SNP Alliance

The National Voice for Special Needs and Medicare-Medicaid Plans

A National Nonprofit Leadership Organization

Position Statement

SNP Alliance Position Statement on Senate Finance Drug Pricing Proposal (October 2020)

Problem Statement

In December 2019, the Senate Finance Committee, through bi-partisan negotiations, updated the Prescription Drug Pricing Reduction Act of 2019 (S. 2543) designed to lower prescription drug prices. One of the key provisions in S.2543 shifts a significant percentage of the risk of Part D drug costs to insurance plans (Section 121) by making plans responsible for 60% of catastrophic coverage vs the current 15%. While many aspects of this bill have merit in helping to control the escalation of drug costs, some of these provisions, as currently defined, could unintentionally cause significant harm to persons in need of high-cost drugs (as there is no cap on cost sharing for Part D drugs)[1] and to Special Needs Plans that specialize in their care.[2] This is particularly true for smaller plans (< 10,000 enrollees) and those that serve a disproportionately high percentage of enrollees in need of high-cost drugs.

Analysis

This adverse effect on plans can be seen most clearly by looking at costs associated with caring for persons receiving a low-income subsidy.[3] According to MedPAC's June 2020 Report to Congress,[4] in 2018 the mean spending for low-income subsidy (LIS) was $6,371 compared to $2,740 for non-LIS. The average annual drug costs for persons without low-income subsidy is $2,700 per enrollee. Under the current program, plans would be responsible for 28% of those costs. Under the proposed provisions, plans would be responsible for 65% of those costs. While under the new proposal all plans would be required to assume financial risk for low income subsidy beneficiaries, the adverse effect on some Special Needs Plans could be devastating because:

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[1] Once a beneficiary's drug coverage enters into the "catastrophic phase," they still are responsible for 5 percent of their drug cost, without limit, which in some cases can reach thousands of dollars per year. These high cost persons are also more heavily enrolled in SNPs, as according to the June 2019 MedPAC Report to Congress, in 2017 31% of those enrolled in traditional MA plans reached their maximum out of pocket limit vs 68% of D-SNPs enrollees.

[2] As of September 2020, 3.6 million persons are enrolled in Special Needs Plans (CMS Comprehensive SNP Report). Over 3 million of these persons are dually eligible for Medicare and Medicaid. Many are frail, disabled and/or with complex medical conditions. According to MedPAC, Report to Congress, June 2019, dually eligible beneficiaries accounted for less than 10 percent of enrollment in just over half of traditional MA plans and less than 30 percent of enrollment in about 95 percent of traditional plans, which is roughly in line with their overall prevalence in the Medicare. About 18 percent of all Medicare beneficiaries in 2017 were dually eligible.

[3] For plan year 2020, Medicare beneficiaries can receive a federal subsidy to help cover the cost of their prescription drugs if their income is below $19,140 per year for a single person or $25,850 for a married person, AND their assets are below $13,110 for a single person or $26,160 if married.

[4] Additional SNP Alliance comments and observations on MedPAC's comments in the MedPAC June 2020 Report to Congress are provided in Appendix I.

- *Low-income subsidy beneficiaries have significantly higher drug costs because of greater than average medical complications*.[5]
- *SNPs enroll a significantly higher percentage of low-income Medicare beneficiaries than general MA plans*.
- *Most SNPs are less able to manage the added drug-cost risk — variability*. Larger plans (>50,000 enrollees) can manage fluctuations in drug expenditures even with the addition of a few high-cost pharmaceuticals, as they are distributed over a larger enrollment. They often rely on other products to manage their overall margins. Small plans do not have such ability. But most SNPs are offered by smaller health plans (<10,000 enrollees), which, by convention of scale, are less nimble than larger insurers. Most SNPs also:
    - Are less able to negotiate price differences with drug manufactures, access affordable reinsurance, and draw upon other products to help compensate for financial challenges.
    - Are unable to rely on premiums and co-pays to help manage lost revenue or consumer-level utilization behaviors (a common strategy for general MA plans).[5]
    - Moreover, the current diagnostic-based risk adjustment is not sensitive enough to capture wide variations in actual drug utilization by diagnosis.
    - The additional impact of COVID-19 on high-risk populations is producing additional costs and uncertainties for plans specializing in care of vulnerable populations.

Recommendations

As Congress continues the important work of reducing the cost of drugs for seniors, Congress should consider providing risk protection not only for beneficiaries with high-drug costs but for those plans that specialize in their care. Options include:

- Developing more protective risk corridors for smaller plans. For example, separate risk corridors might be established for plans with enrollment greater than 50K members, those with 10K – 50K members, and those with less than 10K members.
- Expanding reinsurance options that address affordability concerns for small plans and plans specializing in care of high-risk populations.
- Using more precise risk adjusters that incorporate actual predicted use of high cost drugs (eg: Chronic SNPs serving HIV/AIDS members), such as incorporating actual use of high cost drugs.
- Having CMS pay a carve-out similar to national coverage determinations in Medicare Parts A and B for new high-cost drugs entering the market, based on national coverage determinations and care standards.
- Establish a new risk pools for SNPs or simply exempt SNPs and MMPs from this proposal.

Conclusion

Currently, over 3 million individuals are enrolled in plans that specialize in care of persons with multiple and high-cost drug regimens. These are some of America's most vulnerable citizens, and the services and care coordination provided to them by Special Needs Plans are vital to maintaining their health and independence. If these specialty health plans must assume considerable increases in drug expenditures, some will simply cease to remain in business – causing additional harm to those most in need.

[5] According to the 2017 MedPAC/MacPAC Databook Beneficiaries Dually Eligible for Medicare and Medicaid, persons dually eligible for Medicare and Medicaid are almost three times as likely as non-dual Medicare beneficiaries (18% vs 6%) to have poor self-reported health, and three times as likely to be disabled (52% vs 17%).

Appendix I: SNP Alliance Responses to MedPAC June 2020 Report to Congress

MedPAC provided comments on the issue of prescription drug pricing. Many of MedPAC's recommendations are supportive of and aligned with the recommendations made by the SNP Alliance. In Appendix I below, the SNP Alliance highlights key statements made by MedPAC and the observations of the SNP Alliance on those comments.

MedPAC Statement	SNP Alliance Response
It will be critically important for CMS to recalibrate Part D's risk adjustment model to reflect the increased plan liability. (page 121) We believe that CMS will be able to recalibrate the model to ensure that overall payment rates are adequate for both LIS enrollees and other Part D beneficiaries. (page 122)	**The SNP Alliance is not sure CMS can accurately predict premium coverage for LIS qualified enrollees, given the current risk adjustment model.**
(O)ne concern is that because risk adjustment models tend to underpredict very high spending and overpredict very low spending, plans that enroll a relatively large share of high-cost beneficiaries could be disadvantaged. Of particular concern to the Commission are smaller plan sponsors that enroll a high share of LIS beneficiaries. (page 122)	**MedPAC's concern is precisely aligned with the SNP Alliance concern for LIS SNP enrollees and smaller plans.**
Policymakers could also consider different risk-sharing percentages in the corridors, potentially increasing plans' aggregate stop-loss protection (i.e., reducing plans' insurance risk above a threshold). While the enhanced protection would be available to all plans, in practice, the protection would be particularly valuable for smaller plans and plan sponsors that do not have the scale to spread the insurance risk or the capital to reinsure themselves. (page 122)	**MedPAC's observation that smaller plans, especially those with high LIS enrollment, are at greater risk is aligned with the SNP Alliance concern.**
In therapeutic classes where such competition is weak or does not exist, private plans have little or no bargaining leverage with manufacturers for price reductions. (page 124)	**MedPAC observes that plans may not have sufficient negotiating power in many of the therapeutic classes used by LIS SNP enrollees and these therapeutic classes need to be identified for LIS enrollees before legislative approval. The SNP Alliance concurs.** **In potential legislation, Congress needs to identify the therapeutic classes.**
LIS enrollees are much more likely than other enrollees to reach the catastrophic phase of the benefit (19 percent vs. 3 percent, data not shown), reflecting their higher average drug spending. (page 132)	**This observation underlines the concern that there is insufficient stop-loss protection for SNP plans that enroll a high number of LIS-enrollees.**
Private reinsurers of commercial plans may exclude individuals with predictably high	**This observation underlines SNP-A concerns that there is insufficient stop-loss protection for LIS enrollees in the private market.**

spending from future reinsurance coverage. (page 135)	
As a result, LIS beneficiaries account for a relatively small share of enrollment in traditional MA–PDs (18 percent) but account for virtually all D–SNP enrollment. (page 137)	**Because all D-SNP enrollment are LIS beneficiaries, this Rx change is especially impactful on SNP Alliance members.**
Under the recommended reform package, Medicare's payments for reinsurance and the LICS would be lower but would be mostly offset by higher capitated payments. (page 138)	**While this may be true, the SNP Alliance is not sure the savings gained would be worth the effort.**
Although the LIS helps ensure access to medicines, its limits on cost sharing also give LIS enrollees weaker incentives to use lower cost drugs and make it more difficult for plan sponsors to manage enrollees' drug spending. (page 143)	**MedPAC observes the Rx changes may have relatively little impact on the change in LIS-enrollee consumption behaviors. The SNP Alliance concurs.**
Medicare's requirement that plans cover "all or substantially all" drugs in the six classes ensures that beneficiaries who have conditions for which drugs play a key role in treatment have broad access to coverage. However, because manufacturers know that their products cannot be excluded from plan formularies, the policy also limits plan sponsors' ability to obtain rebates on brand name drugs. (page 143)	**The Rx changes proposed do not curb the ability of manufactures to continue gaming formulary structures.**
However, current LIS copayments provide much weaker financial incentives than those faced by other enrollees. If plan sponsors are to take on more risk for LIS enrollees, additional tools would help them better manage spending for this population. (page 144)	**"Additional tools" are required according to MedPAC but not defined other than a two-tiered formulary system – one preferred and other non-preferred -- with increased copays for LICs-enrollees for non-preferred drugs.**
One concern is that, because risk adjustment models tend to underpredict very high spending and overpredict very low spending, plans that enroll a relatively high share of high-cost beneficiaries could be disadvantaged. The Commission is particularly concerned about smaller plan sponsors that enroll a higher share of LIS beneficiaries. (page 148)	**It might be helpful for MedPAC to model the impact of these Rx changes as if there were in effect during 2019 (or other model year), showing how smaller plans with 100% LICs-enrollees might be impacted.**
For LIS enrollees (including those with no drug spending as well as individuals well above the OOP threshold), catastrophic spending averaged $3,306 and varied widely (a CV of 506 percent) (Table 5-9). (page 149).	**MedPAC observes that as LIS-enrollees enter the catastrophic phase, costs appear to vary widely with limited ability to predict, even for a recalibrated method. The SNP Alliance concurs.**
These high-cost outliers might pose a greater risk for regional PDPs and MA–PDs because, compared with large plans offered by national sponsors (for which the effects of high-cost outliers are more likely to average out), they typically have lower enrollment and thus less ability to absorb losses. (page 150)	**As noted by MedPAC, smaller plans have limited ability to absorb losses. The SNP Alliance concurs.**

Policymakers could also consider different risk-sharing percentages in the corridors, including greater aggregate stop-loss protection, which could be particularly valuable for smaller plans and plan sponsors that do not have the scale to self-reinsure. (page 151)	**MedPAC observes smaller plans are at greater risk without a stop-loss safety net. The SNP Alliance concurs.**
Introducing differential cost sharing between plans' preferred and nonpreferred drugs would give LIS beneficiaries stronger financial incentives to use lower cost drugs. If beneficiaries switched to preferred therapies, those individuals would see no change in OOP spending. However, if a nonpreferred therapy was medically necessary, the beneficiary would have to pay the modestly higher copayment or pursue a tiering exception to obtain the nonpreferred therapy at a preferred (lower) copayment. Because the higher nonpreferred copayment would also apply to drugs not on a plan's formulary (nonformulary drugs), a beneficiary who obtained a nonformulary drug through the plan's exceptions process would also pay somewhat higher cost sharing than under current law. (page 153)	**"Modestly higher co-payments" could be quite significant to LIS-enrollees and result in a higher level of administrative exceptions to enable those enrollees to access non-preferred (but necessary) drug tiers.**
Under Part D's risk adjustment model, with separate risk adjusters for LIS beneficiaries, CMS would be able to recalibrate the model to account for the disproportionate impact that the reform package would have on the average capitated payments for LIS beneficiaries. (page 154)	**More information is required on how this "recalibration" would occur and what level of premium it would produce for smaller, LIS-enrollee plans.**
There is also uncertainty as to whether the policy change would restrain or worsen the growth in launch prices of new therapies. (page 155)	**MedPAC observes there is limited understanding and analysis given to how the Rx changes will shape manufacturer behavior. The SNP Alliance concurs.**