

PROTECTING SENIORS FROM HIGH DRUG COSTS

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About the Author



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Executive Summary

Although drug prices have increased little overall in recent years, the rapid growth in availability and utilization of specialty drugs means that out-of-pocket drug costs represent a growing burden. Much of this problem is due to gaps in insurance coverage. While insurance or entitlements pay for all but 3% of hospital spending, Americans bear 18% of drug costs out of pocket.

These costs are particularly burdensome on senior citizens, who suffer from more chronic conditions than the population as a whole. While only a sixth of Medicare beneficiaries are hospitalized in a year, nine out of 10 use prescription drugs.

For its first 40 years, Medicare did not cover prescription drugs at all, and Medicare's Part D prescription drug benefit still lacks a cap on out-of-pocket costs. Furthermore, Medicare Part D's payment structure encourages drug manufacturers to inflate list prices and rebates to the program's private drug plans, which serves to increase patients' out-of-pocket costs, which are linked to gross drug expenditures.

To fix these problems, Congress should increase the responsibility of Medicare's private plans for reining in drug costs. This can be done partly within Part D, by shifting mandatory rebates to the catastrophic segment of the insurance benefit, but more completely within Medicare Advantage (MA). Because taking medications can prevent costly hospitalizations, MA plans typically offer prescription drug coverage with lower premiums and cost-sharing than in traditional Medicare, making them especially popular with beneficiaries who seek to enroll in Part D. Since MA plans already bear full responsibility for the medical costs of their members, Congress should be able to cap out-of-pocket drug costs in MA without diminishing the appeal of MA plans or adding to federal expenditures.

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Introduction: A Snapshot of Drug Prices and Spending

A study of 49 best-selling branded drugs found that, between 2012 and 2017, list prices increased by an average of 76%.¹ But insurers typically receive substantial discounts and rebates from these sticker prices—and what individuals actually pay out-of-pocket depends on their insurance coverage. While drug spending—before rebates and discounts are accounted for—increased by 69% from 2010 to 2019, drug manufacturer revenues rose by 36%, and individual out-of-pocket costs increased by only 8%.²

Overall payments to drug manufacturers increased from \$262 billion in 2014 to \$356 billion in 2019—largely driven by \$68 billion in spending on newly developed drugs and \$44 billion in increased consumption of existing drugs. Revenue declines due to loss of market exclusivity (most often, patent expiry) reduced manufacturer revenues by \$70 billion, while changes in net prices of existing drugs increased revenues by only \$14 billion.³

From 2006 to 2018, prices paid for prescription drugs by Medicare Part D increased by 14% after accounting for generic substitution, while prices of physician-administered Part B drugs increased by 18%.⁴ This increase in drug prices paid by Medicare is less than the 27% increase in the Consumer Price Index (CPI) over that period and much less than the 51% increase in CPI for hospital services.⁵ Real per-capita drug spending increased only slightly, from \$1,000 in 2009 to \$1,044 in 2018. In fact, over that period, real per-capita spending on traditional drugs fell substantially, from \$738 to \$527. However, this decline was offset by a wave of new specialty drugs—those that treat rare diseases—on which real spending per capita soared from \$262 to \$517.⁶

Specialty drugs account for only 2% of prescriptions but 49.5% of U.S. drug spending.⁷ The enormous up-front development costs for these drugs cannot be spread over large patient populations; but in many cases, insurers are required to pay for them, as alternative treatments are unavailable. As a result, specialty drugs typically cost over \$10,000 for a course of treatment, and drugs to treat genetic diseases can cost up to \$800,000 for a single patient.⁸

Prescription Drugs and Medicare: Out-of-Pocket Costs

Prescription drug costs loom large as visible expenses for seniors, who are more likely to suffer from chronic medical conditions. Consider that while 18% of adults aged 18–44 had multiple chronic conditions, 81% of those aged 65 and older had chronic conditions.⁹ Adults aged 25–34 filled an average of four prescriptions in 2015, while those aged 65–74 filled 26.¹⁰

Another way of looking at the burden: 15% of Medicare beneficiaries were hospitalized in 2015 while 91% used prescription drugs.¹¹ The cost of these prescription drugs was also more likely to be borne out of pocket; only

3.4% of hospital costs were not covered by insurance or entitlements, compared with 17.5% of prescription drug costs.¹² From 2014 to 2019, rising prescription drug consumption increased out-of-pocket costs borne by Medicare beneficiaries by \$13.7 billion (even though net *price* declines due to expired patents reduced out-of-pocket spending by \$5.2 billion).¹³

Private health insurance accounts for the largest share (\$135 billion) of total prescription drug spending in the U.S., but Medicare is not far behind (\$92 billion),

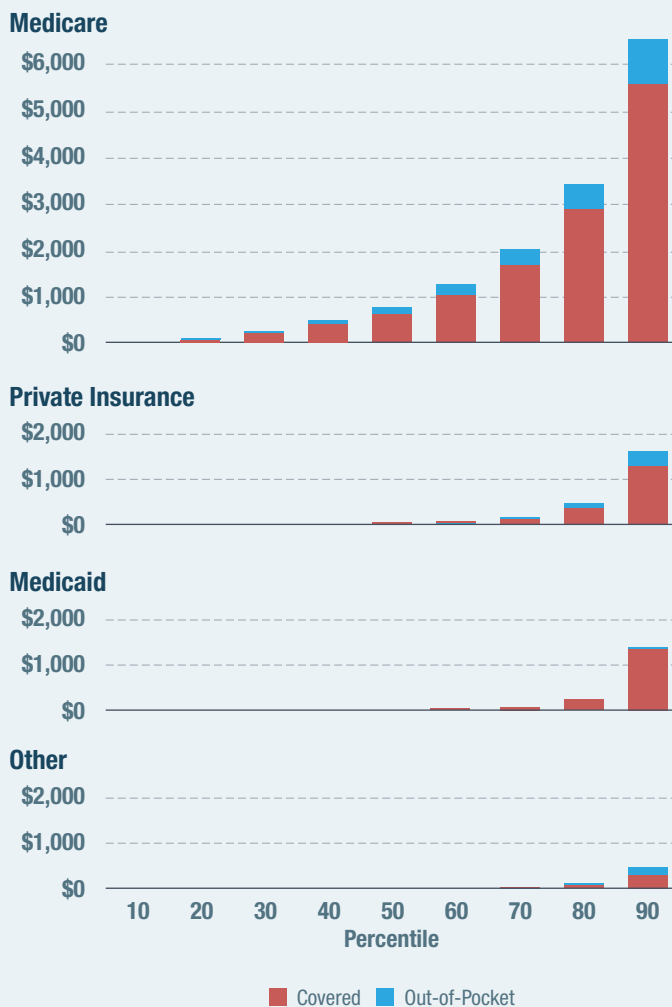
despite covering far fewer individuals (174 million vs. 41 million, respectively). Medicare beneficiaries are more likely than individuals with private insurance to incur any drug costs, and those who do tend to incur much higher costs (**Figure 1**). Medicaid beneficiaries, by contrast, typically incur slightly lower prescription drug costs than privately insured Americans but do not face significant out-of-pocket costs.

Manufacturers often waive out-of-pocket costs through patient assistance programs but are prohibited

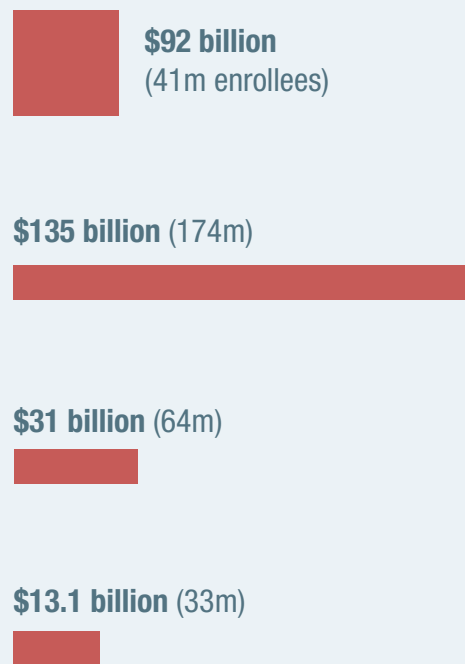
FIGURE 1.

Drug Spending by Type of Health-Care Coverage

Drug Spending per Enrollee (MEPS, 2015):



Total covered spending by payer (CMS NHE, 2015):



Source: U.S. Dept. of Health & Human Services, Medical Expenditure Panel Survey, MEPSnet/HC Trend Query, 2015; Kaiser Family Foundation, Health Insurance Coverage of the Total Population, 2019; Centers for Medicare & Medicaid Services (CMS), National Health Expenditure Data (NHE)

from doing so for Medicare beneficiaries due to the federal Anti-Kickback Statute.¹⁴ In 2019, 44% of all prescriptions for branded drugs were dispensed without out-of-pocket costs.¹⁵ Yet Medicare beneficiaries, 13% of the population, accounted for 33% of Americans' out-of-pocket drug costs of over \$1,000.¹⁶

Medicare's Drug Coverage: Part B and Part D

When the program was enacted in 1965, Medicare consisted of insurance for hospital services (Part A) and physician services (Part B). At the time, drugs were seen as a low-cost, routine expenditure, which weren't typically covered by insurance plans. Yet after increasing numbers of physicians began hospitalizing patients to get drugs paid for, physician-administered drugs (such as for chemotherapy and dialysis, which can't be self-administered) were added to Part B.

Medicare reimburses physicians for Part B drugs at 106% of their Average Sales Price (ASP), net of discounts and rebates, with patients required to contribute 20% of the cost out of pocket as coinsurance.¹⁷ Multisource drugs—those that are available as a brand name and also as a generic—are paid an average price, weighted according to utilization, which causes ASP to

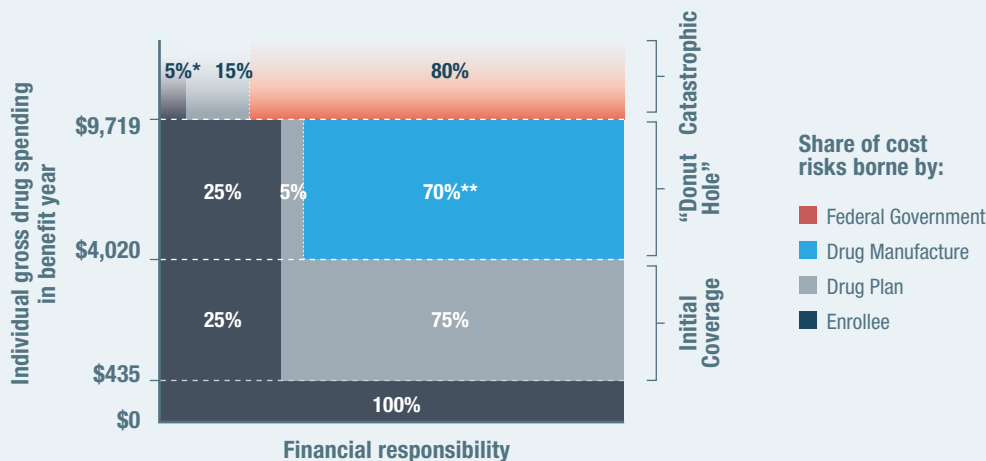
decline as the proportion of generics increases. From 2005 to 2018, average prices for biologic drugs (which typically have only a single source) increased by 46%, while prices for non-biologics fell by 19%.¹⁸ Total Part B drug spending increased from \$15 billion in 2009 to \$35 billion in 2018 because of the combined effect of new drugs becoming available, growing utilization of existing drugs, increased Medicare enrollment, and price increases.¹⁹

The annual out-of-pocket costs to patients for Part B drugs are capped at \$6,700 for seniors in Medicare Advantage plans. There is no cap on Part B out-of-pocket drug costs for seniors in traditional Medicare who are not also covered by Medicaid, Medigap, or an employer-sponsored supplemental benefit.

Medicare added prescription drug insurance in 2006 with the creation of Part D. By 2018, 72% of Medicare beneficiaries were enrolled, on which federal spending amounted to \$95 billion.²⁰ A total of 74.5% of Part D funding comes from the federal government, but the program is operated through competing Prescription Drug Plans (PDPs), which may charge enrollees additional premiums and must cover a defined set of medically necessary therapies.²¹ PDPs can negotiate discounted prices or rebates for drugs by threatening to exclude them from formularies, by requiring prior authorization, or by using cost-sharing tiers to steer enrollees toward drugs for which they had secured lower prices.

FIGURE 2.

Medicare Part D Standard Cost-Sharing Structure, 2020



Source: MedPAC, "March 2020 Report to the Congress: Medicare Payment Policy" (Mar. 13, 2020), 410

*5% coinsurance above catastrophic threshold, unless a \$3.60 copay for generics and \$8.95 copay for branded drugs is greater

**Donut hole: manufacturer discount applies to brand-name drugs only; drug plan bears 75% of cost of generics; federal government pays full undiscounted price for Low-Income Subsidy (LIS) enrollees, with drug plans, manufacturers, and enrollees not bearing costs.

The Centers for Medicare & Medicaid Services (CMS) sets limits every year on permitted cost-sharing, which PDPs can reduce or adjust on an actuarially equivalent basis. Unlike health-insurance plans on the individual market, which must cap out-of-pocket drug costs, *there is no fixed upper limit on out-of-pocket costs to which most enrollees in Medicare’s Part D drug benefit are exposed.*²²

From Part D’s establishment in 2006 to 2019, average monthly premiums increased from \$22 to \$29, the standard deductible rose from \$250 to \$435, and the catastrophic threshold—that is, the upper limit beyond which the federal government covers 80% of a patient’s out-of-pocket costs—rose from \$5,100 to \$9,719.²³ In between the deductible and the catastrophic threshold, the cost structure is more complex.

After the deductible, the member of a Part D plan enters the “initial coverage” phase—today, between \$435 and \$4,020 (Figure 2). The individual’s cost share (copay) today is 25%. After the initial coverage phase, enrollees enter a coverage gap called the “donut hole.” Originally, enrollees in the donut hole were responsible for 100% of drug costs until they reached the catastrophic coverage threshold—today \$9,719. Congress reduced enrollees’ share of costs in the donut hole to 25%, mostly by requiring that drug manufacturers provide a discount to PDPs equivalent to 70% of drug costs incurred in the donut hole (PDPs are required to pick up 5%).

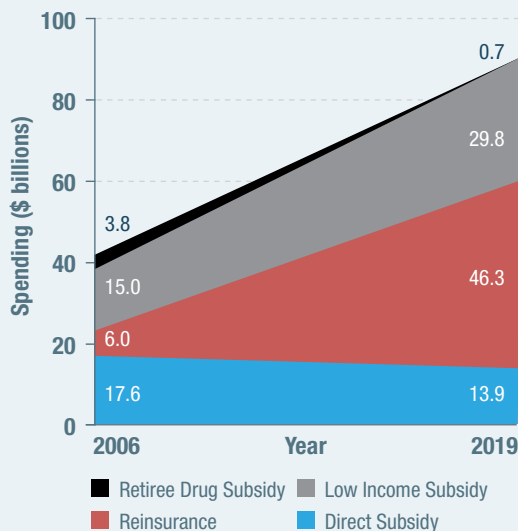
Yet this donut-hole arrangement inadvertently established an incentive for drug manufacturers to inflate the list prices of their products and for PDPs to go along with the arrangement in return for higher discounts and rebates. Inflated prices also increase the proportion of Part D enrollees who reach the catastrophic spending threshold—above which the federal government picks up 80% of the undiscounted cost, drug plans pick up an additional 15%, and patients are responsible for 5%. In 2017, beneficiaries who reached the catastrophic threshold accounted for 59% of Part D spending, compared with only 40% in 2011. Meanwhile, rebates to PDPs have soared from less than 10% of drug costs in 2007 to 25% in 2018.²⁴

In turn, federal spending on reinsurance for the catastrophic portion of the Part D benefit has increased from \$6 billion in 2006 to \$46 billion in 2019, while the direct subsidy to PDPs has fallen from \$18 billion to \$14 billion (Figure 3). As a result, the Part D benefit has been transformed from an arrangement where most of the insurance risk is borne by PDPs to one where the cost of rising prices is mostly borne directly by the federal government.

The donut hole had another perverse result. Beneficiaries enrolled in Part D are also directly harmed by the incentive that the donut hole provides for PDPs and manufacturers to inflate both list prices and rebates, *as their out-of-pocket costs are tied to drugs’ list prices (not the prices paid by drug plans after rebates and discounts).*

FIGURE 3.

Part D Spending by Category



Source: CMS, “2019 Annual Report,” 145; CMS, “2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund,” July 22, 2015, 146

Medicare Advantage Part D

Instead of having their medical care paid for directly by the federal government in traditional Medicare, seniors may opt to receive their benefits through a choice of privately administered plans known as Medicare Advantage (MA). In return for a lump sum from the federal government and any additional premiums that they charge enrollees, MA plans must cover Medicare’s standard package of benefits. This gives them an incentive to develop more cost-effective ways of purchasing medical care and to encourage the use of preventive services that reduce overall treatment costs.²⁵

Prescription drugs are among the most important preventive medical services. Part D prescription drug coverage has served to reduce hospital admissions by 4% and Medicare inpatient costs per beneficiary by 2% to 5%—with particularly significant reductions in admissions for heart failure and COPD.²⁶

Thanks to lower hospital costs, MA plans have an incentive to offer more generous Part D coverage. A study by Amanda Starc and Robert Town found that increased enrollment in MA reduced enrollees' out-of-pocket drug costs and increased their consumption of drugs relative to stand-alone Part D plans. The higher utilization was concentrated among drugs for chronic conditions, particularly those that have significant preventive value. The researchers estimate that \$1 of increased drug spending served to offset other medical costs by 20 cents.²⁷

Because drug costs are highly salient to seniors, improved drug coverage is a major selling point of Medicare Advantage. That makes expanding the generosity of drug coverage an attractive use for the money that MA plans save in the delivery of hospital and physician services.²⁸ In 2018, 84% of Medicare beneficiaries had access to MA plans that included Part D drug coverage with no additional premium.²⁹

In fact, Part D premiums are much lower in MA plans. In 2017, for example, the annual Part D premium charged for those in an MA plan (and not receiving the federal Low-Income Subsidy (LIS) or an employer Retiree Drug Subsidy (RDS) averaged \$264 versus \$505 for those purchasing stand-alone Part D coverage alongside traditional Medicare.³⁰

MA drug plans also have lower out-of-pocket costs than stand-alone Part D plans. In 2019, 98% of MA Part D enrollees received enhanced drug coverage—with cost-sharing reduced below standard Part D levels—compared with only 42% of enrollees in traditional Medicare Part D plans.³¹ Out-of-pocket costs are lower for MA Part D enrollees relative to other Medicare beneficiaries at all levels of drug utilization, with savings being particularly large when the cost of premiums is included.³²

The proportion of Medicare beneficiaries not receiving LIS or RDS but in MA and without drug coverage (6%) was much lower than that in traditional Medicare and without drug coverage (22%).³³ By contrast, the proportion of non-LIS/RDS Medicare beneficiaries who enrolled in Medicare Advantage plans with drug coverage (24%) was not far behind that who enrolled in traditional Medicare while also purchasing drug plans (29%).

Conclusion: Recommended Reforms

1. Rationalize the cost-sharing structure

Medicare Part D's cost-sharing structure encourages PDPs and manufacturers to inflate list prices and rebates, thereby driving more enrollees past the catastrophic benefits threshold, where costs will be picked up by the federal government. The donut-hole phase of the payment structure is a vestige of Part D's original design; it now serves only to inflate costs. Congress should eliminate it and extend the initial coverage arrangement up to the catastrophic threshold, making PDPs responsible for all non-out-of-pocket costs up to that point.

MedPAC, the agency established by Congress to advise it on Medicare payment policy, has endorsed this recommendation and also reasonably proposes moving drug manufacturer rebates from the donut hole to the catastrophic phase of Part D.³⁴ Such a reform would increase PDPs' incentive to keep drug costs down, while eliminating the incentive to manipulate list prices and rebates—which would reduce seniors' out-of-pocket costs.

2. Add an out-of-pocket cap to Medicare Advantage Part D

Politicians of both parties are looking to cap out-of-pocket costs for seniors with Part D but have so far failed to do so because it would increase costs to taxpayers. However, requiring Medicare Advantage plans with Part D to cap out-of-pocket drug costs would not increase taxpayer costs, as MA plans could make up additional expenses by adjusting cost-sharing on other medical services. Reinsurance subsidies to plans for catastrophic drug costs could simply be incorporated into risk-adjustment payments that are already made to MA plans to compensate them for attracting disproportionately sicker enrollees.

Unlike traditional Medicare plans, MA plans already must cap out-of-pocket drug costs in Part B. And private insurance plans on the individual market must cap out-of-pocket prescription drug costs. Medicare Advantage Part D plans should be required to do the same.

Endnotes

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- ¹⁸ MedPAC, “July 2020 Data Book,” 148.
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- ²⁰ CMS, “2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund,” Apr. 22, 2019, 10.
- ²¹ MedPAC, “Part D Payment System,” October 2020.
- ²² Ibid. Medicare enrollees with low incomes, however, are entitled to additional assistance that may serve to reduce or eliminate their premiums and out-of-pocket costs (In 2020, 28% of seniors in Medicare were eligible for the federal Low-Income Subsidy (LIS).
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