The Medicare prescription drug program (Part D): Status report and a proposal for restructuring

Rachel Schmidt, Shinobu Suzuki, and Eric Rollins

January 16, 2020

MEDPAC

Snapshot of the Part D program

- Among 61.3 million Medicare beneficiaries in 2019:
  - 45.4 million (74.1%) enrolled in Part D plans
  - Another 2.3% received retiree drug subsidy (RDS)
  - 23.6% had coverage as generous through other sources, or had no or less generous coverage
- Program spending of $83.4 billion in 2018
  - About $82.6 billion for payments to Part D plans
  - $0.8 billion for RDS
- Plan enrollees
  - Paid $14.1 billion in basic premiums*; does not include cost-sharing
  - Most continue to say they are satisfied with their plan

Note: Results are preliminary and subject to change. *Excludes Medicare premium subsidies for beneficiaries receiving Part D's low-income subsidy and enrollee premiums for enhanced (supplemental) benefits.

Key trends

- Enrollment has grown 5% per year through 2019
- In 2019, among all Part D enrollees:
  - 44% in MA-PDs, 56% in PDPs
  - 28% received low-income subsidy (LIS) compared with 39% in 2007
  - 16% in employer-group plans, a shift from RDS
- Average monthly premiums decreased slightly to $29 in 2019
  - Stable at around $30 per month since 2010
  - However, there is wide variation across plans
- More plan offerings for 2020
  - Larger increases for MA-PDs (16%) and SNPs (20%) than PDPs (5%)
  - More premium-free* benchmark PDPs (13%)

Note: MA-PD (Medicare Advantage-Prescription Drug [plan]), PDP (prescription drug plan), RDS (retiree drug subsidy), SNP (special needs plan). Results are preliminary and subject to change. *Premium free for beneficiaries who qualify for Part D's low-income subsidy.

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

Spending category	Spending in billions			Percentage growth, 2007—2018	
	2007	2017	2018	Cumulative	Average annual
Direct subsidy*	$17.6	$14.6	$13.1	-26%	-2.6%
Reinsurance	8.0	37.6	40.9	411%	16.0%
Low-income subsidy	16.7	27.3	28.6	71%	5.0%
Retiree drug subsidy	3.9	0.9	0.8	-79%	-13.4%
Medicare program total	$46.2	$80.4	$83.4	81%	5.5%

MEDPAC

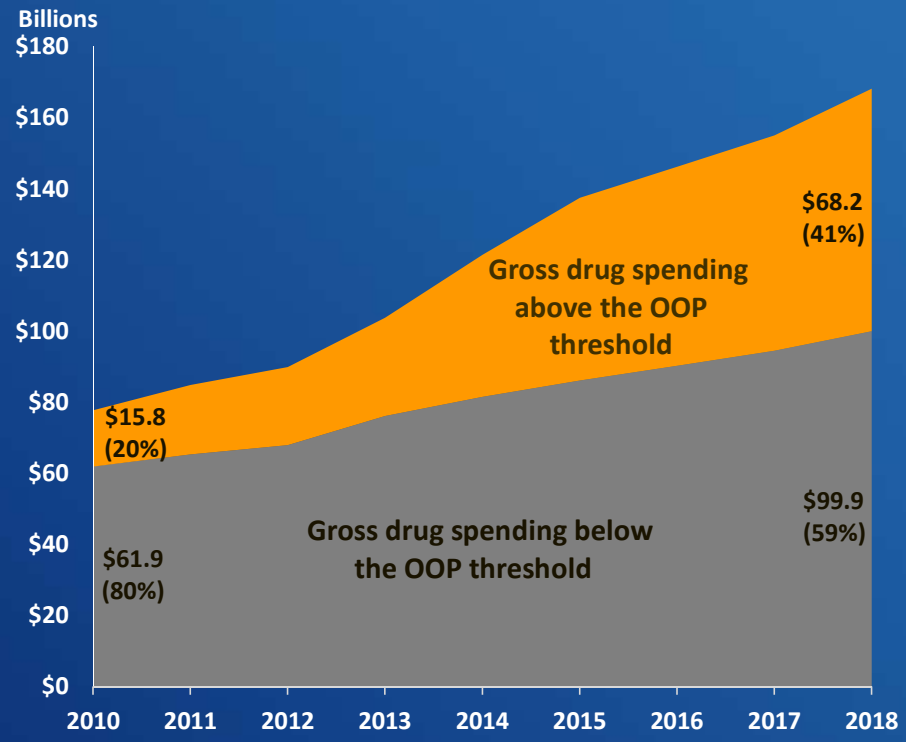
Source: MedPAC based on Table IV.B.10 of the Medicare Board of Trustees' report for 2019.
Note: Results are preliminary and subject to change. *Net of Part D risk-corridor payments.

Part D's goals and approach

- Expand beneficiary access to prescription drug coverage
- Use a market-based approach:
  - Wide choice among competing private plans
  - Plan sponsors have financial incentives and "commercial-like" tools to manage benefit spending
- Beneficiary protections
- Medicare subsidies, risk sharing, and late-enrollment penalty to encourage plan participation and broad enrollment

What has changed since 2006?

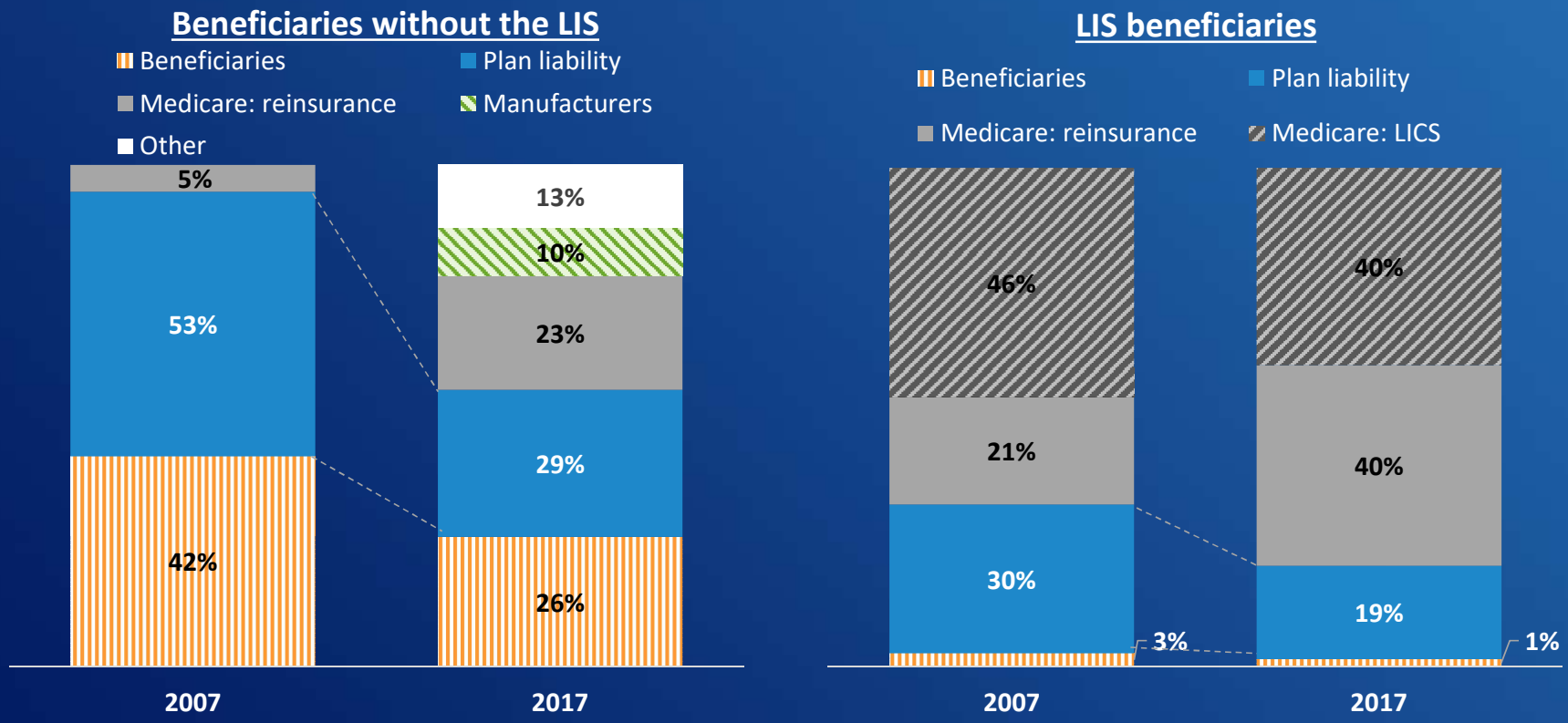
- Many enrollees switched to generics
- Brand manufacturers developed high-priced specialty drugs
- Part D's benefit design changed
- Expanded role of cost-based reimbursement
- Share of spending in Part D's catastrophic phase has more than doubled



MEDPAC

Note: OOP (out-of-pocket). Data are preliminary and subject to change.
Source: MedPAC analysis of Part D prescription drug event data.

Plans are responsible for a much smaller share of Part D costs than in 2007



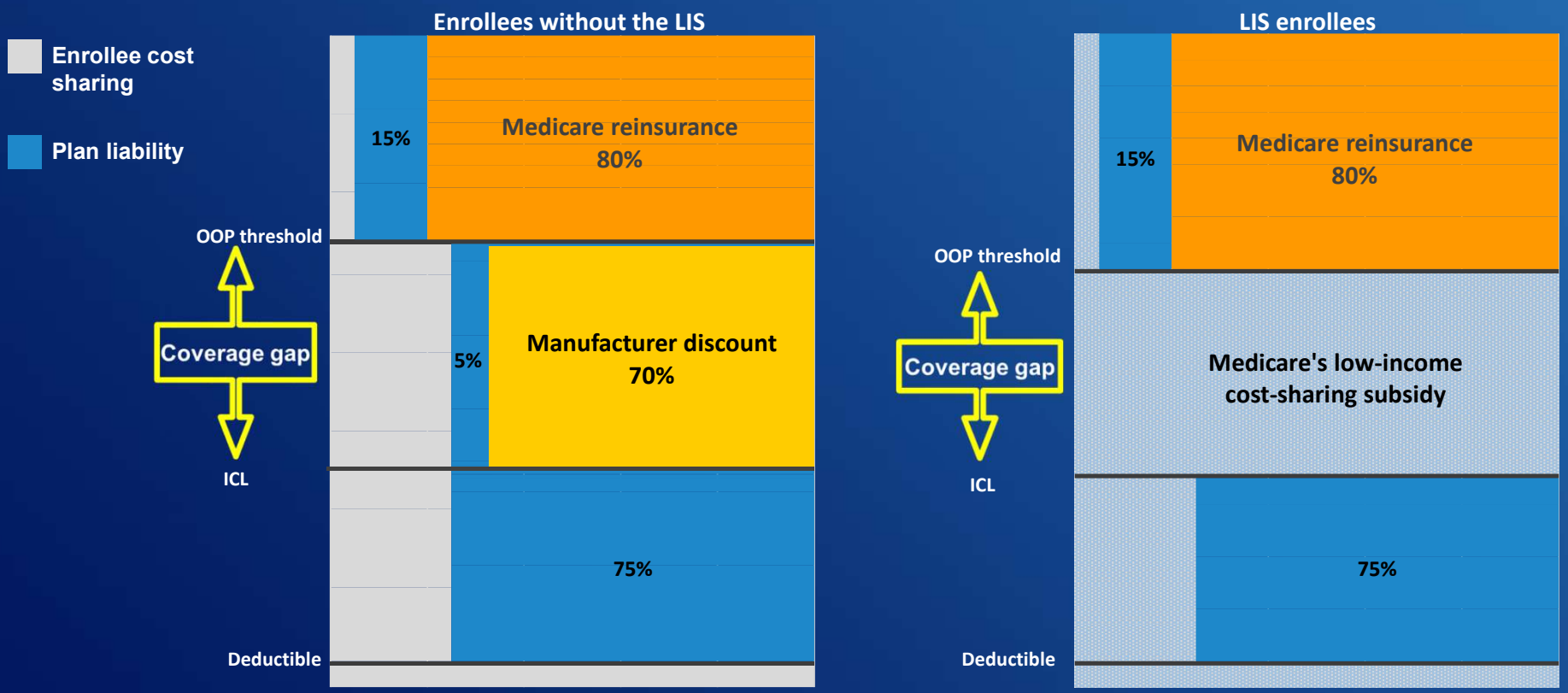
Notes: LIS (low-income subsidy), LICS (low-income cost-sharing subsidy). Data are preliminary and subject to change. Percentage estimates reflect amounts in Part D prescription drug event data minus average rebates as reported by Medicare Trustees. Figures assume that the percentage reductions in total spending attributable to rebates do not systematically differ between enrollees with and without the LIS.

Why Part D needs to be restructured

- Commission's 2016 recommendations:
  - Would strengthen financial incentives for managing benefits (i.e., increase plan liability for catastrophic spending from 15% to 80%)
  - Give greater flexibility for plan sponsors to use formulary tools
  - Modify LIS cost sharing to encourage generic use
- Since 2016, changes in benefit design and specialty drug spending have:
  - ➔Further reduced plan incentives to manage spending
  - ➔Encouraged preferential formulary treatment of certain high-price, high-rebate drugs (results in higher program costs and premiums)
  - ➔Affected some manufacturers' pricing decisions

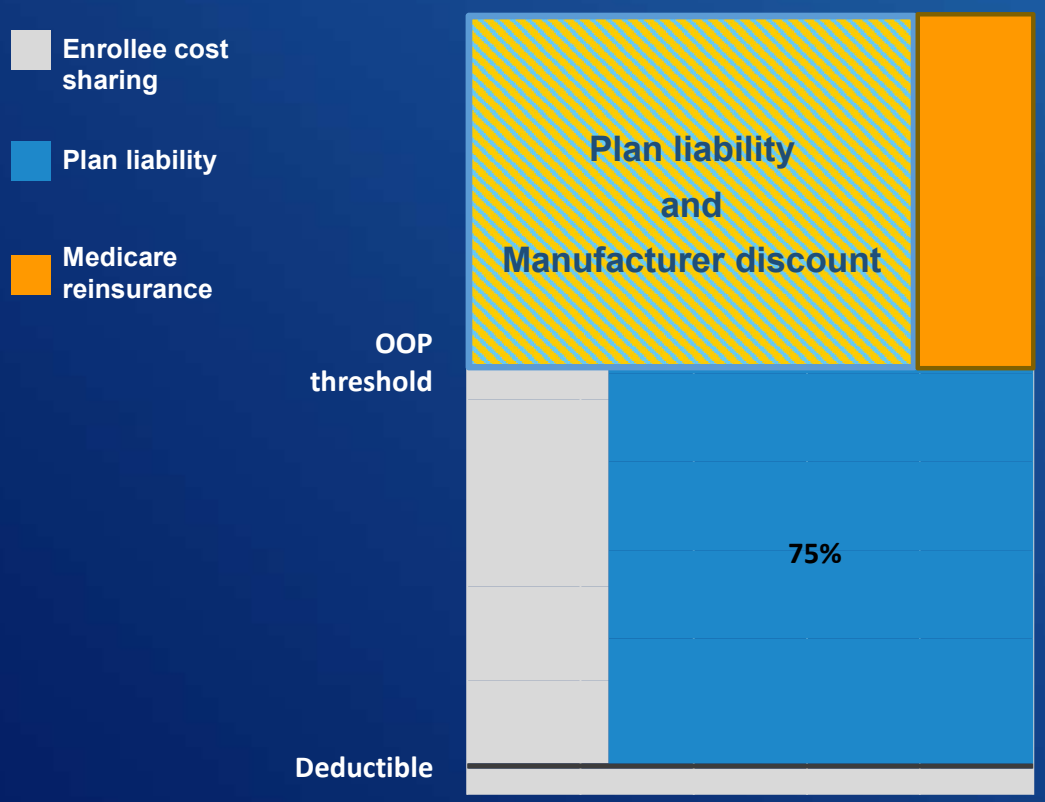
Note: LIS (low-income subsidy).

Misaligned incentives in Part D



Notes: LIS (low-income subsidy), OOP (out-of-pocket), ICL (initial coverage limit). The coverage gap for non-LIS beneficiaries is depicted as it would apply to brand-name drugs and biologics.

How Part D could be restructured



Notes: LIS (low-income subsidy), OOP (out-of-pocket), ICL (initial coverage limit). The coverage gap phase (between the initial coverage limit and OOP threshold) is depicted as it would apply to brand-name drugs for an enrollee who does not receive Part D's low-income subsidy.

Potential package of reforms

- Major components
  - Make plans responsible for a consistent 75% of spending between the deductible and OOP threshold
  - Restructure the catastrophic benefit to eliminate enrollee cost sharing and shift insurance risk from Medicare to plan sponsors and pharmaceutical manufacturers
- Restore risk-based capitated approach
- Eliminate program features that distort market incentives

An example of parameters of the restructured benefit

	Current benefit	Restructured benefit
Phase-in period	n/a	4 years
Below OOP threshold		
Enrollee cost sharing between deductible and ICL	25%	25%
Plan liability between deductible and ICL	75%	75%
Coverage gap?	Yes	No
Brand manufacturer discount	70% in coverage gap	None
Projected OOP threshold in 2022	**$3,100 ($7,100)***	**$3,100**
Total spending at OOP threshold	About $11,000	About $11,000
Above OOP threshold (catastrophic phase)		
Enrollee cost sharing	5%	0%
Medicare reinsurance	80%	20%
Plan liability	15%	80% for lower-price generics 60% for brands and high-priced generics
Manufacturer discount**	0%	20% for brands and high-priced generics

Notes: LIS (low-income subsidy), OOP (out-of-pocket), ICL (initial coverage limit). *In 2022, a non-LIS beneficiary would pay about $3,100 of the $7,100 threshold while manufacturers would pay the remaining $4,000 in coverage-gap discount. **Applies to brand-name drugs, biologics, biosimilars, and certain high-priced generics.

Changes to ensure successful transition as plans assume greater insurance risk

- Phase in new catastrophic benefit structure
- Recalibration of the risk adjustment model to ensure adequate payments and to discourage plans from engaging in risk selection
- Potential temporary changes to risk corridors during transition to the new benefit structure
- Provide plans with new tools to manage spending

CMS has experience recalibrating the risk adjustment model

- Recalibrate for annual change in benefit parameters, expansion of non-LIS coverage-gap benefits, and recent increase in manufacturer discounts
- LIS enrollees have *higher average spending* but *lower relative variation* than non-LIS enrollees
  - ➔Suggests recalibrating the RxHCC model to reflect an increase in LIS benefit liability no more difficult than for non-LIS benefit
- CMS could investigate ways to incorporate major therapeutic innovations more quickly to minimize large, systematic under- or overpayments for conditions

Notes: RxHCC (prescription-drug hierarchical condition category), LIS (low-income subsidy).

Risk corridors could provide more financial protection during transition to new benefit structure

- Potential temporary changes:
  - Narrow risk corridors: plans fully at risk for less than 5 percent of their aggregate expected benefit costs
  - Increase plans' aggregate risk protection (i.e., reduce plans' insurance risk above a threshold)
- Enhanced protection would be available to all plans
- In practice, would likely be most valuable for smaller plans

New tools to manage spending

- Differentiate LIS cost sharing for preferred and non-preferred drugs
- Allow plans to use a non-preferred tier for specialty drugs
- Give plans greater flexibility in the protected drug classes
  - The Commission recommended removing antidepressants and immunosuppressants from protected classes (2016)
  - The Commission supported a CMS proposal to provide plans with additional tools to manage protected-class drug spending (2019)

Multiple layers of beneficiary protection continue under a reformed benefit

- Formulary protections
  - CMS's formulary review ensures broad coverage of medications
  - Generally, formularies must include at least one therapy on preferred tier (among therapeutic alternatives)
- Exceptions and appeals process
  - Beneficiaries can request a "tiering exception" to obtain nonpreferred tier drugs at preferred tier cost sharing when medically necessary
  - The majority of appealed cases are approved in favor of the beneficiary

Discussion questions and next steps

- Potential package of reforms
  - Make plans responsible for a consistent 75% of spending between the deductible and OOP threshold
  - Restructure the catastrophic benefit to eliminate enrollee cost sharing and shift insurance risk from Medicare to plan sponsors and manufacturers
- Need guidance from Commissioners on:
  - Distribution of insurance risk in the catastrophic phase
  - Alternative rate (%) or formula (e.g., indexed to price increases) for the new manufacturer discount?
  - Other changes to add (e.g., risk corridor changes, add a new non-preferred copay for LIS enrollees, allow plans to use preferred and non-preferred specialty tiers)