

The Medicare prescription drug program (Part D): Status report

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Roadmap

- Part D's approach and role of manufacturer rebates
- Effects of COVID-19 on Part D
- Current program snapshot and key trends
- Drug prices and high-cost enrollees
- Commission's 2020 recommendations
- Questions and discussion

Part D's goals and approach

- Expand beneficiary access to prescription drug coverage
- Use a market-based approach:
 - Wide choice among competing private plans
 - Program was intended to give plan sponsors tools and financial incentives to manage benefit spending
- Beneficiary protections and low-income subsidy (LIS)
- Medicare subsidies, risk sharing, and late-enrollment penalty to encourage plan participation and broad enrollment

Multiple actors in pharmacy benefits



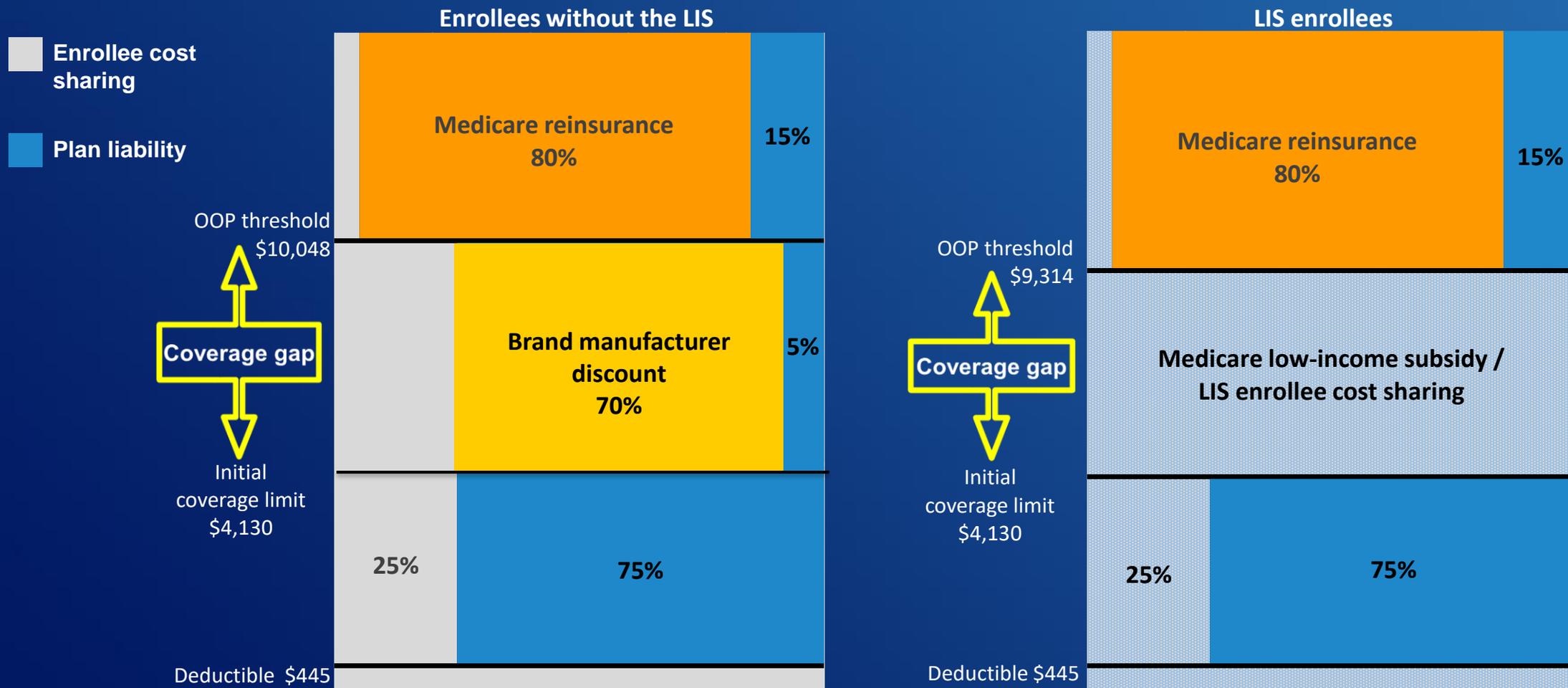
Plan sponsors' role and drug price negotiations

- Plan sponsors accept insurance risk and own or contract for services of a PBM
- Sponsors and PBMs negotiate with:
 - Pharmacies over payments for prescriptions filled, post-sale fees
 - Pharmaceutical manufacturers for rebates on brand-name drugs
- By law, Secretary may not interfere with negotiations among drug manufacturers, pharmacies, and plan sponsors, require a particular formulary, or institute a price structure

Rebates and drug prices in Part D

- Postsale payments to plans/PBMs from brand manufacturers
 - When there are competing therapies and drugs can be excluded from formulary
 - Used by manufacturers to tailor prices depending on plan's ability to expand market share
 - Generally used by plans to lower premiums
- Amounts are highly proprietary, final drug prices are not transparent
- Growing gap between prices at pharmacy and net-of-rebate prices
- When plans use coinsurance, it is based on pharmacy price
- DHHS OIG rule would no longer exempt rebates from antikickback statute in Part D as of 1/1/2022, but would permit rebates at the point of sale

Two distinct defined benefit structures for enrollees without and with the LIS



COVID-19 and Part D

- Comparatively less disruption of access to medicines than to other types of health care
 - Grocery stores, community and mail-order pharmacies often remained open during restrictions
 - Enrollees initially stockpiled supplies, returned closer to patterns from previous year by late summer
- Medicare's monthly payments to plans during 2020 based on bids submitted in June 2019
- Symmetric risk corridors around plan bids

Snapshot of the Part D program

- Among 63 million Medicare beneficiaries in 2020:
 - 47 million (nearly 75%) enrolled in Part D plans
 - Another 1 million (nearly 2%) received retiree drug subsidy (RDS)
 - Remaining 23.5% had coverage as generous through other sources, or had no or less generous coverage
- Program spending of \$88.4 billion in 2019
 - About \$87.7 billion for payments to Part D plans
 - \$0.7 billion for RDS
- Plan enrollees
 - Paid \$13.9 billion in basic premiums*; \$16.7 billion in cost sharing
 - Most continue to say they are satisfied with their plan

Key trends

- Enrollment has grown 5% per year through 2020
- In 2020, among all Part D enrollees:
 - 47% in MA-PDs, 53% in PDPs
 - 27% received low-income subsidy (LIS) compared with 39% in 2007
 - 15% in employer-group plans, a shift from RDS
- Average monthly premiums decreased to \$27 in 2020
 - Stable at around \$30 per month since 2010
 - However, there is wide variation across plans
- More plan offerings for 2021
 - Larger increases in MA-PDs (12%) and SNPs (14%) than PDPs (5%)
 - More premium-free* benchmark PDPs (6%)

CMMI's new Part D Senior Savings model in 2021

- Coverage of certain insulins at cost sharing of no more than \$35 per one-month supply
- Limited to non-LIS beneficiaries who enroll in participating enhanced plans (about 1,600 plans in 2021)
- Allow plans to offer enhanced benefits for insulins without losing manufacturer discounts in the coverage gap
- Could improve access and adherence to insulins
- Does not address high insulin prices
- Enrollees may face higher supplemental premiums

Overall Part D prices grew more slowly in 2019

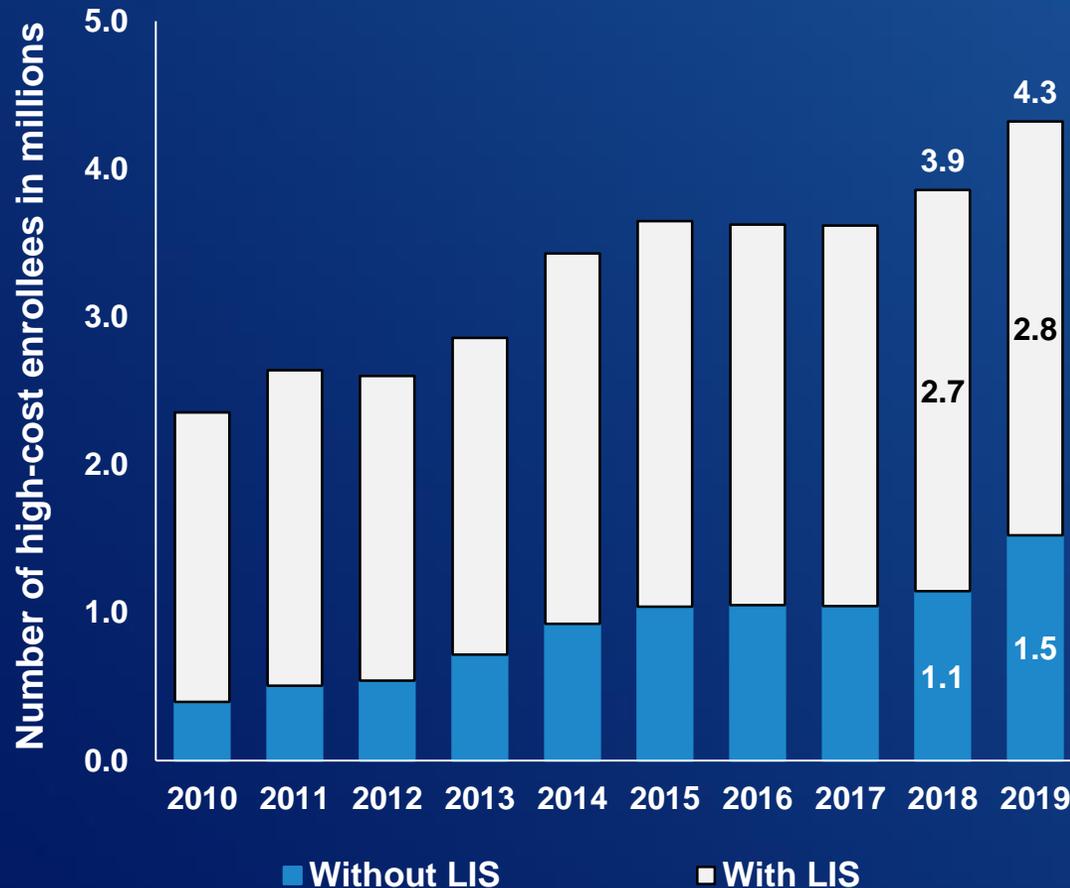
	Price index as of December*		Average annual change (%)	
	2018	2019	2006-2018	2018-2019
All drugs and biologics	1.86	1.91	5.3%	2.6%
Single-source brand-name drugs	3.36	3.55	10.6%	5.7%
Generic drugs	0.17	0.15	-13.7%	-11.0%
After accounting for generic substitution	1.14	1.11	1.1%	-2.1%

- Changes in price indexes between 2018 and 2019 varied widely
- Prices decreased for classes with new/increased generic competition (e.g., anticonvulsants)
- Prices continued to rise for therapeutic classes dominated by brand-name drugs or biologics (e.g., anti-inflammatory drugs)

Medicare's reinsurance continues to be fastest growing part of program spending

Spending category	Spending in billions			Percentage growth, 2007—2019	
	2007	2018	2019	Cumulative	Average annual
Direct subsidy*	\$17.6	\$13.5	\$11.6	-34%	-3.4%
Reinsurance	8.0	40.6	46.3	479%	15.8%
Low-income subsidy	16.7	28.5	29.8	78%	4.9%
Retiree drug subsidy	<u>3.9</u>	<u>0.8</u>	<u>0.7</u>	<u>-82%</u>	<u>-13.3%</u>
Medicare program total	\$46.2	\$83.4	\$88.4	91%	5.6%

2019 saw the largest ever increase in non-LIS beneficiaries reaching the catastrophic phase



- In 2019, 4.3 million (9% of enrollees) reached the catastrophic phase
- 12% increase from 2018, mostly among non-LIS enrollees
- Surge in high-cost, non-LIS enrollees driven by:
 - Recent law changes
 - Use of prescriptions for which a single claim is sufficient to reach the catastrophic phase (>480,000 in 2019, up from 378,000 in 2017 and 33,000 in 2010)

Access to medications under Part D

- General program-wide indicators of access show improvements in formulary and coverage decisions
- >80% report their plans provide good value with reasonable cost sharing*
- However, for beneficiaries without the LIS, access depends on their medication needs:
 - Good access if taking generic drugs for common conditions
 - High cost sharing could be a barrier to access if one needs many brand-name drugs or specialty drugs

Commission's 2020 recommendations to improve Part D

- Address distortions in plan incentives created by rebates and discounts that increase Medicare's reinsurance costs
 - Eliminate coverage-gap discount
 - Increase plan liability in the coverage gap and the catastrophic phase of the benefit
- Address high prices and high cost sharing
 - Manufacturer discount in the catastrophic phase
 - Complete insurance protection in the catastrophic phase
- Restore market-oriented incentives and provide greater flexibility to manage benefits

Questions and discussion

- Feedback on draft chapter
- Future work:
 - Rebates and risk adjustment
 - Low-income premium benchmarks
 - Long-term care pharmacy
 - Other ideas?