BETTER MEDICARE ALLIANCE

Issue Brief: Overview of the Medicare Part D Program

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I. Overview

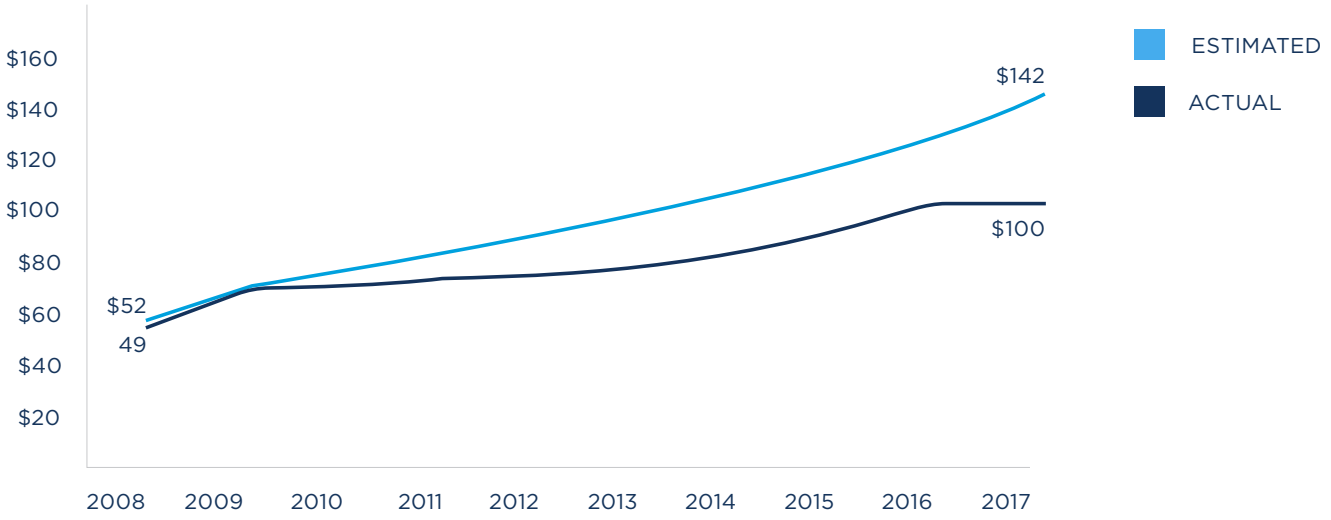
Medicare Part D is a voluntary prescription drug program available to Medicare beneficiaries that provides coverage for outpatient prescription drugs (i.e., non-inpatient prescriptions that patients typically fill at pharmacies). Established in 2006 by the Medicare Modernization Act (MMA), more than 42 million, or roughly 73% of all Medicare beneficiaries, are now enrolled in Part D coverage.[1,2] While Part D was considered controversial at the time of its passage, primarily due to the cost to government and the use of private plans to operate the new benefit, Part D has been a successful program. It greatly expanded coverage for prescription drugs to millions of Medicare beneficiaries, and the annual costs of the program have been below spending projections.

There have been significant changes made to the Part D program, including, most recently, action taken by Congress to gradually close the gap in coverage, known as the "donut hole," which largely has been completed, guaranteeing continuity of coverage for beneficiaries. There is also increasing interest in addressing the cost of prescription drugs, both in Part D and for drugs covered by Part B (i.e., drugs administered by physicians). This Issue Brief does not directly address how to further ensure access to affordable prescription drugs.

Rather, it explains how Part D plans, and in particular integrated Medicare Advantage-Part D plans, MA-PDs, have worked to keep costs low for beneficiaries, through negotiating lower drug prices and using management tools to ensure appropriate access and keep premiums and cost-sharing low for beneficiaries.

FIGURE 1

Annual Part D Costs, Estimated vs. Actual, in Billions



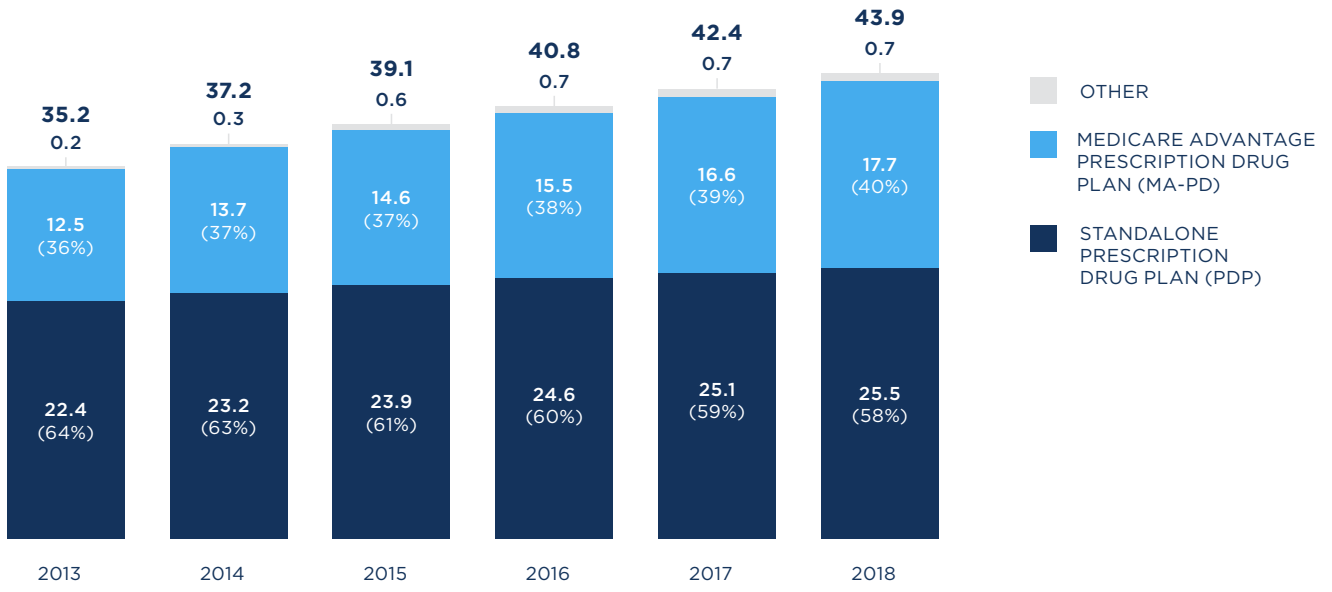
Source. Estimates based on 2008 CMS Medicare Trustees Report. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/downloads/tr2008.pdf. Actual estimates based on 2018.

Part D coverage is offered through private plans that are approved by the federal government. Beneficiaries who enroll in Medicare Fee-for-Service (FFS) have the option to purchase a standalone prescription drug plan (PDP) to supplement their coverage. Alternatively, beneficiaries can choose to enroll in MA-PDs, which integrate prescription drug coverage with other Medicare benefits (Parts A and B) into one plan with one monthly premium.

The majority (58%) of Medicare beneficiaries with drug coverage are enrolled in PDPs. However, enrollment in MA-PDs comprises a growing share of overall Part D enrollment as more beneficiaries choose plans with integrated medical and drug benefits. Most Medicare Advantage enrollees (88%) are in Medicare Advantage plans that provide prescription drug coverage.[3]

FIGURE 2

Part D Enrollment by Plan Type in Millions, 2014–2018



Note: MA-PDs include Special Needs Plans (SNPs). Other category includes Cost Plans, Medicare-Medicaid Plans (MMPs), and Program for All Inclusive Care of the Elderly (PACE) plans.
Source. Avalere Health analysis using enrollment data released by the Centers for Medicare & Medicaid Services. The analysis uses enrollment files released in February of each year, from 2014 through 2018, reflecting enrollment effective in January of each respective year.

II. Part D Payment Structure

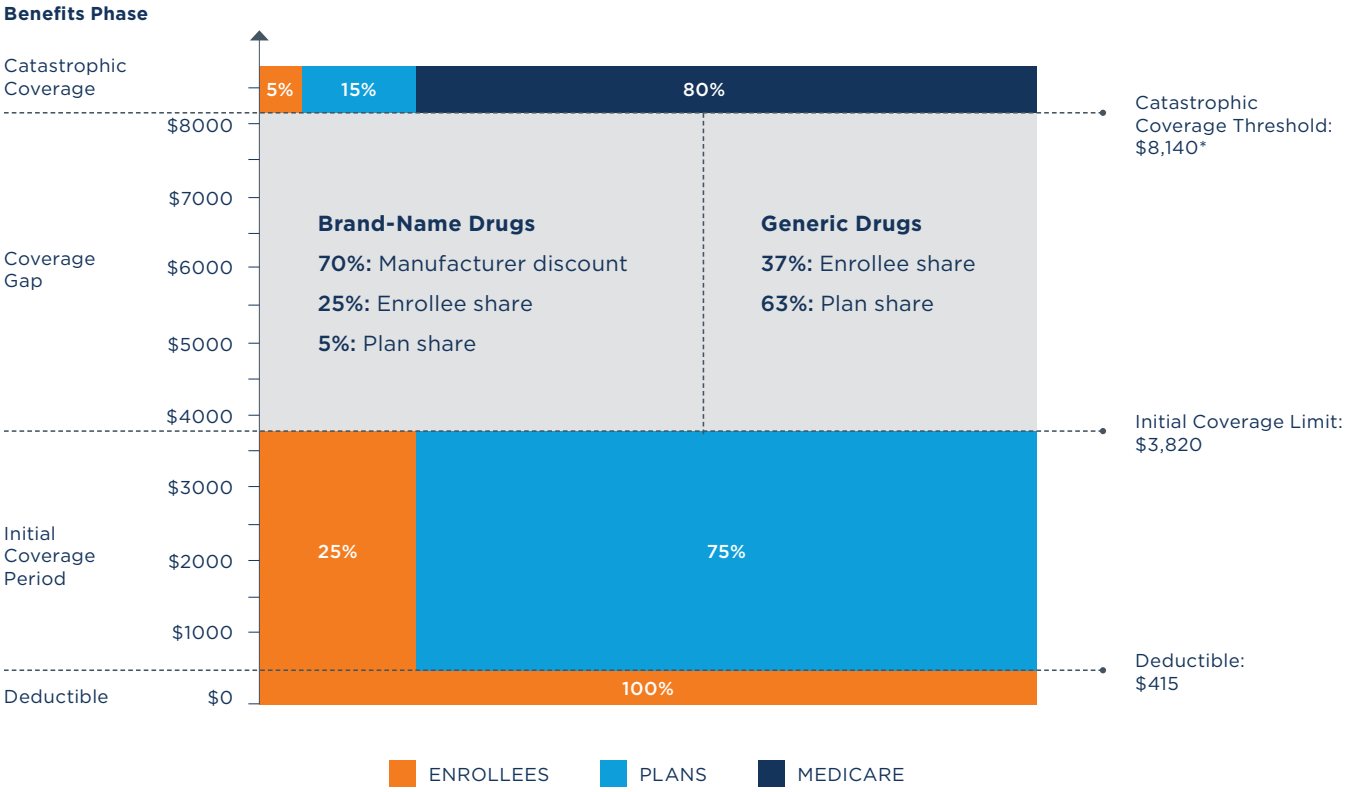
Similar to Medicare Advantage, payments to PDPs are determined through a bidding process, and enrollee premiums are tied to plan bids. The plan's bid is based on the expected benefit payments plus the operational costs less the expected federal reinsurance subsidies. The bid estimates are first calculated based on the average health of a Medicare beneficiary then adjusted for actual health status of the plan's enrollee population.

There is a standard benefit design in Part D, outlined in Figure 3. In 2019, the standard Part D benefit includes:

- A $415 deductible
- A 25% coinsurance until an initial coverage limit of $3,820 in total drug costs, at which point the beneficiary enters what is known as the coverage gap, or "donut hole."
- A $5,100 catastrophic limit on true out-of-pocket spending (or $8,140 in total spending); and
- A 5% coinsurance for drug spending above the out-of-pocket threshold.

FIGURE 3

Medicare Part D Standard Benefit Design in 2019



Note. Some amounts rounded to nearest dollar. *The estimate of $8,140 in total drug costs corresponds to a $5,100 out-of-pocket threshold for catastrophic coverage in 2019.
Source. KFF, Based on 2019 Part D benefit parameters.

Prior to the Patient Protection and Affordable Care Act of 2010 (ACA), beneficiaries were responsible for the full cost of drug spending between the initial coverage limit and the out-of-pocket threshold. The ACA required that CMS phase out the coverage gap before 2020. The Bipartisan Budget Act of 2018 made additional changes to cost sharing rules for brand name and generic drugs, gradually reducing each until the coverage gap is eliminated.

Medicare offers three forms of subsides to plans. The first is a direct subsidy, which is a capitated, monthly prospective payment calculated through the bid process. The second is an individual reinsurance payment, which is the percent of drug costs above the out-of-pocket limit. Medicare has instituted risk corridors to control plans' losses and limit their profits by financing the high cost enrollees and rescinding the profits. These payments are intended to ensure plan participation by taking potential risk of high cost enrollees away from plans. And the third is the low-income subsidy (LIS), which covers Part D prescription drug costs for enrollees whose annual incomes are below an established threshold.

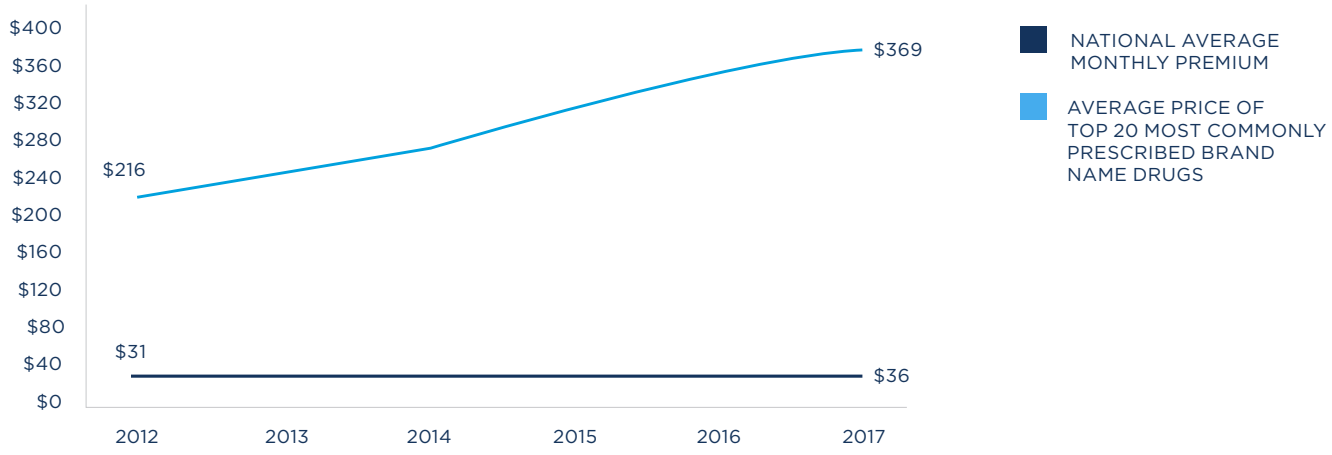
The LIS program assists in subsidizing Part D premiums, deductibles, coinsurances, and copayments for eligible enrollees. LIS enrollees are not affected by the coverage gap, because their cost-sharing would be covered by Medicare. In 2018, 28% of beneficiaries received LIS, of which 39% were enrolled in integrated MA-PD plans.[4]

III. Costs for Beneficiaries

The government subsidizes the majority of costs for the program, with most beneficiaries paying a portion of costs through cost sharing, including monthly premiums, annual deductibles, and co-payments or coinsurance at time of purchase. Beneficiaries can choose from a variety of Part D plan options—in 2018, beneficiaries had, on average, 23 PDPs and 17 MA-PD plans available in their area.[5] Beneficiaries can compare plans based on monthly premiums and covered drugs. Therefore, plans have an incentive to offer low premiums and appealing benefits to attract enrollees. Despite the rising costs of prescription drugs, Part D plans have been able to offer stable premiums to beneficiaries since the program's inception.

FIGURE 4

National Average Monthly Beneficiary Premium vs. Average Price of the Top 20 Most Commonly Prescribed Brand Name Drugs in Part D, 2012-2017

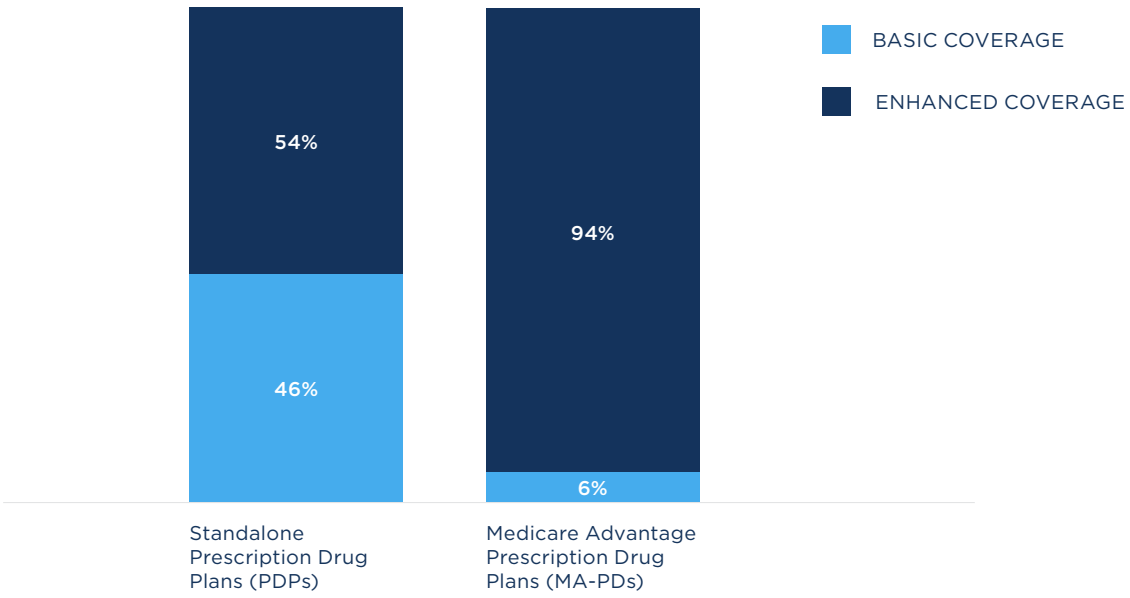


Note. Reflects Wholesale Acquisition Cost (WAC) the top 20 most commonly prescribed brand name drugs in Medicare Part D.
Sources. CMS Annual Release of Part D National Average Bid Amount.

By integrating prescription drug coverage with other Medicare benefits in one plan, MA-PD plans are able to coordinate care and manage costs across both the medical and drug benefits compared to PDPs. Additionally, while the Part D program requires all plans to offer at least a minimum level of benefits, MA-PD plans are allowed to use a portion of their Medicare Advantage capitated payments to offer more generous Part D benefits, such as lower premiums, reduced cost sharing, or coverage of more drugs. In fact, in 2018, 94% of Medicare Advantage plans offered enhanced benefits with more generous coverage, while only about 54% of PDPs offered enhanced benefits.[6] These more generous benefits often reduce costs for beneficiaries and ensure improved access to needed medications, which contributes to a reduction in overall healthcare spending.

FIGURE 5

Part D Plan Benefits, 2018



Source. Avalere Health analysis using PlanScape®, a proprietary database of plan formularies and benefit designs and 2019 PDP and MA plan data released by CMS on September 28, 2018.

IV. Drug Coverage and Care Management Tools

All Part D plans develop a list of drugs that the plan covers, called a formulary, based on clinical guidelines and other requirements set by the federal government. Although all Part D plans must meet certain minimum requirements for drug coverage, plans have significant flexibility in designing their formularies. The federal government reviews all Part D plan formularies to ensure that plans meet these minimum coverage requirements and do not discriminate against certain beneficiaries who may have high drug utilization. Additionally, all Part D plans (both standalone plans and integrated MA-PD plans) are accountable for quality through the Medicare Star Ratings program, which measure Part D plans based on quality metrics such as patient access and adherence. However, unlike PDPs, Medicare Advantage plan payments are tied to Star Ratings, which give integrated MA-PD plans more incentive to provide high quality, coordinated care to beneficiaries.

Part D plans have tools that they can use in developing their formularies to encourage use of the most appropriate, cost-effective therapies and to manage the rising cost of drugs. Almost all Part D plans (99% in 2018) use tiered formulary designs, which place drugs into groups, or "tiers," based primarily on cost. Because the tier on which a drug is placed determines the beneficiary's cost sharing required for the drug, tiered formularies encourage patients to use equivalent, less costly drugs from lower tiers (e.g., using a low-cost generic over a clinically-equivalent brand name drug, or clinically-equivalent brand name drugs over higher cost brands). Because integrated MA-PD plans manage both the medical and drug benefit, they are incentivized to design formularies such that patients have access to not only the lowest-cost, but also the most clinically effective treatment options. Without access to clinically effective and necessary medications, a beneficiary's health may worsen, and adverse drug interaction might be missed, potentially leading to poorer health outcomes and higher medical costs.

Part D plans also use utilization management tools to ensure beneficiaries have access to the most effective, lowest-cost prescription drugs. Utilization management tools include:

1. **Prior Authorization:** Requires beneficiaries to work with their provider to get approval from their plan to ensure medical necessity and plan coverage of the drug, and to help deter misuse or overuse of drugs
2. **Step Therapy:** Requires beneficiaries to use a lower-cost drug that may be more cost-effective, before using a more expensive drug
3. **Quantity Limits:** Limits the amount of medication that a patient can receive at one time to deter overuse and ensure patient safety

Plans use utilization management for a variety of reasons, including to ensure that the prescribed drug is medically necessary and clinically appropriate for the patient, to validate that the patient is not taking any other medications that might be harmful when used together, and for safety purposes when a drug has a high potential for misuse.

V. Integrated MA-PD Plans are Addressing the Nation's Opioid Crisis

The federal government expects plans to use utilization management in cases where drugs have a high potential for misuse. In fact, since the opioids crisis has intensified, plans are being asked to use utilization management and other tools to identify patients who might be misusing or misdirecting opioids. Beginning in 2019, Part D plans are required to implement specific controls for opioid prescriptions such as limits on initial opioid fills for acute pain to no more than a seven-day supply and requirements for pharmacists to engage in care coordination with the beneficiary's prescriber for opioid prescriptions above a certain dosage.[7] Also beginning in 2019, Part D plans have new tools to help further deter opioid misuse, including the ability to implement drug management programs that limit access to opioids for certain at-risk beneficiaries.[8]

Many Medicare Advantage plans already have implemented strategies to deter opioid abuse and misuse. Because Medicare Advantage plans manage both the medical and drug benefit, they are particularly well-equipped to engage in care coordination with medical providers to ensure patient safety and the medical appropriateness of prescribed prescriptions. In fact, a recent study found that enrollment in an MA-PD plan reduced beneficiaries' likelihood of filling an opioid prescription by 11.6% when compared to PDPs. Further, nearly half of the 11.6% reduction in opioid use by MA-PD enrollees was due to a reduction in prescriptions from the top 1% of opioid prescribers.[9]

The Part D program offers beneficiaries safeguards against diminished access to needed medications. For instance, plans must meet minimum coverage requirements, including covering at least two drugs in each drug class and covering all drugs in six "protected classes,":[10]

- Antidepressants (depression medications),
- Antipsychotics (drugs for schizophrenia and bipolar disorder),
- Anticonvulsants (drugs to treat seizures),
- Antineoplastics (cancer drugs),
- Antiretrovirals (HIV/AIDS drugs), and
- Immunosuppressants (drugs to prevent organ rejection after transplants).

Additionally, plans must also offer at least a minimum standard level of benefits to all enrollees set in law, and follow guidelines set by CMS around marketing activities, pharmacy networks, and enrollment and disenrollment processes. CMS reviews and approves all formularies to ensure that to ensure that minimum coverage requirements are being met and that formulary tiering and utilization management does not inappropriately hinder patient access or discriminate against certain beneficiaries. Beneficiaries also have the right to file an appeal to the plan to request coverage for a drug that is not on-formulary or that is subject to utilization management requirements. Part D plans are required to follow strict guidelines for addressing and adjudicating beneficiary appeals.

Plans work with Pharmacy Benefit Managers (PBMs) to develop formularies that meet the needs of their beneficiaries by establishing tier placement and options for utilization management. PBMs partner with many plans to develop formularies and therefore have considerable leverage to negotiate discounts with manufacturers on behalf of plans. Plans use these discounts to lower costs for beneficiaries by reducing premiums.

VI. Conclusion

The Part D program has been delivering prescription drug coverage to Medicare beneficiaries since 2006 through PDPs and integrated MA-PD plans. MA-PD plans, because they offer coverage that integrates medical and prescription drug benefits, are uniquely positioned to coordinate care and manage costs for their enrollees, particularly those with multiple chronic conditions. Formularies, prior authorization, drug price negotiations, and cost sharing that encourages use of clinically-equivalent lower cost drugs, as well as efforts to promote adherence to drug protocols, all make it possible to offer affordable drug coverage to millions of Medicare beneficiaries. Beginning in 2019, Medicare Advantage plans will have new flexibilities and tools to manage care across both the medical and drug benefit, which will further allow Medicare Advantage plans to offer affordable coverage and integrated, coordinated, high-value care for beneficiaries.

Sources

[1] Avalere Health analysis using enrollment data released by the Centers for Medicare & Medicaid Services in February 2018, reflecting enrollment effective in January 2018.

[2] MedPAC. March 2018 Report to Congress. Available at: http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf. CMS Medicare Trustees Report. Available at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2018.pdf.

[3] Avalere Health analysis of CMS October 2018 enrollment files.

[4] MedPAC, public meeting, Jan 17, 2019

[5] Kaiser Family Foundation (KFF). Medicare Part D: A First Look at Prescription Drug Plans in 2018. October 2017. Available at: http://files.kff.org/attachment/Issue-Brief-Medicare-Part-D-A-First-Look-at-Prescription-Drug-Plans-in-2018. US Senate Homeland Security & Government Affairs Committee, Minority Office Report. Manufactured Crisis. March 2018. Available at: https://www.hsgac.senate.gov/imo/media/doc/Manufactured%20Crisis%20-%20How%20Devastating%20Drug%20Price%20Increases%20Are%20Harming%20America's%20Seniors%20-%20Report.pdf

[6] MedPAC. March 2018 Report to Congress. Available at: http://www.medpac.gov/docs/default-source/reports/mar18_medpac_entirereport_sec.pdf

[7] CMS. CY 2019 Rate Announcement and Final Call Letter. April 2018. Available at: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2019.pdf

[8] CMS. CY 2019 Medicare Advantage and Part D Final Rule. April 2018. Available at: https://www.gpo.gov/fdsys/pkg/FR-2018-04-16/pdf/2018-07179.pdf

[9] National Bureau of Economic Research. The Effects of Medicare Advantage on Opioid Use. December 2018. Available at: https://www.nber.org/papers/w25327

[10] Note: CMS states that "all" does not extend to coverage of all brand and generic drugs. Under this definition, plan sponsors are not required to cover: multi-source brand drugs of identical molecular structure; extended release products when an immediate-release product is included; products that the same ingredient or moiety; or dosage forms that do not provide a unique route of administration. (Part D Manual, Chapter 6. Available at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Part-D-Benefits-Manual-Chapter-6.pdf)