# Part D Assumption Update

**Prior Papers**

Part D Short-Range Projections, OAct, PowerPoint, September 2016 meeting
Drug Forecasts, Yamamoto, PowerPoint, October 2016 meeting
Part D Program Assumptions, Yamamoto, Word, December 2016 meeting
Perspective on Prescription Drug Costs, Aitken, PowerPoint PDF, December 2016 meeting

**Prior Panel Findings and Recommendations**

***2004 Technical Panel***

This panel's report included the first review of OAct assumptions for Part D since the program was created by the 2003 law and with 2006 implementation. Therefore, no experience of the program was available.

The panel concluded that OAct/Trustee assumptions used in most recent projections were generally reasonable. They recommended three changes. One, that the expected number of beneficiaries participating in program be reduced and to incorporate explicit model of beneficiary selection. Two, the panel recommended monitoring employer program availability and, three, to assume that employer-provided prescription drug coverage will decline over time.

The panel also recommended using additional data sources to inform their utilization and cost projection assumptions. The panel recommended using actual Part D data as soon as they become available.

The panel recommended that OAct maintain its assumption that the Part D program will not affect utilization or costs for Part A or Part B. They also recommended that further research be done on the effect of changes in prescription drug utilization on Part A and Part B utilization and costs.

The panel supported OAct's continued development of stochastic methods for Part D.

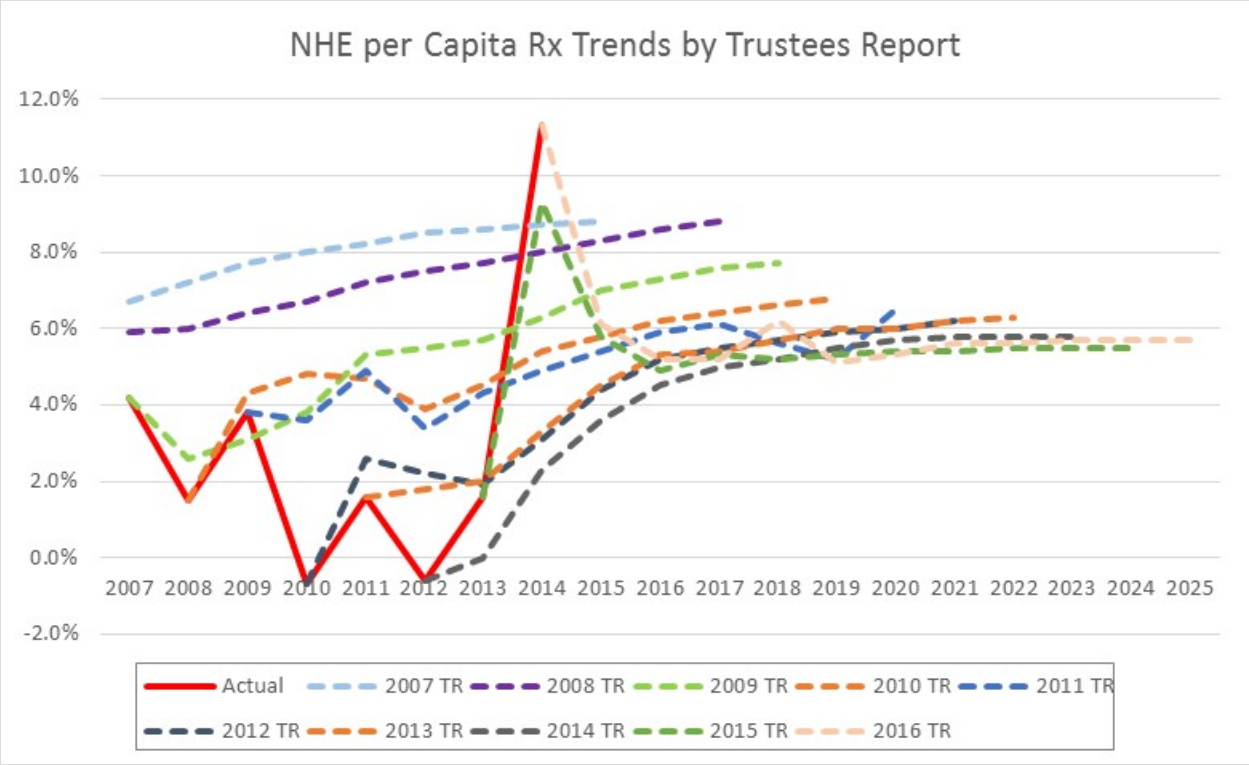
Note that this panel reviewed many assumptions that were deriving expected Part D experience from a variety of sources such as the Medicare Current Beneficiary Survey and making assumptions of induction for different levels of coverage under Part D and well as expected costs of the various provisions of the Medicare Modernization Act (e.g., administrative costs, risk corridor payments, participation in low income subsidies).

***2010-11 Technical Panel***

The panel found that the use of NHE forecasts for drug estimates supplemented by adjustments based on industry experts was reasonable. It also found that the induction factors (effectively, price elasticity of -0.2) and employer participation in RDS (substantial decline due to ACA elimination of tax advantage) was reasonable.

The panel recommended that OAct identify the sources of discrepancy between recent forecasts of prescription drug spending growth and actual experience. They recommended exploring the potential for using a bottom-up model of both the NHE drug component and Part D to improve short-range forecasts (first three years). The panel recommended that OAct explore ways to build Part D experience into the short-range projections for years four and beyond. They also recommended continued monitoring of employer retiree programs.

The following chart updates Figure II.10 included in 2010-11 Panel report showing NHE prescription drug cost trend projections included in the Trustees reports that prompted the recommendation to identify sources of discrepancy.



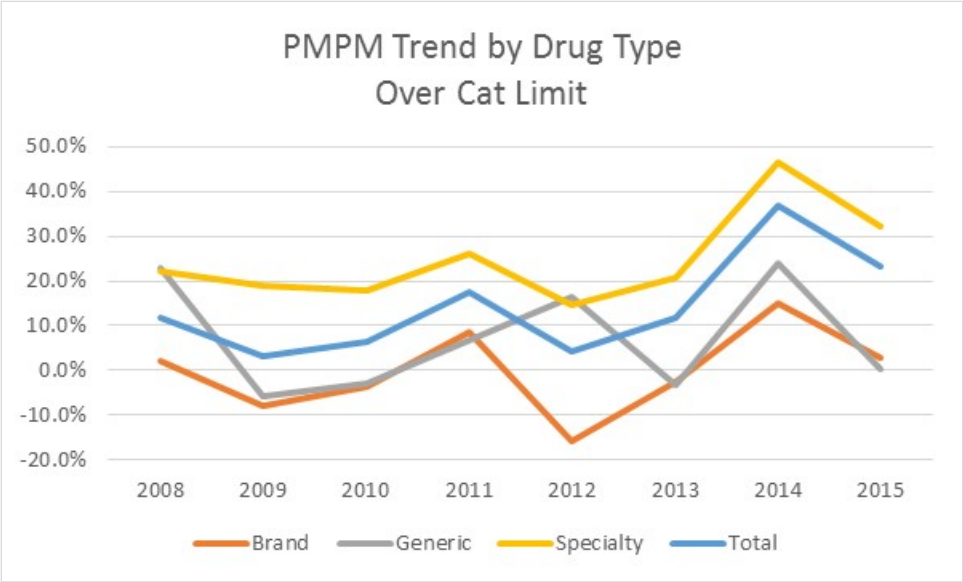

**Potential Finding**: Projected NHE prescription drug costs have gotten better. Probably need some commentary of why.

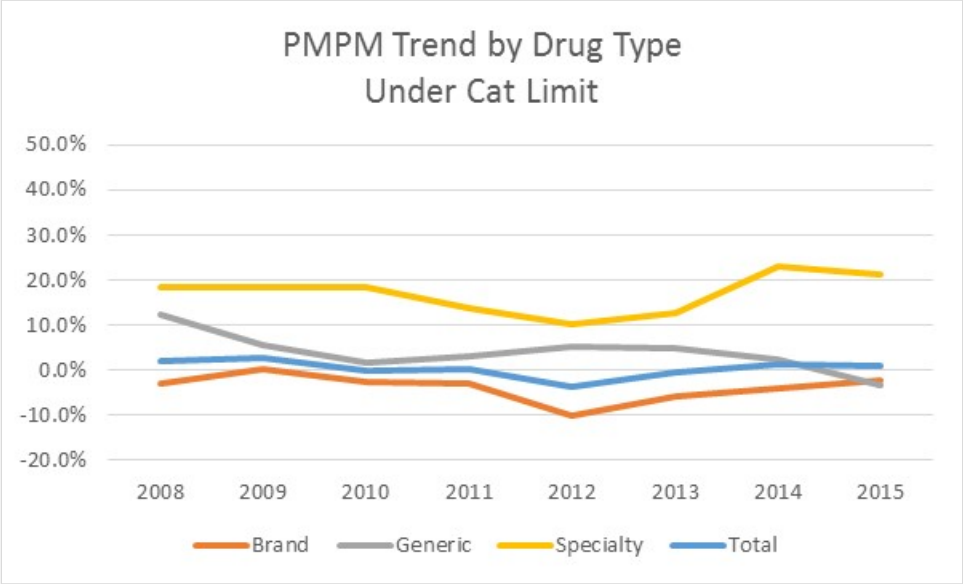
**Potential Finding**: Bottom-up model for short-term trend projection used by OAct is reasonable and should be continued.

**Potential Finding:** The current assumption on the decline of employer provided drug coverage, including shifts from RDS to EGWP, is reasonable.

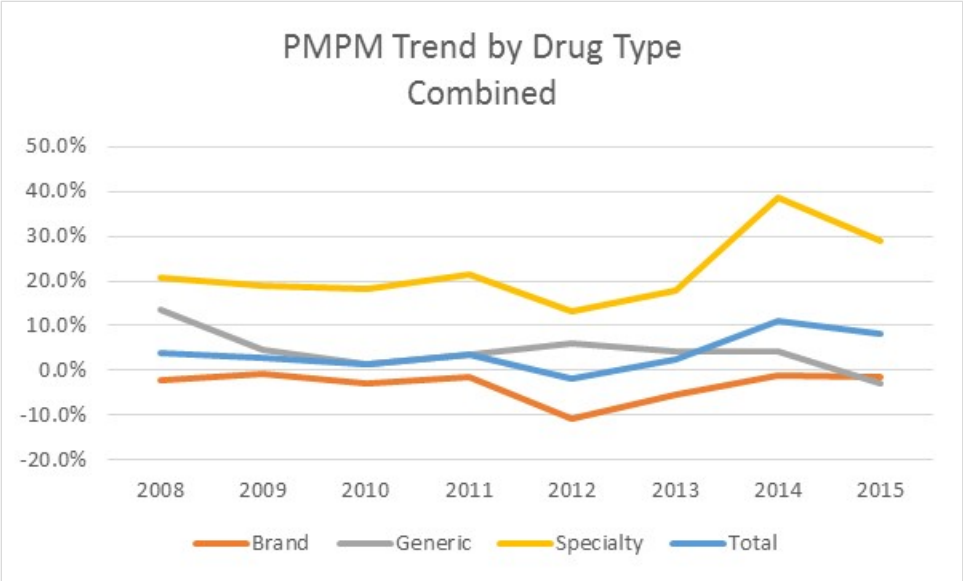
**OAct Analysis of Historical per Capita Cost Trends**

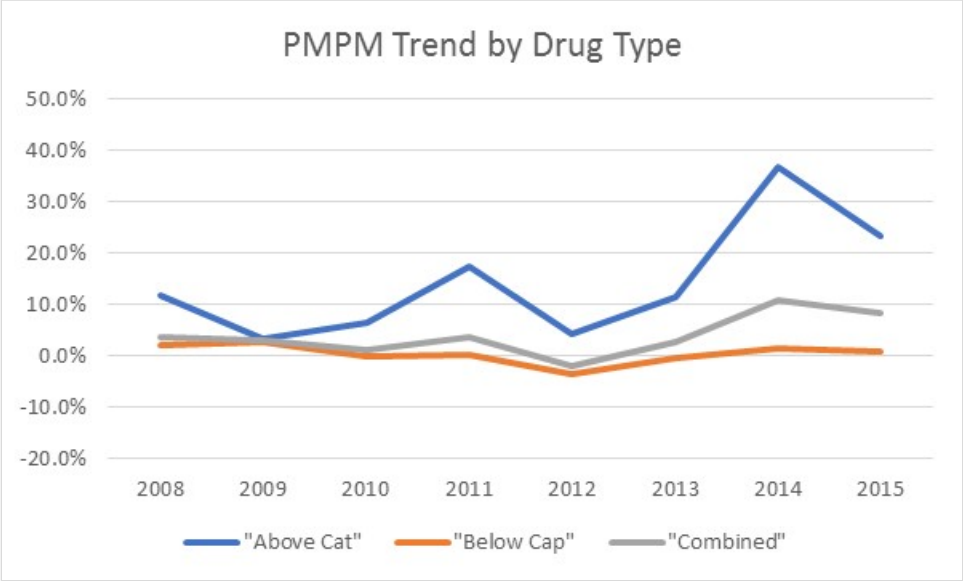
OAct provided analysis of per member per month cost trends under the Part D program with data split between generic, brand name and specialty drugs.[1]




[1] Specialty drugs identified as any prescription that cost $600 per 34-day supply or greater.




**Potential Recommendation:** Assume long-term cost trend for the reinsurance portion of Part D to be one percentage point greater than projected trend for other components of Part D. Actual experience should continue to be monitored. Raises issue of whether combined Part D trend should be equal to overall NHE prescription drug trend. Also, given recent trends, should gap be larger during transition period.