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What's in the Administration's 5-Part Plan for Medicare Part D and What Would it Mean for Beneficiaries and Program Savings?

Juliette Cubanski

Introduction

Today more than 43 million older adults and people with disabilities have prescription drug coverage under Medicare Part D. Part D helps people with Medicare afford their medications by subsidizing the purchase of drug coverage from private stand-alone prescription drug plans (PDPs) and Medicare Advantage drug plans (MA-PDs), and offering additional financial help to people with low-incomes. Although premiums for Part D plans have been stable in recent years, cost-sharing requirements for drugs covered by plans have increased over time. While there have been changes to the benefit since it took effect in 2006 to enhance financial protections—in particular, phasing out the coverage gap—Part D coverage does not fully protect beneficiaries from high drug costs because the benefit does not have an annual cap on out-of-pocket spending. Enrollees who do not receive low-income subsidies are required to pay 5 percent of their total drug costs above the catastrophic coverage threshold.

Against this backdrop, and with rising concern over increases in prescription drug costs, the Trump Administration has proposed what it calls a "5-part plan" that would change several features of the Part D drug benefit. These proposals were included in the Administration's FY2019 budget proposal and referenced in the Administration's May 2018 blueprint on drug costs. (The budget and the blueprint included other proposals related to Medicare Part B drug reimbursement, including shifting coverage for some Part B drugs to Part D, and proposals related to Medicaid. Those proposals are not discussed here.) This brief describes the Administration's five Part D proposals and discusses the potential implications for people with Part D prescription drug coverage and program spending, based on estimates from the Congressional Budget Office (CBO).

What are the proposals in the Administration's 5-part plan for Part D?

1. Share rebates with Part D enrollees

Currently, Part D plans and pharmacy benefit managers (PBMs) negotiate rebates with drug manufacturers in exchange for favorable placement on drug plan formularies. These rebates, which are not disclosed publicly, help to lower plan costs and are currently shared with plan enrollees in the form of lower premiums, but they are not shared directly at the pharmacy counter with enrollees who take the specific drugs for which rebates are negotiated. Part D plans have negotiated steadily higher

manufacturer rebates over time, rising from 9.6 percent of total plan costs in 2007 to an estimated 23 percent in 2017, according to Medicare's Office of the Actuary.

Under the Administration's proposal, Part D plans would be required to pass on at least one-third of total rebates and price concessions to enrollees at the point of sale. The Administration solicited comments on potential policy approaches related to this idea in a November 2017 proposed rule for the Medicare Advantage and Part D programs. The Administration's stated rationale for this proposal is to "improve price transparency" and "allow beneficiaries to share directly in the savings from discounts."

BUDGET EFFECTS

CBO estimated that this proposal would increase federal spending by $43.4 billion over 10 years (2019-2028). The CBO score suggests that Medicare spending would increase substantially as the amount of premium subsidies increases to cover higher plan bids, since plans could no longer use the entire value of these rebates to reduce their costs.

EFFECTS ON BENEFICIARIES

Requiring plans to share a portion of rebates with enrollees at the point of sale would produce savings for enrollees who take these drugs, since they would face lower out-of-pocket costs on these specific medications when they fill their prescriptions. This could be especially helpful for enrollees who pay cost sharing in the form of a coinsurance rate, which is a percentage of the drug's total cost. But this change would also lead to higher premiums for all enrollees since it would increase plan costs.

2. Change the calculation of "TrOOP"

Under current law, drug manufacturers are required to provide a 50 percent discount on the price of brand-name drugs filled by beneficiaries in the coverage gap. The Bipartisan Budget Act of 2018 increased this discount to 70 percent beginning on 2019. The value of this discount counts towards the calculation of an enrollee's "true out-of-pocket spending" (TrOOP), the amount used to determine when catastrophic coverage begins. Once enrollees reach the catastrophic phase of the benefit, they pay 5 percent of their total costs, plans pay 15 percent, and Medicare pays 80 percent. Based on KFF analysis of Part D claims data, the aggregate value of this manufacturer discount increased from $2.6 billion in 2012, the first year the coverage gap discount was offered, to $5.7 billion in 2016, and the average discount received by Part D enrollees increased from $677 to $1,090 per person over this same time period.

The Administration's proposal would exclude the value of the manufacturer price discount on brand-name drugs filled in the coverage gap from the calculation of beneficiaries' "true out-of-pocket spending." MedPAC also recommended this change, in combination with the proposed changes to catastrophic coverage (described below). The Administration's stated rationale for this proposal is to "correct the misaligned incentive" whereby plans might encourage enrollees to use more expensive brands so that enrollees move more quickly through the coverage gap and into catastrophic coverage, where plans' share of costs is relatively low.

BUDGET EFFECTS

CBO estimated that this proposal would reduce federal spending by $58.5 billion over 10 years. The CBO score indicates that plan costs would decrease substantially as the burden of out-of-pocket costs in the coverage gap shifts to enrollees, as enrollees progress more slowly through the coverage gap and into catastrophic coverage, and as fewer enrollees ultimately qualify for catastrophic coverage—thus lowering plan costs and federal subsidies for Part D coverage. The effects of this proposal would also interact with the Administration's proposal to add an out-of-pocket limit and change reinsurance, as described below.

EFFECTS ON BENEFICIARIES

Although the manufacturer discount has generated significant savings for Part D enrollees who reach the coverage gap, as noted above, it has also been cited as a factor in driving more beneficiaries through the coverage gap and into the catastrophic phase of the benefit. The number of non-LIS enrollees who reached catastrophic coverage was relatively stable between 2007 and 2011, the year before the discount took effect—between 0.4 and 0.5 million—but has increased each year since then, from 0.5 million in 2012 to 1.0 million in 2015.

If the value of the manufacturer discount no longer counted towards TrOOP, Part D enrollees who reach the coverage gap would face higher out-of-pocket costs in that phase of the benefit and would progress through the coverage gap more slowly, meaning fewer enrollees would reach the catastrophic coverage threshold. Higher out-of-pocket costs could also lead to lower utilization, which could lower plan costs. If plan costs are lower as a result of changing the TrOOP calculation, that would also lower plan premiums paid by all enrollees and Medicare spending on premium subsidies.

3. Add an out-of-pocket limit to part d and change reinsurance

Under the current design of the Part D benefit, beneficiaries are required to pay 5 percent of their total drug costs during the catastrophic coverage phase, after their TrOOP spending exceeds an annual threshold ($5,000 in 2018). During this phase, plans pay 15 percent of an enrollee's total costs and Medicare pays 80 percent.

The Administration has proposed to establish an out-of-pocket limit in the Part D benefit by phasing down beneficiary coinsurance in the catastrophic coverage phase of the benefit from the current 5 percent level to 0 percent (no cost sharing) over four years, beginning in 2019. This proposal is paired with another proposal that would increase plans' share of costs for catastrophic coverage from 15 percent to 80 percent, and decrease Medicare's reinsurance from 80 percent to 20 percent. The Medicare Payment Advisory Commission (MedPAC) recommended similar changes in 2016. The Administration's stated rationale for these proposals is to give beneficiaries "more predictable" annual out-of-pocket costs and to "incentive plans to better manage spending throughout the entirety of the benefit."

BUDGET EFFECTS

CBO estimated that adding an out-of-pocket limit, increasing the share of costs that plans pay for catastrophic coverage, and reducing Medicare's reinsurance would reduce federal spending by $1.5 billion over 10 years. The CBO score for these proposals suggests that any increase in Medicare spending that might have resulted from adding an out-of-pocket limit would be more than offset by reducing Medicare reinsurance payments and increasing plans' share of costs for catastrophic coverage, and also by an expected reduction in the number of enrollees who reach catastrophic coverage due to the change in the TrOOP calculation described above. Requiring plans to bear a larger share of costs for catastrophic coverage would also apply greater pressure on plans to exercise more control over their enrollees' total drug costs and utilization, which could reduce plan costs.

EFFECTS ON BENEFICIARIES

Adding an out-of-pocket limit would reduce out-of-pocket costs for Part D enrollees who reach the catastrophic coverage phase of the benefit. In 2015, one million Part D enrollees who did not receive low-income subsidies had spending in the catastrophic coverage phase of the Part D benefit, and their average out-of-pocket costs in the catastrophic phase were $1,215. This added coverage would provide peace of mind to all Part D enrollees, who would benefit from having their annual out-of-pocket costs limited in the event that they had high drug spending. Fewer enrollees would have out-of-pocket spending high enough to qualify for this additional financial protection, however, if the Administration's proposal to exclude the value of the manufacturer discount from the TrOOP calculation was also adopted, as described above.

4. Relax Part D formulary standards

Under current program regulations, Part D plans are required to cover a minimum of two drugs per drug category or class, and to cover all or substantially all drugs in six protected classes (anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection).

The Administration's proposal would loosen Part D plan formulary standards by requiring plans to cover a minimum of one drug per drug category or class, down from the current two-drug requirement. The proposal would also expand plans' ability to use utilization management tools for specialty drugs and drugs in the six protected classes. The Administration's stated rationale for this proposal is to allow plans to "better manage" the Part D benefit.

BUDGET EFFECTS

CBO estimated that this proposal would reduce federal spending by $6.3 billion over 10 years (2019-2028). By relaxing the current two-drug standard for Part D formulary coverage and allowing plans to limit coverage to only one drug per class, plans could have greater leverage in price negotiations. If plans are able to negotiate steeper discounts on the drugs they choose to cover, that could lower plan costs, generate savings for enrollees in the form of lower premiums, and lower Medicare spending. Similar

effects could result from giving plans greater ability to apply utilization management restrictions to specialty drugs and drugs in the protected classes, which would enable plans to exercise greater control over use of these drugs.

EFFECTS ON BENEFICIARIES

Relaxing Part D formulary standards and giving plans greater ability to apply utilization management restrictions to specialty drugs and drugs in the six protected classes could mean that enrollees face more restrictive plan formularies, greater burdens in getting access to certain medications, and more difficulty finding plans that cover all of the drugs they take. Looser coverage standards and greater use of utilization management could lower premiums if plans negotiate higher rebates and if utilization declines, both of which would lower plan costs.

5. Eliminate cost sharing for generics for low-income enrollees

Under current law, low-income subsidy (LIS) enrollees currently pay relatively low cost-sharing amounts for brand-name and generic drugs. For enrollees receiving full subsidies, cost sharing in 2018 is $1.25 for generics and $3.70 for brands; those receiving partial subsidies pay $3.35 and $8.35, respectively.

This proposal would eliminate cost sharing on generic drugs for Part D enrollees receiving LIS, including biosimilars and preferred multisource drugs, beginning in 2019. MedPAC recommended a similar change in 2016. The Administration's stated rationale for this proposal is to encourage the use of "higher value" drugs among LIS enrollees.

BUDGET EFFECTS

CBO estimated this proposal would increase federal spending by $18.7 billion over 10 years. The CBO score for this proposal indicates that the proposal would increase spending for Medicare because the amount of low-income cost sharing subsidies that Medicare provides to plans would increase. Also, to the extent that making generics less expensive for LIS enrollees, including relatively high-cost biosimilars, could lead to higher utilization of these drugs, the amount of low-income cost-sharing subsidies that Medicare provides would be even greater than under the current cost-sharing structure for LIS enrollees.

EFFECTS ON BENEFICIARIES

Because the cost differential between brands and generics is relatively small for LIS enrollees, there is some concern that these enrollees do not face a strong financial incentives to use generic drugs, which increases both their out-of-pocket costs and the cost to Medicare, since the remainder of their cost sharing is subsidized by Medicare. Eliminating cost sharing for generic drugs for LIS enrollees would provide a stronger financial incentive to use generics, and would reduce out-of-pocket costs for LIS enrollees who take generic drugs and for those who are able to switch from brands to generics.

Conclusion

The Administration's 5-part plan for Part D would likely affect all Part D enrollees in terms of their out-of-pocket costs, premiums, and access to medications, although some enrollees would be affected to a greater degree than others. The Administration has emphasized that these proposals are intended to be implemented together, since eliminating any of them would change the impacts of the plan overall. This makes it difficult to precisely measure the effects for beneficiaries, since the effects would depend on several factors specific to an individual enrollee, including what drugs they take, what plan they're enrolled in, how their plan premium changes, how their formulary coverage and access to medication changes, whether they receive low-income subsidies, their level of drug costs in any given year, whether they reach the coverage gap and/or catastrophic coverage phase in any given year, and the level of rebates negotiated by their plan for drugs they take.

Despite the many factors and interactive effects that complicate efforts to examine the potential impact of the Administration's 5-part plan for Part D, it will be important to fully assess the implications of these proposals for Part D enrollees' drug costs, access, and plan premiums, and Part D plan and Medicare program spending.