Medicare Part D in its Second Decade

Elizabeth Hall, Vice President, Federal Affairs
Prior to the Medicare Modernization Act

• 1988 – Catastrophic Coverage Act Passage
• 1989 – Catastrophic Coverage Act Repeal
• 1999 – Breaux (D-LA)-Thomas (R-CA) Commission
• 2000 – Presidential, Congressional candidates of both parties pledge to add Rx coverage to Medicare
• 2001 – President George W. Bush Proposal
• 2002
  – House passes prescription drug bill with premium support demo.
  – Senate considers 3 bills, none advance
• 2003 – Medicare Modernization Act passed
Policy Objectives During 2013 Negotiations

• Provide Affordable Drug Coverage to Medicare Beneficiaries
• Promote Competition
• Promote Consumer Choice
• Constrain Overall Medicare Costs
Medicare Modernization Act – Brief Implementation History

• Dec. 2003 – MMA signed into law
• May 2004 – Drug Discount Cards available
• Aug. 2004 – Proposed Part D rules published
• Oct. 2004 – Comment period ends
• Jan. 2005 – Final rules published
• Jan. 2005 – New Medicare preventive benefits available
• June 2005 – LIS-eligible beneficiaries can start applying for subsidies
• Nov. 2005 – Open enrollment begins
• Jan. 2006 – Part D coverage begins
• May 2006 – First open enrollment ends
Projected vs. Actual Costs

Medicare Part D: Projected vs. Actual Costs*

*Part D costs defined as total payments to Part D plans minus beneficiary premiums and transfers from state Medicaid programs.

Beneficiary Costs

Average Enrollment-Weighted Premium

Changes Over Time

• Formulary Changes
• Increased Income Relating
• Shifts from Part B to Part D
• Payment Standards
• Coverage Gap Changes
• Biosimilars
Proposed Changes

• Non-interference
• MedPAC Proposals
• Budget Proposals
Part D Benefit - 2018

Standard Medicare Prescription Drug Benefit, 2018

<table>
<thead>
<tr>
<th>BENEFIT PHASE:</th>
<th>TOTAL DRUG SPENDING:</th>
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<tbody>
<tr>
<td>Catastrophic Coverage</td>
<td>Enrollee pays 35%; Plan pays 15%; Medicare pays 80%</td>
</tr>
<tr>
<td>Coverage Gap</td>
<td>$8,000</td>
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<tr>
<td></td>
<td>$7,000</td>
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<td>$6,000</td>
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<tr>
<td>Initial Coverage Period</td>
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<td></td>
<td>$2,000</td>
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<tr>
<td></td>
<td>$1,000</td>
</tr>
<tr>
<td>Deductible</td>
<td>$0</td>
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</tbody>
</table>

Brand-name drugs
- Enrollee pays 35%
- Plan pays 15%
- 50% manufacturer discount

Generic drugs
- Enrollee pays 44%
- Plan pays 56%

Catastrophic Coverage Threshold = $8,418 in Estimated Total Drug Costs (5,000 in True-Out-of-Pocket Spending)

Initial Coverage Limit = $3,750 in Total Drug Costs

Deductible = $405

NOTE: Some amounts rounded to nearest dollar. Amount corresponds to the estimated catastrophic coverage limit for non-Low-Income Subsidy (LIS) enrollees ($7,509 for LIS enrollees), which corresponds to True Out-of-Pocket (TrOOP) spending of $5,000, the amount used to determine when an enrollee reaches the catastrophic coverage threshold in 2018.

Medicare Part D

IS A VALUABLE BENEFIT FOR BENEFICIARIES

There was a time when there was no Part D

HAS CHECKS AND BALANCES

Competition & Choice
The Centers for Medicare & Medicaid Sets Rules

IS DYNAMIC, EVOLVES

Recent Changes
Medicare Part D: A Valuable Medicare Benefit

- Created by the Medicare Modernization Act (MMA) of 2003, and formally implemented in 2006

- Provides affordable prescription drug coverage to about 44 million seniors and people living with disabilities.

- Provides low cost sharing to over 12 million low income subsidy patients.

- Beneficiaries are still satisfied with their coverage 10 years later.

- Increased access to prescription drugs through Part D coverage was linked to an 8% decrease in hospital admissions for seniors, according to a 2014 National Bureau of Economic Research study.

HAS CHECKS AND BALANCES

Competition & Choice
The Centers for Medicare & Medicaid Sets Rules
COMPETITION IN PART D

PROMOTES ACCESS
AND
HELPS CONTROL COSTS

Mechanisms to PROMOTE ACCESS
- Plans compete for enrollees based on benefits and quality.
- Beneficiaries have a choice among plans to best meet their needs.
- Enrollees can switch plans each year during open enrollment.
- Premium and cost-sharing subsidies assist low-income beneficiaries.
- There are no limits on the number of prescriptions.
- Defined standard benefit and formulary rules set minimum plan requirements.

Mechanisms to CONTROL COSTS
- Plans are paid based on competitive bids submitted each year.
- Plans and manufacturers negotiate discounts for covered medicines.
- Plans attract enrollment through lower premiums and quality of coverage.
- Plans use tiered formularies, tiered copays, and other utilization management tools.
Beneficiaries Still Have Many Choices of Plans

The average Medicare beneficiary has a choice of 23 stand-alone drug plans and 17 Medicare Advantage drug plans in 2018.

- Stand-alone PDPs
- MA-PD plans

Bar chart showing number of plans from 2007 to 2018:
- 2007: 56 Stand-alone, 16 MA-PD
- 2008: 55 Stand-alone, 26 MA-PD
- 2009: 50 Stand-alone, 26 MA-PD
- 2010: 47 Stand-alone, 21 MA-PD
- 2011: 30 Stand-alone, 14 MA-PD
- 2012: 31 Stand-alone, 15 MA-PD
- 2013: 31 Stand-alone, 15 MA-PD
- 2014: 35 Stand-alone, 15 MA-PD
- 2015: 29 Stand-alone, 15 MA-PD
- 2016: 26 Stand-alone, 16 MA-PD
- 2017: 22 Stand-alone, 16 MA-PD
- 2018: 23 Stand-alone, 17 MA-PD

NOTE: PDP is prescription drug plan. MA-PD is Medicare Advantage drug plan. Plan counts are beneficiary weighted. Number of PDPs is reported at the region level; number of MA-PD plans is reported at the county level. Number of plans excludes Special Needs Plans, Medicare-Medicaid plans, and the territories except Puerto Rico.

The Star Ratings Program creates an incentive for plans to provide quality service and coverage as high performing plans receive a 5% bonus, and gain greater market share as beneficiaries choose to enroll in high scoring plans.
The Centers for Medicare and Medicaid create regulatory documents with opportunity to provide public comment

CMS provides structure to program; oversight on matters for example, discrimination, access restrictions and appeals.

Demonstrations can pilot various options for plans to experiment with benefit offerings to improve patient care and reduce costs
Medicare Part D

IS DYNAMIC, EVOLVES

Recent Changes
Medicare Part D 2019 Defined Standard Plan Design

Before Bipartisan Budget Act 2018

- **5%**
- **15%**
- **30%**
- **20%**
- **5%**
- **15%**
- ***25%**
- **75% plan**
- **100% beneficiary**

80% reinsurance

50% manufacturer

Benefit Phases

**Catastrophic Threshold** $5,100 true out-of-pocket costs (TrOOP)

**Coverage Gap**
- 20% increase in manufacturer discounts
- 5% reduction in beneficiary cost sharing

**Initial Coverage Limit (ICL)**
$3,820 total drug cost

**Deductible**
$415 total drug cost

After Bipartisan Budget Act 2018

- **5%**
- **15%**
- **25%**
- **5%**
- **70% manufacturer**
- ***25%**
- **75% plan**
- **100% beneficiary**

80% reinsurance

70% manufacturer

100% beneficiary
How the Medicare D Program is Working for Beneficiaries Living with Chronic Medical Conditions

Andrew Sperling
asperling@nami.org

May 4, 2018
Part D is Working for Beneficiaries

- Stable affordable monthly premiums – still averaging about $33 per month
- Overall costs 45% below the original 10-year projections
- 87% of Part D prescriptions are generic (up from 50% before implementation) keeping costs low
- Multiple studies have demonstrated 90% of beneficiaries are satisfied with the program
- “Donut Hole” coverage gap has been narrowing each year
What do Beneficiaries Like About Part D

• Affordable monthly premiums
• Catastrophic coverage for individuals with very high drug costs
• Robust choice of plans plan options (contrast with the ACA Exchanges in many states)
• Ability to choose integrated care with Medicare Advantage (MA) plans
• Allowing retirees that have employer coverage to keep it
• Robust drug formularies, including the “6 Protected Classes” policy
6 Protected Classes Policy

- Put in place in late 2005
- Codified by Congress in 2008 and 2010
- Requires Part D and MA plans to include on their formularies “all or substantially all” of the drugs in 6 therapeutic classes
  - Antineoplastics
  - Antiretrovirals
  - Immunosuppressants
  - Anticonvulsants
  - Antidepressants
  - Antipsychotics
- Threats?
  - January 2014 Obama Administration rule
  - Medpac 2015 recommendations
Coverage for Dual Eligible and Low Income Subsidy (LIS) Beneficiaries

- Coverage before Part D
- Beneficiaries concurrently eligible for both Medicare and Medicaid
  - “full” benefit duals
  - “partial” duals – MSP programs and QMBY/SLMBY beneficiaries
- Beneficiaries below 135% of FPL ($18,200 for an individual, $24,690 couples) can apply for LIS
  - Benefits include $0 monthly premiums for plans at or below regional benchmark
  - No coverage gap (aka “Donut Hole”)
  - Fixed cost sharing –
    - $0 for institutionalized duals,
    - $1.25 generic/$3.70 brand below 100% FPL
    - $3.35 generic/$8.35 brand above 100% FPL
- Automatic enrollment and auto-reassignment
- Threat?
  - Medpac recommendations from 2011 and 2015
Challenges Going Forward

• Proliferation of specialty tiers
• Increasing use of Co-insurance as opposed to cost sharing
• Medpac recommendations on 6 protected classes and LIS dual eligible cost sharing
• “Out-of-Pocket Cliff” looming in 2020
Out of Pocket Cliff

- The ACA reconciliation bill in March 2010 began multi-year transition to gradually close the donut hole
- Budget reconciliation expires at the end of its 10-year budget window, in this case 2020
- Costs go up every year and the amount beneficiary out-of-pocket before reaching the catastrophic coverage threshold goes up annually
- The ACA slowed the growth rate of the catastrophic threshold in order to help reduce beneficiary out of pocket spending
- Catastrophic threshold is projected to jump by $1,500 between 2019 and 2020
- Congress needs to fix this cliff!!!