Impact of Proposed Rule to Eliminate Prescription Drug Rebates on Medicare Advantage Beneficiaries

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Overview

On January 31, 2019 the Administration proposed a rule to amend the federal anti-kickback statute, which would transition toward a system of point-of-sale reductions in price on prescription pharmaceuticals, beginning in 2020. The proposed changes reflect the Administration's focus on reducing patient out-of-pocket (OOP) costs and addressing certain potentially anticompetitive aspects of the current manufacturer rebating system. Yet, these changes would likely have the consequence of increasing beneficiary premiums and reducing benefit offerings by Medicare Advantage-Prescription Drug (MA-PD) plans.

The shift from pharmaceutical rebates to point-of-sale reductions in price reduces the funding that Medicare Part D and MA-PD plans have available, which would impact beneficiaries. As a result:

- **Beneficiaries enrolled in plans with premiums would likely see an increase in their monthly premiums if they are to continue to have access to the same benefits; and**
- **Beneficiaries in plans with zero-dollar premiums would likely see a reduction in the supplemental services they have if the plan maintains a zero-dollar premium.**

The rule would go into effect on January 1, 2020.

Impact on Beneficiaries' Plan Premiums

Payments to Medicare Advantage plans are based on the plan's bid—the amount the plan projects it requires to provide Medicare Part A and B services to its enrollees in the service area. Plan payments are capped at the lesser of the fee-for-service (FFS) county spending or a rate calculated under pre-Affordable Care Act rules, the county benchmark. By law, if plans submit bids below the county benchmark, which is the "ceiling" for payment, they receive a percentage of the difference between their bid and the benchmark as funds to offer additional benefits such as lowered plan premium, reduced cost-sharing, or additional medically-related benefits.

While plans that bid below the benchmark do not charge beneficiaries a premium, plans that bid above the benchmark must charge a premium. MA-PDs also reduce beneficiary premiums using pharmaceutical rebates on brand name drugs that manufacturers contract to pay to gain access to Part D formularies.

These lower Part D premiums help integrated MA-PDs offer beneficiaries zero-premium or plans with low premiums. The shift of pharmaceutical rebates to the point of sale, as proposed by the Administration, will remove a tool that MA-PDs currently use to keep premiums low for beneficiaries. BMA commissioned Avalere to conduct an analysis of the potential impact to beneficiaries based on the Office of the Chief Actuary's (OACT) projections across all 50 states and DC.

If this proposed rule is finalized, Avalere estimates that pharmaceutical rebates passed to MA-PDs would **decrease by $5.6 billion**, proportionally to their enrollment. As a result, MA-PDs would either need to increase premiums or decrease supplemental benefits.

Assuming that MA-PDs that have premiums, in which **approximately 8.5 million beneficiaries** are currently enrolled, choose to offset the entire reduction in pharmaceutical rebates by increasing those premiums, Avalere's analysis finds that consolidated Part C and D monthly premiums would increase by $29 per beneficiary. In addition, the plans that continue to offer zero-dollar premium plans in 2020, in which **7.7 million beneficiaries** are currently enrolled, may need to reduce their supplemental benefit offerings as a result of the decrease in rebates.

Impact on Beneficiary Access to Supplemental Benefits

Based on existing Medicare Advantage plan bids and current market dynamics, zero-dollar premium plans will likely continue to offer zero-dollar premiums. However, as pharmaceutical rebates transition to point-of-sale discounts, plans will need to offset the loss by using funds received from bidding below the benchmark. Specifically, zero-dollar premium plans are likely to reduce supplemental benefits and, over time, these losses in bid-to-benchmark funds could lead to fewer zero-dollar premium plans.

For zero-dollar premium plans, reductions in supplemental benefits will be required as these plans cannot, by law, charge premiums for mandatory benefits. The **7.7 million beneficiaries** who are currently enrolled in MA-PD plans with **$0-premiums, or 48% of all MA-PD enrollees**, would be impacted by this reduction in benefits.

Funds received from bidding below the Medicare Advantage benchmark to provide supplemental benefits are plan-specific. Avalere analysis finds that, on average, plans with zero-dollar premiums would experience a **28% decrease ($19 PMPM) in the funds** available to provide supplemental benefits to beneficiaries.

Notably, the impact of the proposed rule would vary by state, ranging from **15% to as much as 78% reductions in funds** available for supplemental benefits. For example, Minnesota would see **a 68% decrease in the funds** available to provide supplemental benefits, while Texas would see a **23% decrease**.

The reduction in funds received from bidding below the Medicare Advantage benchmark could affect those with access to the most widely available supplemental benefits such as dental, vision, and hearing. For example, dental benefits typically cost **at least $15 PMPM**, depending on the benefit generosity and type of network (e.g., Health Maintenance Organization [HMO], Preferred Provider Organization [PPO]).

The reduction in rebate also puts at risk the Administration's policy goal of providing additional benefits to address social determinants of health for the chronically ill, foster more effective care by providing lower cost sharing for preventive services, and avoid expensive hospital care by providing better access to preventive services.

Impact on Beneficiary Access to New Supplemental Benefits for the Chronically Ill

Importantly, the proposed safe harbor rule could offset the benefit from other initiatives from the Administration granting additional flexibility to plans to offer important supplemental benefits the most high-need beneficiaries. Beneficiaries may not be able to fully realize these new benefits and flexibilities, potentially resulting in the burden of the reductions in pharmaceutical rebates inadvertently falling on beneficiaries.

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