INTERNATIONAL BROTHERHOOD OF TEAMSTERS VOLUNTARY EMPLOYEE BENEFITS TRUST

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International Brotherhood of Teamsters Voluntary Employee Benefits Trust Comments on Draft Medicare Part D Legislation

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The International Brotherhood of Teamsters Voluntary Employee Benefits Trust ("VEBT") is a voluntary employee beneficiary association plan created for the benefit of Teamster members and retirees and their families. In 2005, the VEBT entered into a direct contract with CMS to offer Medicare Part D prescription drug benefits to retired Teamsters and their spouses. The VEBT program is an Employer Group Waiver Plan that currently provides coverage to about 17,000 individuals, most of whom pay 100 percent of their premium. The program paid $43 million in prescription drug claims in 2017.

We commend the Committee leadership on exploring ways to reduce prescription drug costs for Medicare Part D participants. However, we are very concerned about the impact that reducing the reinsurance subsidy would have on our plan and our members, and believe the proposed timeline of beginning the reduction with plan year 2020 is unworkable.

We generally support the concept of implementing a maximum-out-of-pocket limit, particularly if we are given sufficient time to make necessary adjustments to provide this benefit improvement.

1) Reduction in the Reinsurance Subsidy

We understand the desire to reduce the cost of the reinsurance subsidy paid by CMS. It is the fastest growing component of Medicare Part D program spending. The theory behind this proposed legislation seems to be that if the reinsurance subsidy is decreased, shifting more of the burden on to plan sponsors, plan sponsors will have greater incentive to reduce drug spending under Part D, through choosing lower-priced drugs in formularies and negotiating better deals with drug companies. However, this does not seem to be an accurate analysis of the impact this would have.

First, according to the Medicare Payment Advisory Commission (MedPAC), Medicare Part D program spending has increased from about $46 billion in 2007 to $80 billion in 2017. While that is a huge spending increase, the average spending per enrollee has actually decreased slightly, from about $1,900 per enrollee in 2007 to $1,882 per enrollee in 2017. The program spending growth is primarily due to a huge increase in enrollees, from 24.2 million in 2007 to 42.5 million in 2017.[1]

What has changed is the spread of the costs incurred per enrollee. The share of Part D enrollees reaching the catastrophic phase in 2016 was lower than the share of Part D enrollees that reached

[1] MedPAC. *March 2018 Report to the Congress: Medicare Payment Policy*. Chapter 14: The Medicare prescription drug program (Part D): Status report, pp. 387, 396.

the catastrophic phase in 2007 (8.3 percent in 2017, compared to 8.8 percent in 2007).[2] But the costs incurred for those who reach the catastrophic phase have increased at such an enormous rate that it has resulted in substantially greater costs being incurred in the catastrophic phase, even though the percentage of enrollees reaching that phase is smaller.

This is primarily due to the 80 percent cumulative decrease in generic drug pricing from 2006-2017, combined with the 216 percent cumulative growth in brand-name drugs over the same time period. [3]

For anyone who can be treated with only, or mostly, generic drugs (and due to several "blockbuster" drugs losing patent, and becoming available as generics), their costs decreased, and some who previously reached the catastrophic phase of coverage, no longer did so.

However, for the smaller percentage of participants, who require brand-name drugs, particularly single-source brand-name drugs in protected classes, with no generic equivalent, they became more likely to reach the catastrophic phase of coverage, and when they did, the total spending was much, much higher.

In recent years, this has also been slightly exacerbated by a provision of the PPACA to close the coverage gap phase of Part D coverage (which we strongly support). PPACA temporarily restrained increases to the True Out-of-Pocket (TrOOP) threshold, so the amount enrollees had to pay before reaching the catastrophic phase did not keep up with other increases. In 2020, this restraint will be eliminated, and the TrOOP threshold will increase to what it would have been if it had not been restrained. This will mean an increase of more than 20 percent, [4] increasing from $5,100 in 2019 to $6,350 in 2020. This will likely result in a further decrease of the percentage of enrollees reaching the coverage gap; a significant increase in out-of-pocket costs for many enrollees, who previously barely reached the coverage gap, and it could result in a decrease in the percentage of reinsurance as part of the total subsidy, depending on the rate at which brand-name drug prices increase.

Additionally, our Part D plan has little room left to push for lower costs on drugs. We are already pushing hard against drug manufacturers on pricing through our pharmacy benefit manager, and using techniques to encourage enrollees to keep their costs low.

Generic drugs already account for nearly 90 percent of prescriptions filled for all Part D plans (including ours). The generic utilization rate has continued to increase (it was 61 percent in 2007 for Part D plans), despite reports suggesting that the coverage gap discount, rebates and manufacturer discounts may incentivize plans to push higher priced drugs over lower priced drugs, in order to increase rebate revenue. MedPAC suggests that Part D generic substitution may have reached its saturation point[5], which eliminates that as a way for Part D plans to reduce their costs and offset the proposed reduction in reinsurance subsidy.

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[2] MedPAC. *March 2018 Report to the Congress: Medicare Payment Policy*. Chapter 14: The Medicare prescription drug program (Part D): Status report, p. 412.
[3] MedPAC. *March 2018 Report to the Congress: Medicare Payment Policy*. Chapter 14: The Medicare prescription drug program (Part D): Status report, p. 405.
[4] MedPAC. *March 2018 Report to the Congress: Medicare Payment Policy*. Chapter 14: The Medicare prescription drug program (Part D): Status report, p. 393.
[5] MedPAC. *March 2018 Report to the Congress: Medicare Payment Policy*. Chapter 14: The Medicare prescription drug program (Part D): Status report, p.402.

Reducing stringency requirements on formularies could increase Part D plans negotiating power with drug manufacturers, and subsequently reduce costs. However, this would also result in reduced access to certain drugs for enrollees, and the health consequences that could result should be further evaluated.

MedPAC has suggested that the reduction in reinsurance subsidy could be offset by larger capitated payments to plan sponsors, excluding manufacturer discounts in the coverage gap from counting towards enrollees' TrOOP spending, and greater flexibility with formulary decisions.[6] Including these suggestions in this legislation could make these proposed changes easier for our plan to manage, though they would also increase costs for some enrollees who would remain in the coverage gap longer, and any additional cost incurred from the reduced reinsurance subsidy, and not offset by increased capitated payments, would likely result in increased premiums for enrollees.

And finally, implementing these changes for 2020 would be disastrous for Part D plan sponsors. All Medicare Part D plans have submitted their 2020 bids to CMS, assuming that the reinsurance subsidy will be 80 percent, as it is in current law.

2) Establishment of Maximum Out-of-Pocket Limits for Part D

Medicare recipients who need expensive drugs currently have no limit on how much they could end up spending in a given year, making paying for such treatments difficult, if not impossible, for many. By placing a maximum out-of-pocket cap on drug spending in Part D, the benefit would be brought more in line with current health care and drug plan design, and people facing catastrophic illnesses and costly treatment for those illnesses would know what the upper limit of their costs will be.

We generally support this concept, and since inception of Part D, we have limited cost-sharing in the catastrophic phase of coverage to no more than $100 for any claim, in order to protect members from some of the impact of excessively high-cost drugs. (The benefit as written in statute sets coinsurance at 5 percent during the catastrophic phase, but for a drug that costs $2,000 or more, which many specialty drugs do, the catastrophic phase coinsurance would be more than $100).

However, eliminating the coinsurance in the coverage gap entirely will require the plan to pay an additional 5 percent of drug costs during the catastrophic phase of coverage, if the current reinsurance subsidy remains as it currently is.

On its own, this might be manageable, given sufficient notice prior to implementation. But to also reduce the federal reinsurance subsidy, would result in our plan having to shift those costs onto our plan participants, most likely by dramatically increasing premiums for most of our members.

As with all health insurance, we try to find a balance between keeping premiums low enough to encourage healthier participants to join, while charging enough to cover the cost of providing the benefit to higher utilizers. We are concerned that the premium increases that would be necessary

[6] MedPAC, "Payment policy for prescription drugs under Medicare Part B and Part D," Testimony before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 30, 2019.

to cover the cost of both the proposed reduced subsidies, and the elimination of all cost sharing in the catastrophic phase, would cause healthier individuals to choose to go without Medicare Part D coverage at all, even with the threat of late enrollment penalties at some point in the future.

Conclusion

In the end, the most effective way to reduce exorbitant drug costs, and subsequently the costs incurred in the Part D catastrophic phase of coverage, is to actually reduce drug prices charged by drug manufacturers. Reducing the reinsurance subsidy CMS pays to plans is unlikely to do that on its own, and will just change who is paying those costs. If Part D plans have to pay those costs, and additional payments, subsidies or discounts are not provided through other means, they will have little choice but to pass those costs on to their enrollees, most likely through increased premium costs.