

# The Impact of Healthcare Reform on Medicare Part D



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While Medicare Part D (Part D) is not the focal point of the recent healthcare discussion, the prescription drug plan has garnered some attention as one area of potential reform. Following are some of the proposals related to Part D, as well as their short- and long-term ramifications. These proposals include only what we believe to be the most significant of those discussed, and this discussion reflects their status as of the beginning of the August congressional summer recess. Note that the proposed legislation is broad in scope, and other provisions of the bills could also have an impact on Part D.

## PART D PRICE CONTROLS

Under Part D and most commercial pharmacy arrangements, individual plans are expected to negotiate prices with pharmaceutical companies, which they generally do through pharmacy benefit managers (PBMs). However, early in the healthcare reform effort, price controls under Part D for dually eligible beneficiaries (i.e., Medicare and Medicaid) were seen by many as a ready target for Medicare program savings, given the precedent with best price regulations under state Medicaid programs. The scope has been further expanded in some proposals recently to require government price *negotiations* for all Medicare beneficiaries under Part D, which is of great concern to the pharmaceutical industry.

Proponents of price controls have raised this issue for some time, arguing that significant savings are available. However, the Congressional Budget Office (CBO) has concluded the government would have insufficient leverage to negotiate significant savings on behalf of plans, given that discounts and rebates are usually driven by increasing usage of particular drugs in competitive drug classes, rather than by sheer volume.<sup>1</sup> Opponents will likely use the CBO study to support their claims that government price controls will not lower the cost of drugs significantly.

The implications of price controls would be far reaching. Part D plans would be forced to compete in their rates largely on the basis of their drug management programs and administrative efficiency, rather than contract terms. Commercial drug pricing may increase as a result of cost-shifting under this type of reform to subsidize the Part D market, similar to the relationship of commercial and Medicare fees for

medical services (Parts A and B). Also, it is important to keep in mind that price controls can take different forms, from negotiated prices (likely driven by volume and formulary) to mandated prices (regulated as under state Medicaid programs), with the details under most proposals left undefined at this time.

## CLOSING THE COVERAGE GAP

The most widely raised concern regarding Part D benefits has been the coverage gap (i.e., donut hole). Originally designed to keep Part D program costs more manageable, critics assert that the coverage gap leaves seniors vulnerable to high out-of-pocket costs. Further, while plans can optionally fill the gap under enhanced Part D plans, the number of plans that actually do so is very low because of the adverse selection potential, the reduction in catastrophic reinsurance (which increases the premium) and lack of risk corridor protection from the government (only standard benefits are protected), and the poor experience on these plans in the early years of the program.

Several legislative proposals discuss closing the gap gradually over the next 10+ years, at an estimated cost of more than \$100 billion<sup>2</sup> to the government (i.e., taxpayers). Additionally, the pharmaceutical manufacturers have pledged \$80 billion in response to President Obama's call for *shared responsibility* to cover 50% of brand prescription drug costs in the coverage gap.<sup>3</sup>

Closing the coverage gap would be expected to improve drug adherence for seniors reaching the gap, but on the other hand this runs counter to the consumer-driven healthcare thinking that requiring more *skin in the game* (higher cost sharing) helps to contain costs. There has also been some concern expressed that the drug manufacturer pledge only applies to brand drugs, which could reduce incentives for generic drug use. To date, generic utilization has been a big driver of program savings, with overall program generic dispensing rates reported to be 64% in 2008, with many plans exceeding 70%.<sup>4</sup>

## STANDARDIZED AND SIMPLIFIED PLANS

A little-known feature of the Part D program legislation is that it actually included fallback provisions for a public plan option, in the

<sup>1</sup> CBO (April 10, 2007). Issues regarding drug price negotiation in Medicare, letter to the Honorable Ron Wyden. Washington, D.C. Retrieved Aug. 6, 2009, from <http://www.cbo.gov/ftpdocs/79xx/doc7992/DrugPriceNegotiation.pdf>.

<sup>2</sup> CBO (Dec. 2008). Budget Options Volume 1: Health care. P. 162.

<sup>3</sup> Kaiser Health News (Aug. 11). For major health industry players, reform's positives outweigh negatives. <http://www.kaiserhealthnews.org/Stories/2009/August/11/health-industry-winners-and-losers.aspx>

<sup>4</sup> USA Today (October 31, 2009). Medicare Drug Program Snips \$6B from Year's Tab.

event that enough private plans did not participate in the program beginning in 2006. Program choice has never been a problem, however. Interestingly, a criticism of the program has actually been the opposite—too many choices that may confuse seniors. Some discussion (although less than for other Part D reforms) has centered around further standardizing and simplifying plan designs, as well as potentially adding a public Part D plan to compete with private carriers.

Standardizing Part D plans could be a two-edged sword. On one hand, proponents argue that fewer options or differences among plans would help seniors navigate the program. Critics argue that choice is a good thing and further standardization would take away another means for plans to compete and distinguish themselves.

A public Part D plan raises the same polarizing discussion as it does under overall healthcare reform. Proponents argue a public option is needed to keep private carriers honest and costs down, while critics argue that having the government set the program rules and manage the program, while serving as a competitor in the market, would create inherent advantages for the public plan. This would produce, they argue, a cost spiral for private plans and inevitably lead to a single-payer (i.e., government-only) program.

## OTHER REFORMS

- **Formulary changes:** Reform discussions from both sides exist around Part D formularies. Similar to plan design, some argue that the formularies should be further standardized and simplified to limit confusion with seniors. Counter to this and arguing for more flexibility, a recent *Health Affairs* article asserted that substantial savings could be achieved by removing the restriction of covering at least two drugs in each therapeutic class.<sup>5</sup> Formulary management savings are well documented in commercial programs where few restrictions exist.
- **High-income premium hikes:** Consistent with the Part B program, most industry experts anticipate eventual legislation that will provide for Part D premiums to be increased for higher-income beneficiaries, likely using similar income thresholds. Operationally, collection of the additional Part D premiums would differ from the Part B program in that insurers would likely be responsible

for collection of the additional premiums and have offsets to their government subsidy payments for these amounts.

- **Low-income beneficiary reallocation and benchmark calculation changes:** One proposal would give the Centers for Medicare and Medicaid Services broad authority to modify its low-income beneficiary auto assignment process using an *intelligent assignment* process, as opposed to having to work within the constraints included in the Medicare Modernization Act of 2003. Although few specifics around the potential modifications have been provided, this issue has been an area of concern since program inception because low-income members have been moved between plans in large numbers based on program regulations that require plans to bid below the low-income benchmark (LIB) to retain these members.
- **Low-income benchmark (LIB) calculation changes:** Changes to the LIB calculation process have also been included in the details of some of the proposals. The biggest change would increase the LIBs by removing the impact of Part C savings from Medicare Advantage (MA) prescription drug bids. This would have a particularly large effect in areas with high MA enrollment, such as Florida, California, and Arizona. This change could also potentially have a significant impact on MA enrollment because it would reduce the amount of savings required on the Part C side to meet the LIB on the Part D side. Given the proposed reductions in Part C reimbursement, such changes could take some pressure off of MA plans facing benefit reductions and/or premium increases.\*

Which, if any, of these proposals may be adopted remains to be seen. However, the general theme in many of these suggested reforms involves greater government oversight and involvement in Part D.

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\* Editor's Note: CMS did in fact announce a demonstration to implement this provision for 2010 only (after this article was completed). The proposed Congressional legislation would make this change permanent going forward.

<sup>5</sup> Outterson K. & Kesselheim, A. (July 2009). How Medicare Could Get Better Prices on Prescription Drugs [Internet]. *Health Affairs*: w832 – w841.

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