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Avalere Analysis Highlights Complexities of Transitioning Medicare Part B Drugs into Part D /

Moving certain Part B drugs to Part D, a proposal being evaluated by the Trump administration, would have disparate financial impacts on patients.

A new analysis from Avalere finds that Medicare patients' out-of-pocket costs for new cancer therapies can vary substantially based on whether a drug is covered by Part B or Part D, due to differing benefit designs and the use of supplemental health coverage. In 2016, average out-of-pocket costs were about 33% higher for Part D-covered new cancer therapies ($3,200) than for those covered in Part B ($2,400).

Drugs are covered by Medicare Part B or Part D, depending on how the drug is administered. In Part D, there is a complex benefit design structure that requires a degree of patient out-of-pocket spending for those not qualifying for low-income cost-sharing subsidies (LIS). In Part B fee-for-service (FFS), beneficiaries pay a 20% coinsurance on all medical services, including drugs; however, most patients have some type of supplemental medical insurance (e.g., Medigap, employer plans) to cover this coinsurance amount. CMS caps coinsurance for Part D plan specialty tiers at 33%, but cost sharing for non-preferred drug tiers can be close to 50%.

"Medicare beneficiaries typically have lower out-of-pocket costs in Part B – especially since so many seniors carry supplemental coverage," said Richard Kane, senior director at Avalere. "Any proposal for shifting drugs to Part D needs to account for these differences."

In both Part B and Part D, patients can be exposed to high cost sharing because there is no required out-of-pocket maximum in either program. In Part D, we found that 72% of the 20,000 patients receiving new cancer therapies in 2016 were non-LIS; this group of patients paid $4,400, on average, in out-of-pocket costs. In Part B FFS, we

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found15,000 patients receiving new cancer therapies; we estimate that 25% of them had no supplemental coverage and thus paid $9,700, on average, out-of-pocket.

As the Trump administration evaluates the potential cost savings from transitioning certain Part B drugs into Part D (as articulated in the Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs), the effect on beneficiary out-of-pocket costs is an important consideration. Our analysis suggests that if new cancer therapies, or any high-cost drug therapies, are switched from Part B to Part D, many Medicare patients would pay more out-of-pocket because they purchase supplemental health coverage for Part B medical services and are not eligible for LIS in Part D. However, Medicare patients that do not have supplemental health coverage would pay less out-of-pocket from such a switch, especially if they were eligible for LIS.

Understanding the impact is made complex by the interplay of numerous factors that influence patient out-of-pocket costs, including drug price, mix of the drugs used by a patient, a beneficiary's income level, and whether a beneficiary has Part D coverage or supplemental health insurance, among others. Another factor to consider is that shifting Part B drugs into Part D could put upward pressure on Part D premiums, which may not be fully offset by a decrease in Part B premiums, because the Part B program pays for both drugs and physician services.

"Beneficiary out-of-pocket costs under Part B and Part D are based on a combination of many factors," said Matt Brow, executive vice president at Avalere. "The financial impact of a transition of certain Part B drugs into Part D would not be uniform across patients, but rather will differ for particular groups of beneficiaries."

METHODOLOGY

Avalere analyzed prescription drug event (PDE) data and Medicare Part B FFS claims for 2016 under a CMS research data use agreement. We analyzed a cohort of patients representing less than 20% of total beneficiaries; this cohort included beneficiaries we identified as receiving new cancer treatments during 2016. We defined new cancer therapies based on new FDA indications approved in 2015 or 2016; our source for this list of new indications was the list of drugs eligible for the Novel Therapy Adjustment (NTA) in the Medicare Oncology Care Model (OCM).

We identified a patient was receiving a new Part D therapy if they had two or more PDE events for the drug, and a Part B E&M visit with a diagnosis for the corresponding indication. We identified a patient was receiving a new Part B therapy based on if they

had two or more Part B claims for the drug with a diagnosis for the corresponding indication. Average per enrollee total drug costs for new Part D therapies was $70,000. Average per enrollee total drug costs for new Part B therapies was $48,000. We used the PDE data to estimate the amount patients paid out-of-pocket for Part D therapies. We used FFS claims data to estimate the beneficiary liability for Part B therapies, and then assumed the share of patients without supplemental coverage was similar for this group of patients as for all Medicare Part B enrollees.

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