Medicare Part D Effective and Stable

The Medicare prescription drug program, known as Part D, has been in effect since 2006. Unlike the government-run, traditional Medicare program, the market-based Part D program gives senior and disabled beneficiaries a choice among competing private plans that offer prescription drug insurance. Part D also offers substantial assistance to Medicare beneficiaries with low incomes and modest assets. Recent calls to mandate minimum rebates in the program would have a negative impact on Medicare beneficiaries and disrupt a program that is working well and saving money for seniors and taxpayers.

Background

The Medicare Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for people on Medicare, known as Part D, which went into effect in 2006. Of the nearly 54 million senior and disabled beneficiaries in Medicare in 2014, 40.5 million were enrolled in the Medicare drug benefit (Part D) through private plans approved by the federal government. Beneficiaries with low incomes and modest assets are eligible for assistance with Part D plan premiums and cost-sharing.

The Medicare drug benefit is offered through stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans (mainly HMOs and PPOs) that cover all Medicare benefits including drugs. These private plans operate under strong incentives to achieve savings. Each Part D plan submits an annual bid to the Centers for Medicare & Medicaid Services (CMS) that reflects the plan’s expected cost to provide prescription drug coverage for the average beneficiary. From these bids, the nationwide average bid and the average monthly beneficiary premiums are calculated. Consequently, plans that submit competitive bids may secure lower-than-average premiums and attract more enrollees.

Part D plans negotiate discounts and rebates with prescription drug manufacturers that contribute to a plan’s ability to offer a lower bid. The Medicare Trustees have reported that plans in the Part D program negotiate substantial rebates, often as much as 20-30 percent, which the Congressional Budget Office (CBO) has said “approach the lowest prices obtained in the private sector.” These negotiations yield substantial savings to beneficiaries and taxpayers through lower plan bids, resulting in lower premiums for Part D enrollees.

Some critics of the current market-based structure have introduced proposals to mandate minimum rebates in Medicare Part D to reduce the cost of drugs for beneficiaries and taxpayers. Medicaid is cited as an example where government “negotiation” reduced drug prices. Some policymakers claim that mandating similar rebates in Medicare Part D for low-income subsidy (LIS) and/or dual-eligible beneficiaries (that is, those who get their coverage through both Medicare and Medicaid) offers savings to the federal government with no negative impact on drug access for Medicare beneficiaries.

Changing the operation of a successful program like Medicare Part D by mandating certain discounts is risking the disruption of a program that serves Medicare beneficiaries well. Part D successfully created a competitive market for Medicare PDPs with strong incentives to keep costs low while offering coverage that meets the needs of an older and sicker population. Medicaid should not be seen as a model for Medicare due to the significant access restrictions Medicaid beneficiaries often face. Medicare Part D avoids the type of government-imposed access restrictions common in Medicaid. For example, as of 2014, 16 states set limits on the number of prescriptions per month that could be dispensed to enrollees. Prescription limits are associated with declining use of medicines and increased rates of nursing home admissions. Medicaid payment is not used as a benchmark to set Medicare payment; doing so jeopardizes the program and threatens to treat LIS beneficiaries differently from other Medicare beneficiaries. Dual-eligible beneficiaries also receive physician and hospital care, all paid for at Medicare—not Medicaid—rates. Treating these beneficiaries differently for the purpose of pricing could fundamentally alter the program and open the door to different treatment for these most vulnerable beneficiaries.

Key Facts and Figures

- **Reductions in mortality**: A recent study in *The American Journal of Managed Care* found that since the implementation of Part D in 2006, nearly 200,000 Medicare beneficiaries have lived at least one year longer, with an average increase in longevity of 3.3 years. On average, 22,100 lives were saved each year between 2006 and 2014, primarily from fewer deaths from medication-sensitive conditions like diabetes and cardiovascular disease.

- **Reductions in medical spending**: Research shows that the availability of Part D has led to a significant reduction in nondrug medical spending for Medicare beneficiaries with limited prior drug coverage. A 2011 study estimated that Part D saves the Medicare program $12 billion annually in hospital and nursing home costs.
Improvements in adherence saves money: Improved medication adherence associated with expansion of drug coverage under Part D saved Medicare more than $2.3 billion in annual medical expenditures among beneficiaries diagnosed with congestive heart failure and without prior comprehensive drug coverage. The study also found further improvements in adherence could save Medicare another $1.9 billion annually.7

High Patient Satisfaction: Beneficiaries are extremely satisfied with the program. Several surveys show that about 90 percent or more of Part D enrollees are satisfied with their coverage and say that their coverage works well. Additionally, dual eligible Part D enrollees and all those with incomes below $15,000 exhibited a higher rate of satisfaction than other beneficiaries.8

Price controls could raise costs and reduce access: According to a former CBO analyst and a former chief actuary of CMS, imposing Medicaid rebates in Part D would create serious problems that undermine how Part D functions, potentially leading to higher premiums, reduced choices, higher copayments and more restrictive formularies.9

Pfizer’s Position
Pfizer supports the current market-based Part D program, which gives senior and disabled beneficiaries a choice among competing private plans that offer prescription drug insurance, as well as the ability to choose a plan that best suits their needs. The market-based system has worked as it does best, delivering an array of high-quality options to consumers at low prices. Changing the program to require a minimum rebate for dual eligibles or other low-income beneficiaries is discouraged and could ultimately result in poorer program performance and disruption for enrollees who have the lowest incomes and the poorest health.

How Patients Benefit
The market-based Part D program offers Medicare beneficiaries an array of good choices and saves money for seniors. A 2011 study found implementation of the Medicare prescription drug program resulted in a $1,200-per-year decrease in nondrug medical spending among those who previously had limited drug coverage.10

How the Health Care System Benefits
Strong competition among Part D plans reduces costs for beneficiaries and taxpayers. The reduced costs for seniors and persons with disabilities helps patients stay on their medications as prescribed, which can result in better health outcomes and lower costs for other health care services.

What It Means for Pfizer
The existing structure of Part D protects incentives for pharmaceutical innovation by allowing for reimbursement that reflects product value. Arbitrarily mandated discounts or price cuts would interfere with this incentive structure and have serious consequences for pharmaceutical research and development (R&D). According to the CBO, price controls on Part D prescription drugs would “reduce manufacturers’ incentives to invest in R&D on products that would be expected to have significant Medicare sales.”11 This could stifle potential breakthrough discoveries to treat Parkinson’s disease, arthritis, osteoporosis and other diseases affecting seniors. As one scholar at the American Enterprise Institute noted, “[O]ther than the dismantling of intellectual property, no policy would be more destructive to innovation than price controls.”12

1 2015 Medicare Trustees Report, p. 11.