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Proposed Rules for Part D Would Create Undue Disruption for Seniors

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The Obama Administration's Centers for Medicare and Medicaid Services (CMS) has announced that it will not finalize controversial elements of its proposed Medicare rule. The proposed rule would have undercut patient choice and reduced the competition that controls costs in the Medicare drug program (Part D).[1] Many key stakeholders and Members of Congress expressed concern with the proposed rules, and in response, Representative Renee Ellmers (R–NC) introduced H.R. 4160, the Keep the Promise to Seniors Act, to block the regulation.

Under its original plan, the Administration's proposed changes would have inflicted serious damage on seniors' Medicare Part D benefits.

Restricting Plan Choice. The proposed rules would have restricted plan choice by:

1. **Limiting "parent company" to one contract per PDP region.** CMS proposed to limit an insurer to one prescription drug plan (PDP) sponsor contract per region. According to CMS, in contract year 2013, there were 57 parent organizations that held more than one PDP sponsor contract through subsidiary contracting organizations. CMS argues that duplicate contracts create inefficiencies and do not reflect true competition: "Two subsidiaries of the same parent organizations offering plans in the same PDP region are not truly competitors as decisions concerning their operations are ultimately controlled by a single entity, or parent organization."

   While the truest form of competition among plans is at the insurer level, this rule would still have reduced the number of plans and thus decreased the plan choices available to seniors.

2. **Limiting plans per sponsor to two.** The rule proposed to limit an insurer to offer only two plans, one standard plan and one enhanced plan. CMS justified this by arguing that it "may ... help ensure that beneficiaries can choose from a less confusing number of plans that represent the best value each sponsor can offer."

   Restricting the number of plans an insurer can offer would hamper seniors' choice and cause significant disruption in the Part D market.

   Avalere Health, a health care consulting firm, estimates that "the change would require 214 of the current 552 enhanced PDPs to be terminated or consolidated with an existing plan." Those 214 plans are sold by carriers that currently offer two enhanced PDPs in the same region and account for 39 percent of total enhanced plans. The study goes on:

   > The anticipated change in policy would impact 7.4 million of the 7.9 million (94 percent) Medicare beneficiaries who are currently enrolled

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> in an enhanced plan—including both beneficiaries whose plan will be terminated or consolidated and those whose plan will remain but may see changes in benefits or premiums as plan options and enrollees are consolidated.[2]

Change in Drug Coverage Mandates. Obamacare granted the Secretary of Health and Human Services authority to establish new criteria to identify categories or classes of Part D drugs that must be included in every Part D plan formulary. Based on the criteria established in the proposed rule, three of the six existing classes of protected drugs would not meet the newly established criteria and therefore would not be required to be covered in each plan's drug formulary (though they propose to allow one to maintain its status through 2015).

The effect of this rule would have been a reduction in the drug mandates that a plan formulary must abide by. Thus, this would have had a positive impact on a plan's ability to compete. A plan could still include these drugs if that is what the market dictates, or it could exclude them from coverage, which could potentially reduce the cost of that plan, which would benefit both seniors and taxpayers. However, it is also critical that seniors have a broad scope of coverage options to ensure that they have a choice, something that this rule begins to limit.

Interpretation of Non-Interference Clause. The noninterference clause in Part D excludes the government from participating in negotiations. It states:

> (i) NONINTERFERENCE.—In order to promote competition under this part and in carrying out this part, the Secretary— (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered part D drugs.

Despite the clear text of the law, CMS's proposed rule aimed to "formally interpret" the clause in a way that outlined more specifically what CMS can and cannot do. For example, CMS clarified that it cannot set a price formula or benchmark and cannot establish the parameters of any price concession (e.g., Medicaid-style rebates that are often proposed, including in the President's fiscal year 2015 budget proposal)—even though this is already understood to be what the non-interference clause means.

However, CMS's interpretation also stated that "the prohibition on interference in negotiations… would not pertain to negotiations between Part D sponsors and pharmacies."

The legality of CMS's ability to interpret the clause in such a way is highly questionable.[3]

Patient Satisfaction. Although the Medicare prescription drug benefit adds to the insolvency of the Medicare program, using private-run plans rather than a government-run plan in Medicare Part D has exceeded all expectations. The program offers seniors a wide choice of drug therapies at competitive prices, and its dramatic achievement in controlling costs for both seniors and taxpayers is beyond dispute.[4]

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1. *Federal Register*, Vol. 79, No. 7 (January 10, 2014), pp. 1918–2073, http://www.gpo.gov/fdsys/pkg/FR-2014-01-10/pdf/2013-31497.pdf (accessed March 10, 2014).
2. Matthew Eyles, "7.4M Medicare Beneficiaries Could Be Affected by Proposed Meaningful Differences Policy," Avalere Health, February 12, 2014, http://avalerehealth.net/expertise/managed-care/insights/7.4m-medicare-beneficiaries-could-be-affected-by-proposed-meaningful-differ (accessed March 10, 2014).
3. Boyden Grey and Associates PLLC, "The Medicare Modernization Act's Prohibition Against Federal Negotiation of Drug Prices," February 24, 2013.
4. Medicare Part D's overall costs have defied official expectations. The program's total costs from 2006 to 2011 were 48 percent *lower* than the Medicare Trustees' original projections for the same time period. Centers for Medicare and Medicaid Services, *2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table II.C18, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/tr2004.pdf (accessed May 15, 2013), and *2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table III.D3, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf (accessed May 15, 2013). In addition, seniors' premium costs have remained remarkably stable. See Robert E. Moffit and Alyene Senger, "Real Medicare Reform: Why Seniors Will Fare Better," Heritage Foundation *Backgrounder* No. 2800, May 20, 2013, http://www.heritage.org/research/reports/2013/05/real-medicare-reform-why-seniors-will-fare-better.

Concerning Part D and CMS's proposed rules, seniors understood that it would have a negative impact on them. According to a recent survey conducted by the Morning Consult, 88 percent of all seniors—in different age, gender, and income categories—are very or somewhat satisfied with the program, and three out of four prefer less expensive plans with smaller preferred networks rather than more expensive plans with broader networks. Significantly, eight out of 10 seniors opposed limiting the number of plans a company can offer to two in any geographic area.[5]

Bottom line: The Administration's effort to cancel or reduce Part D plans was no more popular than its policy to cancel plans or reduce competition in the commercial health insurance markets.[6] As the Administration reevaluates the rules, it would be wise to avoid the same mistakes as the original plan.

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5. Michael Ramlet, "Poll: Seniors' Opinions on Medicare," the Morning Consult, March 3, 2014, http://www.themorningconsult.com/2014/03/seniors-opinions-on-medicare-and-proposed-changes-poll-analysis/ (accessed March 10, 2014).
6. Edmund F. Haislmaier, "Health Insurers' Decisions on Exchange Participation: Obamacare's Leading Indicators," Heritage Foundation *Backgrounder* No. 2852, November 7, 2013, http://www.heritage.org/research/reports/2013/11/health-insurers-decisions-on-exchange-participation-obamacares-leading-indicators, and Alyene Senger, "Lack of Competition in Obamacare's Exchanges: Over Half of U.S. Has Two or Fewer Carriers," Heritage Foundation *Issue Brief* No. 4082, November 8, 2013, http://www.heritage.org/research/reports/2013/11/obamacare-insurance-exchanges-and-the-lack-of-competition.