Advising the Congress on Medicare issues

Improving Medicare Part D

Rachel Schmidt and Shinobu Suzuki

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MEDPAC

Future challenges require changes to Part D's structure

- Growing Medicare population
- Unsustainable trends in program spending
  - Spending growth increasingly driven by enrollees who reach out-of-pocket (OOP) threshold
  - About 70% of program spending for the 30% of enrollees who receive the low-income subsidy (LIS)
  - Price growth for older drugs and high launch prices
  - Reinsurance spending has grown at about 20% per year
  - Plan bids and reconciled payments have led to higher subsidy rate than the 74.5% in law
- Need to balance beneficiary access to medicines with financial sustainability for taxpayers

Keep overall subsidy at 74.5%, but transition reinsurance from 80% to 20%

- Unsustainable growth in open-ended reinsurance spending (cumulative 248% between 2007-2014)
- Bidding incentives have resulted in Medicare subsidy rate above 74.5% specified in law
- Plan liability for catastrophic spending (15%) could be less than rebates received

➔Transition reinsurance from 80% to 20%

- Greater pressure on plans to negotiate lower prices and manage benefit spending
- Some plan sponsors may build in risk premiums
- Savings to Medicare/taxpayers and Part D enrollees

Exclude manufacturer discount from counting towards OOP threshold (cap)

- Two changes made by Patient Protection and Affordable Care Act of 2010
  - Inequitable treatment of brand and generic drugs; in 2016, an enrollee would reach the cap at $7,260 using all brand-name drugs vs. $9,780 using all generic drugs
  - Use of high-cost drugs and rising drug prices resulting in more of non-LIS enrollees reaching the cap

➔ No longer count brand manufacturer discount as OOP

- Among the 2013 high-cost, non-LIS beneficiaries*,
  - 1/2 no longer reach the cap, incur higher cost sharing and manufacturer discounts
  - 1/2 incur higher cost sharing and manufacturer discounts, but pay no cost sharing above the cap under the catastrophic protection policy
- More equitable treatment of brand and generic drugs
- Potential effects on drug pricing
- Fewer non-LIS enrollees reaching the cap results in savings to Medicare/taxpayers and Part D enrollees

*Estimated effects are based on analysis of Part D claims data for non-LIS enrollees who had high spending in 2013.

Provide real catastrophic protection

- Eliminate 5% cost sharing above the OOP threshold
- 5% of high-cost drugs or high use of drugs can result in significant financial liability
- Among the high-cost, non-LIS enrollees who reached the OOP threshold in 2013,
  - ¼ with the highest costs spent $2,600 (62% of their total cost sharing) above the cap because they had very high spending (about $32,000) above cap
- Protect all beneficiaries from unlimited financial liability
- Costs to Medicare/taxpayers and Part D enrollees

Policy change related to LIS copays

- Lower generic use among high-cost LIS enrollees
  (In 2013, 71% among high-cost LIS enrollees vs. 86% for other enrollees)
- Use of brand-name drugs when generic substitutes available increases program costs
  - Higher low-income cost-sharing subsidy
  - More people reaching the OOP threshold increases reinsurance costs
- LIS copay same for biosimilars and reference biologics
- Financial incentives matter

➔ Moderately increase financial incentives to use lower-cost drugs, including biosimilars

- Secretary determines the appropriate classes/copay amounts
- Only in classes where generic substitutes are available

Policy changes related to formulary management

- Eliminate antidepressants and immunosuppressants for transplant rejection from protected classes
  - Included in previous CMS proposed rule, never implemented
  - Plans must still cover at least 2 distinct drugs per class
  - Many generics available in those classes
- Rules for formulary changes
  - Provide additional opportunities to apply for changes between the time plan submits its bid and annual open enrollment
  - Allow plans to put in place mid-year “maintenance” changes that CMS would normally approve

Policy changes related to formulary management (cont'd.)

- Permit new ways to manage specialty drugs while maintaining beneficiary access
  - Split fills (15-day initial supply) to avoid waste and diversion
  - Allow preferred and nonpreferred specialty tiers
- Standardize supporting justifications for exceptions from prescribers
  - Aim is to reduce delay for beneficiary associated with exceptions and appeals
  - More clinical rigor than what some prescribers now provide
  - But required information would be predictable, simpler process

Steps toward improving exceptions and appeals process

- Plans required to have processes to help ensure beneficiary access to needed medications
- All stakeholders have concerns about these processes
- Continue to test plan strategies for resolving issues at the point of sale
- Encourage more availability and use of formulary information at the point of prescribing

Summary of draft 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%
  - 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