

# **Cost Estimate of S. 2563**

## **Pharmacist Access and Recognition in Medicare (PhARM) Act of 2006**

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# **Cost Estimate of S. 2563:** **Pharmacist Access and Recognition in** **Medicare (PhARM) Act of 2006**

## **Summary**

The Moran Company (TMC) was engaged by the Pharmaceutical Care Management Associations (PCMA) to estimate the budgetary effects of S. 2563, the “Pharmacist Access and Recognition in Medicare (PhARM) Act of 2006,” a bill that would:

- establish “prompt pay” standards governing the treatment and payment of pharmacy claims by prescription drug plans (PDPs) and Medicare Advantage-Prescription Drug (MA-PD) plans under Part D, the new Medicare prescription drug benefit;
- restrict pharmacy co-branding arrangements;
- establish new Federal requirements on PDPs and MA-PDs regarding Medication Therapy Management (MTM) services and payment; and,
- create a MTM “best practices” commission and a two-year MTM demonstration project.

Assuming enactment of S.2563 in this session of Congress, we estimate that Federal Part D spending will increase by:

- \$0.5 billion in FY 2008 (the first year affected by the legislation),
- \$2.9 billion over the five year budget window between FY 2007—2011, and
- \$7.7 billion over the ten-year budget window between 2007—2016.

The increases in Part D Federal spending plan spending result from higher PDP and MA-PD plan spending of \$0.6 billion in FY 2008, \$3.4 billion in FY 2007—2011, and \$9.4 billion in FY 2007—2016. Higher premiums paid by beneficiaries would total \$0.1 billion in FY 2008, \$0.6 billion in FY 2007—2011, and \$1.7 billion in FY 2007—2016. On average, monthly premiums would increase by \$7.20 in calendar year 2008. Higher premiums also increase Low Income Subsidy (LIS) costs.

This estimate concentrates on the financial implications of the provisions imposing Federal “prompt payment” and MTM requirements. These requirements would significantly change contractual provisions under which Part D plans are currently operating. Because the most recent Centers for Medicare and Medicaid Services (CMS) guidance for 2007 on co-branding effectively imposes similar limitations, the S. 2563 provisions regarding co-branding are unlikely to change costs. We note that the budgetary costs associated with the provisions regarding the MTM “best practices” demonstration are difficult to estimate due to lack of clarity and internal inconsistencies.

# S. 2563: Pharmacist Access and Recognition in Medicare (PhARM) Act of 2006

## Introduction

The Moran Company (TMC) was engaged by the Pharmaceutical Care Management Associations (PCMA) to estimate the budgetary effects of S. 2563, the “Pharmacist Access and Recognition in Medicare (PhARM) Act of 2006.”<sup>1</sup> Our assignment was to analyze the provisions of S. 2563 and present estimates of how the Congressional Budget Office (CBO) might “score” such a proposal if enacted in 2006, with the key provisions first affecting contracts governing plan operations in 2008.

In this report, we present the findings of our analysis and describe the methodology we used to arrive at our conclusions about the fiscal impact of the proposed policy in four sections:

- Scoring Against the CBO Baseline
- Summary of the Policy Being Scored – S. 2563
- Basis for the Estimate
- Results

## **Scoring Against the CBO Baseline**

Each year, CBO projects the revenues and spending of the Federal budget, under the assumption that current Congressional policy regarding taxes and spending programs will be maintained throughout the budget period.<sup>2</sup> In addition to informing Congressional policymakers and the public about the future fiscal outlook, these projections, and the detailed economic and technical assumptions that underlie them, serve as the “baseline” against which the fiscal impact of specific changes to current law are measured.<sup>3</sup> Scoring the estimated impact of policy options being considered by the Congress in a single year against a prospectively established common baseline gives CBO the capacity to assist

<sup>1</sup> [http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109\\_cong\\_bills&docid=f:s2563is.txt.pdf](http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:s2563is.txt.pdf)

<sup>2</sup> *The Budget and Economic Outlook: Fiscal Years 2007 to 2016* (January 2006) is available at <http://www.cbo.gov/ftpdocs/70xx/doc7027/01-26-BudgetOutlook.pdf> Typically, the Medicare and Medicaid estimates used for budget scoring reflect the baseline presented in conjunction with the President’s budget (*An Analysis of the President’s Budgetary Proposals for Fiscal Year 2007* (March 2006)). <http://www.cbo.gov/ftpdocs/70xx/doc7069/03-14-PresidentsBudget.pdf>

<sup>3</sup> As part of the Congressional Budget process first established by *The Congressional Budget and Impoundment Control Act of 1974*, CBO estimates the effects on spending and revenues of any bill reported by a Congressional Committee. Through 1995, CBO projections and cost estimates covered a 5 year budgetary period – the forthcoming budget year plus 4 “out years”. Starting in 1996, CBO began providing 10 year projections and cost estimates (e.g., for fiscal year (FY) 1997—2006) to support revised budgetary requirements adopted by Congress. As a matter of convention, CBO publishes 10 year estimates.

policymakers in evaluating policy alternatives on an “apples to apples basis,” permitting meaningful comparison of the cost of alternative approaches to specific issues.<sup>4</sup>

In preparing its annual baseline projections, CBO forecasts costs of different Federal health care programs using a variety of techniques and data sources. These forecasts have varying levels of detail about individual programs.

CBO separately estimates several key elements of Part D spending, including overall and Low Income Subsidy (LIS) enrollment in Part D, payments to PDPs and MA-PDs, and premiums.<sup>5</sup> CBO does not publish detail on the share of Part D participants enrolled in PDPs and MA-PDs, versus those participating in employer- or union-sponsored retiree drug plans. Similarly, CBO does not make available assumptions regarding prompt pay or the cost of MTM.

Developing estimates of how CBO might score S. 2563 first requires establishing a baseline of current (contractual) arrangements between pharmacies and PDPs, MA-PDs or plan administrative agents, such as pharmacy benefits managers (PBMs). These arrangements determine the terms and conditions governing (i) the adjudication and payment of Part D claims and (ii) the eligibility, scope and payment for MTM services. The second step requires estimating the costs associated with the changes proposed in S. 2563.

Both to establish the baseline of current practices and to estimate the changes arising from S. 2563, we surveyed large insurers and PBMs running Part D plans, systematically asking detailed questions regarding current business practices and anticipated modifications in response to the provisions of S. 2563. Wherever possible, we have attempted to “line up” our projection model to each relevant piece of information regarding baseline data and assumptions disclosed by CBO about its baseline forecast to date, and we have employed analytic approaches we believe to be consistent with the way in which CBO has approached comparable questions in the past. We cannot warrant, however, that CBO analysts evaluating this policy in the future will adopt a comparable methodology or rely on the information upon which we have relied in preparing our estimates. To assist CBO analysts and others in evaluating our estimate, this report presents the data, key assumptions, and methodologies used in this analysis.

### **Summary of the Policy Being Scored—S. 2563**

S. 2563 amends Title XVIII of the Social Security Act. The legislation would:

- establish “prompt pay” standards governing the treatment and payment of pharmacy claims by prescription drug plans (PDPs) and Medicare Advantage-

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<sup>4</sup> For scoring purposes, CBO may revise aspects of the baseline to reflect known departures from the assumptions underlying its annual baseline forecast, such as the issuance of final regulations or more recent data on inflation update factors.

<sup>5</sup> CBO made available additional details on Part D enrollment, premiums and spending in its “Fact Sheet for CBO’s March 2006 Baseline: Medicare” (corrected 3/15/2006).

Prescription Drug (MA-PD) plans under Part D, the new Medicare prescription drug benefit;

- restrict pharmacy co-branding arrangements;
- establish new Federal requirements on PDPs and MA-PDs regarding Medication Therapy Management (MTM) services and payment; and,
- create a MTM “best practices” commission and a two-year MTM demonstration project.

We summarize the key elements of these provisions below.

### Prompt Pay

The “prompt pay” section of S. 2563 creates new standards in 7 distinct areas. The new requirements apply to all Medicare Part D prescription drug plans (PDPs) and Medicare Advantage Prescription drug plans (MA-PDs). The requirements apply to all contracts entered into or renewed 90 days after date of enactment. Assuming enactment later in 2006, contracts for plan operations in 2007 will have, for the most part, already been negotiated. As a result, these requirements will generally become effective for operations in 2008.

The prompt pay provisions:

- define what constitutes a “clean claim”;
- define the timeliness standards for clean claims submitted electronically and by other means (e.g., paper) – 14 and 30 days, respectively;
- establish both a penalty for any clean claim not paid within the 14 and 30 day timeliness standards and a method for computing the amount of the penalty;
- require that a plan notify a pharmacy within 10 days of receipt of a clean claim;
- impose multiple requirements regarding the determination of whether a claim is clean, including establishing the presumption that any claim not explicitly identified as defective within the 10 day standard will be treated, by default, as clean and requiring that the specific reason for a claim not being clean be cited in writing;
- provide that a claim is paid only when full payment is received by the pharmacy; and
- mandate that all clean claims submitted electronically must be paid by electronic funds transfer (EFT).

These provisions constitute a detailed and prescriptive set of Federal requirements that vary significantly from current practice.

### Pharmacy Co-Branding

Section 3 of S. 2563 restricts pharmacy “co-branding” on Medicare prescription drug cards. This requirement appears quite similar to the guidance issued by Centers for Medicare and Medicaid Services (CMS) in its 2007 PDP call letter, which states that:

“Effective with the beginning of CY 2007 marketing (October 1, 2006), PDP Sponsors that contract with a provider or providers as co-branding partners will not be permitted to place co-branding names and/or logos on the member identification card. In addition, organizations will be required to include the following language located below all cobranding names and/or logos on applicable marketing materials:

*Other <Pharmacies/Physicians/Providers> are available in Our Network.”<sup>6</sup>*

As a result, this provision to restrict co-branding is unlikely to add costs to the baseline, because it essentially duplicates the requirements under which plans will operate.

### Medication Therapy Management (MTM)

Subsection (a) of section 4 of S. 2563 specifies MTM requirements in 7 areas, all of which would be effective starting January 1, 2008. That subsection:

- adds “other health care provider with advanced training in medication management” as individuals, in addition to pharmacists, permitted to furnish MTM services;
- stipulates new criteria for the Secretary in specifying Part D beneficiaries eligible for MTM, thereby expanding the target population;
- mandates nine elements (replacing the 3 currently specified in statute) in a new “minimum defined package” of MTM services, converting them from discretionary considerations (“may”) to mandatory requirements (by substituting “shall”);
- directs that MTM services be delivered face-to-face, in a manner individualized, and distinct from other activities;
- permits pharmacists and other health care providers to identify Part D enrollees who should receive MTM services;
- adds new requirements regarding fees paid to pharmacists; and,
- adds a new network adequacy requirement to assure that MTM services are accessible directly from community-based retail pharmacies.

### MTM Demonstration and Commission

Subsection (b) of section 4 establishes both an MTM demonstration program and a “Best Practices Commission”. The provisions direct the Secretary to select “not less than 10” plans, with the demonstration to start on January 1, 2008. The Secretary is charged with ensuring that the designated participants are consistent with recommendations of the Commission. The statutory language of S. 2563 addresses neither the issue of paying for the costs of the Commission (which would appear to involve spending subject to appropriations rather than direct spending) nor financing the costs of the demonstration.

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<sup>6</sup> CMS 2007 PDP Call Letter, pp. 25-26.

To the extent that the Secretary would mandate both participation in the demonstration project and implementation of all aspects of the recommended best practices, the provisions regarding the demonstration would raise plan bids for designated PDPs and MA-PDs by imposing higher costs. Without any alternative financing provision, any increased costs associated with the “best practices” MTM requirements would raise plan costs. Higher plan costs, in turn, would be reflected in higher bids. Higher bids would raise both the national and regional benchmarks (and Federal costs), as well as beneficiary premiums. In the absence of a financing provision (such as one which might “socialize” the costs among all plans and not just plans participating in the demonstration), the higher costs associated with the demonstration would increase, dollar-for-dollar, premiums charged to beneficiaries enrolled in those plans designated to participate in the demonstration. Depending on the extent of the higher premiums, this could both lower enrollment and engender adverse selection among plans designated to participate. At a minimum, requiring selected plans to participate in the demonstration would change bids, the national benchmark, regional benchmarks (affecting LIS participation), and beneficiary premiums. This would complicate the competitive processes envisioned as a key feature of Part D and adversely affect selected plans.

The timing implied by the requirements of this section is also problematic. Because the demonstration is to begin on January 1, 2008, the costs of the required MTM “best practices” demonstration would need to be reflected in the bids of designated plans, which are due to CMS on June 4, 2007. CMS would need to issue guidance substantially in advance of when bids are due to permit designated plans to incorporate the MTM best practices requirements into their bids. Assuming enactment of S. 2563 in the second half of 2006, it is unclear whether the Secretary would be able to appoint members to the Commission and that the Commission would have time to meet, consider, and agree upon recommendations in time for CMS to issue guidance to plans as they prepare their bids in the winter and spring of 2007.

As a result of these complications, we have not estimated the costs associated with the demonstration.

### **Basis for the Estimate**

This estimate is based on CBO data regarding its Part D baseline, the most recent Medicare Trustees Report, and a survey of insurance companies and PBMs participating in Part D. We have used annual CBO estimates of total Part D enrollment, total and monthly Part D premiums, total Part D plan spending, payments to Part D plans, and the Consumer Price Index (CPI-U). To allocate Part D enrollment between employer and union sponsored retiree drug plans and PDPs/MA-PDs, we calculated the ratio of PDP and MA-PD enrollment to total Part D enrollment based on projections by the Office of the Chief Actuary of CMS published in the May 2006 Medicare Trustees Report.<sup>7</sup>

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<sup>7</sup> “Fact Sheet for CBO’s March 2006 Baseline: Medicare” (corrected 3/15/2006), *op cit* and

On a confidential basis, The Moran Company surveyed PCMA members to establish their current (2006) business practices and costs regarding prompt pay and MTM, any modifications planned in their 2007 bids, and the costs of implementing the changes associated with the provisions of S. 2563. Our estimates reflect responses from 5 large companies that collectively account for over 20 percent of enrollees in Part D plans. We posed detailed questions regarding:

- the number of covered Part D enrollees;
- the number of PDPs and MA-PDs that the entity served;
- the number of Part D regions in which the entity operated;
- the dollar-weighted breakdown of claims and payment cycle in 2006, along with any significant changes expected for 2007, by retail (community), long-term care, specialty and mail-order pharmacy for electronic claims under current law;
- the dollar-weighted breakdown of claims and payment cycle in 2006, along with any significant changes expected for 2007, by retail (community), long-term care, specialty and mail-order pharmacy for non-electronic (paper) claims under current law;
- similar dollar-weighted information by type of claim and type of pharmacy, assuming enactment of S. 2563, along with information on the estimated amount of payments that would exceed the timeliness standards (and the average duration beyond the 14 or 30 day standard);
- information on the average daily interest rate projected for 2007, along with what index best predicts the entity's short-range interest rate on these balances;
- one-time systems costs associated with implementing the prompt pay requirements of S. 2563, along with an explanation of key factors driving the higher costs;
- the initial year and ongoing administrative costs associated with implementing the prompt pay requirements of S. 2563, along with an explanation of the key factors driving the higher costs;
- the extent to which plans currently pay pharmacies by electronic funds transfer for pharmacies that submit claims electronically;
- the initial year and ongoing costs associated with the requirement that pharmacies that submit claims electronically must be paid by electronic funds transfer, along with an explanation of the key factors driving the higher costs;
- information related to current MTM services, including cost and the number of members served; and,
- the planned changes to MTM services to comply with the requirements of S. 2563, the cost of the new MTM services, and details on the key factors driving the higher costs.

After analyzing the data submitted by the insurance companies and PBMs, we developed our assumptions regarding the changes that plans would have to implement in response to the various prompt payment and MTM requirements discussed previously that would be imposed under S. 2563. We modeled the change in plan costs for prompt payment and MTM, deriving per member per year (PMPY) costs for each component. In deriving our assumptions, we attempted to incorporate adjustments for scale economies, as appropriate. For example, the costs of implementing new automated systems to handle prompt pay requirements are unlikely to scale directly to enrollment. Given the somewhat fixed nature of systems costs, plans with limited enrollment are likely to have higher PMPY costs than plans with extremely large enrollment. For example, we discounted the high systems cost reported by some survey respondents as excessive on a per member basis. However, other costs (such as average daily balances used in calculating “float”) are likely to scale with the number of members.

We applied the PMPY cost increase to the number of beneficiaries enrolled in PDPs or MA-PDs for each year. As described earlier, using projections from the Medicare Trustees Report, we derived the number of PDP and MA-PD enrollees by calculating the proportion of total Part D enrollment associated with plans (as opposed to retirees receiving drug benefits through employer or union sponsored plans). We applied this proportion to CBO baseline enrollment in Part D for each year. We also inflated the annual PMPY cost by the annual increase in the CPI-U projected by CBO.<sup>8</sup>

We interpret costs associated with both the prompt pay and MTM provisions as affecting plan administrative costs. Because they are administrative in character and don’t affect benefit costs, they are neither subject to reinsurance nor affected by beneficiary cost-sharing requirements.

Higher administrative costs, however, are included in plan bids. As such, these costs required to comply with the prompt pay and MTM provisions would raise the benchmark and average premiums. As a result, the Federal government would subsidize 74.5 percent of the higher PMPY costs. On average, beneficiary premiums would be increased by 25.5 percent of the higher cost.

On a monthly basis, one-twelfth of 25.5 percent of the PMPY cost of Part D drug coverage (or 25.5 percent of the per member per month cost) is paid by beneficiaries. However, premiums for PDP and MA-PD enrollees who receive the LIS are generally paid by the Federal government. As a result, we adjusted the premium collections to reflect the LIS payment of premiums.<sup>9</sup> Finally, calendar year costs were converted to

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<sup>8</sup> The CPI-U is forecast to increase modestly. To the extent that pharmacist wages are a key driver of MTM costs, the CPI-U probably understates the rate of increase. To be conservative, we have avoided selecting indices (such as the Employment Cost Index or other Bureau of Labor Statistics measures) which would increase faster.

<sup>9</sup> Most LIS recipients have their full premiums paid by Medicare, although a small share of eligibles (e.g., those with incomes between 135—150 of the Federal poverty level) have a sliding scale portion of their monthly premiums financed by the LIS. See Table 4, <http://www.cbo.gov/ftpdocs/48xx/doc4814/11-20-MedicareLetter2.pdf>. Anecdotal reports suggest that relatively few of the higher income LIS recipients who qualify for the partial premium subsidy have actually enrolled in PDPs and MA-PDs.

fiscal year estimates to reflect the one-quarter difference between the Federal fiscal year (October—September) and the calendar year.

## Results

Assuming enactment of S. 2563 during this 2006 session of Congress, its provisions mainly affect plan operations beginning January 1, 2008, Table 1 presents the annual increase in Federal direct spending associated with S. 2563, which results from the increase in plan spending offset by the increase in beneficiary premiums.

**Table 1: Increase in Federal Spending**  
(\$ in Millions)

<b>Fiscal Years</b>	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2007-2011</u>	<u>2007—2016</u>
Increased Plan Spending		620	880	950	1,000	1,070	1,120	1,180	1,250	1,300	3,450	9,370
Increased Premiums		(100)	(150)	(180)	(180)	(200)	(200)	(210)	(225)	(225)	(610)	(1,670)
<b>Change in Federal Spending</b>		<b>520</b>	<b>730</b>	<b>770</b>	<b>820</b>	<b>870</b>	<b>920</b>	<b>970</b>	<b>1,025</b>	<b>1,075</b>	<b>2,840</b>	<b>7,700</b>

Table 2 presents the monthly premiums assumed in the CBO baseline and the increase in premiums associated with enactment of S. 2563.

**Table 2: Increase in Average Annual Premiums**  
(Calendar Year)

	<u>2007</u>	<u>2008</u>	<u>2009</u>	<u>2010</u>	<u>2011</u>	<u>2012</u>	<u>2013</u>	<u>2014</u>	<u>2015</u>	<u>2016</u>
<b>S. 2563 Premium Increase</b>		\$7.20	\$6.90	\$7.00	\$7.20	\$7.35	\$7.50	\$7.70	\$7.85	\$8.00