



Advising the Congress on Medicare issues

Status report on Part D

Shinobu Suzuki and Rachel Schmidt
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Overview of the presentation

- Snapshot of Part D
 - Key trends
 - Enrollment and plan offerings
 - Access and quality
- Program costs
- Sponsor strategies for controlling premiums
- Drug pricing
- Ongoing and future Part D work

The Part D program

- 37 million enrollees
 - 69% of Medicare beneficiaries in Part D plans
 - 5% receive benefits through retiree drug subsidy (RDS)
- Program spending of \$65 billion in 2013
 - \$63 billion for payments to Part D plans
 - \$2 billion for RDS
- Plan enrollees generally satisfied

Key trends since 2007

- Enrollment growth
 - Higher among enrollees without low-income subsidy (8%) than with LIS (3%)
 - Move from RDS to Part D employer groups
- Average monthly premiums
 - Grew by 3% per year
 - Stable at around \$30 per month between 2010 – 2014
- But Medicare reinsurance payments to plans have grown much faster
 - 8% per year, 2007 – 2014
 - 10% per year, 2010 – 2014

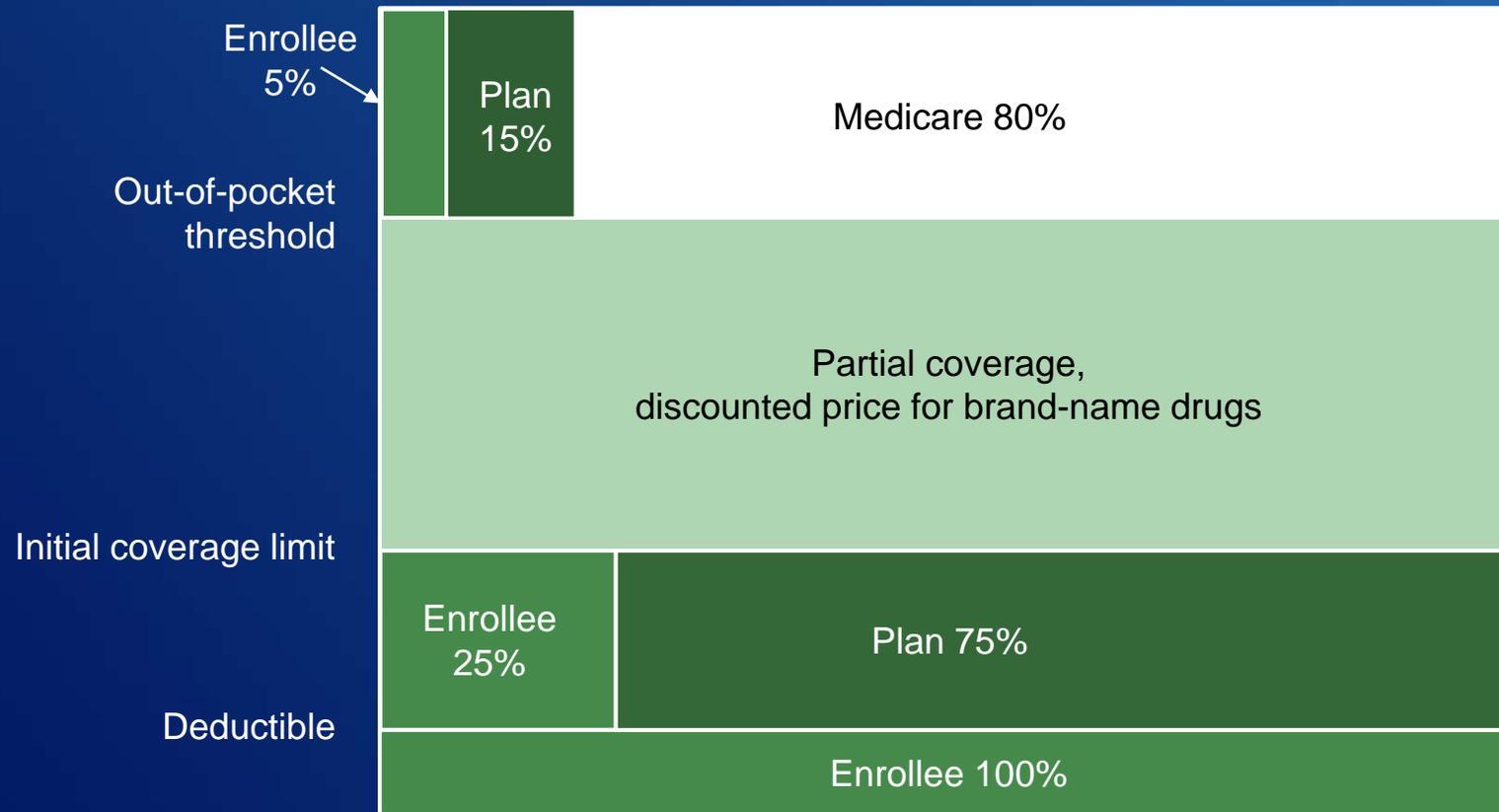
Part D enrollment in 2014 and plan offerings for 2015

- **PDPs**
 - 62% of all Part D enrollees (down from 70% in 2007)
 - 14% fewer plans in 2015, but still broad choice (24–33 PDPs in each region)
- **MA-PDs**
 - 38% of all Part D enrollees (up from 30% in 2007)
 - Total number of plans stable (a typical county has 3–10 MA-PDs)
- **Low-income subsidy (LIS)**
 - 30% of all Part D enrollees receive LIS (down from 39% in 2007)
 - About 28% of LIS enrollees in MA-PDs (up from 14% in 2007)
 - Fewer benchmark PDPs, but still 4–12 PDPs

Access and quality in Part D

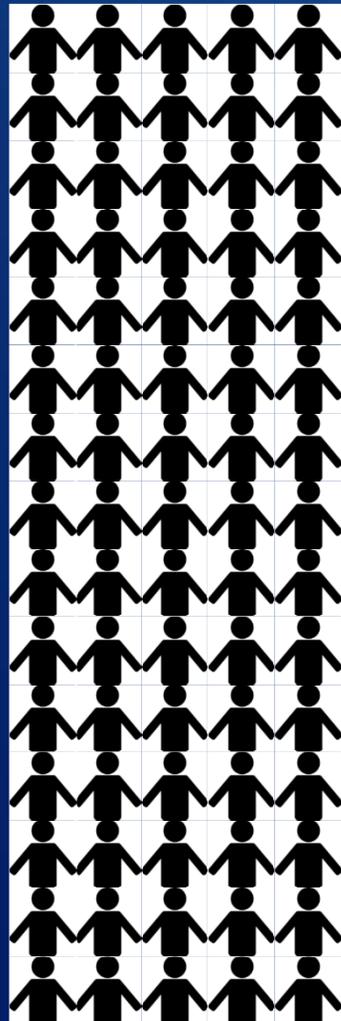
- Most are satisfied with the drug coverage and pharmacy access; 5% reported trouble filling at least 1 medication in 2012
- CMS collects plan quality and performance data to rate plans on a 5-star system (similar to Part C)
 - Average ratings have generally increased over time, particularly among MA-PDs
 - MA-PDs may have stronger incentive to improve their ratings because of effect on bonus payments under Part C
 - Changes in metrics used to rate plans make it difficult to assess changes in quality over time

Part D's defined basic benefit structure



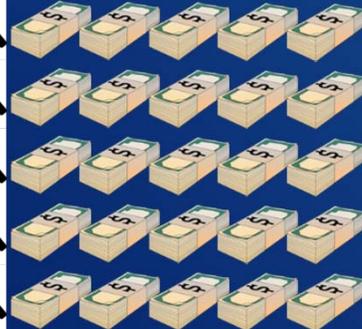
Tails for the distribution of Part D drug spending in 2012

75% of enrollees had spending below the coverage gap



- Plan premiums reflect spending below coverage gap, small share of gap, 15% of catastrophic
- Medicare's reinsurance pays 80% of covered benefits in catastrophic phase

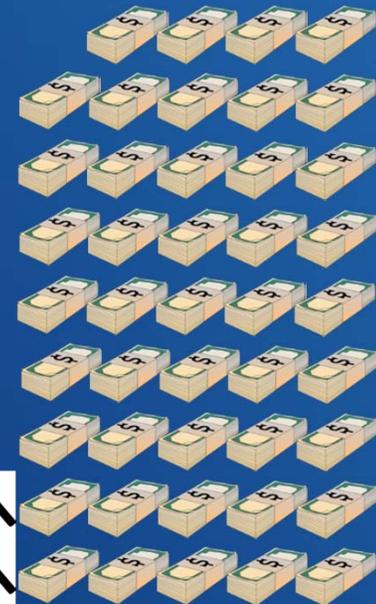
25% of gross spending



8% of enrollees reached the catastrophic phase

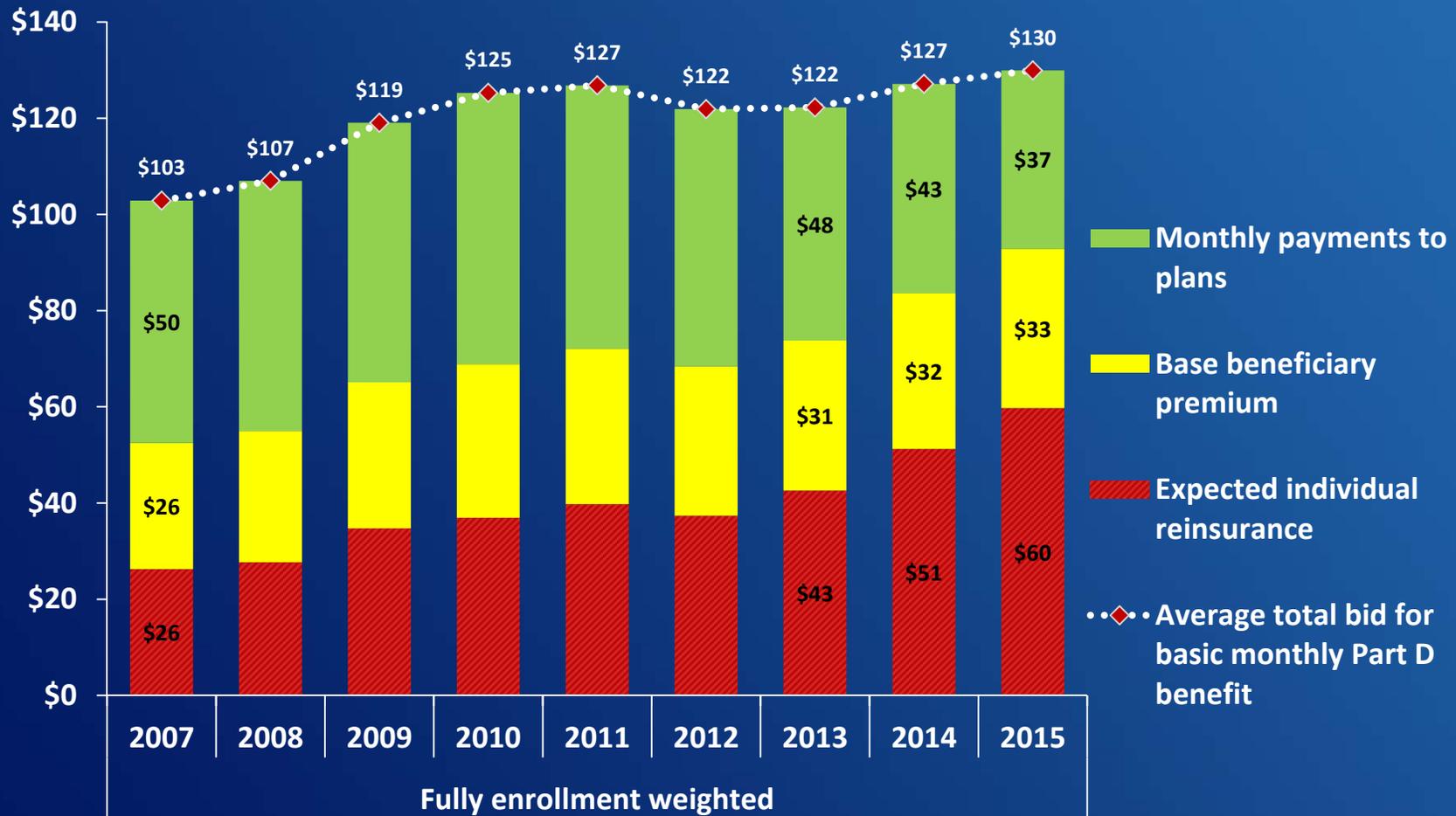


44% of gross spending



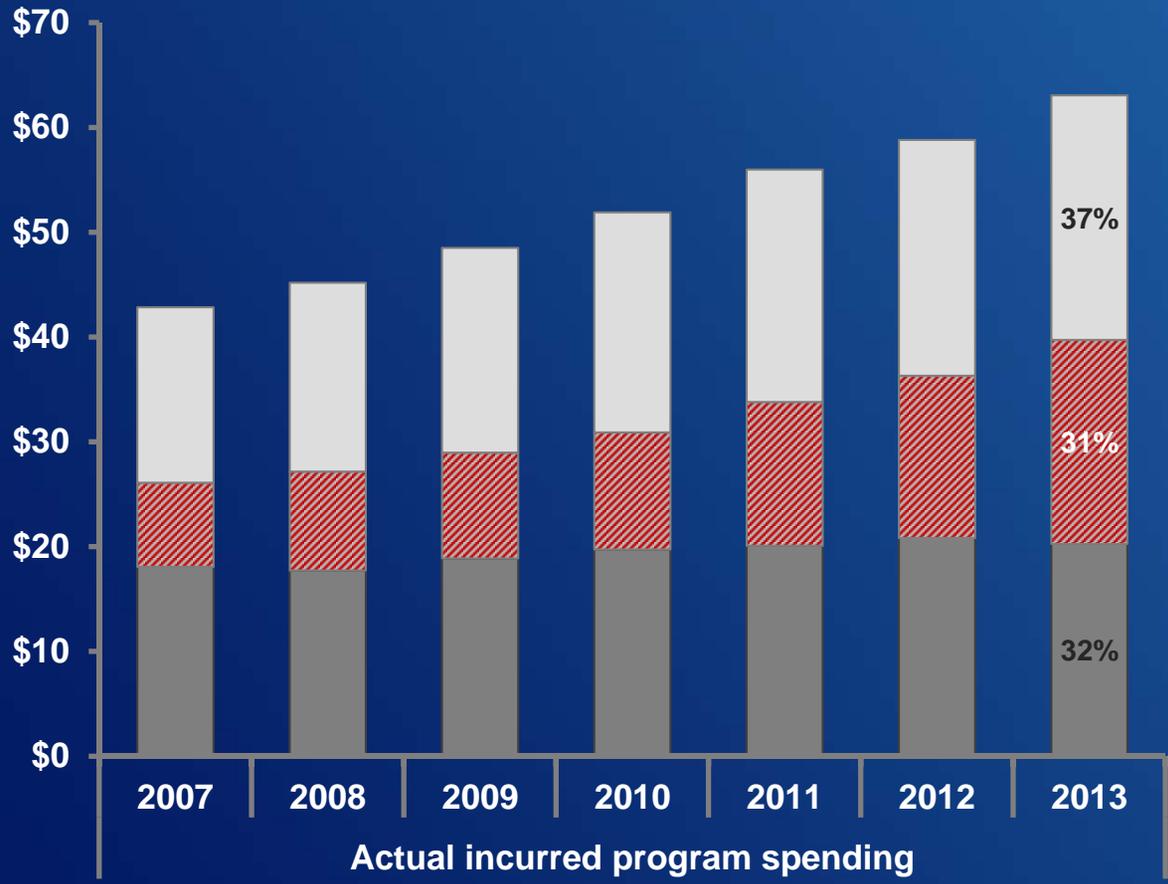
Individual reinsurance is the largest component of plan bids

National average bid for an enrollee of average health



Reinsurance and LIS have grown much faster than the direct subsidy

In billions of dollars



Cumulative growth
2007-2013

■ Low-income subsidy	39%
▨ Reinsurance	143%
■ Direct subsidy	12%

In 2013, LIS enrollees accounted for:

- 1/3 of enrollment
- 2/3 of total program spending

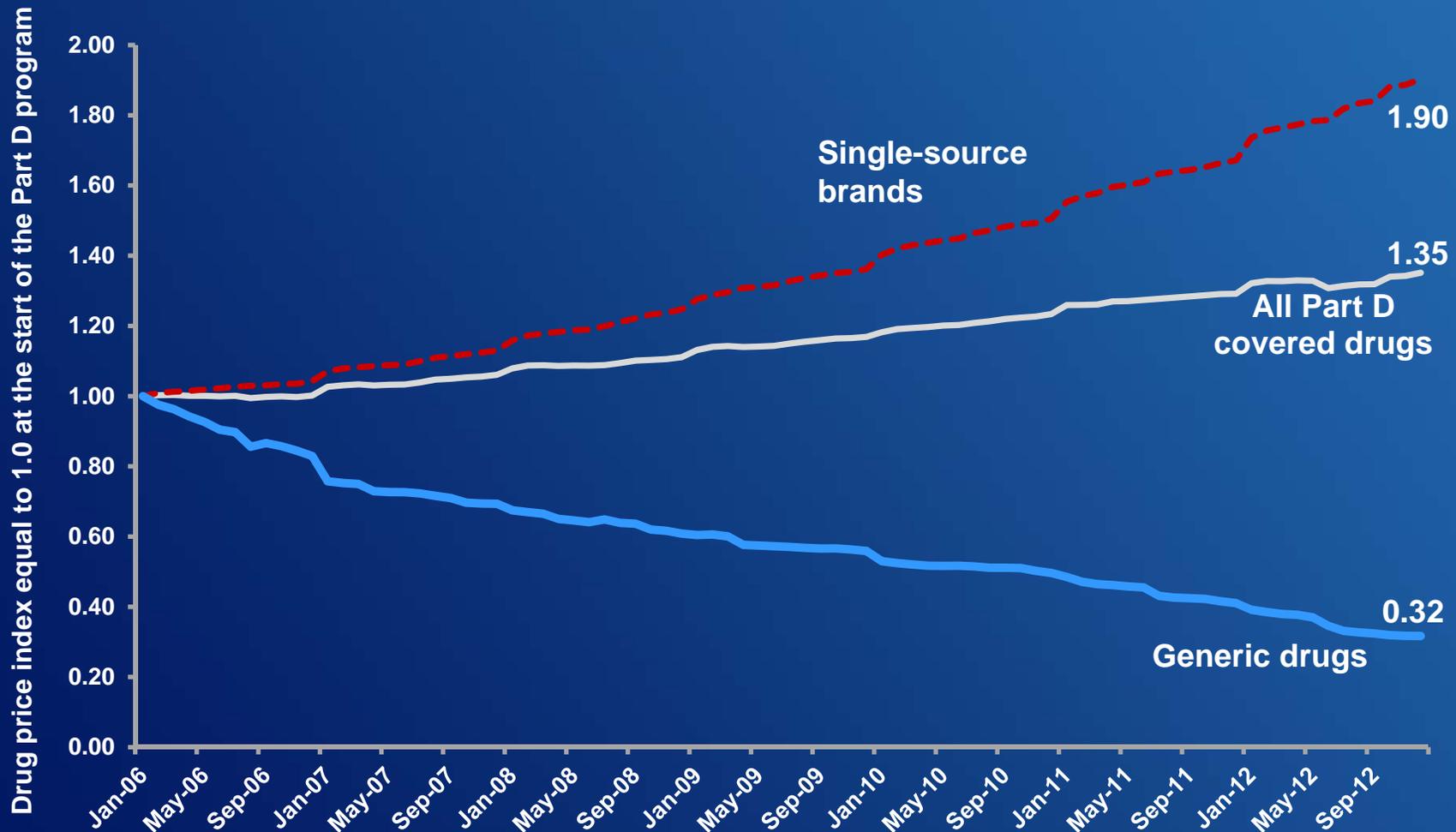
Strategies for controlling growth in plan premiums

- More plans use cost sharing differentials to encourage the use of lower-cost drugs
 - In 2015, over 80% of PDP offerings use 5-tier structure w/ nonpreferred and preferred tiers for both brands and generics, and a specialty tier
- In 2015, 90% of PDP offerings use lower cost sharing at preferred pharmacies
 - Plans get lower prices (rebates/discounts) at preferred pharmacies in return for increased volume
 - Availability of preferred (lower cost sharing) pharmacies vary widely by plan and by region
- ➔ Both strategies provide financial incentives to use lower-cost drugs/providers, potentially reducing program costs
- ➔ However, these approaches could also increase Medicare's spending for LIS

Two underlying trends affecting drug prices in Part D

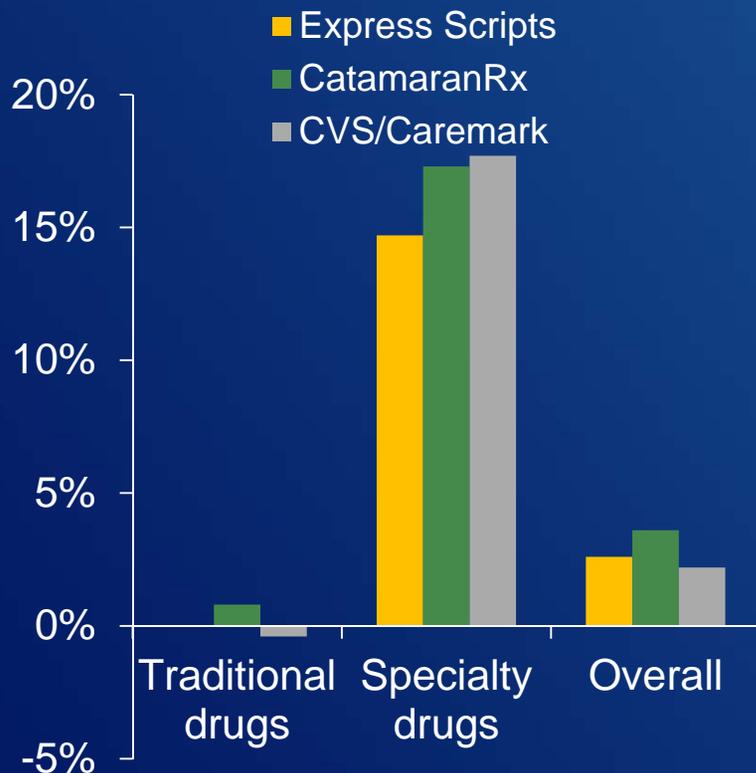
- Large number of patent expirations for blockbuster drugs in recent years
 - Average GDR grew from 61% (2007) to 81% (2012)
 - Lower per capita spending for most enrollees
 - Decrease in the share of enrollees reaching the catastrophic phase in 2012 claims data
- Drug pipeline dominated by higher-priced biologics and specialty drugs
 - Increased use of biologics by high-cost enrollees
 - Implications for LIS and reinsurance spending
 - Available data do not yet reflect recent Hep-C drugs

Growth in brand prices, decline in generic prices, 2006–2012



Upward pressure on prices

Growth in capita spending for Medicare Part D business, 2012-2013



- Generics

- Fewer patent expirations
- Some sharp price increases

- Specialty drugs

- Unprecedented launch prices, some for therapies that treat broad populations
- Beginning to drive overall trend in PBMs' spending

- Can plan sponsors negotiate lower prices?

- Depends on availability of therapeutic substitutes
- Role of biosimilars

Summary

- High satisfaction among Part D enrollees
 - Stable premiums and good access to prescription drugs
 - Many plan options to choose from
- But cost trends are increasingly of concern
 - Costs for individual reinsurance and the LIS (where Medicare bears the risk) are growing much faster than the premiums
 - Prices of single-source drugs continue to grow aggressively and drug pipeline is shifting towards higher-cost biologics/specialty drugs
 - Large increases in prices of older generics

On-going and future Part D work

- Part D's risk-sharing arrangement, plan incentives, and implications for financial sustainability (Spring 2015)
- How do plans' strategies to encourage use of lower-cost drugs/providers affect the LIS?
 - Revisit Commission's recommendation to change LIS cost sharing structure to encourage use of lower-cost drugs?
- Other issues
 - Effects generic drug price increases
 - Polypharmacy and adverse drug events