MILLIMAN WHITE PAPER

MedPAC's Proposed Changes to Medicare Part D

Paper 1 of 2: Impacts on Various Part D Stakeholders

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Background

In its June 2016 report, the Medicare Payment Advisory Commission (MedPAC) proposed several changes to the Medicare Part D program. MedPAC advises Congress on policies related to Medicare, and while these recommendations are non-binding, they often indicate future program changes that could potentially be enacted by Congress.

This paper discusses the impact that MedPAC's proposed changes could have on plan sponsors (e.g., insurers or employers), Part D members, and pharmaceutical manufacturers. A second Milliman white paper outlines key considerations for plan sponsors as they prepare for the proposed changes.[1]

The Medicare Part D program was launched in 2006 to provide comprehensive pharmaceutical coverage, which was not previously available through the Medicare program. Part D coverage is offered through private insurance companies who participate in a competitive bidding process. There are different phases to the Part D benefit, each of which has a different cost for each Part D stakeholder (members, plan sponsors, pharmaceutical manufacturers, and the federal government). The Centers for Medicare and Medicaid Services (CMS) prescribes the defined standard (DS) benefit design, which has four distinct benefit phases and 2017 cost sharing as follows:

- **Deductible phase:** A $400 deductible during which members pay 100% of allowed claim costs.
- **Initial coverage phase:** Members pay 25% coinsurance and plan sponsors pay the remaining 75% until reaching $3,700 in total allowed costs. This threshold is known as the initial coverage limit (ICL).
- **Coverage gap phase:** In 2017, members in this phase pay 51% coinsurance and plan sponsors pay 49% of generic medication costs. For brand medications, members pay 40% coinsurance, pharmaceutical manufacturers provide a subsidy of 50%, and plan sponsors pay the remaining 10% of brand costs. The 50% pharmaceutical manufacturer subsidy, known as the Coverage Gap Discount Program (CGDP), applies only to non-low-income (NLI) members because low-income (LI) members already receive cost-sharing subsidies from the federal government during the gap (as well as during the other benefit phases).
- **Catastrophic phase:** Once a member reaches the true out-of-pocket (TrOOP) threshold, which in 2017 is $4,950 in combined member and pharmaceutical manufacturer spending, they enter the final phase, known as the catastrophic or reinsurance phase. At this point, members pay approximately 5% coinsurance, plan sponsors pay 15%, and the federal government pays for the remaining 80% of claim costs through federal reinsurance.

Plan sponsors can offer Part D plans that provide the same or better value to the member than the DS benefit. Enhanced alternative (EA) plan designs include changes from the DS benefit such as a reduced deductible, reduced cost sharing in the initial coverage phase, or additional coverage in the coverage gap phase. Employer Group Waiver Plans (EGWPs) generally instead enhance the Part D benefit through a separate wrap around product that could also be affected by MedPAC's recommendations.

Medicare Part D rising costs

MedPAC expressed concerns over Part D cost increases observed in the last few years, particularly for the federal reinsurance. As is seen in Figure 1 on page 2, the national average federal reinsurance bid amount has more than doubled since the inception of the program in 2006, and the majority of this growth occurred from 2013 through 2017. Much of the recent increases in reinsurance can be attributed to shifts to higher cost specialty products such as those used to treat the hepatitis C virus (HCV).

1 MedPAC's Proposed Changes to Medicare Part D. Paper 2 of 2: Considerations for Part D Plan Sponsors. Retrieved October 27, 2016, from http://us.milliman.com/insight/2016/MedPACs-proposed-changes-to-Medicare-Part-D-Considerations-for-Part-D-plan-sponsors/.

FIGURE 1: MEDICARE PART D PROGRAM BID METRICS PMPM

YEAR	NATIONAL AVERAGE BID AMOUNT	NATIONAL AVERAGE MEMBER PREMIUM	DIRECT SUBSIDY	FEDERAL REINSURANCE
2006	$92.30	$32.20	$60.10	$33.97
2007	$80.43	$27.35	$53.08	$26.82
2008	$80.52	$27.93	$52.59	$29.01
2009	$84.33	$30.36	$53.97	$34.73
2010	$88.33	$31.94	$56.39	$36.92
2011	$87.05	$32.34	$54.71	$39.77
2012	$84.50	$31.08	$53.42	$37.38
2013	$79.64	$31.17	$48.47	$42.60
2014	$75.88	$32.42	$43.46	$51.26
2015	$70.18	$33.13	$37.05	$59.74
2016	$64.66	$34.10	$30.56	$69.07
2017	$61.08	$35.63	$25.45	$78.65

In contrast to average reinsurance amounts, national average member premium (NAMP) has stayed relatively constant over the past 12 years. The national average bid amount (NABA) decreased by about 33% from 2006 to 2017. The direct subsidy, which is paid to plans by the government and equals the difference between the NABA and the NAMP, has also decreased nearly 60% since 2006. Figure 1 shows individual Part D plans now receive a larger government subsidy from the federal reinsurance metric (paid only for members reaching TrOOP) than from the direct subsidy (paid for every member) EGWP reinsurance subsidies are generally lower due to the coverage enhancements they provide.

MedPAC's concern is that plan sponsors do not have enough incentive to manage pharmaceutical costs under the current structure of the Part D program. MedPAC is particularly concerned with the management of high-cost/high-risk members, for whom a very large portion of claim costs are covered by federal reinsurance. MedPAC's proposed changes to the Part D program seem to be largely intended to restructure the catastrophic benefit to better incentivize plan sponsors to manage high costs leading up to, and in, this phase.

Recommendation 1: Transition federal reinsurance from 80% to 20%

MedPAC proposes to reduce the federal reinsurance subsidy from 80% to 20%. MedPAC anticipates this proposal will incentivize plans to better manage the care and costs for high cost members through better contracting with pharmaceutical manufacturers and care management measures.

By decreasing federal reinsurance from 80% to 20%, the plan sponsor would be responsible for the difference and would cover 75% of the costs in the catastrophic phase (assuming no other changes). This change is not expected to significantly impact member premiums, as the NAMP is calculated as 25.5% of the sum of the NABA and the federal reinsurance. If a decrease in federal reinsurance is offset directly by an increase in the liability to the plan sponsor, plan bid amounts will naturally increase and the sum of these two items should not markedly change. On average, members would not see a change in costs. Note this assumes no significant change to plans' ability to manage high-cost members, though MedPAC hopes this proposal will spark plans to do so.

The direct subsidy is the difference between the NABA and the NAMP (prior to risk-adjustment). As a result, we expect that the direct subsidy will increase as NABA increases. This could impact individual Part D plans and EGWPs differently:

- Individual Part D plan sponsors *on average* would receive the same amount of total subsidization from the government, but it would now be weighted more on the direct subsidy than the federal reinsurance relative to the current structure. While this is an average scenario, plan sponsors that underestimate the amount of high-cost/high-risk members enrolled in their plan (typically low income subsidy (LIS) members) will be left with a greater financial burden than those plan sponsors that overestimate. In this scenario, plans will need a greater outlay of cash to pay claims until the reinsurance payment is reconciled. This creates a timing risk, and could cause further

cost increases if the risk model does not properly compensate for the high-cost/high-risk members.

- EGWPs would likely benefit from this change given their reinsurance subsidies have historically been significantly lower than individual plan sponsors, while their direct subsidies are only marginally lower (simply due to lower risk scores). Shifting more funding to the direct subsidy component would likely be a financial benefit to most EGWPs, all else equal.

In any case, the RxHCC risk adjustment model would need to be adjusted to compensate for the resulting increase in the direct subsidy payment to ensure that the risk-adjusted direct subsidies appropriately correspond with plan liability. The change in risk model could impact how both individual and EGWP plans benefit from the change. Even with the RxHCC change, plans would likely seek to manage catastrophic pharmacy costs more closely than they do today in Part D. This could impact negotiations with pharmaceutical manufacturers as a result.

Recommendation 2: Exclude CGDP from TrOOP accumulation

MedPAC proposes to alter the accumulation to TrOOP so that only member cost sharing would count toward a member's accumulation of out-of-pocket expenses, rather than the current structure in which the CGDP also counts toward TrOOP. This provision is likely to have the largest impact on members, employers, and pharmaceutical manufacturers.

As discussed above, brand pharmaceutical manufacturers must provide a 50% discount on allowed costs for any Part D eligible brand product utilized by NLI members in the coverage gap. This is a valuable benefit for the member, because:

- The CGDP counts toward TrOOP and thus, helps the member reach the catastrophic phase sooner (even though the CGDP is not truly an out-of-pocket cost for the member).
- The cost sharing required for the product is lower.

The plan sponsor also benefits from the CGDP, as they are liable for a smaller portion of the overall brand medication costs for NLI members, while still collecting rebates on those products.

This proposal would dramatically increase member cost sharing as members would need to spend more cost sharing to make up for the loss of the CGDP accumulation toward TrOOP. Members would now spend a longer time in the coverage gap and would also spend more cost sharing because members currently pay a higher coinsurance in the coverage gap than in the catastrophic phase. Fewer members would make it to the reinsurance phase of the benefit, in which members are given relief through significantly lower cost sharing.

Members enrolled in EA plans with reduced cost sharing are even less likely to reach the catastrophic phase of the benefit because they will only have low cost-sharing amounts contributing toward TrOOP. EGWPs are expected to be greatly affected by this proposal. These plans currently have a unique structure through a secondary wrap plan to fully leverage the value of the CGDP while requiring low member cost-sharing in the coverage gap. Low member cost-sharing amounts greatly reduce the number of EGWP members who accumulate enough out-of-pocket costs to reach TrOOP without CGDP payments under this proposal. This could lead some employers to drop Part D coverage entirely or to consider a transition from an EGWP plan to a Retiree Drug Subsidy (RDS) plan.

Additionally, this proposal will increase CGDP costs for pharmaceutical manufacturers. CGDP payments will apply for a longer duration because members spend more time in the coverage gap. It is possible that manufacturers would impose stricter contracting terms for discounts and/or rebates to try and recoup these additional costs, with those types of changes potentially affecting costs in all Part D benefit phases.

Recommendation 3: Eliminate all member cost sharing above TrOOP

MedPAC proposes to eliminate the 5% cost sharing paid by members in the catastrophic phase of the benefit.

This would cause the TrOOP to become a hard out-of-pocket maximum (OOPM) for the member since the member would not be responsible for any additional cost sharing above the OOPM. In conjunction with the removal of the CGDP subsidy from TrOOP accumulation, this change would somewhat offset the member cost-sharing increase discussed in Recommendation 2 above. However, this change would not fully offset the large increase in member cost sharing associated with the change in TrOOP accumulation. Since removing the CGDP from the TrOOP accumulation results in fewer members reaching the catastrophic phase, the impact of eliminating member cost sharing about the TrOOP is much less meaningful when combined with the change to TrOOP accumulation.

This change would primarily impact NLI members, because fully-subsidized LI members already have $0 copayments above the TrOOP. However, the proposal would slightly increase premiums for all members and employers as a result of providing richer DS coverage. Pharmaceutical manufacturers would be largely unaffected by this change.

Recommendation 4: Adjust LIS member cost sharing to encourage generic utilization

MedPAC proposes to change the LIS member cost sharing to better incentivize these members to utilize generics rather than brand medications. This could mean decreasing or eliminating generic cost sharing, increasing brand cost sharing, or some combination of reduced generic and increased brand cost sharing. Increased brand cost sharing will disadvantage LI members who utilize band medications.

As of 2017, LI members who are eligible for full subsidy, are dual-eligible for full Medicaid benefits, and have incomes below 100% of the federal poverty level (FPL) will pay $1.20 for generic or preferred multi-source products and $3.70 for all other medications. LIS members who are eligible for full subsidy and have incomes over 100% of FPL will pay $3.30 for generic or preferred multi-source products and $8.25 for all other medications. The spread between generic and brand cost sharing for both income levels is relatively small compared to the average generic-brand cost sharing differential paid by NLI members. Additionally, generic use in the LI population is already fairly high, meaning this change has limited savings potential on average for plans or members.

Currently, most plans with a large portion of LI membership remove products from the formulary as a means to direct members to other lower cost medications. However, for a plan with the same formulary for both NLI and LI members/plans, this strategy is difficult to balance. MedPAC's proposal could allow more flexibility in the formulary design and allow for broader/richer formularies, as members would have a greater financial incentive to utilize generics rather than brands on formulary. This could help pharmaceutical manufacturers gain better formulary access, even if the cost-sharing change further incentivizes generics.

Recommendation 5: Remove protected classes

MedPAC proposes to remove two of the six protected therapeutic classes—immunosuppressants and antidepressants.

Currently in the Part D program, plans must cover all or substantially all medications in six protected classes. The protected classes safeguard members currently utilizing a product from one of these classes to not be denied treatment or have a utilization management criteria (such as step therapy or prior authorization) placed upon their medication, which prevents them from continuing on their recommended treatment path. Removing the antidepressant and immunosuppressant classes from the protected classes list would allow plan sponsors to have greater control over their formularies and may lead to less access and higher rebate payments for pharmaceutical manufacturers in these formulary classes.

As antidepressants account for slightly more than 3% of all Part D spending, this class would account for most of the plan sponsor savings if this proposal were implemented. Immunosuppressants are utilized much less and therefore the impact on potential savings would be less for this class. Overall, savings are likely to be limited because neither of these classes contain a significant amount of high cost products with lower-cost alternatives and only members taking medications in these classes would be materially affected.

Recommendation 6: Allow for greater formulary control

MedPAC's final proposal relates to other measures that allow plan sponsors greater formulary control. These changes include:

- Streamline the process for making formulary changes. This includes giving plans at least one chance to alter their formularies prior to open enrollment, as well as allowing plans to more quickly make midyear formulary changes. The ability to make these changes would give plans greater flexibility and the ability to react more quickly to unexpected increases in costs driven by a particular type of product. However, this proposal could introduce complications related to rebate negotiations, and midyear changes may increase out-of-pocket costs for members in need of a particular product (NLI members are not able to change plans mid-year).
- Allowing plans to manage specialty drug utilization by doing either or both of the following:
  - Split fill (i.e., 15-day initial supply) medications to reduce pharmaceutical waste
  - Allow for preferred and non-preferred specialty tiers
- Creating more standardization in exceptions from providers. The intent of this change is to reduce the delay for members applying for exceptions and provide more clinical objectivity than what is currently provided.

Granting individual plans and EGWPs more formulary flexibility will generally help control total Part D spending. However, it is difficult to determine how meaningful the savings would be at this time. Pharmaceutical manufacturers and members could be affected by the formulary changes in varying ways. It is unlikely that the added controls and savings from this recommendation would entirely offset the additional costs associated with MedPAC's other recommendations.

Conclusion

Each stakeholder in the Part D benefit will be affected differently by the MedPAC proposals. MedPAC's proposed changes are intended to reduce the financial burden on the federal government (and therefore the taxpayers) from subsidizing high pharmaceutical costs, while not adversely affecting a significant proportion of Part D members.

Members: NLI members would experience an adverse financial impact from the exclusion of the CGDP from TrOOP accumulation. As a result, MedPAC's proposal could impact adherence and lead to other long-term medical costs. LI members would be much less affected by the recommendations, with the biggest impact from the change in LIS cost sharing. This results in a financial savings if generic cost sharing is reduced, but a potential cost increase is possible if brand cost sharing is increased.

Plans: Plan sponsors are affected by all of the MedPAC proposals, with the largest individual Part D plan impact being the reduction of federal reinsurance from 80% to 20%, significantly increasing the financial risk for all plans. If this change were enacted, it is possible some small plans could exit the market entirely, which would disrupt members. A corresponding change to the risk adjustment program is also required to avoid creating winners and losers from plans with varying degrees of catastrophic spending. EGWPs, on the other hand, are more affected by the CGDP TrOOP exclusion that could significantly increase plan sponsor liability.

Pharmaceutical manufacturers: Pharmaceutical manufacturers also experience a negative financial impact from the exclusion of the CGDP from the TrOOP. MedPAC's proposal increases the length of the coverage gap since only member cost sharing would count toward TrOOP. As the duration of the coverage gap increases, pharmaceutical manufacturers' liability for the CGDP also increases.

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