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## **Costs under Medicare's Prescription Drug Benefit and a Comparison with the Cost of Drugs under Medicaid Fee-for-Service**

Anna Cook

*Health, Retirement, and Long-term Analysis Division*

# Overview

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- Background on Medicare Part D
- Comparing actual Part D costs to CBO's original estimate
- Growth in Part D drug costs and plan payments
- Comparing costs of drugs under Part D and Medicaid Fee-for-Service (FFS)

# Background on Medicare Part D

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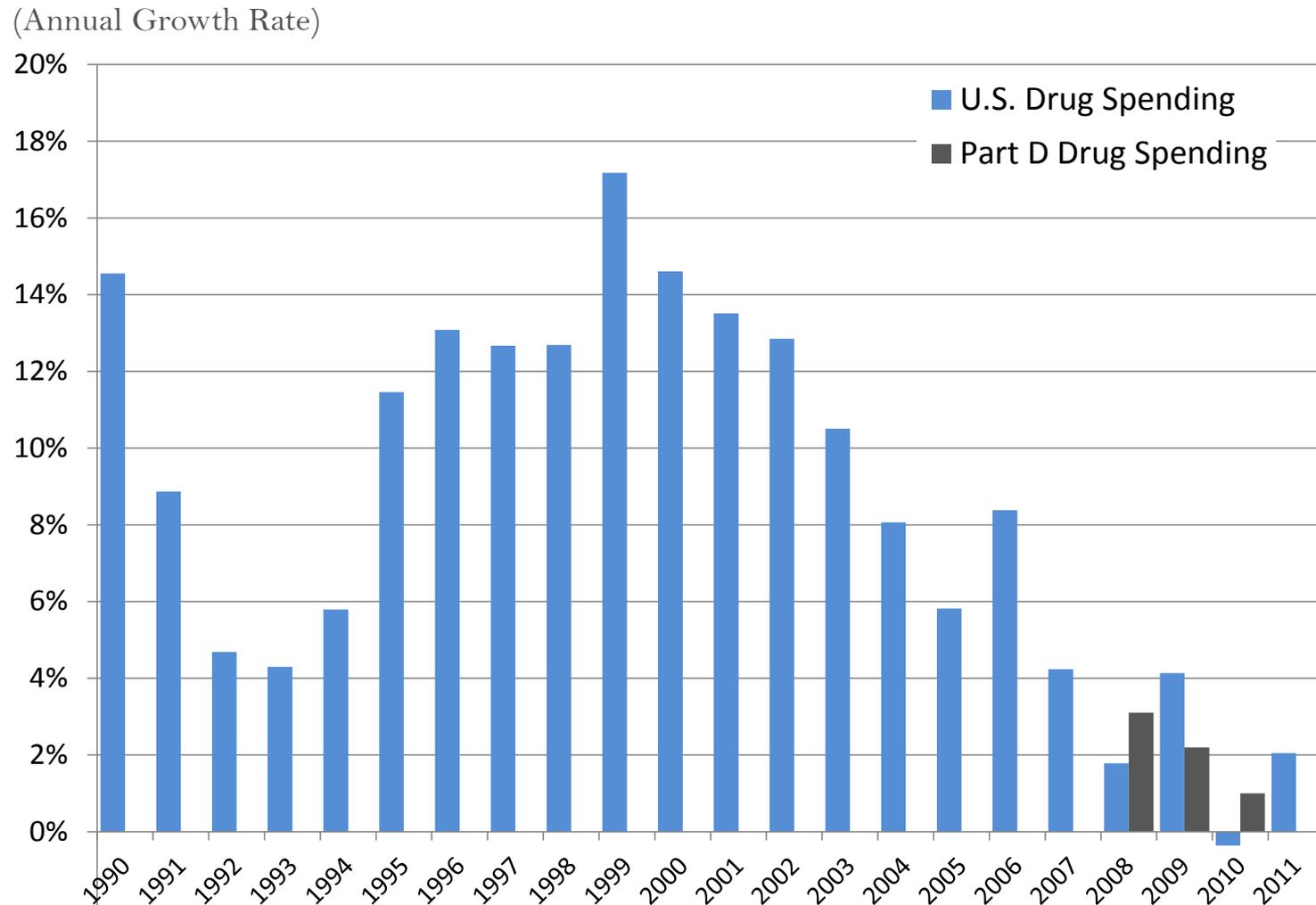
- Federal program administered by private plans
  
- Subsidizes outpatient drug benefits for Medicare beneficiaries
  - Plan bids = plans' estimated share of drug costs + administrative costs + profits
  - Basic benefit costs = plan bids + reinsurance
  - Basic government subsidies = 74.5% of basic benefit costs
    - Direct subsidies based on plan bids
    - Reinsurance payments
  - For enrollees in the basic benefit, beneficiary premiums and cost sharing cover the remaining costs
  
- Government provides additional subsidies for low-income beneficiaries to lower their premiums and cost sharing

## Part D Costs Less Than CBO Anticipated

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- In 2003 CBO projected that program costs would be \$88.5 billion in fiscal year 2012; actual program costs were \$44.2 billion (or about \$49 billion on a 12 month payment basis).
- That difference was driven primarily by two factors:
  - Lower growth in per capita drug spending than anticipated between 2003 and 2012
  - Lower enrollment than anticipated
- CBO's estimate included a projection of the effect of competition on program costs

# Annual Growth Rates of Drug Spending per Capita (1990 – 2011)



Note: Administrative costs are not included in Part D drug spending.

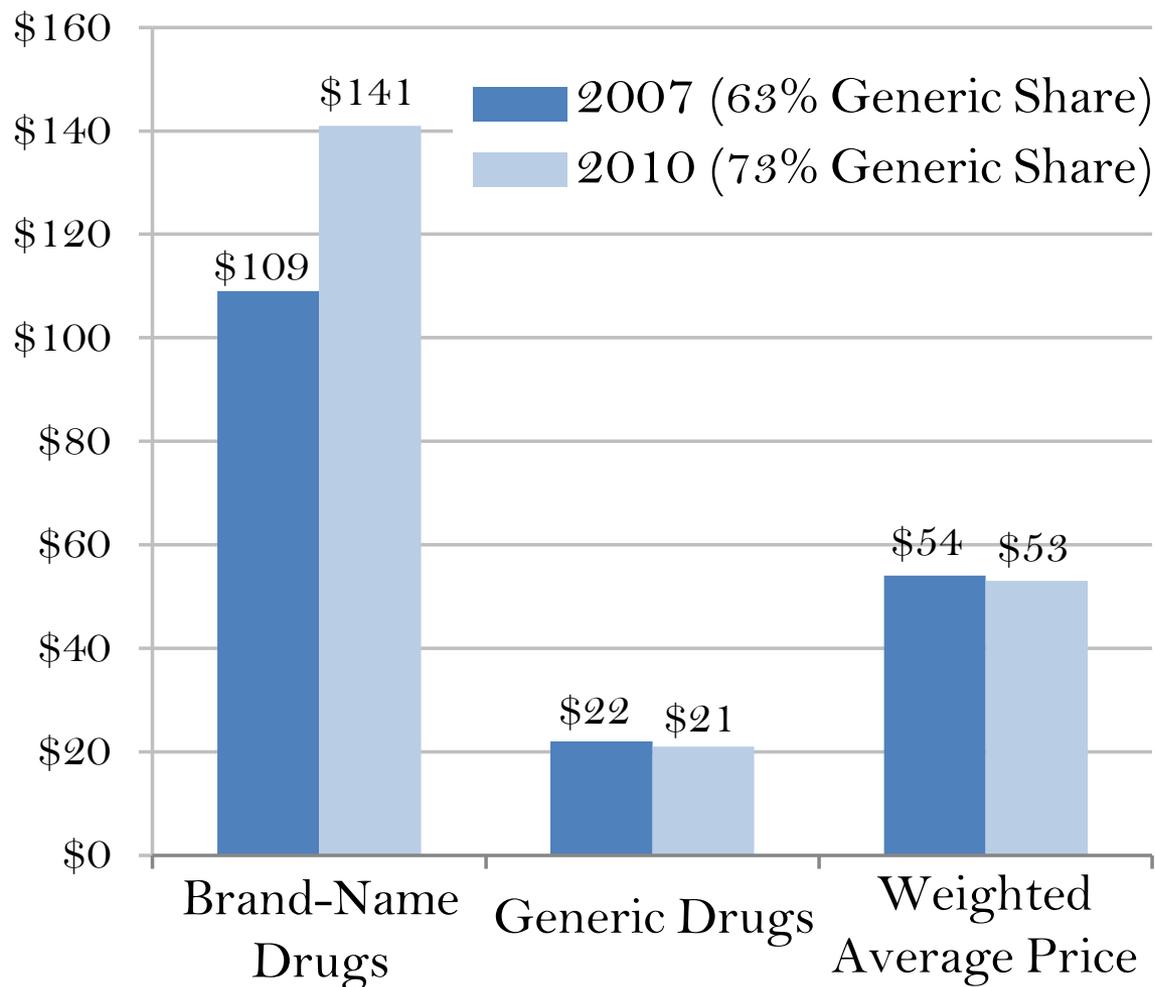
# Changes in Drug Market Slowed Growth in National Drug Spending

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- Lower rate of introduction of new brand-name drugs
- Patent cliff: many top-selling brand-name drugs losing patent protection
- Increased use of generic drugs

# Changing Part D Drug Costs and Composition Between 2007 and 2010

(Dollars per 30-day supply)



Note: Part D drug costs are equal to the total amount paid to the pharmacy for the drugs less any rebates paid by drug manufacturers to the plans.

# Average Drug Costs Declined Slightly in Part D Between 2007 and 2010

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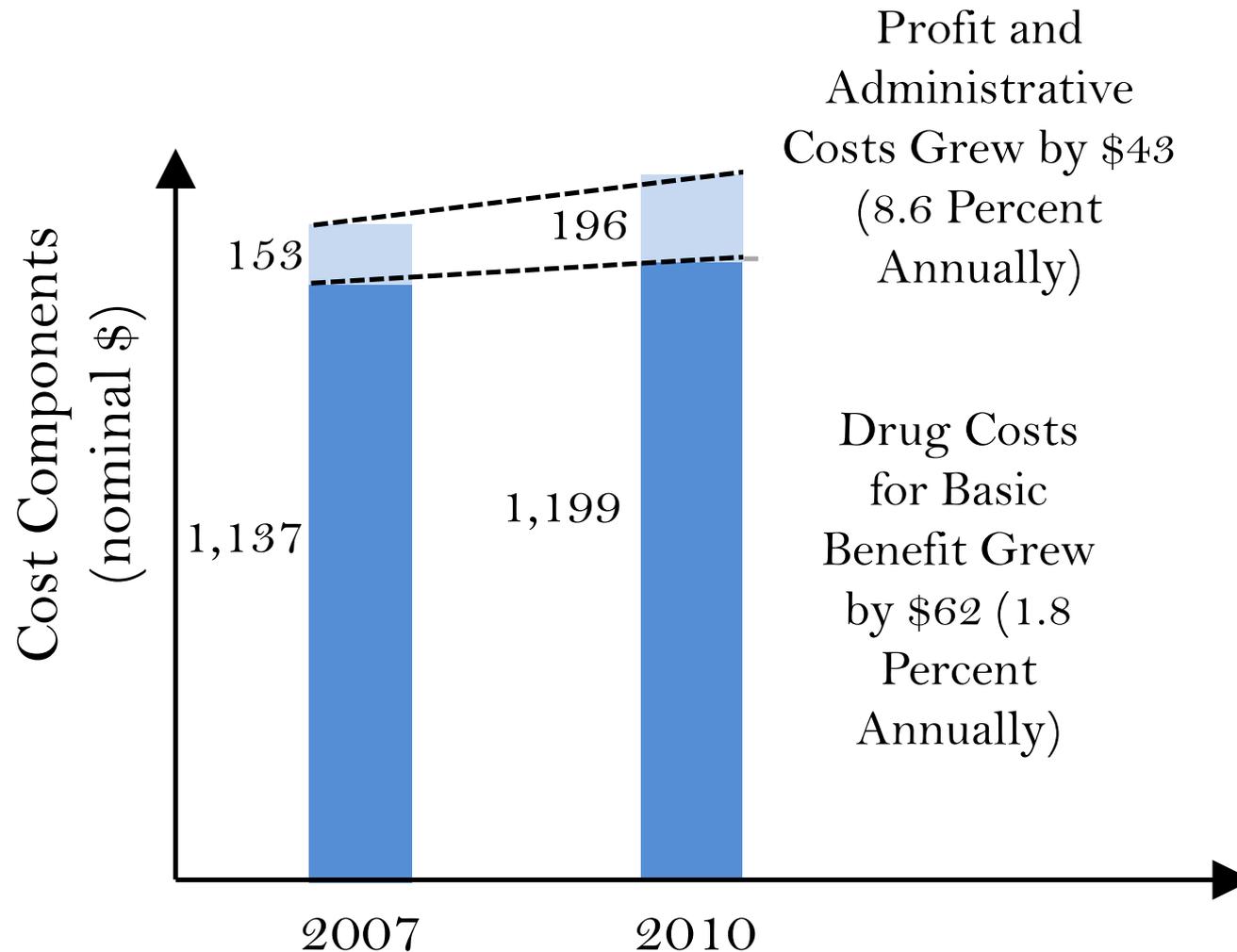
- The average cost of a month's supply of a brand-name drug net of rebates increased from \$109 to \$141
- Little change in the cost of generics
- Use of generic drugs increased from 63% to 73% of drugs supplied
- The shift toward generic drugs more than offset the rising cost of brand-name drugs
- The average cost of a 30-day supply of a drug declined slightly from about \$54 to about \$53

# Net Per Capita Drug Costs Grew More Slowly Than Drug Use in Part D Between 2007 and 2010

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- Per capita use increased by 2.6% annually
- Total per capita drug spending net of rebates grew by 2.1% annually (includes drug costs not covered by the basic benefit)
- Average drug costs per 30-day supply declined by 0.5% annually (or a total decline of 1.5% over the 2007 to 2010 period)

# Changing Basic Benefit Costs per Beneficiary Between 2007 and 2010



# Payments to Plans Grew Faster than Drug Costs Between 2007 and 2010

- Drug costs under the basic benefit, net of rebates, increased by just 1.8% per year per beneficiary (growing more slowly than total per capita drug costs)
- Profits plus administrative costs per beneficiary were higher relative to drug costs in 2010 than in 2007
- Thus, not all of the slow growth in drug spending was passed back through plan bids
- Payments to plans for the basic benefit grew by 2.6% per year per beneficiary

Revised July 3, 2013, to correct an error in the last bullet point.

# Part D Plans Have an Incentive to Contain Drug Costs

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- Plans are “at risk” for drug spending
- Lower drug costs allow lower premiums (for any given level of administrative costs and profits) which attract more beneficiaries

# Managing Drug Costs in Part D

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- Key methods used to contain drug costs
  - Promote the use of generic drugs
  - Promote the use of cost-effective brand name drugs
  - Negotiate with drug manufacturers and pharmacies over pricing
- Managing drug costs in Part D is complicated by two factors
  - Part D plans are required to cover all drugs in six protected classes
  - Subsidies that cover cost sharing for low-income beneficiaries protect beneficiaries but make it more difficult to steer use toward preferred drugs

## Managing Drug Costs in Part D (continued)

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- Rate of generic drug use in Part D is about the same as across the U.S. market as a whole in 2010
  - However, more informative to look at generic use by therapeutic class
- Rebates negotiated by Part D plans on preferred brands appear to make the net prices approach the lowest prices obtained in the private sector

# How Medicaid FFS Contains Drug Costs

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- Statutory rebates on brand-name and generic drugs
  
- Some state Medicaid agencies do one or more of the following:
  - Use preferred drug lists and negotiate for supplemental rebates
  - Require lower copayments for generic drugs than brand-name drugs to promote the use of generics
    - Across many top therapeutic classes, Medicaid FFS generic use rates are similar to those in Part D
  - Place caps on the number of prescriptions dispensed per month per beneficiary

# Statutory Rebates for Medicaid Brand-name Drugs Are Tied to Prices Paid by Other Purchasers

- Medicaid's statutory rebates on a brand-name drug are based on two prices
  - Average manufacturer price (AMP): the average price manufacturers receive on sales to retail pharmacies
  - Best price: the lowest price paid by certain private-sector purchasers and nonprofit entities
- Basic rebate is equal to 23.1 percent of the AMP or the difference between the AMP and the best price
- Inflation-based rebate is equal to the amount by which the drug's price (AMP) has risen faster than inflation since the drug was first marketed

# Comparing Drug Costs in Medicare Part D and Medicaid FFS

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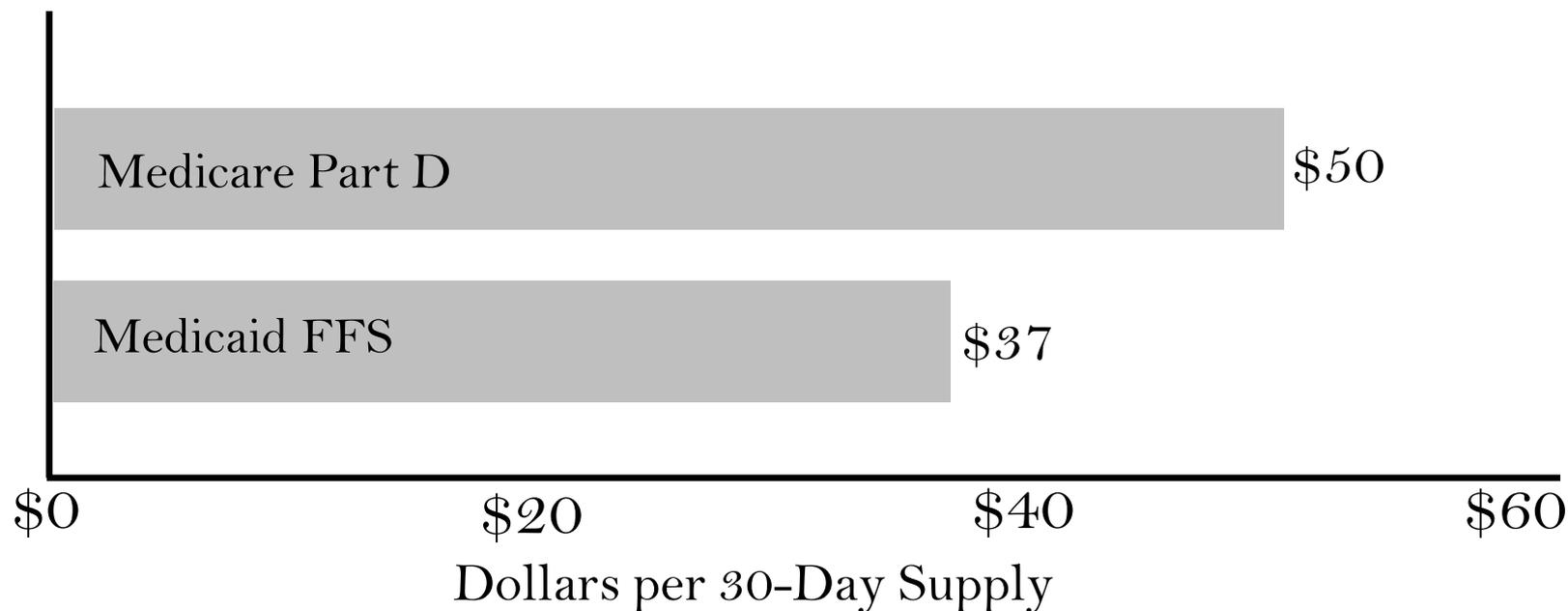
- Select 53 top therapeutic classes in terms of either use or spending in Part D; that approach covers over 70% of Part D spending
- Estimate cost of a 30-day supply for each class in each program
  - Retail pharmacy prices net of manufacturer rebates
- Create weighted average of the 53 classes, based on Part D use
- Controls for differences in patterns of drug use between Part D and Medicaid FFS beneficiaries *across* therapeutic classes

# Limitations of Drug Cost Comparison

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- Net Medicaid drug costs do not account for supplemental rebates collected by state Medicaid agencies
- Therapeutic class approach may not fully control for all of the medical differences between the two populations
- The analysis is an average price comparison, but program costs (and total health costs) are also affected by the quantity of drugs used

# Average Cost of Drugs for 53 Therapeutic Classes in Medicare Part D and Medicaid FFS in 2010



Note: Over time CBO expects this cost difference between Part D and Medicaid FFS to lessen somewhat as manufacturers respond to the change in Medicaid's basic rebate under the Affordable Care Act. Other changes in the drug market over time, such as the relative usage of brand-name and generic drugs, will also affect this cost difference in the future.

# Implications for Extending Statutory Rebates to Part D

- Initially: With statutory rebates like Medicaid's, the net prices of drugs in Part D would probably fall to a level closer to that in Medicaid
  - For brand-name drugs across the 53 therapeutic classes examined, Medicaid FFS's statutory rebates averaged 56% and Medicare Part D's rebates averaged 17% of the retail prices of drugs
- Over time: Manufacturers would offset an increasing share of the new rebates by launching new brand-name drugs at higher prices
  - Launch price impact would be larger than for the Medicaid rebates because Part D is about 25 percent of the total drug market compared with Medicaid's 8 percent
  - Higher launch prices would raise prices for Medicaid
  - Higher launch prices could raise prices for private purchasers
  - Incentive to invest in R&D for new drugs would decline somewhat

# Implications for Extending Statutory Rebates to Part D (cont.)

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- After 15 to 20 years: Manufacturers would probably offset much of the new rebates by launching new brand-name drugs at higher prices
  - Any remaining savings would probably stem largely from the inflation rebate

# One Policy Approach: Applying Medicaid's Statutory Rebates to Low-Income Subsidy Beneficiaries in Part D

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- CBO estimated that this type of proposal would save the federal government about \$100 billion over 10 years (see *Reducing the Deficit: Spending and Revenue Options*, March 2011)
- Example: Medicare Drug Savings Act of 2013 (S.740 or H.R. 1588)
- Many other types of proposals could be considered as well to reduce the cost of the Medicare Part D program

# Summary

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- Drug market dynamics have held down costs in the Part D program
- Not all of the slow growth in drug spending has been passed back through lower bids
- Dispensing rates for generic drugs are similar across Medicaid FFS and Medicare Part D when controlling for therapeutic class
- Drug costs are lower in Medicaid FFS than in Medicare Part D because of large statutory rebates
- In long run, manufacturers would offset much of the impact of statutory rebates in Part D by launching new brand-name drugs at higher prices