Advising the Congress on Medicare issues

Sharing risk in Medicare Part D

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Roadmap

- Quick review of June 2015 chapter
- New data and effects of drug prices on program spending
- Potential policy changes
  - Stronger incentive for Part D plans to control spending
  - More flexibility for plans to manage costs
- Next steps

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Mechanisms for and objectives of risk sharing in Part D

Mechanism	Objective
Direct subsidy: Medicare's subsidy that lowers premiums for all enrollees. Medicare pays plans a monthly capitated amount.	Plan sponsors manage enrollees' benefit spending because the sponsor loses money when spending is higher than payment + enrollee premium.
Risk adjustment	Counters the incentive for sponsors to avoid high-cost enrollees
Individual reinsurance	Counters the incentive for sponsors to avoid high-cost enrollees
Risk corridors	• Initially used to establish the market for stand-alone drug plans • Protection against unanticipated benefit spending (e.g., introduction and wide use of a high-cost drug)

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Part D's low-income subsidy (LIS)

- Beneficiaries at or below 150% of poverty
- Subsidizes premiums
- Subsidizes cost sharing
  - $0 or nominal copay amounts set in law
  - No coverage gap
- 12.4 million (1/3 of total enrollment) in 2013
  - Mostly in PDPs
  - Average monthly spending of $377 (vs $179 for non-LIS beneficiaries)
- In 2013, 2/3 of total program spending was for LIS beneficiaries

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Trends in premiums and per capita program spending before 2014

	Spending per member per month for basic Part D benefits (in dollars)							
	2007	2008	2009	2010	2011	2012	2013	Average annual growth
Enrollee premiums	$22.64	$25.00	$28.29	$30.14	$30.94	$29.87	$30.18	4.9%
Direct subsidies	61.56	57.08	58.22	57.48	55.55	53.93	47.59	-4.2%
Reinsurance	25.59	28.33	30.15	32.36	38.86	40.61	44.90	9.8%
Total	$109.79	$110.41	$116.67	$119.98	$125.35	$124.40	$122.67	1.9%

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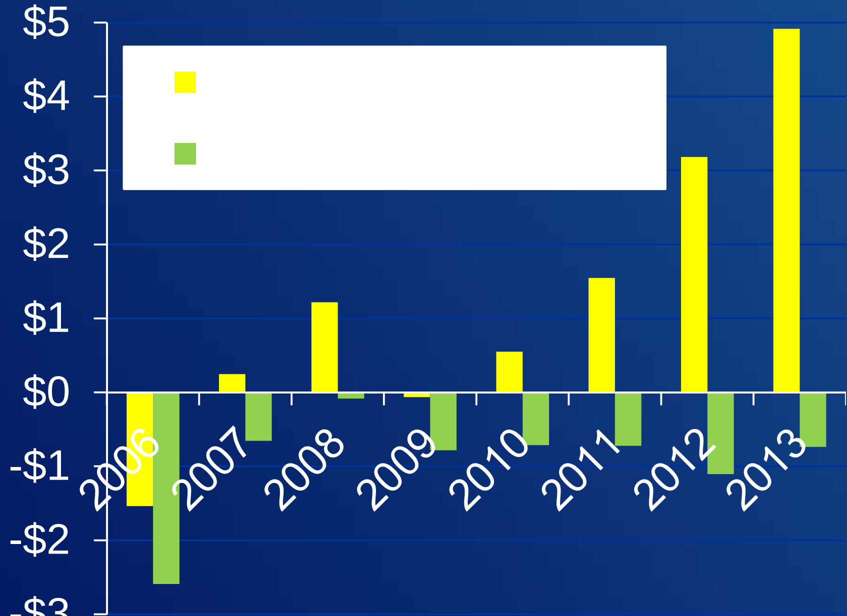
Source: MedPAC analysis of 2013 Part D reconciliation data from CMS.
Note: Data are preliminary and subject to change.

Patterns of reconciliation payments before 2014

Reconciliation payments from Medicare to plans in $billions



Source: MedPAC based on data from CMS.

Note: Data are preliminary and subject to change.

- Individual reinsurance
  - Sponsors underbid on catastrophic spending
  - Medicare paid plans
- Risk corridors
  - Sponsors overbid on rest of covered benefits
  - Actual benefits often 90% of bids or lower
  - Plans paid Medicare

Drug prices have become a major concern

- Rapid growth in prices for both generic and brand-name drugs
- High launch prices for new specialty drugs
- Pipeline shift towards more expensive therapies, such as biologics
- Some drugs have no therapeutic substitutes
  - Little leverage to negotiate rebates/discounts
  - May translate into higher enrollee cost-sharing/premiums

2014 payment patterns may be different

- Medicare trustees estimated that program would make more than $13 billion in reconciliation payments to plans
  - $9.9 billion in additional reinsurance
  - $2.3 billion in additional LIS cost sharing
  - $0.9 billion in risk-corridor payments
- Trustees attributed the higher-than-expected costs to the new Hepatitis C therapies

MEDPAC Source: 2015 annual report of the Boards of Trustees of the Medicare trust funds.

Beneficiaries with spending above the OOP threshold

- 2.9 million (7.6% of all Part D enrollees) in 2013
- Most receive the LIS (75% in 2013)
- Non-LIS enrollees growing faster
- Accounting for a growing share of spending
- Growth in spending driven by prices (2007-2013)

8.4% per year = 6.9% price growth x 1.4% volume growth

MEDPAC Note: Data are preliminary and subject to change.

Combination of policy approaches

- Stronger incentives for plans to control spending, especially of high-cost enrollees
- Provide plans with more flexibility to manage costs
- Consider increasing out-of-pocket protection for enrollees

Stronger incentives to manage: Risk corridors

- Discussed eliminating or modifying corridors last spring
  - Market for stand-alone drug plans well established
  - Over 2006–2013, corridors limited plan profits
- Trustees estimated Medicare will make risk corridor payments to plans for 2014 benefits
- Uncertainty about spending for new therapies
- Might want to revisit corridor policy later

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Stronger incentives to manage: Individual reinsurance

- Reduce or eliminate Medicare's reinsurance
  - Same Medicare subsidy, but more through capitated payments rather than open-ended reinsurance
  - Offsetting behavioral effects on costs
    - Downward pressure through greater incentive to manage
    - Some upward pressure for plan sponsors that need to purchase private reinsurance
- Compared to reducing Medicare reinsurance, eliminating reinsurance would provide:
  - Stronger incentives for plans to manage
  - But also stronger incentives for plans to avoid high-cost enrollees

More flexibility to manage: Formulary tools

- Plans must cover 2 drugs per therapeutic class
- Plans must cover “all or substantially all drugs” in 6 protected classes
  - Codified in 2008 with review process
  - CMS proposed removing antidepressants and immuno-supressants from protected classes, but never implemented
- Mid-year formulary changes
  - “Enhancements” allowed, CMS must approve “negative changes”
  - New drugs generally added without applying utilization management tools (e.g., prior authorization)
- Consider permitting tools used for commercial benefits

More flexibility to manage: LIS cost sharing

- In 2012, the Commission recommended that Congress give the Secretary authority to provide stronger financial incentives for LIS enrollees to use lower-cost generics
- Since then, Part D plans have begun to use new types of differential copays for non-LIS enrollees:
  - Preferred and nonpreferred generic tiers
  - Preferred pharmacy networks
- Consider whether to broaden the recommendation to encompass newer tools

Increasing beneficiary protection: Fixed-dollar copays above OOP limit

- OOP spending burdensome for beneficiaries with certain conditions
- Could reduce burden with fixed-dollar copays
- 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 could grow significantly
  - Numbers of non-LIS enrollees who reach OOP limit is growing faster than LIS
  - Pipeline includes many specialty drugs

Summary of policy options to discuss

- Reduce or eliminate Medicare's individual reinsurance
- Broaden Part D plans' flexibility to use formulary tools
- LIS cost sharing: Modify the Commission's 2012 recommendation
- Fixed-dollar copayments above the out-of-pocket limit

Next steps

- Your comments on this work
- Your guidance for developing policy options
- June 2016 chapter

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