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Why Some of the Proposed Medicare Part D Regulations Dropped by the Administration Were Sound

By Edwin Park

In March, the Centers for Medicare & Medicaid Services (CMS) announced it would not finalize certain aspects of proposed regulations related to the Medicare prescription drug benefit (Medicare Part D).[1] Although one provision of the proposed regulations that wasn't put into effect — scaling back a requirement that insurers cover all drugs in certain protected classes[2] — raised significant concerns and attracted the most public attention, other provisions that some insurers opposed were, in fact, sound.[3] One such provision would have made it simpler for beneficiaries to choose better, potentially more affordable, drug plans. Another provision would have reduced costs to beneficiaries and the federal government. This analysis explains why CMS should consider fully adopting the two proposed regulations in the future if and when it revisits these Medicare Part D issues.

Permitting Part D Insurers to Offer Only Two Plans per Geographic Area

The premise of the Medicare Part D program is that Medicare beneficiaries would make informed choices among an array of plan options, which would encourage competition among Part D insurers based on price and quality. A growing body of research shows, however, that only a small percentage of Medicare beneficiaries are enrolled in the Part D plan that would minimize their out-

[1] Robert Pear, "White House Withdraws Plan Allowing Limits to Medicare Coverage for Certain Drugs," *New York Times*, March 10, 2014, http://www.nytimes.com/2014/03/11/us/politics/white-house-withdraws-plan-allowing-limits-to-medicare-coverage-for-some-drugs.html?_r=0. The final rule was issued on May 23, 2014. See Centers for Medicare and Medicaid Services, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Programs; Final Rule," 79 Fed. Reg. 29844, May 23, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-05-23/pdf/2014-11734.pdf. For the original proposed rule, see Centers for Medicare and Medicaid Services, "Medicare Program; Contract Year 2015 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Programs," 79 Fed. Reg. 1918, January 10, 2014, http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf.

[2] See, for example, Testimony of Joe Baker, President, Medicare Rights Center, before the Subcommittee on Health, House Energy and Commerce Committee, February 26, 2014, http://docs.house.gov/meetings/IF/IF14/20140226/101788/HHRG-113-IF14-Wstate-BakerJ-20140226.pdf.

[3] America's Health Insurance Plans, "What You Need to Know About the Medicare Part D Prescription Program," February 26, 2014, http://www.ahipcoverage.com/2014/02/26/what-you-need-to-know-about-the-medicare-part-d-prescription-drug-program/.

of-pocket costs (premiums, deductibles, and other cost-sharing) considering the prescription drugs they actually use.[4] Moreover, as a Kaiser Family Foundation analysis finds, on average, the overwhelming majority of Part D enrollees — 87 percent — did not change their plan during annual open enrollment periods between 2006 and 2010, even though people who voluntarily switched plans were more likely to lower their costs. Overall, 72 percent of Part D enrollees who were continuously enrolled in Part D between 2006 and 2010 remained in the same plan throughout. Even beneficiaries facing relatively large monthly premium increases of $20 or more for the following year didn't switch to more affordable plans. Nearly 72 percent of enrollees facing such premium increases remained in their existing plans.[5]

To help beneficiaries make more informed choices, CMS has instituted several requirements to reduce beneficiary confusion and to make differences between plans more transparent. For example, CMS now requires insurers to only offer plans that have "meaningful differences" in their benefits and prohibits them from offering more than three plans per region (one plan with "basic" benefits and two plans with "enhanced" benefits[6]). In its proposed rule in January, CMS had originally proposed to reduce the maximum number of plans an insurer can offer to two plans per region — one basic and one enhanced — starting in 2016 although, as noted, CMS did not finalize the proposal.

The enhanced plans that insurers offer have tended to provide some coverage in the coverage gap (commonly called the "donut hole"). CMS pointed out, however, that it was no longer necessary to allow two such enhanced options because health reform has extended Part D coverage to the donut hole and will close it over time. As a result, two enhanced plans can no longer be meaningfully different from each other in how they provide more generous coverage than the basic plan, when the basic plan already provides some (and, eventually, full) donut hole coverage. Moreover, as CMS noted, some insurers offering a second enhanced plan have used that plan to cherry-pick the healthy. Some of these plans offer very few added benefits but end up charging *lower* premiums than basic plans because their enrollees are healthier and hence lower-cost. That leaves enrollees in basic plans sicker-than-average overall, which raises basic plan premiums. Because low-income beneficiaries eligible for the Low Income Subsidy (LIS, which subsidizes premiums, deductibles, and cost-sharing) can be automatically enrolled only in basic plans and few LIS-eligible beneficiaries enroll in enhanced plans, this raises federal LIS costs as well. (CMS also indicated it would consider other policy changes to address insurers' use of enhanced plans to segment risk.)

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[4] Jack Hoadley, Elizabeth Hargrave, Laura Summer, Juliette Cubanski, and Tricia Neuman, "To Switch or Not to Switch: Are Medicare Beneficiaries Switching Plans to Save Money?" Henry J. Kaiser Family Foundation, October 2013, http://kaiserfamilyfoundation.files.wordpress.com/2013/10/8501-to-switch-or-not-to-switch1.pdf. See also Jason Abaluck and Jonathan Gruber, "Evolving Choice Inconsistencies in Choice of Prescription Drug Insurance," National Bureau of Economic Research, June 2013, http://www.nber.org/papers/w19163.pdf?new_window=1 and Chao Zhou and Yuting Zhang, "The Vast Majority of Medicare Part D Beneficiaries Still Don't Choose the Cheapest Plans That Meet Their Medication Needs," *Health Affairs*, October 2012, http://content.healthaffairs.org/content/31/10/2259.abstract?sid=38c49013-6fc4-4f8f-b853-fcaaf15d51f1

[5] Hoadley et al., *op cit.*

[6] Basic plans offer the standard coverage required under Part D (or its actuarial equivalent). Enhanced plans offer more generous coverage such as lower deductibles or cost-sharing charges or coverage of drugs within the coverage gap also known as the "donut hole."

CMS expected minimal disruption from this proposal, as second enhanced plans constitute only *2 percent* of total enrollment in stand-alone Part D plans; many of the second enhanced plans have very limited enrollment.[7] Jack Hoadley, a Part D expert at Georgetown University's Health Policy Institute and lead author of the Kaiser Family Foundation study, concluded that the proposal was sound, noting that only a small share of beneficiaries appear to be enrolled in plans that would no longer be offered under the CMS proposal. (He found that based on the latest enrollment figures, insurers had substantially exaggerated their estimates of the number of people who would have been affected.) Moreover, among those who would be affected, the impact would likely have been modest; although some beneficiaries may have had to switch to plans with somewhat higher premiums, the expected premium increases would have fallen within the range of typical year-to-year premium changes for a plan. Hoadley also pointed out that beneficiaries' current plans are frequently dropped or modified from year to year; he found that these annual disruptions, including the resulting premium increases, would have a greater impact than the CMS proposal would have had.

Hoadley concluded that the proposal would "reduce beneficiary confusion in the Part D market by both lowering the number of choices that they face and ensuring that the differences between competing options are clear and meaningful to them."[8]

Addressing Pricing Issues Arising from Insurers' Use of "Preferred Pharmacies"

Part D insurers are increasingly using preferred pharmacies, through which enrollees may incur lower co-payments or co-insurance charges than if they use other in-network non-preferred pharmacies. Pharmacies may pay insurers periodic lump-sum payments (usually based on the volume of prescriptions filled) in exchange for this preferred status.

These lump-sum payments lower insurers' overall costs and hence beneficiary premiums, which are based on the costs that insurers incur in offering the plans. But some insurers are *not* incorporating these payments into the official "negotiated price" that supposedly represents what they are paying the preferred pharmacies for drugs dispensed to Part D enrollees. And failing to factor these payments into the "official" price of the prescription drugs adds to overall federal costs, because the federal government — through reinsurance — picks up a portion of the cost of drugs furnished to beneficiaries with high drug spending, as well as nearly all of LIS beneficiaries' cost-sharing charges, and both of those sets of transactions are based on these "official" negotiated prices. In other words, for reinsurance and the LIS, the federal government is reimbursing insurers based on the *official* negotiated prices, which are higher than insurers' *actual* drug costs if the official prices don't reflect the lump-sum payments the insurers receive.

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[7] Testimony of Jonathan Blum, Principal Deputy Administrator and Director, Center for Medicare, Centers for Medicare and Medicaid Services before the Subcommittee on Health, House Energy and Commerce Committee, February 26, 2014, http://docs.house.gov/meetings/IF/IF14/20140226/101788/HHRG-113-IF14-Wstate-BlumJ-20140226.pdf.

[8] Jack Hoadley, "Assessing a CMS Proposal to Improve Competition among Medicare Part D Drug Plans," *Health Affairs blog*, March 4, 2014, http://healthaffairs.org/blog/2014/03/04/assessing-a-cms-proposal-to-improve-competition-among-medicare-part-d-drug-plans/.

Failing to factor the lump-sum payments into the official negotiated drug prices can also raise beneficiaries' costs in some cases. For example, if a beneficiary is charged a percentage of a drug's cost, basing that charge on a drug's official negotiated price rather than its actual cost will make the beneficiary cost-sharing charge higher than it would otherwise be. CMS had proposed to remedy these problems by requiring that starting in 2015, insurers incorporate all of these lump-sum payments into their official negotiated prices. (Under the final rule, CMS did not completely drop this provision; it delayed its application until 2016 and then created an exception under which "price concessions that cannot reasonably be determined at the point-of-sale" would continue to be excluded from official negotiated prices. The final rule did not define what price concessions would qualify for this exception or whether it would cover the lump-sum payments discussed here. CMS said it plans to issue additional guidance in the future after consultation with industry stakeholders.)

In addition, CMS has found that in some Part D plans, the negotiated prices for drugs dispensed in preferred pharmacies are actually *higher* than prices for drugs dispensed in non-preferred in-network pharmacies, particularly among preferred mail-order pharmacies. In other words, in some plans, beneficiaries who use preferred pharmacies face lower co-payments or coinsurance to encourage them to use those pharmacies for their prescriptions, even if the negotiated price of a drug is higher than in non-preferred pharmacies. That further drives up federal costs, since Medicare reimburses insurers based, in part, on those negotiated prices, as discussed above. CMS was concerned that in the case of mail-order pharmacies, this may be the product of a conflict of interest; insurers and their pharmacy benefit managers (PBMs) may be using lower cost-sharing in preferred pharmacies to spur enrollees to get their prescriptions at preferred mail-order pharmacies that the PBMs themselves own. As a result, CMS had originally proposed to continue to allow insurers to charge lower co-payments or co-insurance when their prescription drugs are purchased at preferred pharmacies, but only if the insurers ensure that they are offering "consistently lower" negotiated prices in the preferred pharmacies. In other words, insurers can still encourage enrollees to use preferred pharmacies by offering lower cost-sharing charges as long as that would reduce both beneficiaries' out-of-pocket costs *and* federal costs.[9] This provision, however, was not finalized.

Conclusion

Unfortunately, the concerns over the proposed rule's provision related to the protected drug classes and their potential impact on beneficiary access to needed drugs were used to cast a shadow on other, unrelated provisions and resulted in the Administration decision not to proceed with major aspects of the proposed rule as part of the final rule issued this month.

Yet, the provisions related to plan offerings and preferred pharmacy pricing issues were sound, and abandoning them will keep costs both to beneficiaries and to the federal Treasury higher than they should be. CMS should strongly consider fully adopting these proposals as part of future rulemaking.

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[9] CMS also proposed to allow all network pharmacies to obtain "preferred" status if they meet all relevant terms and conditions, which insurers also strongly opposed. CMS also did not finalize that proposal.