Advising the Congress on Medicare issues

Payment and plan incentives in Part D

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April 7, 2017

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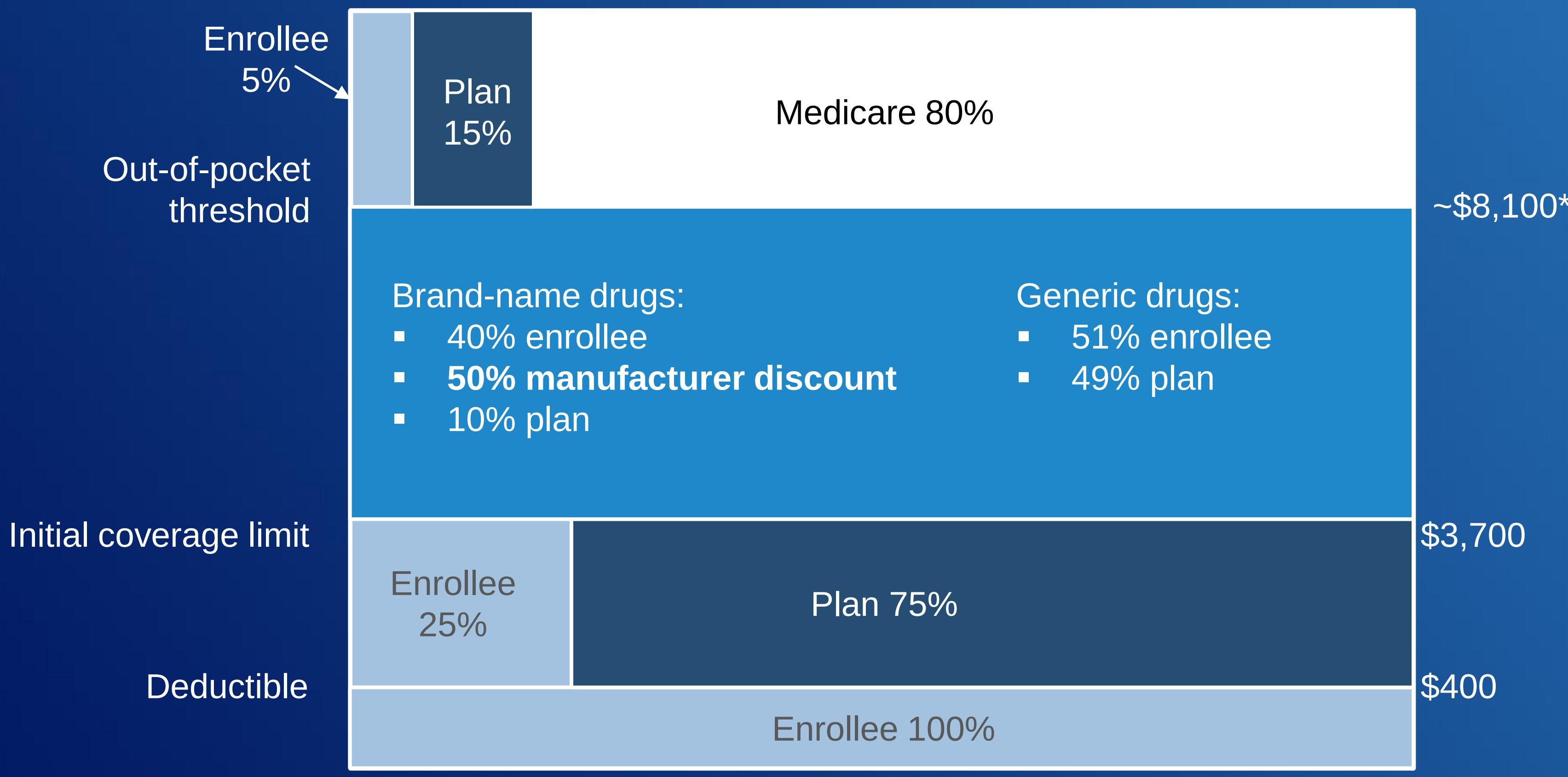
Overview of this presentation

- Changing distribution of Part D spending
- Factors behind expanded catastrophic spending
- Growing gap between gross and net drug prices
- Commission’s 2016 recommendations
- Biosimilars and the coverage-gap discount

Defined standard benefit in 2017



Base beneficiary premium of ~$36 in 2017

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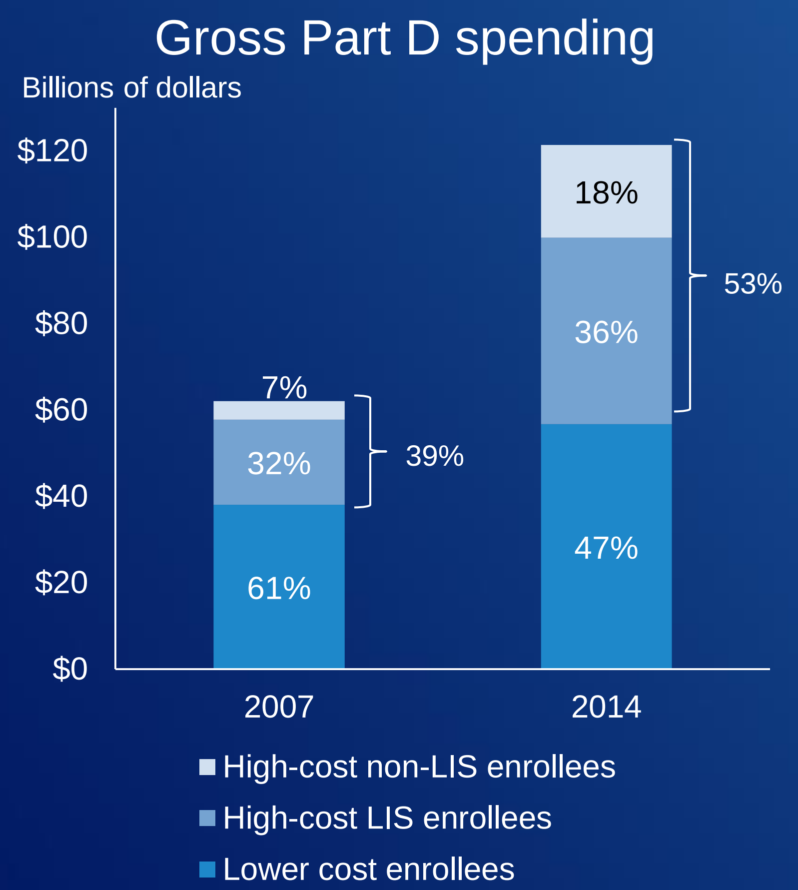
*Total covered drug spending at the annual OOP threshold depends on each enrollee's mix of brand-name and generic drugs filled during the coverage gap. This amount is for an individual who does not receive Part D's low-income subsidy, has no other supplemental coverage, and has the average mix of generic and brand-name spending.

High-cost enrollees now account for more than half of Part D spending



- Number of high-cost enrollees has grown
  - 2.3 million in 2007
  - 3.4 million in 2014
- But high-cost enrollees as a % of Part D enrollees has been stable
  - 8.8% in 2007
  - 8.6% in 2014

Note: Data are preliminary and subject to change. LIS (low-income subsidy). "High-cost enrollees" are individuals who reach Part D's out-of-pocket threshold. In 2014, that threshold was at nearly $6,700 in gross drug spending.
Source: MedPAC based on CMS enrollment and prescription drug event data.

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Factors behind expanded catastrophic spending

- Enrollment growth
- Brand manufacturer discount in the coverage gap
- Higher drug prices
- Growth in direct and indirect remuneration (DIR)
  - Manufacturer rebates
  - Pharmacy fees
  - Other payments that reduce benefit cost

Gross price vs. net price

- Gross price is the amount paid at the point of sale
- Net price is gross price net of rebates and discounts (DIR)
- Gap between gross and net prices (i.e., DIR) has grown by more than 20% per year between 2010 and 2015

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Growing gap between gross and net drug prices raises concerns

- Certain beneficiary and Medicare payments are based on gross prices which are higher than net prices
  - Higher beneficiary coinsurance and low-income cost-sharing subsidy
  - More beneficiaries reaching the OOP threshold
  - Higher Medicare's payment for reinsurance
  - Overpayment for conditions (RxHCC*) with large gross-to-net price differences
- For certain drugs, gross-to-net price difference could provide financial benefit to both plan sponsors and manufacturers
  - May affect plan formulary decisions
  - Plan incentives not aligned with beneficiary and Medicare

Note: RxHCC (Prescription drug hierarchical condition category). *CMS uses the RxHCC model to predict costs based on medical diagnoses, demographic factors, institutionalized status, and whether the enrollee receives the low-income subsidy and risk adjusts payments to reflect the expected costliness of the beneficiary.

More equitable allocation of DIR between plans and Medicare

2015 gross drug spending, in billions

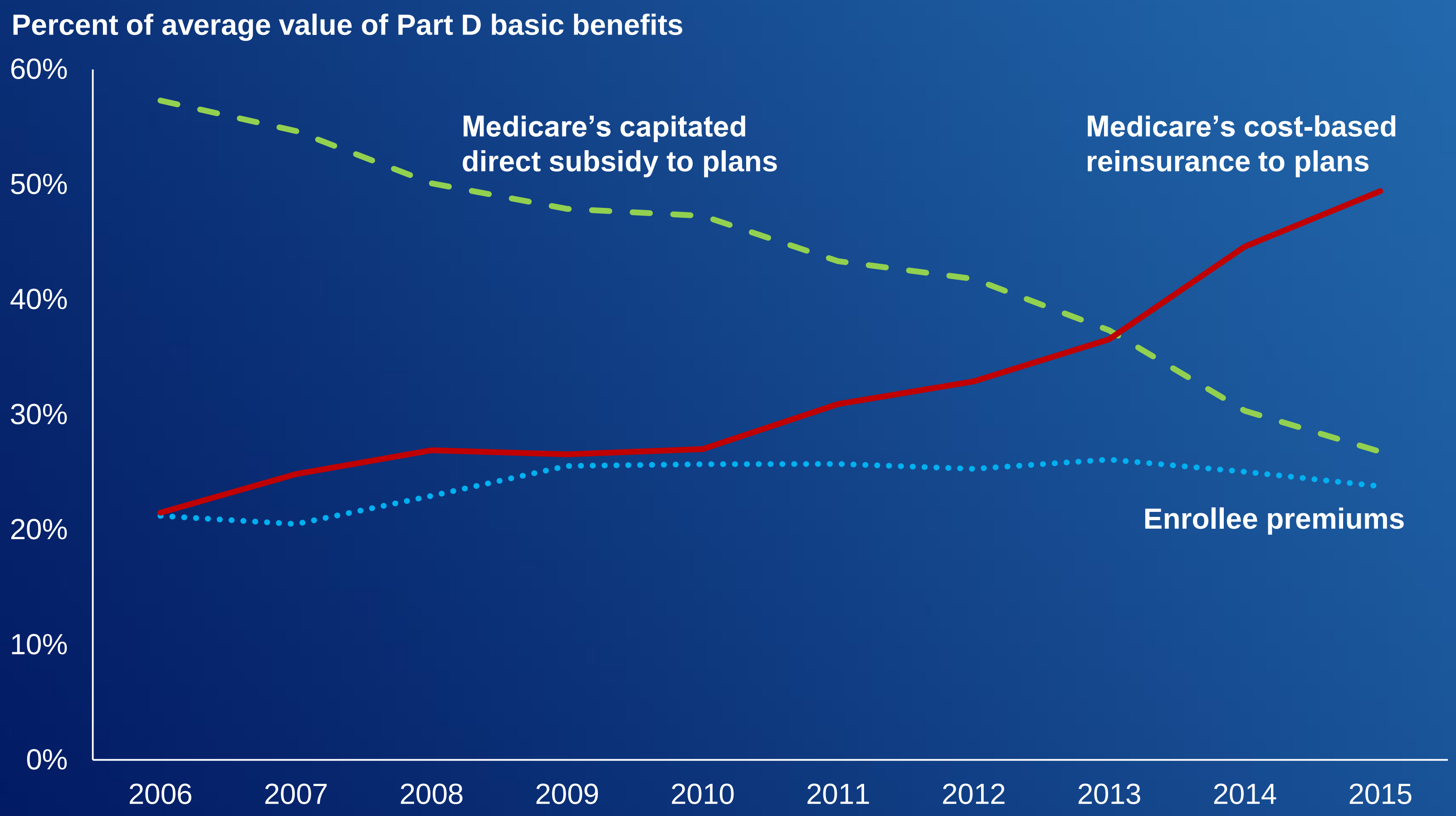
Medicare reinsurance	$41.5	**Total benefit spending = $83.5 billion**
Plan liability	$41.9	
Cost sharing (beneficiary, LIS, other)	$53.5	
Total	**$136.9**	
Total DIR, in billions	**$25.1**	

Current DIR allocation	**Allocation formula (%)**	**DIR amount (billions)**
Medicare (reinsurance)	**% of *gross spending*, or** **$41.5b ÷ $136.9b = 30%**	**$25.1 x 30% = $7.6**
Plan	**Residual**	**$25.1 - $7.6 = $17.5**

Alternative DIR allocation		
Medicare (reinsurance)	**% of *benefit spending*, or** **$41.5b ÷ $83.5b = 50%**	**$25.1 x 50% = $12.5**
Plan	**Residual**	**$25.1 - $7.6 = $12.6**

Note: DIR (direct and indirect remuneration), LIS (low-income subsidy). Data are preliminary and subject to change. Drug spending not covered by the Part D benefit includes cost sharing paid by beneficiaries and by Medicare's LIS and coverage gap discounts paid by brand manufacturers for prescriptions filled by non-LIS beneficiaries during the coverage gap.
Source: MedPAC based on data from CMS's Office of the Actuary.

About half of Part D payments are now cost-based rather than risk-based



Note: Data are preliminary and subject to change. Medicare aims for the combination of direct subsidies and reinsurance payments to sum to 74.5 percent of basic drug benefits.
Source: MedPAC based on data from CMS's Office of the Actuary.

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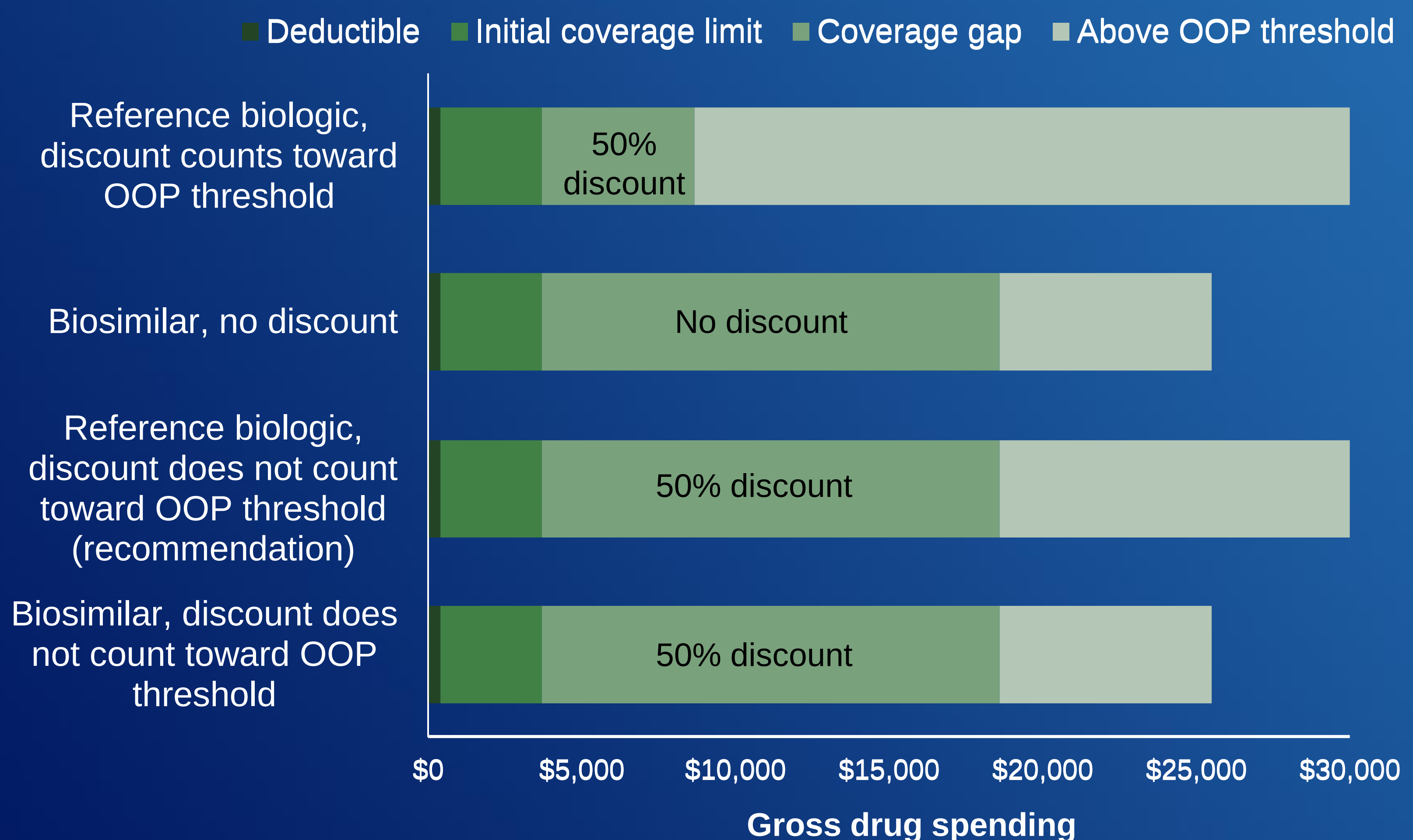
The Commission's June 2016 Part D recommendations

- Change Part D to:
  - Transition Medicare's reinsurance from 80% to 20% of catastrophic spending and keep Medicare's overall subsidy at 74.5% through higher capitated payments
  - Exclude manufacturers' discounts in the coverage gap from enrollees' "true OOP" spending
  - Eliminate cost sharing above the OOP threshold
- Make moderate changes to LIS cost sharing to encourage use of generics and biosimilars
- Greater flexibility to use formulary tools

Example with policy alternatives for coverage-gap discount on biosimilars



Note: OOP (out of pocket). Example depicts a $30,000 reference biologic compared with a $25,500 biosimilar. It uses 2017 Part D benefit parameters with 2020 closure of the coverage gap.
Source: MedPAC.

Summary

- Continued upward pressure on spending
- Need for a fundamental change to Part D’s incentive structure (i.e., the Commission’s 2016 recommendations)
- Potential incremental policy changes:
  - Change DIR allocation
  - Apply coverage-gap discount to biosimilars

Next steps

- Revisions based on commissioner comments
- Intended to be part of March 2018 Report to the Congress