Medicare Financing and the Cost of Drugs: Part D

Introduction

Despite recent volatility, prescription drug costs and spending—including out-of-pocket costs for patients—are projected to rise significantly over the next several years.[1] Further, total government share of all U.S. retail prescription drug spending is expected to near 50 percent by 2026.[2] In recent years, drug manufacturers have dramatically increased prices even on decades-old drugs,[3] contributing to this unsustainable growth.

And Medicare, the federal health program spending the most on drugs—more than $185 billion in 2017 alone—is a significant part of this trend. Overall, Medicare is the second-largest government program, with costs within Medicare increasingly shifting toward drug spending.[4]

Understanding how the major programs that reimburse for drugs in Medicare work—known as Part B and D—as well as the possible policy solutions to address both programs' problems, is vital to engaging in any meaningful debate on how to address the rising prices of prescription drugs.

The following brief provides an overview of how Part D operates and impacts government and beneficiary spending and a summary of leading reform proposals. Part B is discussed in a companion brief *("Medicare Financing and the Cost of Drugs: Part B")*.

MEDICARE BASICS

Medicare provides coverage for individuals over the age of 65, some younger individuals living with disabilities, and patients with End-Stage Renal Disease. There are approximately 60 million people on Medicare.[5] Eight in ten beneficiaries also have private supplemental insurance to their Medicare coverage—largely through an employer or union retiree health plan or an individually purchased Medigap plan.[6] Despite most beneficiaries having supplemental insurance that may change how coverage is paid for, the Medicare program overall represents the most significant avenue of health insurance coverage for older Americans.

Medicare has four distinct programs that provide insurance coverage for different services: Parts A, B, C, and D. Prescription drug reimbursement in Part B and Part D are those most relevant to the discussion on drug pricing, with Part D being the focus of this brief.

MEDICARE'S SERVICES

PART A
Referred to as the "hospital insurance" part of Medicare, Part A is best known as the program that provides coverage for certain in-patient care at hospitals and other similar settings.

PART B
Referred to as the "medical insurance" part of Medicare, Part B is best known as the program that provides coverage for certain doctors' services and outpatient care (including reimbursement for physician-administered drugs).

PART C
Also known as Medicare Advantage (MA), Part C is a group of private plans that provide Part A and Part B coverage as well as typically Part D coverage and sometimes additional coverage such as dental or vision.

PART D
Part D provides coverage for certain retail prescription drugs through individual private plans.

Conversations over Medicare funding generally are often grounded in concerns that funding may eventually be exhausted.[7] This concern, however, is focused on Part A—the part of Medicare that is funded by the "Hospital Insurance" trust fund, which is paid for through payroll taxes.[8] Part C is the Medicare Advantage program—private Medicare plans.[9] Parts B and D, however, are largely funded though general revenue, the majority of which comes from federal income taxes paid by individuals and payroll taxes paid by workers and employers, as well as beneficiary premiums.[10]

This means that Part D's long-term funding concerns are that both general revenues from federal income taxes and premiums must rise to cover increases in costs—for example, from increased drug prices—in a way that directly harms individuals' personal finances and raises government spending concerns.

PART D: HOW IT IS PAID FOR & WHAT IT COVER

In 2017, $154.9 billion was spent on Part D drugs,[11] representing the highest spending on retail prescription drugs in the country outside of private insurance. While Part B is playing an increased role in U.S. drug spending, the Part D program is the clearest illustration of the dramatic impact rising drug prices are having on the government and within households.

Part D Drug Coverage

Part D covers the bulk of the medicines patients typically receive at a retail pharmacy. Part D plans are private insurance plans that the federal government approves and either take the form of a stand-alone prescription drug plan (PDP) that rides along with Part A and B coverage or is bundled into a Medicare Advantage plan (MA-PD). The majority of Medicare beneficiaries with drug coverage select stand-alone PDPs.[12]

Within the context of Part D, each PDP sponsor negotiates prices with manufacturers and sets its own formulary that directs what specific drugs will be covered. There are federal requirements to ensure that beneficiaries have the same basic access to important medicines—a "standard benefit" or its "actuarially equivalent" benefit. PDP sponsors are able to provide "enhanced" plans that include coverage over this benchmark.[13] The Secretary of the U.S. Department of Health and Human Services has no authority to negotiate prices under Part D directly nor to interfere in negotiations between Part D sponsors and drug manufacturers.[14]

PDPs must not be discriminatory in their design—meaning designed to discourage beneficiaries with certain needs to enroll—and they also must set drug classes to cover all disease states, with at least two distinct drugs in each class. Part D formularies must also cover all drugs in six protected classes: immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics.[15] Part D also defines "specialty" drugs included on formularies as those that cost beneficiaries $670 or more a month in 2019.[16]

The number of PDPs available to beneficiaries impacts the competition among plans for beneficiaries and the resulting quality of the plans. After averaging significant decreases for more than a decade, over the past two years, the number of PDPs per region has increased as have the total number of plans offered nationwide (from 746 in 2017 to 901 in 2019).[17] These recent small increases, however, do not offset the dramatic decrease in plan offerings that has occurred since 2007 when 1,866 plans were offered.[18]

This significant decrease in the number of plans available is most often attributed to two factors: (1) mergers among PDP sponsors that have reduced competition and raised costs as consumers are faced with less choice, and (2) 2011 federal consumer protection regulations that required many PDPs to be "meaningfully different" (typically defined as having at least one provision that an average consumer would understand as making the plan noticeably different from another). In April 2018, under President Trump, CMS rescinded the "meaningfully different" requirement and that step is the likely motivator of this recent increase in the number of PDPs.[19]

Another factor influencing plan availability—as well as drug spending by Medicare—is that some plans and the federal government agree to risk corridor arrangements that limit potential losses and/or gains plans can experience while insuring certain populations.[20] Depending on the health and demographics of certain regions, plans may make more money under these arrangements by prioritizing some communities over others.

+ PART D VS. PART B DRUGS

Referred to as the "hospital insurance" part of Medicare Part D was enacted in 2003 (and went into effect in 2006), much later than Medicare Part B. This time lag explains the difference between Part B and Part D drug coverage—while Part B had historically covered the typical physician-administered drugs commonly associated with Part B's medical insurance, Part D was introduced to cover those prescriptions that are self-administered.

General Part D Financing & Beneficiary Cost Sharing

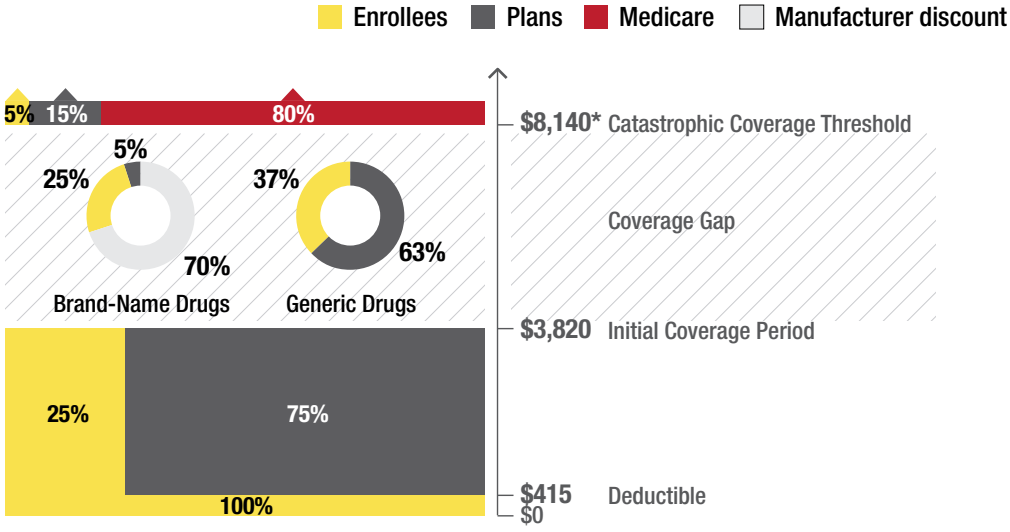
Part D is financed by a combination of beneficiary premiums, general revenues, and state payments to assist with care for beneficiaries who are dually eligible for Medicare and Medicaid.[21] Beneficiaries, in addition to any taxes paid to support general revenues, have a significant stake in the financing of Part D. Overall, the funding for Part D is made up of approximately 15 percent beneficiary premiums, 73 percent general revenues, and 11 percent dual eligible payments from the states.[22] The "dual-eligible" individuals have their drug costs covered by Medicare instead of Medicaid.[23]

Part D spending is expected to continue to grow, having already jumped from 11 to 14 percent of Medicare spending in recent years.[24] Spikes in manufacturers' drug prices, which cause growing catastrophic coverage and reinsurance payments, are playing a defining role in that spending. To understand why this occurs, it is necessary to detail Part D's benefit design for the standard benefit.

There are three main phases of Medicare beneficiary cost-sharing. As seniors' drug costs increase, they move through these different phases:

- **First, there is an initial coverage period.** In this phase, beneficiaries first pay their deductible and then 25 percent of the cost of their drugs. The plan the beneficiary is in pays the remaining 75 percent of these costs.
  - These percentages remain in place until the **"initial coverage limit"** is met—which means the total amount of drug costs paid by both the beneficiary and their plan. The coverage limit is updated annually. For 2019, the limit was set at $3,820.[25]
- **Second, after the initial coverage limit is reached, beneficiaries enter into the coverage gap.** This gap is also referred to as the donut hole. Recent changes in federal law closed this gap, but significant financial challenges remain. While in the gap, drug manufacturers must provide a 70 percent discount for brand-name drugs and beneficiaries pay 25 percent of the list price of a drug. Plans pay the remaining 5 percent.[26] Recently, biosimilars manufacturers were required to offer this discount as well.[27] For generic drugs while in the gap, beneficiaries pay 37 percent and plans play 63 percent.[28]
  - These percentages remain in place until the **"catastrophic threshold"** is met. This threshold, like the initial coverage limit number, is updated annually. For 2019, there is an $5,100 out-of-pocket threshold for individuals (sometimes referred to as true out-of-pocket or "TrOOP" expenses[29]), which corresponds to approximately $8,140 in total drug costs.[30]
- **The third phase is known as catastrophic coverage**. In this final phase, beneficiaries pay 5 percent of their drug costs, plans pay 15 percent, and Medicare pays for 80 percent.[31] As drug prices increase, so do the number of individuals whose drug costs push them through both the initial coverage period and the coverage gap to catastrophic coverage—with Medicare bearing the brunt of the end result.

MEDICARE PART D STANDARD BENEFIT DESIGN IN 2019



Note: *$8,140 in total drug costs corresponds to $5,100 in out of pocket expenses
Note: Some amounts are rounded
Source: KFF, based on 2019 Part D benefit paramenters.

Medicare pays for that 80 percent through what are called "reinsurance" payments to plan sponsors. These payments are increasing quickly (by 6 percent since 2018 alone) and are estimated to total $43 billion in 2019. For comparison, in 2006, these payments totaled $6 billion.[32]

As a result, Medicare spending for catastrophic coverage and reinsurance payments under Part D is a significant part of overall U.S. spending on drugs. And the number of beneficiaries receiving catastrophic coverage is growing quickly, primarily due to rising drug prices generally as well as higher usage of specialty drugs.[33]

Part D Reimbursement & Supply Chain

PDP and MA-PDP sponsors negotiate prices with manufacturers and pharmacies for the different drugs covered under each plan. These negotiations can lead to significant discounts through rebates for PDPs, which are allowed under direct and indirect remuneration (DIR) fees.[34] DIR are payments—such as discounts or rebates provided by manufacturers—that impact the final amount a PDP pays for a specific drug.

Technically, Medicare is entitled to receive all DIR payments. This isn't, however, what occurs in practice because Medicare defines what types of discounts qualify as DIR payments, but PDP sponsors work around this definition to ensure they don't have to pass along certain discounts to Medicare.[35] Further, while DIR payments can result in lower monthly premiums, they often also result in higher coinsurance in the long-run. As a result, this effect is sometimes referred to as "sick subsidizing the healthy."[36]

Furthering this distortion of the system, beneficiaries' cost-sharing amounts are based on the price of a drug before such discounts (the "list price"). So, a perverse incentive emerges for manufacturers to raise their list prices and offer more discounts to plans in order to be more attractive to PDP and MA-PD sponsors, who can collect more and more of the difference while leaving beneficiaries and Medicare to pick up the tab.

PART D: MAJOR POLICY PROPOSALS

Likely the most well-known and long-standing policy proposal is to enable Medicare, through the power of the Secretary, to negotiate directly with manufacturers to lower drug prices under Part D. This must be done through legislation, and there are different proposals in Congress that would give the Secretary this authority through different mechanisms. The basic elements of a negotiation proposal, to be effective in lowering drug prices, include: requiring the Secretary to negotiate on, at least, selected drugs; setting parameters for negotiation; and including enforcement powers in the event that a drug manufacturer won't comply with the negotiated price.

Beyond a larger systemic reform like negotiation, there are other solutions proposed to manage spending in the program as well as provide beneficiaries protection from high out-of-pocket costs. While the significance and merits of these proposals vary, examples include:

- Redesigning the Part D catastrophic coverage phase to shift financial risk from Medicare and beneficiaries to other entities;
- Modernizing the design of the Part D benefit to encourage appropriate use of generics and biosimilars;
- Protecting beneficiaries from high out-of-pocket costs and significant premium increases;
- Reforming DIR fees to enable Medicare to capture more of the savings for taxpayers and beneficiaries;
- Adopting mechanisms to protect the program against excessive price increases; and
- Setting greater transparency requirements in Part D contracting processes.

CONCLUSION

Part D clearly illustrates the impact the rising costs of drugs is having on both the government and individuals. Aggressive action is needed on both an administrative and legislative level to correct this trend, in order to ensure Medicare and beneficiaries don't continue to bear the impact of unreasonable and growing drug prices.

ENDNOTES

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