Medicare Part D: Cost Management Issues

Jack Hoadley
Research Professor
Georgetown University
Health Policy Institute

National Academy of Social Insurance
January 27, 2005

Relevant Projects

- Drug cost containment
  - Kaiser Family Foundation
- Evidence-based formularies
  - Commonwealth Fund
- Case studies of SPAPs
  - Robert Wood Johnson Foundation
- Medicare drug discount cards
  - MedPAC
- Use of formularies
  - DHHS/ASPE

New Entities: Private Prescription Drug Plans

- Basic design of private plans at risk
- Limits to the risk that plans face
  - Risk adjustment, reinsurance, risk sharing
  - Amount of risk is tempered, not eliminated
  - Plans pay portion of costs for those with high costs
- Other types of plans
  - Limited-risk plans
  - Fallback plans

The Part D Benefit

- What is known:
  - 36 regions for PDPs
  - USP's model therapeutic classification system
  - Final program rules (?)
- What is unknown:
  - Number of competing plans per region
  - Which plans will participate
  - How plans will approach formularies and tiered cost sharing

What Will the Market Look Like?

- Players:
  - Medicare Advantage plans
  - PBMs, alone or in partnership with health plans
  - Health plans
  - Other entities
- Amount of competition
  - Minimum of 2 plans (or 1 stand-alone plus 1 MA)
  - Do we expect more than minimum?

Plan Options for Managing Costs

- Formularies
- Tiered cost sharing
- Prior authorization
- Therapeutic substitution
- Step therapy
- Generic substitution

Formularies

- May close some or all drug classes
- Minimum of two drugs per class
- Model classification system
- Plans' choices:
  - Avoid high costs
  - Achieve market share
  - Whether to manage drug use without closing formulary

Current Formulary Practice

- Commercial plans
  - Use of closed formularies is rare
  - Over 90% of plans use open or tiered formularies
- Medicaid
  - At least 18 states now use preferred drug lists
  - May be limited to a few drug classes
- Federal programs
  - About 1/3 of M+C plans use a closed formulary
  - VA closes its formulary for some drug classes

Potential Consumer Protections

- CMS review
  - Enforce the requirement of two drugs per class
  - Nondiscrimination rule: disapprove plan if design, benefits substantially discourage enrollment
  - Guidance: will require more than 2 per class
- Tradeoff for beneficiaries
  - More classes, more drugs covered *versus*
  - More competition and lower prices

More Consumer Protections

- Use of pharmacy and therapeutics (P&T) committees to review formulary decisions
  - Are committee decisions binding on plan?
  - How many independent members?
  - Will committee review design of other tools?
  - Must decisions be based on scientific evidence?
- Appeals and grievances
- Beneficiary education

Issues for Using Formularies

- Nondiscrimination rule
  - How aggressively will it be enforced?
  - How will enforcement work on a tight timetable?
  - Will a fresh review follow midyear changes?
- Other protections
  - How strong a role will P&T committees play?
  - How easy will it be to get exceptions?
  - Should policies, protections vary by therapeutic class?

Tiered Cost Sharing

- Modify basic 25% coinsurance
- Constraint of actuarial equivalence
- Core strategy in private sector
- Considerable range of options

Current Practice for Tiered Cost Sharing

- Commercial and Medicare Advantage plans
  - Three-tier cost sharing has become the norm (2/3 of plans)
  - Small but growing interest in 4-tier arrangements
- Medicaid
  - 10 states, but amounts are nominal

Potential Consumer Protections

- Actuarial equivalence
  - Self-attestation by plan actuary
  - Some restrictions in statute
- CMS review for nondiscrimination
- What will the market bear?

Issues for Tiered Cost Sharing

- Standard does not have to be met in each class
  - Would each class have a low-tier drug?
- How extensive a review by CMS?
- Should certain types of tiering be restricted?
  - Tiers with extremely high coinsurance
- Tiered coinsurance (as opposed to copays) can have perverse results

Prior Authorization

- MMA does not restrict its use
- Regulations raise possibility of role for the P&T committee

Current Practice for Prior Authorization

- Used by 3/4 of commercial plans
- Used by most Medicaid programs
- Can be used to:
  - Enforce a formulary or preferred drug list
  - Control use of certain drugs for reasons of safety, abuse, over-use
- Process can be easy or hard

Potential Consumer Protections

- CMS review for nondiscrimination
  - Unclear how to review in advance
  - No clear provision to review patterns of use after the fact
- P&T committee role
  - What will their role be?
- How long is a prior authorization valid?
- Can be an issue when beneficiaries switch plans

Other Cost Management Approaches

- Therapeutic substitution
- Step therapy
- Generic substitution

Timing Issues

- January 2005: Final rule published
- Late March 2005: Initial PDP applications
- June 6, 2005: Drug plan bids due to CMS
- Sept. 14, 2005: CMS awards PDP contracts
- October 15, 2005: Information campaign begins
- November 15, 2005: Open season begins
- December 31, 2005: Medicaid drug coverage and Medicare discount cards end
- January 1, 2006: Part D benefit begins

Final Thoughts

- Intense year ahead, regardless
- Decisions by potential plan sponsors
  - Who will play?
  - What approaches will they take for cost containment?
- How will CMS define its regulatory role?
- How will politics intervene?
  - Will the law be modified in any way?