Washington State Health Care Authority Public Employees Benefits Board Program

UMP Medicare Pharmacy Benefit Change Impact Analysis

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Prepared for:
Washington State Health Care Authority

Prepared by:
Milliman, Inc.

Ben Diederich, FSA, MAAA
Principal and Consulting Actuary

Mike Hamachek, FSA, MAAA
Actuary

Bill Miller
Actuarial Analyst

1301 Fifth Avenue
Suite 3800
Seattle, WA 98101-2605 USA

Tel +1 206 504-5561

milliman.com

BACKGROUND

At the request of Washington State Health Care Authority (HCA), we have estimated the cost impact of different potential pharmacy benefit changes for the Public Employee Benefits Board (PEBB) Uniform Medical Plans Classic Medicare (UMP Medicare) plan. These results are based on a seriatim pricing model, which takes historical UMP Medicare pharmacy claims and adjudicates the claims under different pharmacy benefit designs in order to calculate each plan's member cost-sharing and plan paid amounts. The model's final results are based on averaging the results of three calendar years of UMP Medicare pharmacy data (2019 through 2021) and reporting the percentage impact.

It is certain that the actual percentage impact that a pharmacy benefit change will differ from what we have modeled. Differences between the historical estimates and future actual amounts depend on a number of variables, including but not limited to the drug formulary, member behavior and health status, the cost of drugs, and the practice patterns of medical providers and drug suppliers. Our analysis has focused on modeling the historical pharmacy data under different cost-sharing assumptions while holding constant these other variables that can be challenging to model. These other variables should be kept in mind when making any decisions based on this report.

While we recognize that HCA will share this report with the Public Employees Benefits Board (PEBB), Milliman does not intend to benefit or create a legal duty and makes no representation or warranties regarding the contents of this information to third parties. Third parties must rely upon their own experts in drawing conclusions or making financial estimates from values in this report.

RESULTS

We have quantified the percent change in paid pharmacy claims on a per member per month (PMPM) basis relative to the modeled value of the current plan design for each of the pharmacy benefit scenarios that HCA provided.

Table 1 presents these results and the corresponding plan design features associated with each scenario. When a benefit description of a lettered iteration of a scenario is blank, the cost sharing provision for that tier matches the "a" version of the scenario. For example, scenarios 1a and 1b have the same Value Tier cost sharing of "Up to $5".

Table 1
Pricing Estimates Effective January 1, 2024
Average across 2019 to 2021

		Benefits					Paid PMPM Change
Scenario		Value Tier	Tier 1	Tier 2	Specialty	Max out of Pocket	Vs. Current
Current		5% up to $10	10% up to $25	30% up to $75	(3)	$2,000	
1	1a	Up to $5	Up to $10	Up to $75	(3)	$2,000	-3.3%
	1b					$3,000	-3.4%
	1c					$4,000	-3.4%
2	2a	No cost;(1)	Up to $5	Up to $75	(3)	$2,000	-0.9%
	2b					$3,000	-0.9%
	2c					$4,000	-0.9%
3	3a	Value tier to Tier 1	Up to $5	Up to $45 (2)	Up to $100	$2,000	-0.6%
	3b					$3,000	-0.6%
	3c					$4,000	-0.6%
4	4a	Value tier to Tier 1	10% up to $25	30% or $47 max (2)	50% or $100 max	$2,000	1.0%
	4b					$3,000	1.0%
	4c					$4,000	1.0%
5	5a	Value tier to Tier 1	10% up to $25	30% or $47 max (2)	50% up to $300 (4)	$2,000	0.7%
	5b			30% up to $75 max (2)	50% up to $100 (4)	$2,000	0.2%
	5c			30% up to $75 max (2)	50% up to $300 (4)	$2,000	-0.1%
6	6a	5% up to $10	10% up to $25	30% up to $75	30% up to $100 (4)	$2,000	-0.1%
	6b				30% up to $300 (4)	$2,000	-0.5%
7	7a	5% up to $10	10% up to $25	30% up to $75	30% up to $100 (4)	$3,000	-0.2%
	7b				30% up to $300 (4)	$3,000	-0.8%
8	8a	5% up to $10	10% up to $25	30% up to $75	30% up to $100 (4)	$4,000	-0.2%
	8b				30% up to $300 (4)	$4,000	-1.1%
9	9a	Up to $5	Up to $10	Up to $75	30% up to $100 (4)	$2,000	-3.4%
	9b				30% up to $300 (4)	$2,000	-3.7%
10	10a	Up to $5	Up to $10	Up to $75	30% up to $100 (4)	$3,000	-3.5%
	10b				30% up to $300 (4)	$3,000	-4.1%
11	11a	Up to $5	Up to $10	Up to $75	30% up to $100 (4)	$4,000	-3.5%
	11b				30% up to $300 (4)	$4,000	-4.4%

Footnotes:
(1) Move preferred insulin to tier 1
(2) Move preferred insulins to tier 2 and cover at $10
(3) Cost share according to tier
(4) Tier 1 Specialty Drugs modeled at Tier 1 Cost Sharing; Tier 2 Specialty Drugs modeled at cescribed Cost Sharing

The current pharmacy benefit structure has a three tier copay design (Value Tier, Tier 1, and Tier 2). Specialty drugs may fall under either Tier 1 or Tier 2, with a majority of these Specialty drugs falling under Tier 2. For the current plan design baseline, and scenarios 1 and 2, the Tier 1 Specialty Drug copays

were modeled under Tier 1 benefits, and the Tier 2 Specialty Drug copays were modeled under the Tier 2 benefits. For scenario 3 and 4 both the Tier 1 and Tier 2 Specialty Drugs follow the Specialty benefits. For scenarios 5 thru 11, the Tier 1 Specialty Drugs follow the Tier 1 benefits rather than the Tier 2 Specialty benefits. For this last set of scenarios, we reviewed the modeled cost sharing for Tier 1 Specialty drugs and found it to be negligible to the overall impact. In each scenario a member's annual copayments were also modeled against the pharmacy maximum out of pocket (MOOP) limit.

Replacing coinsurance with an "Up to a Copay Limit" has the biggest impact within these scenarios. The largest reduction in pharmacy spend occurs as a result of removing the coinsurance on Value Tier, Tier 1, and Tier 2 and replacing with "up to" copays.

To illustrate how this change in cost sharing impacts the plan paid amount, let's look at the Value Tier change in Scenario 1a. The average allowed per script for a Value Tier drug in 2021 is $19 per script. With the current "5% coinsurance up to $10 benefit design", the member paid amount is less than $1 and the plan paid amount is the remaining $18.61 per script. With an "up to $5" benefit design for value tier under Scenario 1a, the member paid amount increases to $1.81 and the plan paid amount drops to $17.24 per script. This benefit change reduces the plan paid on Value Tier by approximately 7%. Tier 1 experiences a drop of 21% due to similar mechanics as the cost sharing is changing from "10% up to $25" to "Up to $10". The Value and Tier 1 benefit changes in Scenario 1 are the biggest driver to the modeled savings of 3.3%.

Adjusting the MOOP has a less than 1% impact within these scenarios. Adjusting the pharmacy MOOP limit has limited impact on reducing the plan paid amount, especially when copays are capped. As seen in scenario 1a vs. 1c, changing from a $2,000 to a $4,000 MOOP lowers the pharmacy paid PMPM by about 0.1%. Before the MOOP is reached, the maximum copay for a specialty drug is $75. The average allowed cost for a Specialty Tier 2 drug is about $8,000 per script. With the relatively low copay, the plan is paying 99.1% of the Specialty Tier 2 cost before the MOOP is reached and 100% of the cost after the MOOP is reach. Adjusting the MOOP to a higher amount will effectively adjust how often the plan pays either 99.1% or 100% of the cost, and therefore has a relatively low impact. When the Specialty Tier 2 copay is increased to a maximum of $300, as seen in letter b of scenarios 6 through scenario 11, adjusting the MOOP has a relatively larger impact. But again the impact is not significant: going from a $2,000 MOOP in scenario 9b to a $4,000 MOOP in Scenario 11b reduces spend by about 0.7%.

Scenarios 4a through 5b result in a benefit increase. The average member cost sharing for a Tier 2 non-Specialty drug is $31 per script under the current benefit design with a $75 max. If the member pay is lowered to $47 under scenario 4a, then the average member cost sharing per script for Tier 2 non-Specialty drops to $18 and the plan paid increases accordingly. This increase in plan paid for Tier 2 non-Specialty outweighs the benefit reductions for the other tiers within scenario 4a. Increasing the Tier 2 and Specialty max copays as modeled in scenarios 5a and 5b reduces the benefit increase that is modeled in scenario 4a. The MOOP increase in scenarios 4b and 4c has no significant impact on the paid PMPM.

CONSIDERATIONS

The seriatim model used in modeling these pharmacy benefit changes involves adjudicating the claims as presented in the original data under either the current or alternative cost sharing scenarios. The individual member by member utilization patterns are evaluated for the benefit design and summarized to an overall average per member per month impact. While there is variation in the member's drug utilization from year to year, the average across the population and across the years should be sufficient data to set reasonable expectations of future results, should these average cost levels per prescription and the utilization remain consistent with the historical data being modeled.

When modeling pharmacy benefit changes on a seriatim basis it is important to keep in mind the following uncertainties:

1. Some members may be disproportionately impacted more so than others. For example, if a member is a heavy utilizer of a particular pharmacy tier, such as Tier 2 Specialty, and that tier has a large cost sharing change, then the member's modeling result will be a significant increase in out-of-pocket expense after the benefit change. These results are then averaged across all members and three years of data to represent the average impact as a percentage change.
2. The pharmacy market can have significant changes over time. The historical data may not represent the market at the time the benefit changes are implemented. Brand new drugs are introduced, which can have a high cost. Generic drugs can be introduced to lower the cost of brand name drug spend. Drugs can have unpredictable price changes over time for various reasons, including due to drug ingredient cost, drug ingredient supply, and consumer demand. The drug formulary could move drugs within Tiers. All of these changes would have impacts to the actual percent impact of the benefit change. Since almost all of the scenarios involve a fixed dollar limit on the copay, as these prices change a greater proportion of the utilization could reach the copay limit and change the overall impact.
3. Pharmacy rebates may also impact both the drug price and consumer behavior. We have not modeled any potential impact of changes in pharmacy rebates.
4. Pharmacy utilization is based on the morbidity or health of the plan population. If the UMP Medicare population changes materially over time, then the utilization across tiers may change and the benefit relativities will also be different.

LIMITATIONS AND CAVEATS

This report has been prepared for the Washington State Health Care Authority and its consultants and advisors. It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this report is provided to third parties, it should be distributed in its entirety. Any user of this information should possess a certain level of expertise in health care modeling so as not to misinterpret the data presented. This analysis is subject to the terms and conditions of the Contract between Milliman and Washington State Health Care Authority.

In performing our analysis, we relied on data and other information provided to us by the HCA and its contracted MCOs and vendors. While we reviewed the data for accuracy and reasonableness, we did not audit the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment. To the extent that there are errors contained within this data, the results of our analysis could produce erroneous results.

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the impacts of potential pharmacy benefit changes. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with ASOP No. 56 relating to modeling.

We are members of the American Academy of Actuaries and meet its qualification standards to perform this analysis.