The Medicare prescription drug program (Part D): Status report

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Snapshot of the Part D program

- Among 59.9 million Medicare beneficiaries in 2018:
  - 43.9 million (73.3%) enrolled in Part D plans
  - Another 2.5% received retiree drug subsidy (RDS)
  - 24.2% had coverage as generous through other sources, or had no or less generous coverage
- Program spending of nearly $80 billion in 2017
  - About $79 billion for payments to Part D plans
  - About $0.8 billion for RDS
- Plan enrollees
  - Paid $14 billion in basic premiums* plus additional amounts in 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.

Part D enrollment in 2018 and plan offerings for 2019

- Enrollment in 2018
  - 58% of all Part D enrollees in PDPs, 42% in MA-PDs (compared with 70% in PDPs, 30% in MA-PDs in 2007)
  - 28% received LIS (down from 39% in 2007)
  - 39% of LIS enrollees in MA-PDs (up from 14% in 2007)
- Plan offerings for 2019
  - 21% more MA-PDs
  - 15% more PDPs, range of 22 – 30 per region
  - Number of PDPs qualifying as premium-free to LIS enrollees remained stable; Florida region has 2 qualifying PDPs, other regions have 3 – 10

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Note: PDP (prescription drug plan); MA-PD (Medicare Advantage prescription drug [plan]); LIS (low-income subsidy). Results are preliminary and subject to change.

Key trends since 2007

- Enrollment grew 6% per year through 2018
  - Higher among non-LIS enrollees (7%) than LIS (3%)
  - Move from RDS to Part D employer-group plans
- Average monthly premiums stable at around $30 per month ($32 in 2018), but wide variation across plans
- Medicare's reinsurance has made up a growing share of payments to plans

Note: Results are preliminary and subject to change

Part D was designed to give plans incentive to manage drug spending

- Private plans compete for enrollees
- Manage benefits through:
  - Formulary design and tiered cost sharing
  - Negotiated rebates from manufacturers
  - Pharmacy networks
- But are incentives for cost control eroding?
  - Growing share of Medicare's payments to plans based on cost-based reinsurance
  - Low plan financial liability combined with high rebates

Recent changes to Part D

- Regulatory flexibility around plan formularies
  - Certain mid-year formulary changes allowed
  - Can vary how to manage a given drug depending on a patient's indication
  - MA-PDs may use step therapy for Part B drugs
- Coverage gap closes one year early for brand-name drugs (BBA 2018)
  - Brand discount increased from 50% to 70%
  - Plan financial liability just 5% in the coverage gap

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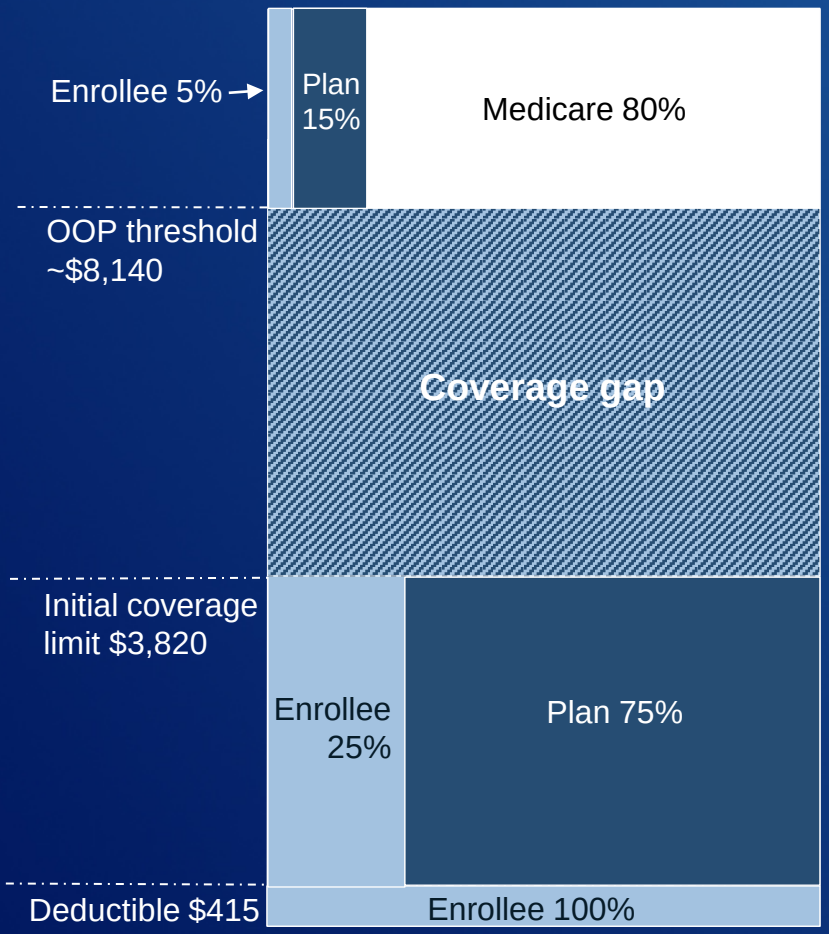
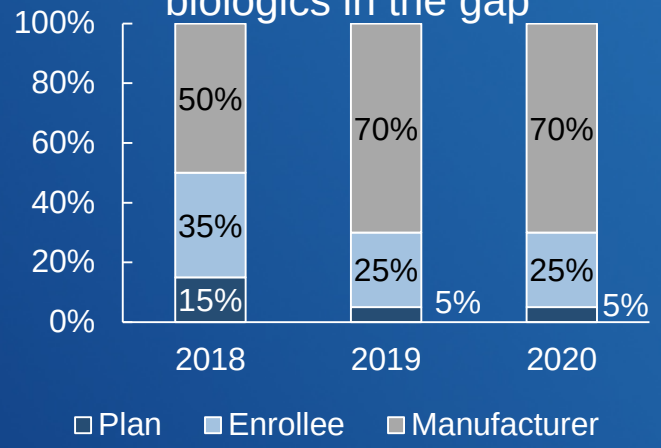
Note: BBA (Balanced Budget Act of 2018).

As of 2019, cost sharing for brand-name drugs in coverage gap is 25 percent

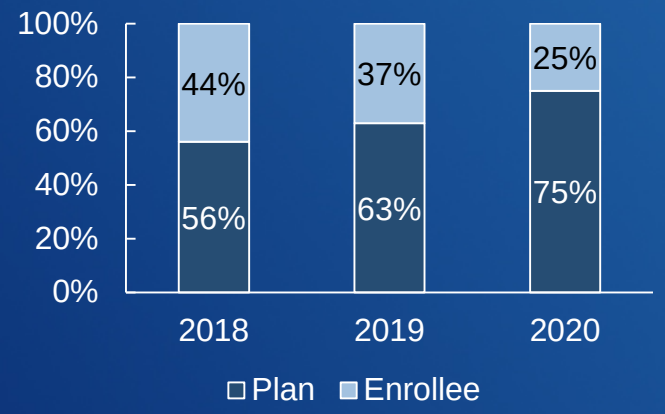
Defined standard benefit in 2019



Brand-name drugs and biologics in the gap



Generics in the gap



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Part D program spending flat in 2017, but continued growth in cost-based reinsurance

Spending category	Spending in billions			Percentage growth, 2007—2017	
	2007	2016	2017	Cumulative	Average annual
Direct subsidy*	$17.6	$17.1	$14.2	-19%	-1.8%
Reinsurance	8.0	35.5	37.4	368%	16.7%
Low-income subsidy	16.7	26.4	27.5	65%	5.1%
Retiree drug subsidy	3.9	1.0	0.8	-79%	-14.7%
Medicare program total	$46.2	$80.0	$79.9	73%	5.6%

Source: MedPAC based on Table IV.B.10 of the Medicare Board of Trustees' report for 2018.
Note: Results are preliminary and subject to change. *Net of Part D risk-corridor payments.

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Overall price growth for drugs covered under Part D moderated, but future is uncertain

- Part D price index (before rebates) decreased by 0.2% in 2016 and increased by 1.6% in 2017
- Brand prices continue to grow, but not as fast as in previous years
  - Grew rapidly in important classes such as insulin
  - Slowed for certain specialty-drug classes, but manufacturers had already raised prices to 3 or more times what they were in 2007
- In 2018, uncertainty about policy changes may have affected decisions about prices

Note: Results are preliminary and subject to change.

High-cost enrollees increasingly drive overall Part D spending growth

- In 2016, 3.6 million (about 8%) had spending high enough to reach the catastrophic phase
- Faster growth among non-LIS enrollees than LIS enrollees

  (18% vs. 5% annually, 2010-2016)
- High-cost enrollees accounted for 58% of spending in 2016, up from 40% in 2010
- Spending growth for high-cost enrollees mostly due to higher prices (prices grew 10% annually vs. -3% for other enrollees)

High-cost enrollees	2010	2016	AAGR
All	2.4	3.6	7%
By LIS status			
LIS	2.0	2.6	5%
Non-LIS	0.4	1.1	18%
% of total Part D spending	40%	58%	N/A

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Note: LIS (low-income subsidy), AAGR (Average annual growth rate), N/A (not applicable). Results are preliminary and subject to change.

Spending patterns for high-cost enrollees differ by LIS status

- In 2016, 1 in 10 high-cost enrollees filled a prescription in which a single claim would have been sufficient to reach the catastrophic phase
  - 18% among non-LIS enrollees
  - 6% among LIS enrollees
- From 2007-2016, average annual spending grew faster among non-LIS enrollees than LIS enrollees
  - 190% for non-LIS enrollees ($29,797 by 2016)
  - 100% for LIS enrollees ($20,899 by 2016)
- Non-LIS enrollees tended to use therapies with higher prices (e.g., treatments for cancer and pulmonary hypertension) compared with LIS enrollees (e.g., insulin and antipsychotics)

Note: Results are preliminary and subject to change.

Higher prices increase the burden on Medicare's reinsurance

Specialty-tier drugs			
	2007	2017	AAGR
Spending (billions)	$3.4	$37.1	27%
% of all Part D spending	*6%*	*25%*	
# of claims (millions)	3.0	8.3	11%
% of all Part D claims	*0.3%*	*0.6%*	
Average cost per claim	$1,151	$4,455	14%

- Specialty-tier drugs, by definition, have high prices*
- Less than 1% of all Part D claims, but 25% of spending in 2017, up from 6% in 2007
- Average cost per claim has grown 14% per year, on average
- Rapid increase in the use of drugs in which a single claim would be sufficient to reach the catastrophic phase:
  - **About 33,000 in 2010**
  - **Nearly 360,000 by 2016**

Note: AAGR (Average annual growth rate). *CMS sets a cost threshold per month ($670 since 2017) for drug and biological products that may be placed on a specialty tier. For this analysis, a specialty-tier drug is identified based on its placement on a specialty tier and varies across plans. Results are preliminary and subject to change.

Part D in a changing environment

- Spending growth driven by specialty drugs and biologics
- Plan sponsors vertically integrating
- Patients facing high prices at the pharmacy
- Factors specific to Part D
  - Regulatory changes to expand plans' tools
  - Increase in manufacturers' coverage-gap discount reduces plans' financial risk
  - Medicare's payments to plans increasingly retrospective, based on cost

➔Need financial incentives and formulary tools to encourage benefits management

Summary

- Questions/comments?
- Spring discussions on Part D
  - Restructuring the coverage-gap discount
  - Approaches to reduce out-of-pocket costs for high-cost drugs