Advising the Congress on Medicare issues

Improving Medicare Part D

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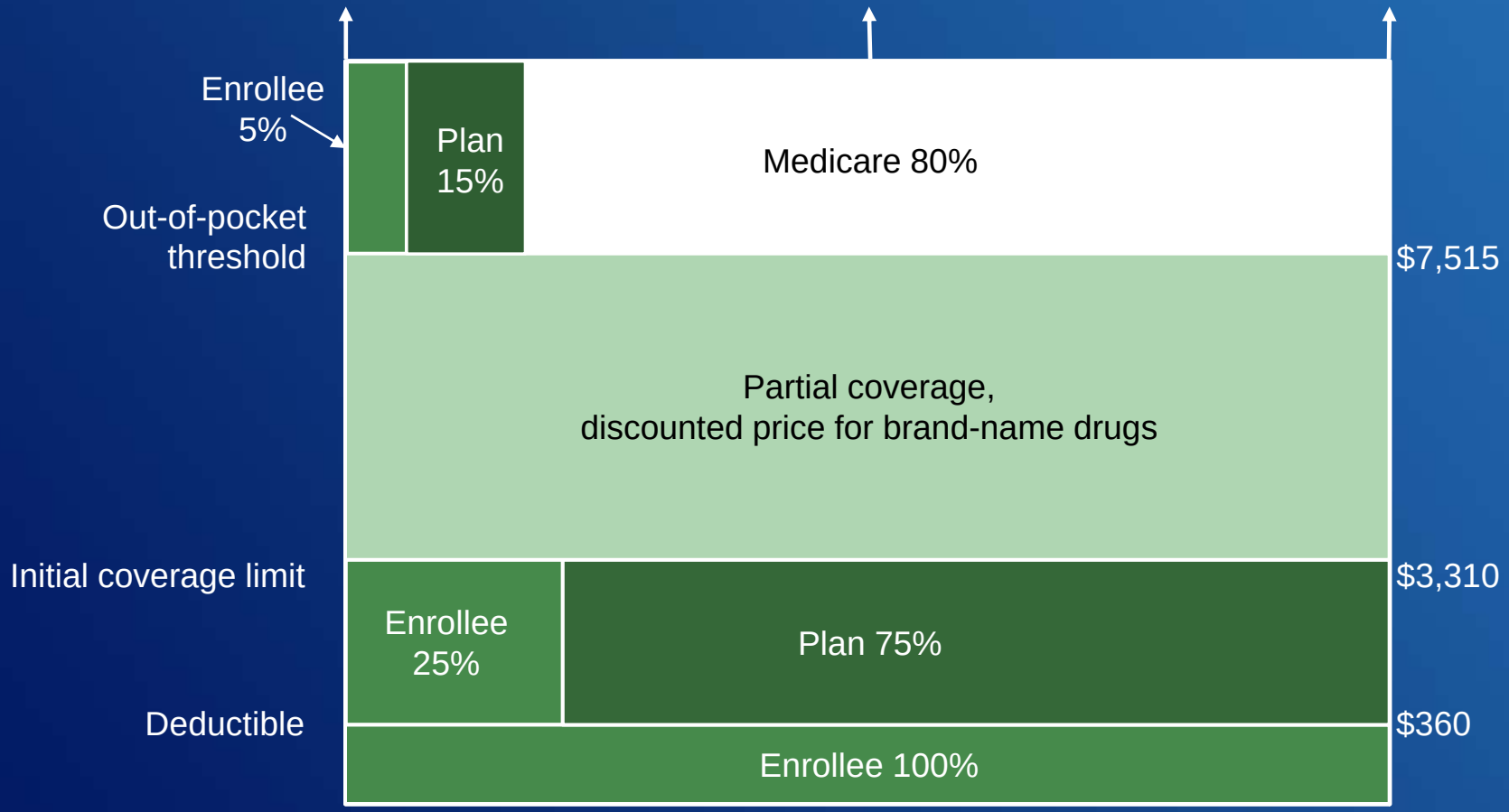
MEDPAC

Future challenges require changes to Part D's original structure

- Designed to encourage broad participation by plans and beneficiaries
- Market-based approach using private plans to deliver benefits
  - Subsidize 74.5% of basic benefit costs
  - Risk-sharing
  - Low-income subsidy (LIS)
- Challenges facing Part D
  - Growing Medicare population
  - Spending growth increasingly driven by enrollees who reach out-of-pocket (OOP) threshold
  - Financial sustainability for taxpayers

Defined standard benefit in 2016



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Patterns of payments and bidding incentives

- Bid too low on catastrophic benefits
- Bid too high on the rest of benefit spending other than catastrophic benefits

➔ Medicare pays an overall Part D subsidy higher than 74.5% specified in law

➔ Lower enrollee premiums

➔ Plan sponsors earn profits above those already included in bids

Policy changes would better align incentives with program goals

- Plan and beneficiary incentives related to the out-of-pocket threshold
  - Stronger incentives for plans to manage high-cost enrollees
  - Treatment of manufacturer discounts towards OOP threshold
  - More complete protection at OOP cap
- Moderate changes to LIS cost sharing to encourage use of lower-cost medicines
- Greater flexibility to use formulary tools

Potential improvements related to OOP threshold: Reinsurance

- Reduce Medicare's reinsurance
  - Keep overall subsidy at 74.5%
  - Provide larger portion through capitated payments
- Increased plan risk would have mixed effects
  - Stronger incentives for plans to manage benefits and negotiate for lower drug prices, which could reduce costs and lower premiums
  - Higher costs of providing benefits if plans require private reinsurance, which could raise premiums
- Plans' negotiating leverage depends on degree of competition within each drug class

Most Part D enrollees are in plans sponsored by large insurers

- Large insurers better positioned to shoulder more insurance risk
- Most of the smaller Part D plan sponsors operate Medicare Advantage (MA) drug plans and are already bearing insurance risk for medical costs
- Much of spending above Part D's OOP threshold is for enrollees with predictably high costs, better addressed through risk adjustment than reinsurance

Potential improvements related to OOP threshold: Brand discount

- Manufacturers must provide 50% discount on brand-name drugs in coverage gap as a condition for Part D coverage
- Discount plus enrollee spending counted together for purposes of reaching OOP threshold
- Quickens pace at which non-LIS enrollees reach OOP threshold

Potential improvements related to OOP threshold: Cost sharing above the cap

- OOP spending burdensome for beneficiaries with certain conditions
- Could reduce burden with fixed-dollar copays or a complete cap on OOP costs (as in MA)
- In 2013, one-year program cost would have been relatively small because Medicare already pays cost sharing for LIS (75% of those who reach the OOP limit)
- But costs of a hard cap could grow significantly
  - Numbers of non-LIS enrollees who reach OOP limit is growing faster than among LIS
  - Pipeline includes many high-priced specialty drugs

Moderate changes to LIS cost sharing to encourage use of lower-cost medicines

- Differences between LIS copay amounts are small
- Medicare pays the difference between plan's cost-sharing amount and the LIS copay amount
- High-cost LIS enrollees have substantially lower use of generics in many drug classes
- Not charging for generics can lead to greater use of generics, even in LIS population
- LIS copay structure does not address biosimilars

Medicare law and guidance lead to more limited formulary management

- Formularies must not substantially discourage enrollment among beneficiaries with certain diseases
  - Plans must cover 2 drugs per therapeutic class
  - Plans must cover “all or substantially all drugs” in 6 protected classes
  - CMS proposed removing antidepressants and immuno-supressants from protected classes, but never implemented
- Rules for mid-year formulary changes
  - Intended to maintain formulary continuity during the year
  - “Enhancements” allowed automatically, but CMS must approve “negative changes,” and plans must apply for negative changes within limited time windows
  - Must give 60 days prior notice to affected beneficiaries

Coverage determinations, exceptions, and appeals

- Plans required to have processes to help ensure beneficiary access to needed medications
- All stakeholders have concerns about these processes
  - Many beneficiaries do not understand their rights, find the processes complex
  - Some prescribers find processes burdensome
  - Some plan sponsors believe their determinations are reversed because of general supporting statements of prescribers
  - CMS says some plans not fully compliant

Commercial plans use other tools for managing specialty drugs

- Split fills (15-day initial supply) to avoid waste and diversion
- Designated specialty pharmacies
- As biosimilars become available, two specialty tiers