Restructuring Medicare Part D

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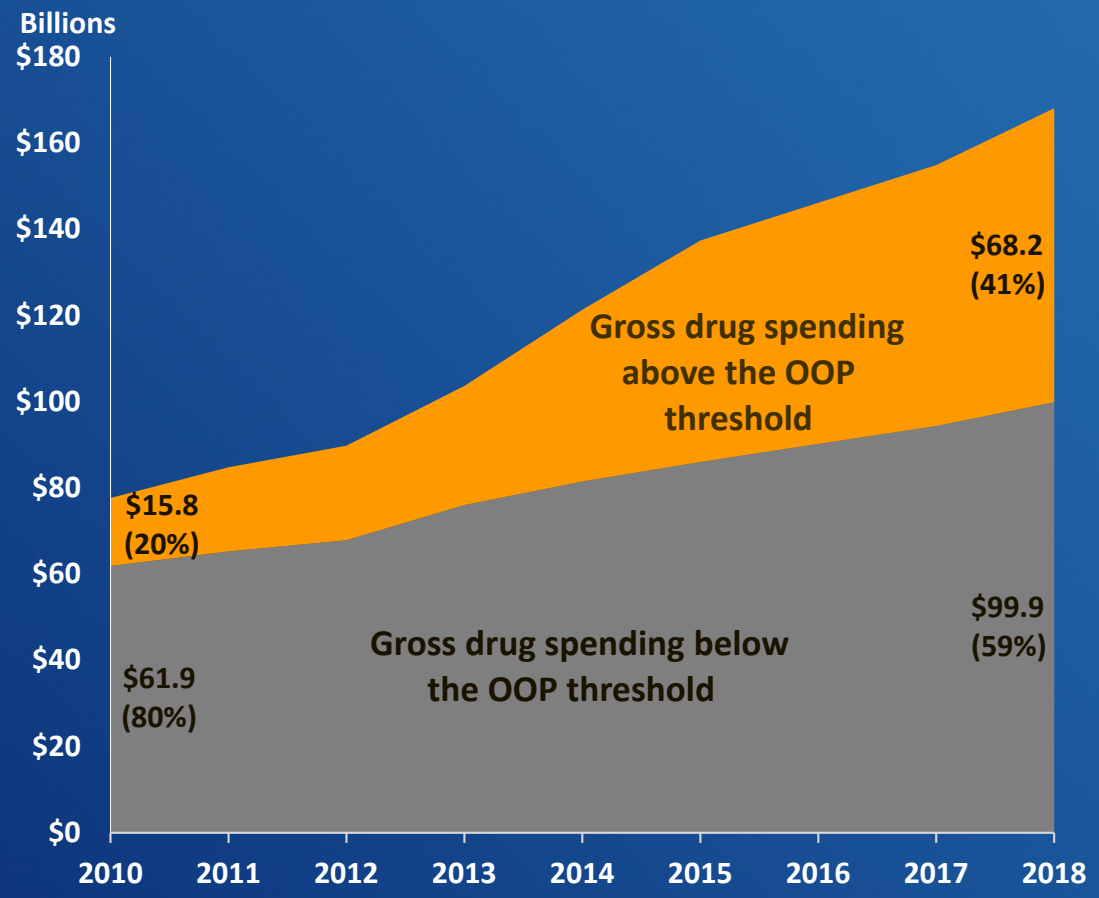
Part D's goals and approach

- 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
- Medicare subsidies, risk sharing, and late-enrollment penalty to encourage:
  - Creation of a new market of stand-alone drug plans
  - Broad enrollment among Medicare beneficiaries

What has changed since 2006?

- Enrollees switched to generics
- Brand manufacturers developed specialty drugs
- Part D's benefit design changed
- Expanded role of cost-based reimbursement (Medicare's individual reinsurance)
- Share of spending in Part D's catastrophic phase has more than doubled



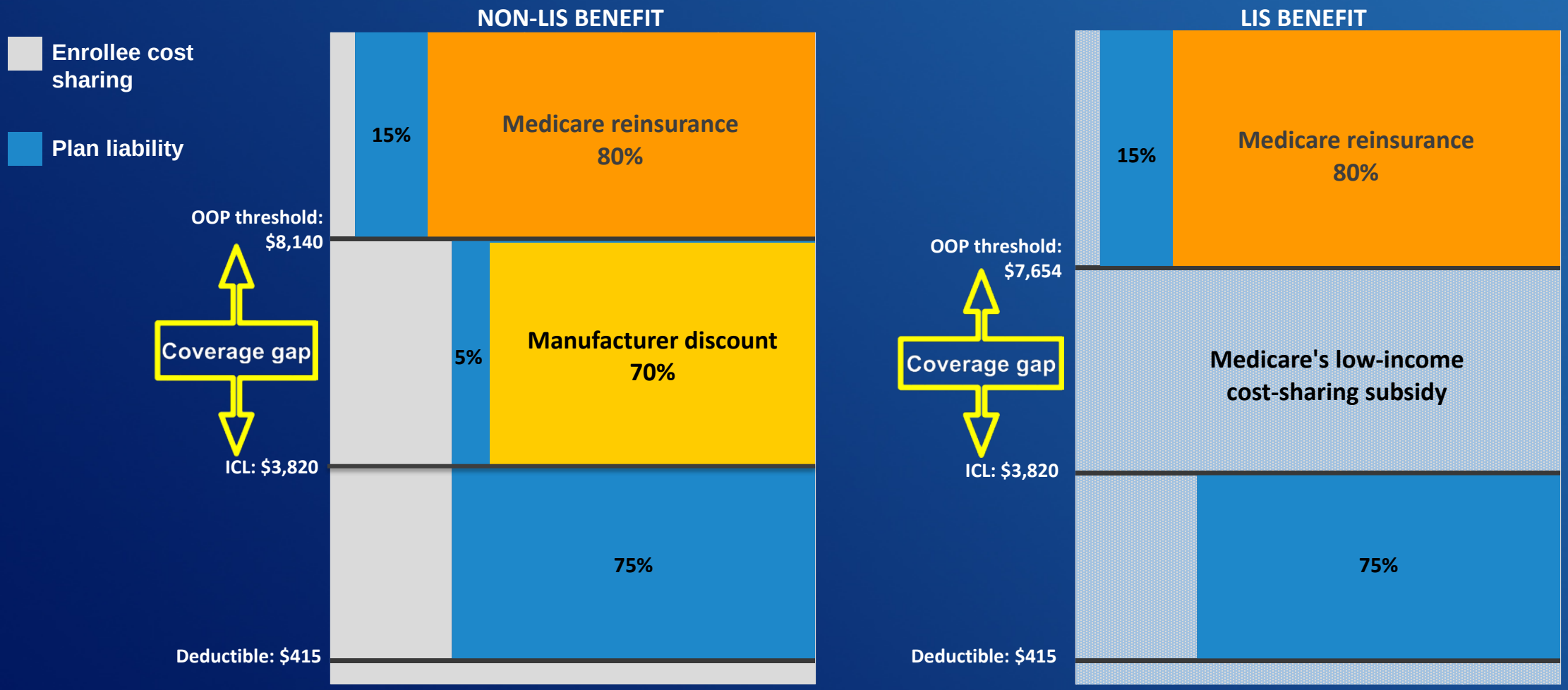
Note: OOP (out-of-pocket). Data are preliminary and subject to change.
Source: MedPAC analysis of Part D prescription drug event data.

Why Part D needs to be restructured

- Commission's 2016 recommendations:
  - Would strengthen financial incentives for managing benefits
  - Give greater flexibility for plan sponsors to use formulary tools
  - Modify LIS cost sharing to encourage generic use
- But changes in benefit design and specialty spending have:
  - ➔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



MEDPAC

Notes: LIS (low-income subsidy), OOP (out-of-pocket), ICL (initial coverage limit). Benefits shown are for 2019. The coverage gap for non-LIS beneficiaries is depicted as it would apply to brand-name drugs and biologics.

Coverage-gap discount affects only a small share of specialty-tier drug spending, 2018

Brand name	Total spending (in billions)	CGD as % of total spending	% of spending above OOP threshold
Specialty-tier drugs and biologics			
Revlimid® (antineoplastics)	$4.1	1.9%	86%
Harvoni® (antivirals)	$1.7	1.1%	89%
Humira pen® (anti-inflammatory)	$2.4	2.4%	78%
Other drugs and biologics			
Lantus Solostar® (insulin)	$2.4	8.6%	25%
Eliquis® (anticoagulant)	$5.0	10.8%	10%
Lyrica® (CNS agents)	$3.0	6.4%	28%

- For most specialty-tier drugs, CGD account for 2% or less because:
  - It applies to a limited range of spending
  - Most spending is above the OOP threshold
- CGD does not apply to LIS beneficiaries
- **CGD is not an effective way to offset rising prices and spending**

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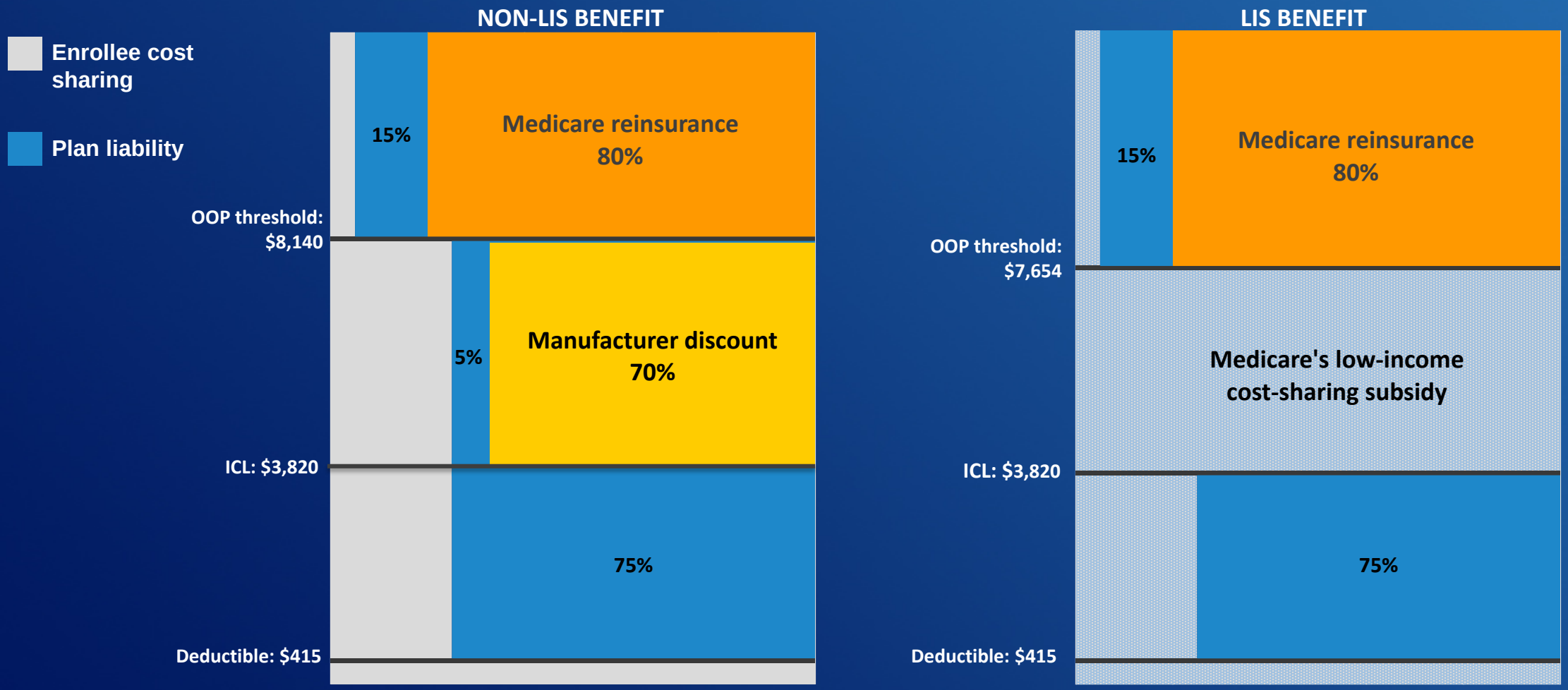
Notes: CGD (coverage-gap discount), CNS (central nervous system), OOP (out-of-pocket). Spending refers to amounts paid at the pharmacy before rebates and discounts. CMS guidance allow plans to place products that cost $670 per month or more on a specialty tier. Most plans have a specialty tier, but drugs placed on specialty tiers vary by plan. Data are preliminary and subject to change.

An approach to restructuring Part D

- Eliminate the coverage-gap discount
- Same benefit design for enrollees with and without the LIS
- Redesigned catastrophic benefit that builds on 2016 recommendations
  - New manufacturer discount
  - Cap on beneficiaries' OOP spending
  - Higher plan liability
  - Lower Medicare reinsurance

MEDPAC Notes: CGD (coverage-gap discount), OOP (out-of-pocket), LIS (low-income subsidy).

How Part D could be restructured



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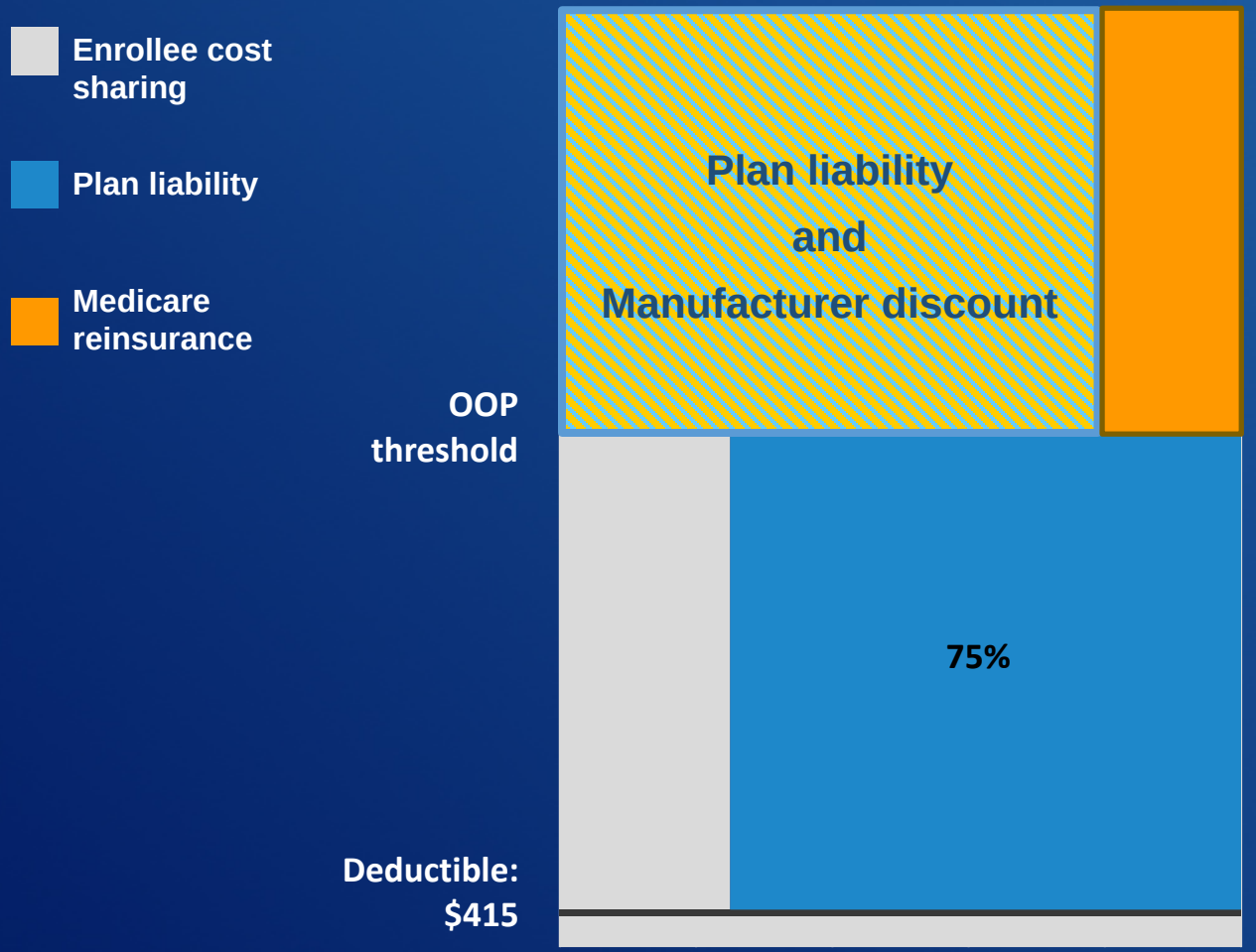
Notes: LIS (low-income subsidy), OOP (out-of-pocket), ICL (initial coverage limit). The coverage gap phase (between the initial coverage limit and OOP threshold) is depicted as it would apply to brand-name drugs for an enrollee who does not receive Part D's low-income subsidy in 2019.

How Part D could be restructured



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Eliminate the coverage gap discount

- Plan liability would be 75% for all drugs and biologics up to the OOP threshold for non-LIS beneficiaries
- Policy implications:
  - Remove price distortions between brand and generic drugs
  - Improve plan's formulary incentives
  - Simplify the benefit structure
  - Eliminate manufacturers' financial contribution ($6.9 billion in 2018, would be higher with a 70% discount)

Notes: LIS (low-income subsidy).

Same benefit design for enrollees with and without the LIS

- For LIS beneficiaries in the coverage gap:
  - Plan liability would increase from no liability to 75%
  - LICS would decrease from 100% to 25%
- Policy implications:
  - Improve plan's formulary incentives
  - Higher benefit costs would lead to increases in Medicare's premium subsidy and enrollee premiums
  - But program spending increase offset by decrease in LICS
  - Plans may need additional tools to manage LIS benefits

Notes: LIS (low-income subsidy), LICS (low-income cost-sharing).

New manufacturers' discount in the catastrophic phase of the benefit

- Discount would apply to all (LIS and non-LIS) prescriptions filled in the catastrophic phase
- Discount rate could be set to ensure manufacturers' financial contribution is no less than under the CGD
- Policy implications:
  - Offset costs of eliminating the CGD
  - Apply more directly to drugs and biologics that command high prices
  - May provide a drag on price growth for some products

Notes: LIS (low-income subsidy), CGD (coverage-gap discount).

Cap on beneficiaries' OOP spending

- Part D's covered benefits would include what is currently 5% cost sharing in the catastrophic phase:
  - For non-LIS enrollees, cost sharing would become zero
  - LIS enrollees already have zero cost sharing, Medicare's LICS would be replaced by Part D's basic benefit
- Policy implications
  - More complete insurance protection
  - Higher benefit costs would lead to increases in Medicare's premium subsidy and enrollee premiums
  - But program spending increase offset in part by decrease in LICS

Higher plan liability / lower Medicare reinsurance

- Consistent with Commission's 2016 recommendations:
  - Lower Medicare reinsurance, increase capitated payments to keep same overall subsidy
  - Higher plan liability in catastrophic phase
  - Risk corridors would remain, risk adjusters recalibrated
- Policy implications
  - Improve plan's formulary incentives
  - Large plan sponsors could self-reinsure, smaller sponsors might need to purchase private reinsurance
  - Plans would need additional formulary flexibility

Do we still need Medicare reinsurance?

- Drug plan market is well established
- Variation in per member pharmacy spending has grown – lower median, more extreme high spenders
- Private reinsurance serves a specific purpose: offset unpredictable risk of extremely high claims
- Medicare's reinsurance is not serving the same role as private reinsurance
- Risk corridors remain in place

Changes to ensure successful transition as plans assume greater insurance risk

- New structure would be phased in over time
- Greater flexibility in formulary management
- Recalibration of the risk adjustment model to discourage plans from engaging in risk selection
- Potential transitional changes to risk corridors
  - Narrow the risk corridors
  - Reduce plans' share of risk

Discussion questions and next steps

- Questions and comments on this general approach?
- How should the catastrophic phase be restructured?
  - Beneficiaries: Zero cost sharing?
  - Medicare reinsurance: 20%?
  - Manufacturer discount: Offset loss of coverage-gap discount revenue, or set a higher rate to offset other costs, e.g., hard OOP cap?
  - Plan liability: High enough to maintain incentives to manage benefits?
- In November, we will have a discussion about plan sponsors that have larger percentages of LIS enrollees