Understanding the Part D Spending Dynamics of Heart Failure Patients

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Heart failure (HF) affected about 1 in 8 Medicare beneficiaries and was accompanied by at least 3 comorbidities in 90% of the cases as of 2015.[1] Understanding pharmacy spending by HF patients requires an evaluation of the complex interactions between members, payers, manufacturers, and the government in Part D.

Part D spending by HF patients is often higher than for other patients due to their condition and related comorbidities. The portions of spending attributable to the member, pharmaceutical manufacturer, Part D plan, and federal government can vary dramatically depending on the member's annual spending due to the nature of the Part D benefit design (see Figure 1).

Given their higher overall medication spending, HF patients are often 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.

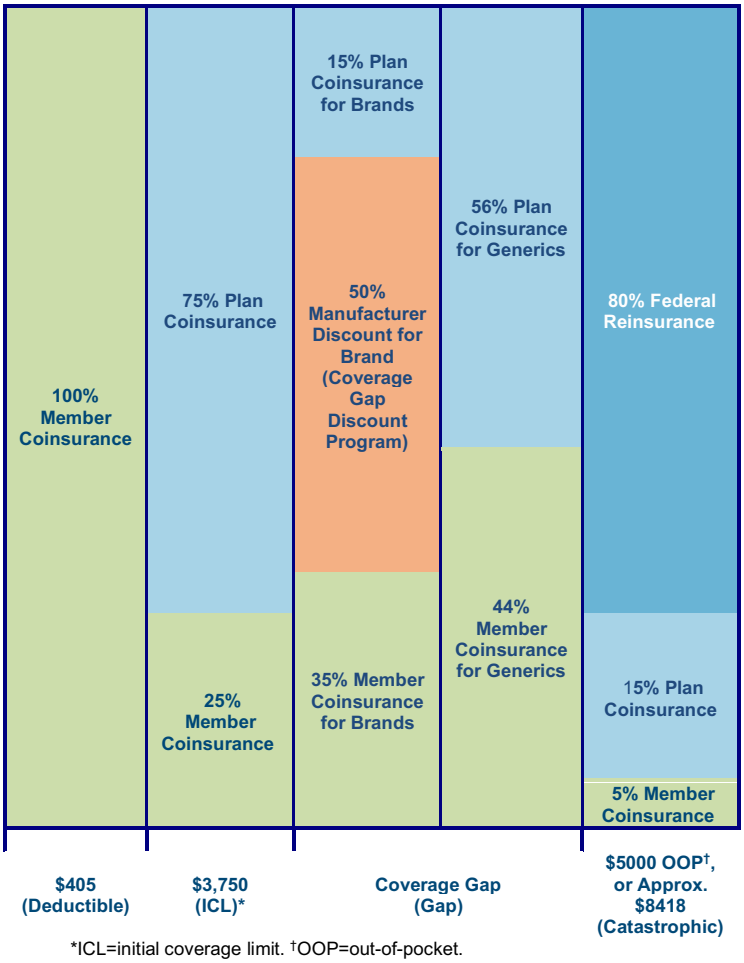
STRUCTURE OF THE PART D BENEFIT

The Part D benefit spreads costs among the following stakeholders:

- The plan, which receives subsidies from CMS and member premiums,
- The patient, in the form of deductibles and copays/coinsurance,
- The pharmaceutical manufacturer, through discounts to non-low-income members in the coverage gap, and
- The federal government, in the form of direct subsidies to plans, premium and cost sharing subsidies for low-income members, and reinsurance.

How much each of these stakeholders pays for a Part D script is determined by the member's prior spending on covered medications for the year (both out-of-pocket and total expenses) and the member's income status. Cost sharing for a script varies depending on which coverage zone the patient finds themselves at the time the script is filled, and is mostly subsidized for low-income beneficiaries. The standard Part D coverage zones are shown in Figure 1.

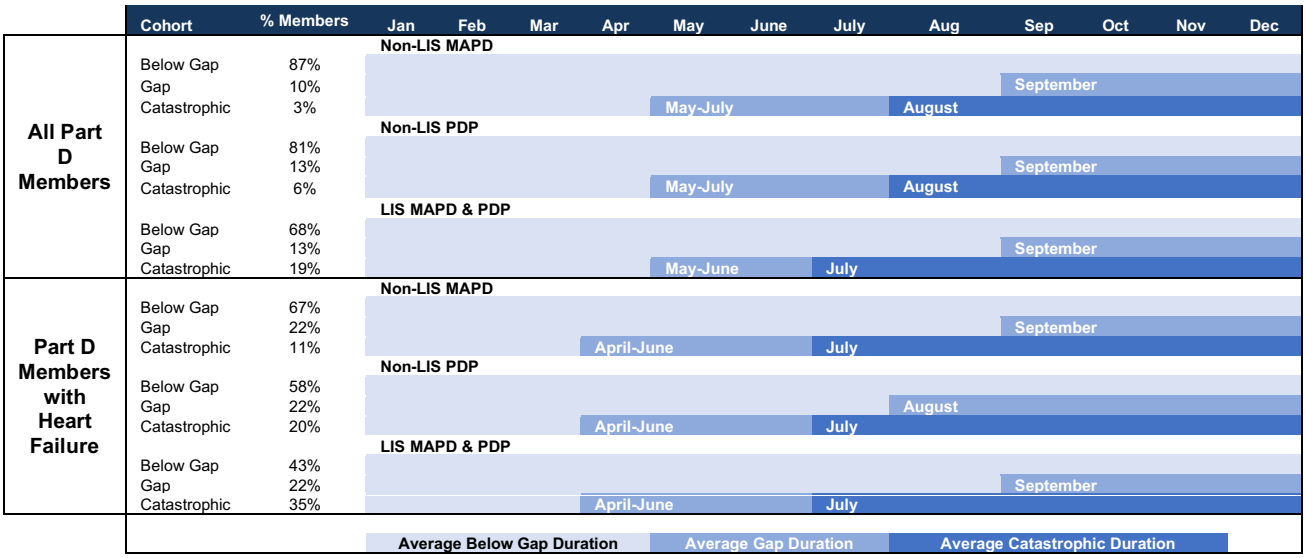
FIGURE 1: 2018 PART D STANDARD BENEFITS FOR APPLICABLE BENEFICIARIES[2]



*ICL=initial coverage limit. †OOP=out-of-pocket.

We analyzed the pharmacy 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. Figure 2 shows our estimates for 2018.

FIGURE 2: PORTION OF PART D MEMBERS REACHING THE GAP AND CATASTROPHIC COVERAGE ZONES – PROJECTED 2018



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 and for enrollees in stand-alone Part D (PDP) or integrated medical and pharmacy (MAPD) plans.

In Figure 2, more low-income HF beneficiaries are likely to reach the coverage gap and catastrophic zones (57%) than non-low-income HF beneficiaries (33% to 42%). Approximately 35% of low-income HF patients will accumulate enough nominal out-of-pocket expenses to exit the gap and enter the catastrophic zone. We note that, for these patients, the low-income cost sharing subsidies cover most of the patient's cost sharing. Among non-low-income patients, those with PDP coverage are more likely to reach the catastrophic zone (20%) than those with MAPD coverage (11%).

The Bipartisan Budget Act of 2018 (BBA) increased the manufacturer discount to 70% and lowered member cost sharing in the coverage gap to 25%, starting in 2019. These changes will accelerate the entry of non-low-income beneficiaries into the catastrophic coverage.

METHODOLOGY AND DATA SOURCES

We analyzed the expenditures of Medicare beneficiaries with individual Part D coverage in Milliman's proprietary databases (2016 and 2017 Part D consolidated database) and trended their Part D spending to 2018. We identified HF patients using a medication marker. We note that this identification criterion for HF is different from that used in the Part D risk adjustment model. We created claims probability distributions (CPDs) of Part D spending for HF and all Part D beneficiaries.

We used these CPDs to estimate the average number of patients reaching the gap and catastrophic coverage zones, and the average time spent in each.

The distributions were calculated separately for non-low-income beneficiaries in MAPD and PDP plans, and for low-income beneficiaries.

CAVEATS

These results represent national averages. Results for any particular plan may vary substantially from those presented here due to demographics, local practice patterns, and other factors. Certain types of benefit programs, such as the employer group waiver plans (EGWPs), can create different dynamics.

This report was commissioned by Novartis Pharmaceuticals Corporation. The findings reflect the research of the authors. Milliman does not endorse any product or organization.

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Dieguez is a member of the American Academy of Actuaries and meets the qualification requirements to issue this report.

[1] Centers for Medicare and Medicaid Services. *Chronic Conditions Charts: 2015. Chartbook: 2015 Edition.*
[2] Applicable beneficiaries are Part D enrollees that do not receive income-related subsidies under section 1860D-14(a) of the Social Security Act (the Act).