Improving Medicare Part D

Shinobu Suzuki and Rachel Schmidt

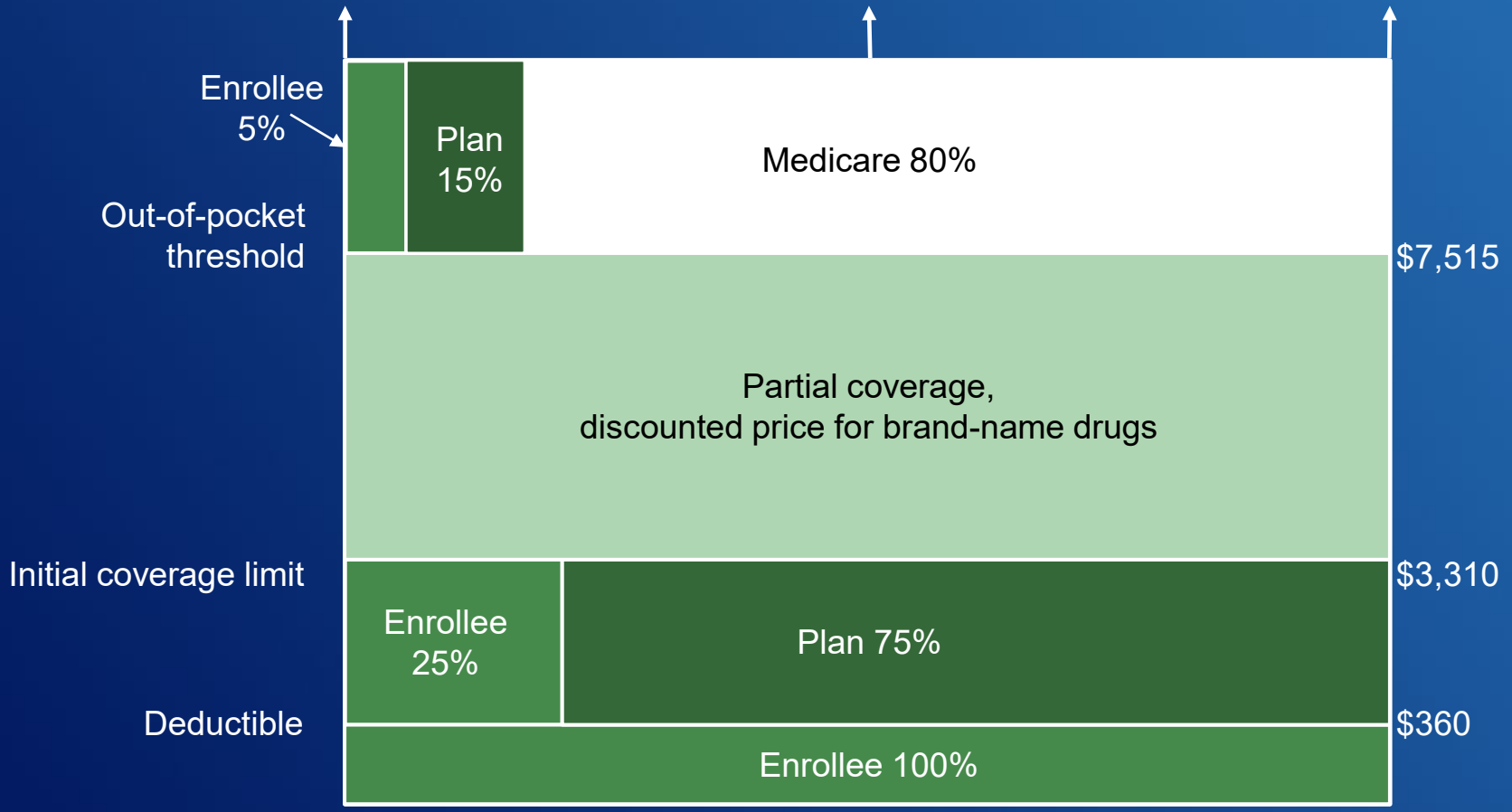
March 3, 2016

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



MEDPAC

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

Chairman's draft recommendation #1

The Congress should change Part D to:

- Lower Medicare's individual reinsurance subsidy from 80% to 20%, while maintaining Medicare's overall 74.5% subsidy of basic benefits,
- Exclude manufacturers' discounts in the coverage gap from enrollees' true out-of-pocket spending, and
- Eliminate enrollee cost sharing above the out-of-pocket threshold.

Implications of Chairman's draft recommendation #1

Spending

The combination of draft recommendations #1, #2, and #3 would lead to program savings relative to baseline spending, but an estimate of the magnitude of savings is not available yet.

Beneficiaries and providers

- Lower Medicare reinsurance: Effects on plan sponsors and average enrollee premiums are indeterminate. Some plan sponsors may need private reinsurance which would raise costs, but sponsors might also more effectively manage benefit spending and negotiate lower prices.
- Brand discount: Some non-LIS enrollees would no longer reach the OOP threshold and would pay higher cost sharing.
- OOP cap: All non-LIS enrollees would benefit from more complete insurance protection. All Part D enrollees would pay slightly higher premiums because the Part D benefit would become more generous.

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

Chairman's draft recommendation #2

The Congress should change Part D to:

- Modify low-income subsidy copayments for Medicare beneficiaries with incomes at or below 135 percent of poverty to encourage the use of generic drugs, preferred multi-source drugs, or biosimilars when available in selected therapeutic classes,
- Direct the Secretary to reduce or eliminate cost sharing for generic drugs, preferred multi-source drugs, and biosimilars, and
- Direct the Secretary to determine appropriate therapeutic classifications for the purposes of implementing this policy and review the therapeutic classes at least every three years.

Implications of Chairman's draft recommendation #2

Spending

The combination of draft recommendations #1, #2, and #3 would lead to program savings relative to baseline spending, but an estimate of the magnitude of savings is not available yet. Draft recommendation #2 would reduce Medicare program spending for the low-income subsidy and reinsurance. CBO estimated savings for a similar policy in the 2015 President's budget proposal of $7.0 billion over 5 years, $17.7 billion over 10 years.

Beneficiaries and providers

Greater use of generics could lower copay amounts for LIS enrollees, particularly if copays were reduced or eliminated for generics. LIS enrollees who chose not switch to generics may pay higher copays for brand-name drugs or might not be as adherent to treatment.

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

Chairman's draft recommendation #3

The Secretary should change Part D to:

- Remove antidepressants and immunosuppressants for transplant rejection from the classes of clinical concern,
- Streamline the process for mid-year formulary changes,
- Require prescribers to provide supporting statements with more clinical rigor when applying for exceptions, and
- Permit plan sponsors to use certain tools to manage specialty drug benefits.

Implications of Chairman's draft recommendation #3

Spending

The combination of draft recommendations #1, #2, and #3 would lead to program savings relative to baseline spending, but an estimate of the magnitude of savings is not available yet.

Beneficiaries and providers

- Protected classes: Plan sponsors may be able to negotiate lower prices, which could reduce premiums. Some beneficiaries may need to switch medications or seek formulary exceptions.
- Other formulary tools: Increased formulary management would reduce costs of providing Part D benefits and constrain enrollee premiums and cost sharing. Some beneficiaries may need to apply for exceptions, redeterminations, and appeals. Some prescribers may find providing more clinical rigor in supporting statements burdensome.

Summary of draft recommendations

- Change Part D to:
  - Lower Medicare's reinsurance to 20% and keep Medicare's overall subsidy at 74.5%
  - Exclude manufacturers' discounts under the coverage gap from enrollees' OOP threshold
  - Eliminate cost sharing above the OOP threshold
- Make moderate changes to LIS cost sharing to encourage use of generics or biosimilars
- Greater flexibility to use formulary tools