Payment and plan incentives in Part D

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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

*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.
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
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

<table>
<thead>
<tr>
<th>Category</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare reinsurance</td>
<td>$41.5</td>
</tr>
<tr>
<td>Plan liability</td>
<td>$41.9</td>
</tr>
<tr>
<td>Cost sharing (beneficiary, LIS, other)</td>
<td>$53.5</td>
</tr>
<tr>
<td>Total</td>
<td>$136.9</td>
</tr>
</tbody>
</table>

Total DIR, in billions $25.1

Current DIR allocation

<table>
<thead>
<tr>
<th>Medicare (reinsurance)</th>
<th>Allocation formula (%)</th>
<th>DIR amount (billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of gross spending, or</td>
<td>$41.5b ÷ $136.9b = 30%</td>
<td>$25.1 x 30% = $7.6</td>
</tr>
<tr>
<td>Plan</td>
<td>Residual</td>
<td>$25.1 - $7.6 = $17.5</td>
</tr>
</tbody>
</table>

Alternative DIR allocation

<table>
<thead>
<tr>
<th>Medicare (reinsurance)</th>
<th>Allocation formula (%)</th>
<th>DIR amount (billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of benefit spending, or</td>
<td>$41.5b ÷ $83.5b = 50%</td>
<td>$25.1 x 50% = $12.5</td>
</tr>
<tr>
<td>Plan</td>
<td>Residual</td>
<td>$25.1 - $7.6 = $12.6</td>
</tr>
</tbody>
</table>

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.
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

Reference biologic, discount counts toward OOP threshold

- Deductible
- Initial coverage limit
- Coverage gap
- Above OOP threshold

Biosimilar, no discount

- Deductible
- Initial coverage limit
- Coverage gap
- Above OOP threshold

Reference biologic, discount does not count toward OOP threshold (recommendation)

- Deductible
- Initial coverage limit
- Coverage gap
- Above OOP threshold

Biosimilar, discount does not count toward OOP threshold

- Deductible
- Initial coverage limit
- Coverage gap
- Above OOP threshold

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