Medicare [Part D]

Health Policy Brief | The structure of Medicare Part D and the problematic incentives it creates call for actionable solutions to provide relief to patients and taxpayers.

THE ISSUE

The structure of Medicare Part D, which pays for retail prescriptions for Medicare beneficiaries, does not provide plans with enough incentives to manage the benefit to the advantage of taxpayers or patients. Currently, after an initial coverage phase, each beneficiary enters the "donut hole" where brand drug manufacturers pay 70 percent of a brand drug's cost, beneficiaries pay 25 percent, and plans only pay 5 percent.[1] There is a somewhat similar structure for generic drugs during this phase of the benefit as well.

After the donut hole, enrollees with very high drug costs enter the catastrophic phase, where they are responsible for 5 percent of costs while plans are only required to pay 15 percent.[2] In this phase of the benefit, the Medicare program provides reinsurance payments to plans that cover 80 percent of drug costs. The Part D plan gets the rebate from the drug, and the taxpayer pays more.

Because of this federal financing structure, plans and manufacturers are incentivized to move beneficiaries quickly through the donut hole and into the catastrophic phase, insulating patients from some of the high costs of medications while forcing the taxpayer to pick up a larger portion of the bill. Additionally, manufactures can use payments to Part D plans, through rebates and other types of remuneration, to incentivize the placement of brands ahead of generics on formularies.[3] This financing structure puts less pressure on PBMs and plans to steer beneficiaries to the lowest cost, clinically equivalent drugs, which leads to high cost products being placed on preferential formulary tiers.

THE EVIDENCE

Drug spending in Medicare Part D is growing quickly. In 2017, the program and its beneficiaries spent about $120 billion on drugs after rebates which represents over 40 percent growth since 2013.[4] This trend shows no signs of slowing. CBO projects that federal spending on Part D will more than double by 2029.[5] From 2007 through 2016, reinsurance payments to Part D plans, which are financed largely by the taxpayer and cover high cost patients in the catastrophic phase, rose at a rate of 17.7 percent per year.[6] In fact, the program's costs to the taxpayer are rising faster than premiums paid into Part D.[7]

This is particularly concerning given that specialty drugs already comprise a significant share of Part D spending and that the drug pipeline is shifting to high cost specialty drugs. Brand-name specialty drugs accounted for just 1 percent of prescriptions and about 30 percent of net spending in Part D in 2015.[8] Net spending on specialty drugs in Part D more than tripled between 2010 and 2015, rising from $8.7 billion to $32.8 billion.[9] For each beneficiary using a specialty drug in Part D, average net spending was nearly $34,000 in 2015. Beneficiaries without cost-sharing subsidies spent $3,540 out-of-pocket for these drugs.[10] Specialty drugs are a significant portion of the drug pipeline and are projected to comprise nearly half of pharmacy industry revenues by 2022.[11]

$120B

The amount spent by Medicare Part D and its beneficiaries on drugs after rebates in 2017

17.7%

The rate at which reinsurance payments to Part D plans rose from 2007 through 2016

$34,000

The average net spending in 2015 for each beneficiary using a specialty drug in Part D

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THE SOLUTIONS

- Exclude manufacturers' discounts in the coverage gap from enrollees' true out-of-pocket spending. These discounts can mask the full cost of drugs from beneficiaries and encourage the use of high-cost products. The Congressional Budget Office (CBO) projected this would save $58.5 billion over 10 years. [12]
- Eliminate enrollee cost sharing above the catastrophic threshold while also transitioning plan responsibility to 80 percent, thus bringing down Medicare's reinsurance liability to 20 percent. This change should protect patients from the financial burden of high-cost drugs while also encouraging stricter management of the drug benefit. CBO projected that these policies, taken together, would save $1.5 billion over 10 years, with much of the savings from the benefit structure change being used to lower patient out of pocket costs.[13]
- Alternatively, require both Part D plans and brand pharmaceutical manufacturers to finance all catastrophic spending. This policy would be designed to eliminate the donut hole and require plans to pay 75 percent until the catastrophic threshold. It would also be designed to ensure that manufacturers pay a level of discount above the catastrophic threshold that has them contributing, at a minimum, the same amount to the Part D program under the proposal as they do under current law.
- Require pharmaceutical manufacturers to pay a penalty to Medicare when a drug's list price grows faster than an inflation benchmark such as the Consumer Price Index for All Urban Consumers (CPI-U). This type of inflation penalty is used in Medicaid to recover excessive price growth. It would generate sizable savings to the Medicare Part D program that could be used to lower beneficiary out-of-pocket costs. [14]
- Grant Part D plans greater flexibility to manage the drug benefit by removing at least the antidepressant and immunosuppressant drug classes from protected status and by considering recent administrative proposals that give plans additional tools to manage the six protected classes. [15] To protect the beneficiary, these policies must be coupled with expeditious, well-functioning exceptions and appeals processes. In 2014, CMS proposed removing antidepressants, antipsychotics, and immunosuppressants from protected status, which was projected to save more than $700 million over five years.[16]
- Streamline the process for formulary changes, require greater justification for prescribing exceptions to established formularies, and permit plans to use selected tools to manage specialty drug benefits while maintaining appropriate access to needed medications. CBO has projected that increased flexibility and management would save $6.34 billion over 10 years. [17]

1 https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/
2 *Ibid.*
3 Socal MP, Bai G, Anderson GF. Favorable Formulary Placement of Branded Drugs in Medicare Prescription Drug Plans When Generics Are Available. JAMA Intern Med. Published online March 18, 2019. doi:10.1001/jamainternmed.2018.7824
4 Arnold Ventures' analysis using the Medicare Part D Prescription Drug Event Data and rebate information in the Medicare Trustees Report published June 2018.
5 https://www.cbo.gov/system/files?file=2019-05/51302-2019-05-medicare.pdf
6 http://www.medpac.gov/docs/default-source/reports/mar18_medpac_ch14_sec.pdf
7 *Ibid.*
8 https://www.cbo.gov/system/files?file=2019-03/55011-Specialty_Drugs_WP.pdf
9 *Ibid.*
10 *Ibid.*
11 http://drugchannelsinstitute.com/files/State-of-Specialty-Pharmacy-2018-Fein-Asembia.pdf
12 https://www.cbo.gov/system/files?file=115th-congress-2017-2018/dataandtechnicalinformation/53906-medicare.pdf
13 *Ibid.*
14 https://www.cbo.gov/system/files?file=2018-09/51431-HealthPolicy.pdf
15 http://www.medpac.gov/docs/default-source/comment-letters/01162019_partd_4180_p_medpac_comment-letter_v2_sec.pdf?sfvrsn=0
16 https://www.pewtrusts.org/en/research-and-analysis/fact-sheets/2018/03/policy-proposal-revising-medicares-protected-classes-policy
17 *Supra* note 12.