Understanding the Part D Spending Dynamics of Heart Failure Patients

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Heart failure (HF) affects almost one of every six Medicare beneficiaries[1]. Understanding the drug spending by HF patients requires an evaluation of the complex interactions between members, payers, and manufacturers in Part D.

Part D spending by HF patients is higher than for other patients due to their costly condition and the comorbidities they often have. In the complicated Part D benefit design, the portions of spending attributable to the member, drug manufacturer, Part D plan and federal government vary dramatically depending on the member's annual spending.

Because of their higher overall drug spending, HF patients are more likely to pass through the initial coverage zone and reach the Part D "donut hole" (Coverage Gap) and Catastrophic spending zones than the average Part D member.

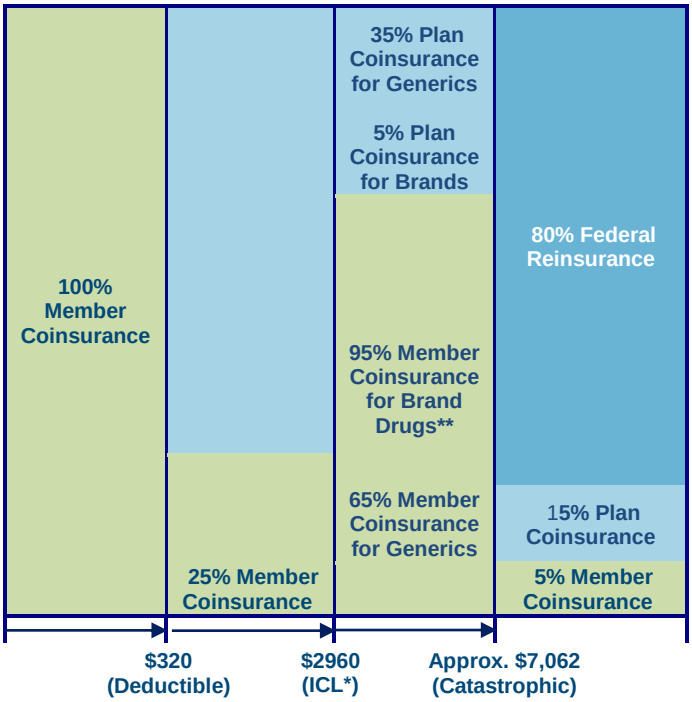
STRUCTURE OF THE DEFINED STANDARD PART D BENEFIT

Most Part D plans offer benefits that are equivalent to the CMS Defined Standard benefit. The standard Part D benefit spreads drug costs among the following stakeholders:

- The plan, which receives subsidies from CMS and member premiums,
- The patient, in the forms of deductibles and copay/coinsurance,
- The drug manufacturer, in the form of Coverage Gap Discount Program liabilities, and
- The federal government, in the form of direct subsidies to plans, cost sharing subsidies for low income members, and reinsurance.

How much each of these stakeholders pays for each Part D script is determined by how much the member spends on covered drugs in the year (both in total and in the form of out-of-pocket expenses), referred to here as the Part D coverage zone. The standard Part D coverage zones are shown in Figure 1.

FIGURE 1: STRUCTURE OF THE 2015 MEDICARE PART D STANDARD BENEFIT



*ICL = Initial Coverage Limit

**50% manufacturer's discount applies at the point of sale for applicable (non-low income) members. Therefore, the effective brand cost sharing in the gap for non-low income members is 45% in 2015.

We analyzed the drug spend for HF patients and compared it to the average Part D member. Then, we estimated how often, and when, these members reach the Coverage Gap and Catastrophic coverage limits. The chart below shows our estimates for 2015.

FIGURE 2: PORTION OF PART D MEMBERS REACHING THE GAP AND CATASTROPHIC COVERAGE ZONES ALL MEMBERS VS. HEART FAILURE PATIENTS – 2015 ESTIMATES

	All Part D Members			HF Part D Patients		
		Average Entry Month			Average Entry Month	
Coverage Zone	% Members	Gap	Catastrophic	% Members	Gap	Catastrophic
Non-Low Income						
Below Gap	78%	--	--	50%	--	--
Gap	16%	August	--	23%	July	--
Catastrophic	6%	March	July	27%	April	August
Low Income						
Below Gap	59%	--	--	29%	--	--
Gap	20%	August	--	30%	August	--
Catastrophic	21%	March	June	41%	March	June

IMPACT OF PART D STRUCTURE ON HEART FAILURE PATIENTS

As shown in Figure 2, HF patients are more likely to reach the coverage gap and catastrophic zones than the average Part D member. In other words, more HF patients have high spending than the general Part D population. This dynamic is consistent for low income and non-low income HF patients.

In Figure 2, more low income HF beneficiaries have reached the coverage gap and catastrophic zones than non-low income beneficiaries. At least two thirds of low income HF patients will have enough spending to reach the coverage gap, and more than half of these patients will accumulate enough out of pocket expenses to exit the gap and enter the catastrophic zone. We note that, for these patients, the low income cost sharing subsidy covers most of the patient's cost sharing.

METHODOLOGY AND DATA SOURCES

We calibrated the Part D expenditures in the Medical Expenditures Panel Survey (MEPS 2010-2012) database to Part D costs in MedPac's 2014 Data Book[2], and trended to 2015. We then identified HF patients in MEPS and created claims probability distributions of their Part D spending as well as the general Part D Populations, separately for non-low income and low income. Using the 2015 defined standard part D design, we estimated the average number of patients reaching the gap and catastrophic coverage zones, and the average time spent in each one.

CAVEATS

The estimates are national averages based on carefully constructed actuarial models and 2010-2012 [3]historical databases. The estimates for 2015 do not reflect therapeutic changes since that time. Results for any particular plan will vary from those presented here. Certain types of benefit programs, such as the employer group waiver plans (EGWPs), can create different dynamics. Demographics, local practice patterns, and other factors could cause actual results to vary substantially from those presented here.

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CONTACT

If you have any questions or comments on this paper, please contact:

Gabriela Dieguez
gabriela.dieguez@milliman.com +1 646 473 3219

Bruce Pyenson
bruce.pyenson@milliman.com +1 646 473 3201

Michael Bellanich
michael.bellanich@milliman.com +1 646 473 3214

The American Academy of Actuaries requires that its members identify their credentials in communications. Dieguez and Pyenson meet the Academy's qualification requirements to issue this report.

For additional information on Medicare spending on Heart Failure, we refer to two publications our team has authored:

The High Cost of Heart Failure for the Medicare Population – An Actuarial Cost Analysis

The High Cost of Heart Failure for Health Systems – Opportunities for Better Management

[1] Center for Medicare and Medicaid Services. *Chronic Conditions among Medicare Beneficiaries. Chartbook: 2012 Edition*; 2012: 6.

[2] Medicare Payment Advisory Commission. A Data Book, Health Care Spending and the Medicare Program; June 2014: 171.