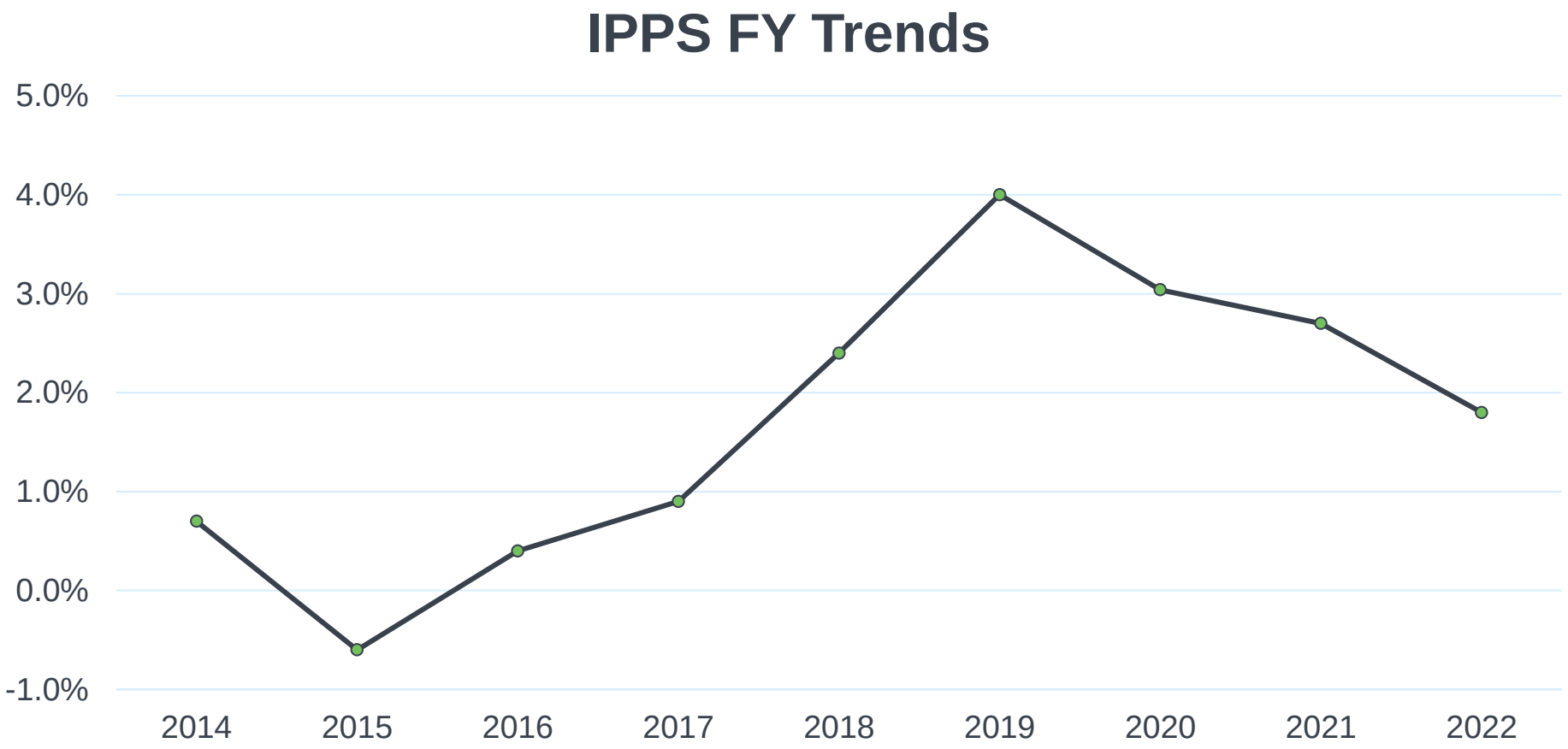
Hospital Acquired Condition (HAC)

Indirect Medical Education (IME) – not paid by Medicare Advantage plan

[1]Based on 2019 MedPAR data

Inpatient Prospective Payment System (IPPS)

Historical Fiscal Year IPPS Trend



Inpatient Prospective Payment System (IPPS)

National vs. Regional and Facility Specific Trends

Regional changes can vary significantly from nationwide changes

For example, from CY2020 to CY2021 the nationwide trend was 2.4%, however regional trends ranged from -9.8% to 10.3%.

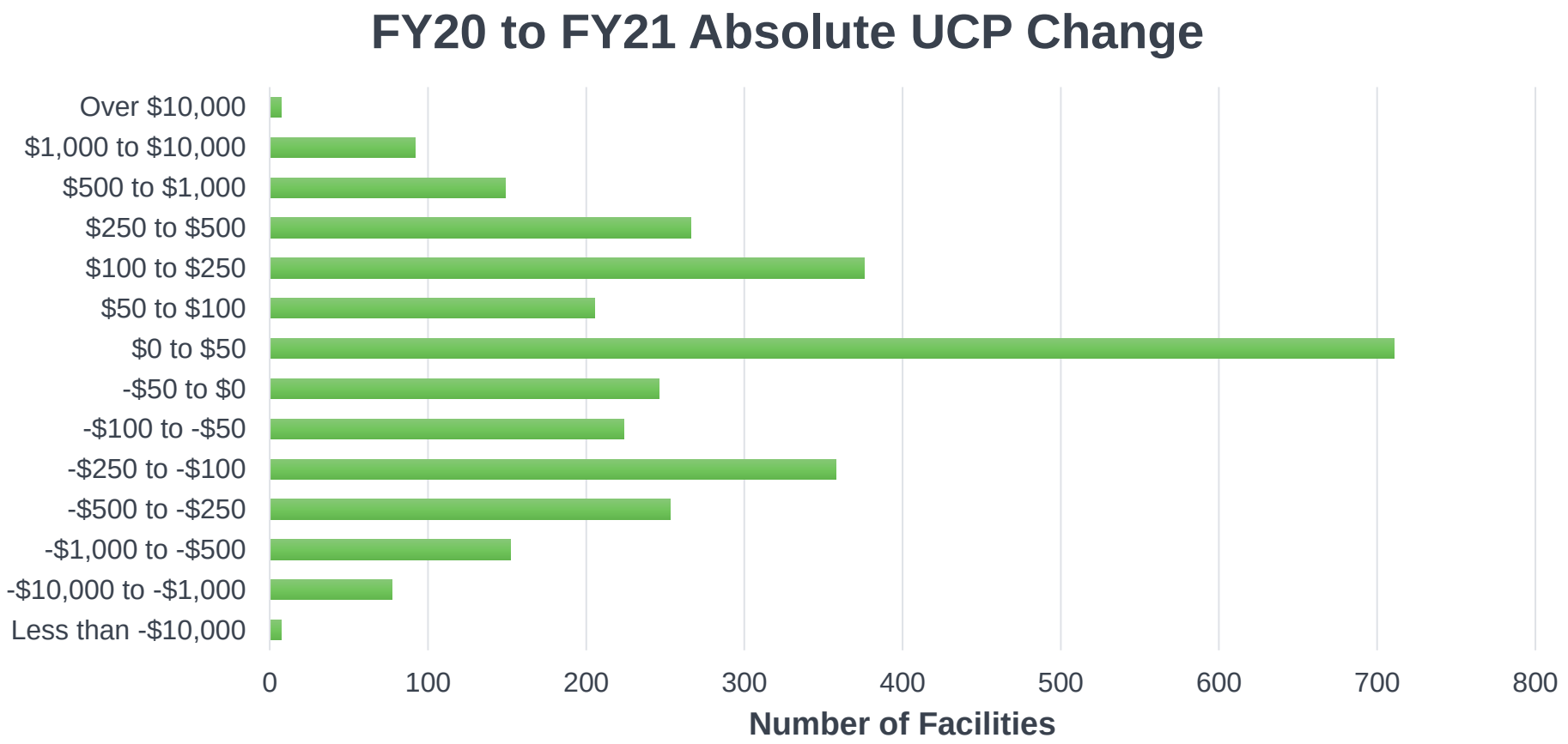
Regional trends are often driven by changes in facility specific adjustments

The 10.3% increase is driven by a change in the low volume adjustment for several facilities

The -9.8% trend is driven by a reduction in the uncompensated care payment for a specific facility.

Inpatient Prospective Payment System (IPPS)

Annual UCP changes can significantly impact facility level trends



Inpatient Prospective Payment System (IPPS)

Other Inpatient Pricing Fee Schedules

IPPS is not the fee schedule for all inpatient admissions

Other inpatient prospective payment systems (PPS)

- Inpatient Rehabilitation Facility PPS
- Inpatient Psychiatric Facility PPS
- Long Term Acute Care Hospitals (LTACH)

Many facilities do not use PPS

- Critical Access Hospitals
- Children’s and Cancer specialty hospitals
- Maryland waiver facilities

Outpatient Prospective Payment System (OPPS)

OPPS Overview

OPPS is the CMS fee schedule for short term acute care facilities

OPPS includes several payment methodologies

- Ambulatory Payment Category (APC)
- Clinical Lab fee Schedule (CLAB)
- Source Based Relative Values System (RBRVS)

APC reimbursement is impacted by the wage index, and changes in the wage index can cause divergence of the nationwide and regional unit cost trends

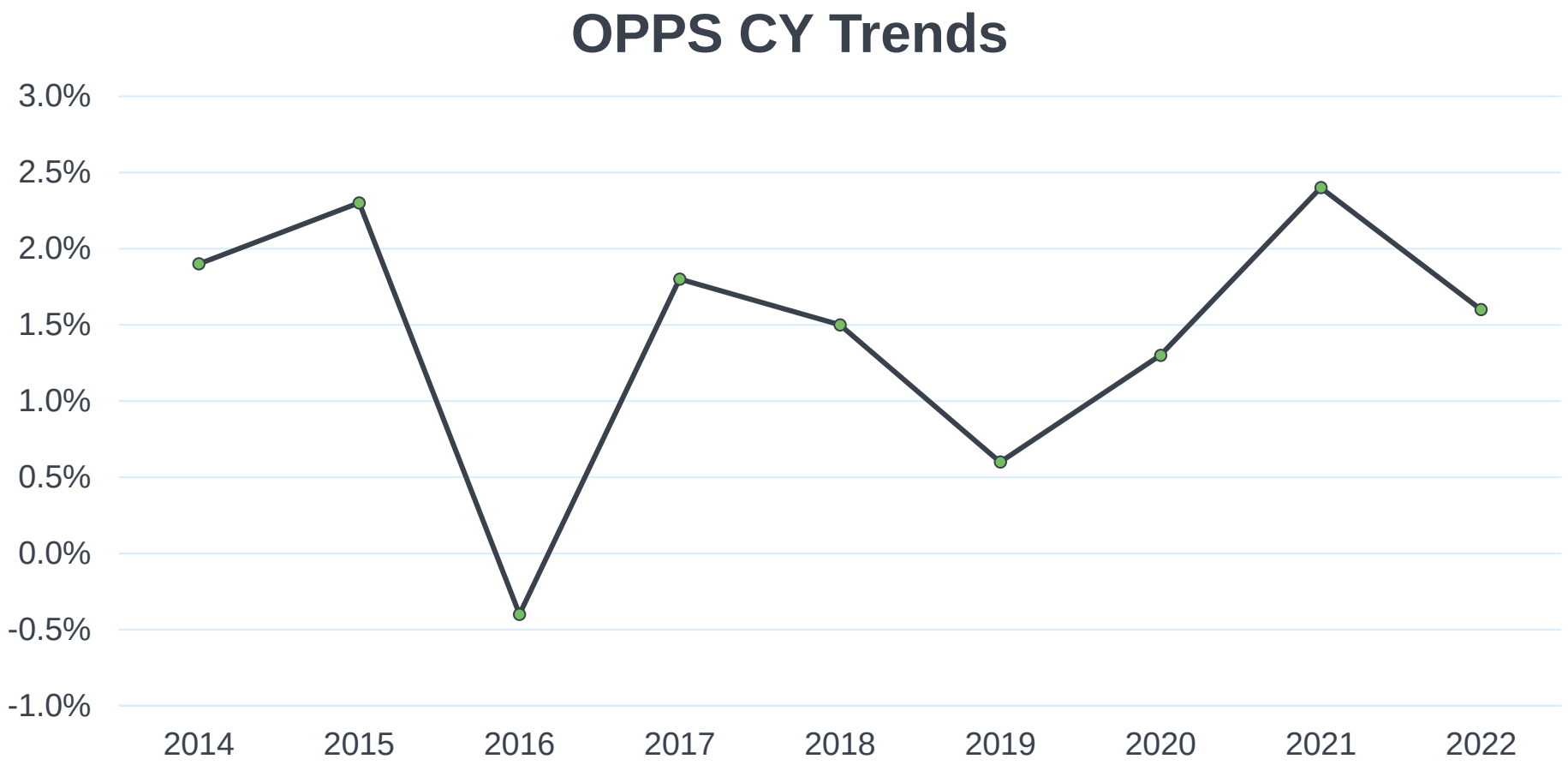
OPPS has fewer provider specific adjustments so regional trends tend to be driven by the national trends and wage index changes

Provider specific adjustments include

- Quality adjustments
- Sole Community Hospital and Essential Access Community Hospital adjustments

Outpatient Prospective Payment System (OPPS)

Historical Calendar Year OPPS Trend



Physician Fee Schedule (PFS)

PFS Overview

Based on the Resource Based Relative Value System (RBRVS)

Trend is based on updates to the conversion factor, and less often updates to the relative value units (RVUs)

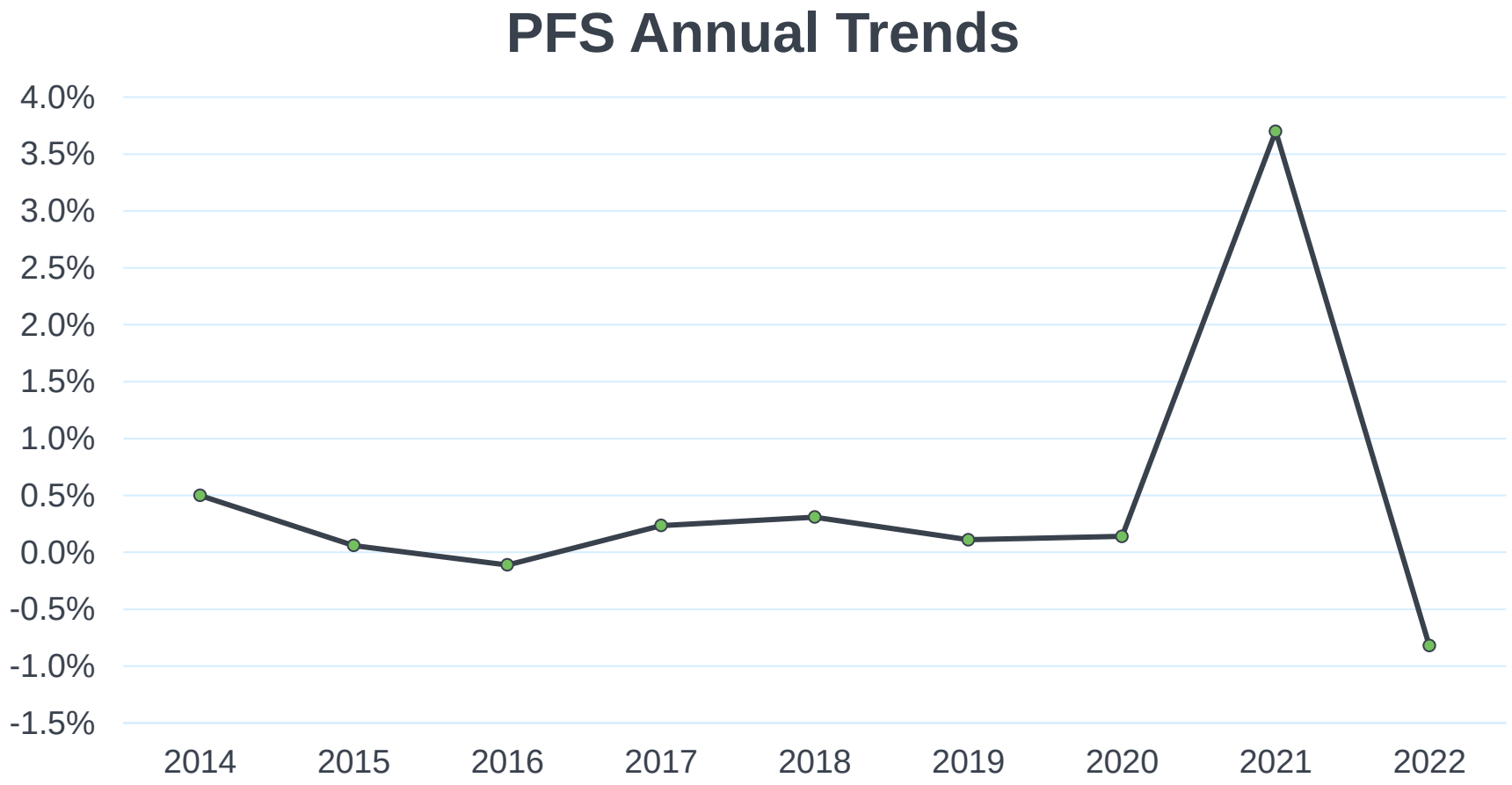
A significant update to the RVUs occurred in 2021

- This update shifted reimbursement towards evaluation and management service
- CMS included and additional 3.75% increase in the RBRVS conversion factor for 2021
- Regional differences driven by changes to GPCI, not wage index

GPCI changes are typically not significant, so the PFS has less regional variation than IPPS and OPPS reimbursement

Physician Fee Schedule (PFS)

Historical Calendar Year PFS Trend



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