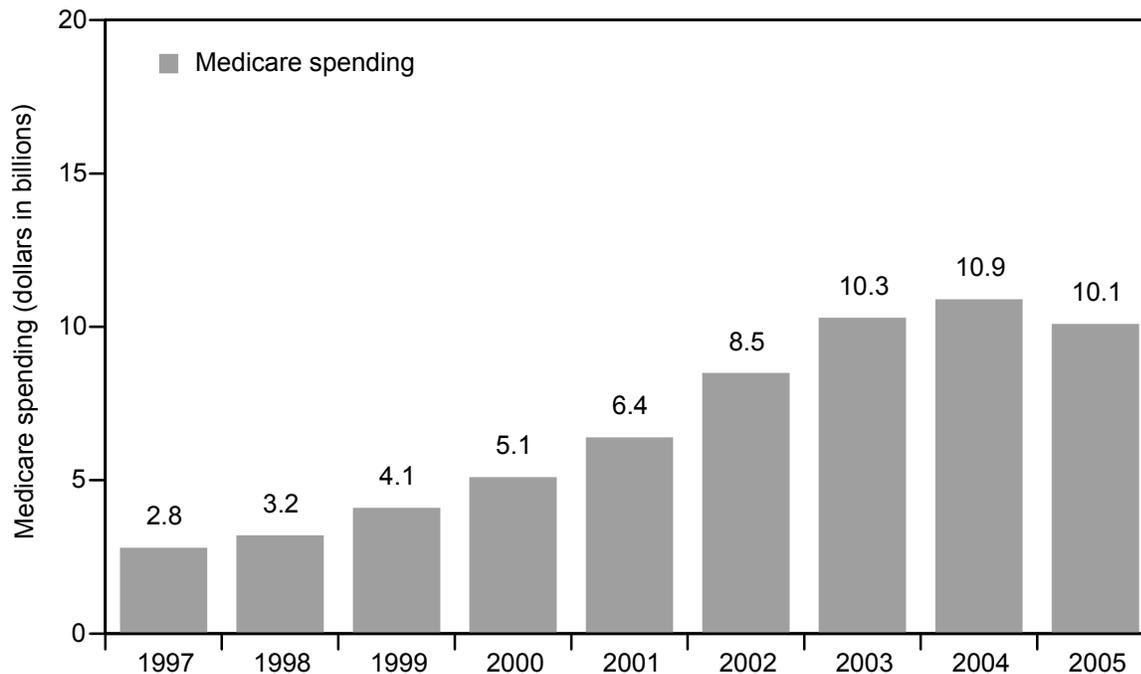


SECTION

11

Drugs

Chart 11-1. Medicare spending for Part B drugs



Source: MedPAC analysis of unpublished CMS data.

- MedPAC estimates that spending for Part B drugs totaled \$10.1 billion in 2005.
- Medicare spending on Part B drugs increased at an average rate of 25 percent per year from 1997 to 2003. Since then the rate has moderated. In 2005, spending declined by 7.8 percent compared to 2004.
- This total does not include drugs provided through outpatient departments of hospitals or to patients with end-stage renal disease in dialysis facilities. MedPAC estimates that payments for separately billed drugs provided in hospital outpatient departments equaled about \$2 billion in 2005. We estimate that freestanding and hospital-based dialysis facilities billed Medicare an additional \$2.9 billion for drugs.
- The primary reason for the decline in Part B drug expenditures is the change in the Medicare payment rate from one based on the average wholesale price to 106 percent of the average sales price. The volume of drugs provided to Medicare beneficiaries continued to rise.

Chart 11-2. Top 10 drugs covered by Medicare Part B, by share of expenditures, 2005

Drug name	Clinical indications	Competition	FDA approval date	Percent of spending
Darbepoetin alfa	Anemia	Sole source	2001	8.4%
Non-ESRD erythropoietin	Anemia	Multisource biological	1989	7.7
Rituximab	Non-Hodgkin's lymphoma	Sole source	1997	7.6
Infliximab	Rheumatoid arthritis, Crohn's disease	Sole source biological	1999	5.3
Pegfilgrastim	Cancer	Sole source	2002	5.2
Bevacizumab	Cancer	Sole source	2004	2.8
Albuterol	Asthma and other lung conditions	Generic	1982	2.8
Docetaxel	Cancer	Sole source	1996	2.8
Oxaliplatin	Cancer	Sole source	2004	2.8
Zoledronic acid	Cancer related	Sole source	2001	2.6

Note: FDA (Food and Drug Administration), ESRD (end-stage renal disease).

Source: MedPAC analysis of 2005 Medicare claims data from CMS and unpublished FDA data.

- Medicare covers about 550 outpatient drugs under Part B, but spending is very concentrated. The top 10 drugs account for about 48 percent of all Part B drug spending.
- Spending for new drugs dominates the list. Of the top 10 drugs covered by Medicare in 2005, eight received Food and Drug Administration approval in 1996 or later.
- Treatment for cancer dominates the list—8 out of the top 10 drugs treat cancer or the side effects associated with chemotherapy. This is because most cancer drugs must be administered by physicians, a requirement for coverage of most Part B drugs.

Chart 11-3. Part D enrollment and other sources of drug coverage

	Millions as of January 16, 2007	Percent of total Medicare beneficiaries
Enrollment that leads to Medicare program spending:		
Voluntary enrollees in stand-alone PDPs	10.98	25%
Enrollees in MA-PDs (including some duals)	6.65	15
Individuals dually eligible for Medicare and Medicaid auto-enrolled in Part D plans	6.27	14
Individuals covered by Medicare RDS	<u>6.94</u>	<u>16</u>
Subtotal	30.84	71
Enrollment that does not lead to Medicare program spending:		
Estimated federal retirees in FEHB and Tricare	<u>3.33</u>	<u>8</u>
Total	34.17	79
Additional sources of creditable coverage*	4.86	11

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), RDS (retiree drug subsidy), FEHB (Federal Employees Health Benefits program). TRICARE is the health program for military retirees and their dependents. Columns do not sum to 100 percent because the remaining share of beneficiaries either have no drug coverage or have coverage of less value than Part D benefits.
* Drug coverage of equal or greater value to Part D benefits through the Department of Veterans Affairs, Indian Health Service, former employers that do not receive Medicare's RDS, current employers, or state pharmaceutical assistance programs.

Source: Presentation by Cynthia Tudor, Director, Medicare Drug Benefit Group, at the National Health Policy Forum, Feb. 22, 2007.

- As of January 2007, CMS estimated that 30.8 million of the 43 million Medicare beneficiaries (71 percent) were either signed up for Part D plans or had prescription drug coverage through employer-sponsored coverage under Medicare's retiree drug subsidy (RDS). (If an employer agrees to provide primary drug coverage to its retirees with an average benefit value that is equal or greater in value to Part D (called creditable coverage), Medicare provides the employer with a tax-free subsidy for 28 percent of each eligible individual's drug costs that fall within a specified range of spending.)
- Voluntary enrollees in stand-alone drug plans numbered 11.0 million, or 25 percent of all Medicare beneficiaries. Individuals who are enrollees in Medicare Advantage-Prescription Drug plans and those dually eligible for Medicare and Medicaid and numbered 6.7 million and 6.3 million, or 15 percent and 14 percent, respectively, of all beneficiaries. Individuals whose employers received Medicare's RDS numbered 6.9 million, or 16 percent. Those four groups of beneficiaries directly affect Medicare program spending.
- Other Medicare beneficiaries have creditable drug coverage, but that coverage does not affect Medicare program spending. For example, 3.3 million beneficiaries (8 percent) were federal retirees who receive drug coverage through the Federal Employees Health Benefits program or TRICARE. Approximately 4.9 million (11 percent) had prescription drug coverage through the Department of Veterans Affairs, Indian Health Service, other former employers that are not a part of Medicare's RDS, current employers because the individual is still an active worker, or state pharmaceutical assistance programs.

Chart 11-4. Defined standard benefit parameters increase over time

	2006	2007
Deductible	\$250.00	\$265.00
Initial coverage limit	2,250.00	2,400.00
True out-of-pocket spending limit	3,600.00	3,850.00
Total covered drug spending at true out-of-pocket limit	5,100.00	5,451.25
Minimum cost sharing above true out-of-pocket limit		
Copay for generic/preferred multisource drug prescription	2.00	2.15
Copay for other prescription drugs	5.00	5.35

Source: CMS, Office of the Actuary, 2006. *Medicare Part D benefit parameters for standard benefit: Annual adjustments for 2007* (May 22).

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 specified a defined standard benefit structure for 2006 that included a \$250 deductible, 25 percent coinsurance on covered drugs until the enrollee reaches \$2,250 in total covered drug spending, and then a coverage gap in which the enrollee is responsible for the full discounted price of covered drugs until their true out-of-pocket spending reaches \$3,600. (“True out of pocket” refers to the fact that cost sharing paid by many sources of supplemental coverage does not count toward this \$3,600 out-of-pocket spending limit.) A person with no other source of drug coverage that supplements Part D would reach this \$3,600 true out-of-pocket limit at \$5,100 in total drug spending (i.e., the combination of the enrollee’s spending plus spending that the Part D plan covered). Enrollees with drug spending even higher than that amount would pay just \$2 to \$5 per prescription.
- The parameters of this defined standard benefit structure increase over time at the same rate as the annual increase in average total drug expenses of Medicare beneficiaries. Benefit parameters for 2006 and 2007 are shown in the table above.
- Within certain limits, sponsoring organizations may offer Part D plans that have the same actuarial value as the defined standard benefit, but a different benefit structure. For example, a plan may use tiered copayments rather than 25 percent coinsurance. Or a plan may have no deductible but use cost-sharing requirements that are equivalent to a rate higher than 25 percent. Both defined standard benefit plans and plans that are actuarially equivalent to the defined standard benefit are known as “basic benefits.”
- Once a sponsoring organization offers at least one plan with basic benefits within a prescription drug plan region, it may also offer a plan with enhanced benefits—basic and supplemental coverage combined.

Chart 11-5. Characteristics of Medicare PDPs

	2006				2007	
	Plans		Enrollees ^a		Plans	
	Number	Percent	Number (in millions)	Percent	Number	Percent
Total	1,429	100%	15.5	100%	1,866	100%
Type of organization						
National ^b	886	62	8.3	54	1,507	80
Near national ^c	339	24	4.0	26	159	8
Other	204	14	3.1	20	200	11
Type of benefit						
Defined standard	132	9	3.4	22	219	12
Actuarially equivalent ^d	689	48	9.5	61	760	41
Enhanced	608	43	2.6	17	887	48
Type of deductible						
Zero	834	58	8.7	56	1,127	60
Reduced	112	8	0.3	2	157	8
Defined standard	483	34	6.5	42	582	31

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Numbers may not add to totals due to rounding.

^a Number of enrollees as of July 2006.

^b Reflects total numbers of plans for organizations with at least one PDP in all 34 PDP regions.

^c Totals for organizations offering 30 or more PDPs across the country, but without one in each PDP region.

^d Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

- Part D drew even more stand-alone prescription drug plans (PDPs) into the field for 2007 than it did in 2006. Plan sponsors are offering 1,866 PDPs in 2007 compared with 1,429 in 2006—about 30 percent more.
- In 2007, 80 percent of all PDPs were offered by sponsoring organizations that had at least one PDP in each of the 34 PDP regions across the country.
- Sponsors are offering larger proportions of PDPs with the defined standard benefit structure or enhanced benefits (basic plus supplemental coverage) for 2007 and a smaller proportion of benefits with the same average value as the standard benefit but with alternative benefit designs (called actuarially equivalent benefits).

Chart 11-6. Benefits in the coverage gap among PDPs

	2006						2007	
	Plans		Enrollees				Plans	
	Number	Percent	Total		With LIS		Number	Percent
			Number (in millions)	Percent	Number (in millions)	Percent of total		
Total	1,429	100%	15.48	100%	8.02	52%	1,866	100%
Drugs covered in the gap								
Generic only	187	13	0.44	3	0.05	10	511	27
Generic and brand name*	33	2	0.47	3	0.03	6	27	1
None	1,209	85	14.56	94	7.95	55	1,328	71

Note: PDP (prescription drug plan), LIS (low-income subsidy). LIS enrollees receive extra help to cover some or all premiums and cost sharing. Their benefit effectively has no gap in coverage. The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Gap coverage refers to benefits provided within the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap. Number of total enrollees and number of enrollees with LIS are not available for 2007. Sums of percentages may not add to totals due to rounding.

*Not all brand name drugs are necessarily covered. Most plans cover preferred brand name drugs in the coverage gap and only two plans cover all branded drugs on the plan's formulary.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

- More prescription drug plans (PDPs) include some benefits in the coverage gap for 2007 than for 2006. Nearly all cover only generic drugs in the gap—27 percent offer generics only while 1 percent of plans offer generics and brand name drugs. Among those plans that provide coverage for brand name drugs, most limit the benefit to drugs on the preferred tier of the plan's formulary.
- In 2006, 94 percent of PDP enrollees were in plans that offered no additional benefits in the coverage gap: 55 percent of the 94 were beneficiaries who receive Part D's low-income subsidies (LISs) and thus do not face a coverage gap. In addition, many enrollees were unlikely to exceed the initial coverage limit for drug spending. Estimates suggest that 3 million to 4 million individuals (or between 25 percent and 40 percent of plan enrollees who did not receive LISs) had spending in the coverage gap in 2006. Those numbers made up between 13 percent and 18 percent of all Part D enrollees in 2006.

Chart 11-7. Average Part D premiums

	2006		2007
	Unweighted plan offers	Weighted by 2006 enrollment	Unweighted plan offers
All plans			
Basic coverage	\$29.01	\$23.49	\$25.86
Enhanced coverage	27.80	20.64	29.16
Any coverage	28.38	22.61	27.85
PDPs			
Basic coverage	33.11	24.16	28.79
Enhanced coverage	43.27	35.34	45.66
Any coverage	37.43	26.03	36.81
MA-PDs*			
Basic coverage	21.88	16.84	18.79
Enhanced coverage	16.47	10.42	17.14
Any coverage	18.43	12.08	17.24

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. The MA-PDs and enrollment described here exclude employer-only plans and plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans.

*MA-PD premiums reflect rebate dollars (75 percent of the difference between a plan's payment benchmark and its bid for providing Part A and Part B services) that plans chose to use to offset Part D premium costs.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

- In 2006, the average (unweighted) premium offered for basic or enhanced Part D plans was \$28.38 per month. However, beneficiaries tended to enroll in lower premium plans. On average, enrollees paid about \$22.61 per month in 2006.
- Medicare Advantage-Prescription Drug plans (MA-PDs) can lower the part of their monthly premium attributable to Part D using rebate dollars—75 percent of the difference between the plan's payment benchmark and its bid for providing Part A and Part B services. MA-PDs may also enhance their Part D benefit with rebate dollars. Many MA-PDs use rebate dollars in these ways, resulting in more enhanced offerings and lower average premiums compared with PDPs.
- Part D basic plans that had premiums at the higher end of the distribution in 2006 tended to lower their bids for 2007, while those with the lowest bids tended to raise them. In 2007, the average premium offered for basic plans—not weighted by enrollment—was lower (\$25.86 versus \$29.01). However, the average (unweighted) premium for plans offering enhanced coverage was higher (\$29.16 versus \$27.80).

Chart 11-8. Characteristics of MA-PDs

	2006				2007	
	Plans		Enrollees ^a		Plans	
	Number	Percent	Number (in millions)	Percent	Number	Percent
Total	1,303	100%	5.0	100%	1,622	100%
Type of organization						
Local HMO	856	66	4.1	82	947	58
Local PPO	275	21	0.2	4	274	17
PFFS	124	10	0.6	12	367	23
Regional PPO	48	4	0.1	1	34	2
Type of benefit						
Defined standard	96	7	0.1	3	84	5
Actuarially equivalent ^b	376	29	1.1	23	321	20
Enhanced	831	64	3.7	74	1,217	75
Type of deductible						
Zero	1,045	80	4.5	90	1,461	90
Reduced	41	3	0.1	2	38	2
Defined standard	217	17	0.4	8	123	8

Note: MA-PD (Medicare Advantage–Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). The MA-PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Numbers may not add to totals due to rounding.

^aNumber of enrollees as of July 2006.

^bBenefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

- As with stand-alone prescription drug plans (PDPs), there were more Medicare Advantage–Prescription Drug plans (MA-PDs) for 2007 than for 2006. Sponsors are offering 1,622 MA-PDs around the country, compared with 1,303 the year before (about 25 percent more). Although local HMOs offer the most MA-PD plans, there was a sizable increase in the number of drug plans offered by private fee-for-service plans—growing from 10 percent of all (unweighted) offerings in 2006 to 23 percent in 2007.
- A larger share of MA-PDs than PDPs offer enhanced benefits. In 2006, 43 percent of all PDPs had enhanced benefits (see Chart 11-5) compared with 64 percent of MA-PDs. In 2007, 48 percent of PDPs were enhanced compared with 75 percent of MA-PDs. In 2006, enhanced MA-PDs attracted 74 percent of total MA-PD enrollment.
- Most MA-PD plans have no deductible: 80 percent of MA-PD offerings in 2006 and 90 percent in 2007. MA-PDs with no deductible attracted about 90 percent of total MA-PD enrollment in 2006.

Chart 11-9. Benefits in the coverage gap among MA–PDs

	2006						2007	
	Plans		Enrollees				Plans	
	Number	Percent	Total		With LIS		Number	Percent
			Number (in millions)	Percent	Number (in millions)	Percent of total		
Total	1,303	100%	5.02	100%	0.75	15%	1,622	100%
Drugs covered in the gap								
Generic only	300	23	1.21	24	0.18	15	448	28
Generic and brand name*	60	5	0.19	4	0.03	14	78	5
None	943	72	3.62	72	0.55	15	1,096	68

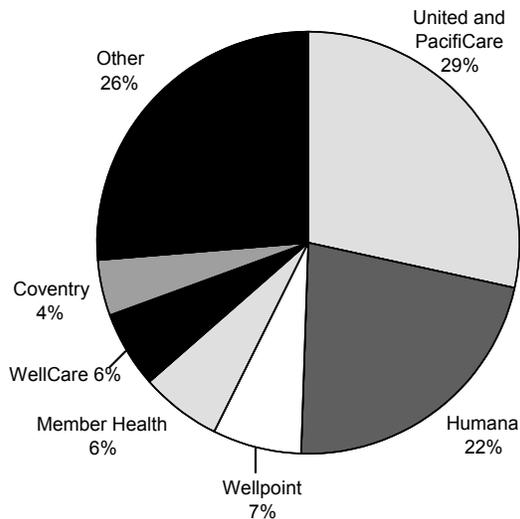
Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). LIS enrollees receive extra help to cover some or all premiums and cost sharing. Their benefit effectively has no gap in coverage. The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Gap coverage refers to benefits provided within the range of beneficiary drug spending above the standard benefit's initial coverage limit and below its out-of-pocket threshold. Part D's defined standard benefit requires the enrollee to pay 100 percent coinsurance in this coverage gap. The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Numbers may not add to totals due to rounding. *Not all brand name drugs are necessarily covered. Most plans cover preferred brand name drugs in the coverage gap and only two plans cover all branded drugs on the plan's formulary.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

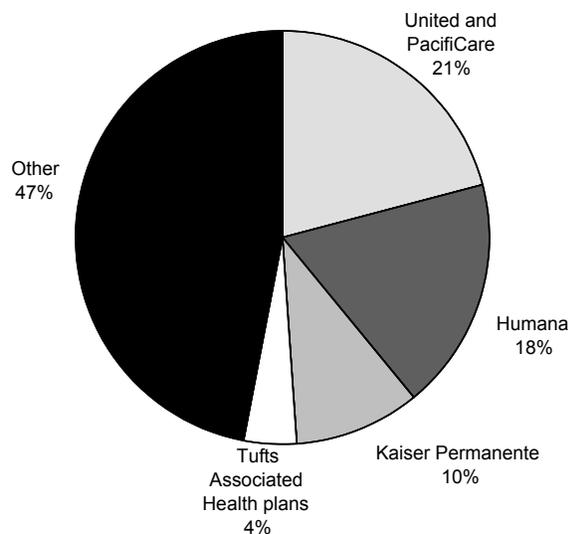
- Medicare Advantage–Prescription Drug plans (MA–PDs) are more likely than prescription drug plans (PDPs) to provide some additional benefits in the coverage gap, although mostly for generics. In 2006, 28 percent of MA–PDs included some gap coverage—23 percent had generic drugs only and 5 percent had both generic and brand name drug coverage. Those plans accounted for 28 percent of MA–PD enrollment.
- Among MA–PD enrollees with no gap coverage, 15 percent of the 72 percent were beneficiaries who received low-income subsidies.
- For 2007, 33 percent of MA–PDs provide some gap coverage (28 percent generics only and 5 percent generic and brand names).

Chart 11-11. Distribution of Part D enrollees by organization

PDP enrollment = 15.5 million



MA-PD enrollment = 5.0 million



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Data are as of July 2006.

Source: MedPAC analysis of 2006 CMS enrollment data.

- As of July 2006, Part D enrollment was concentrated among plans offered by a small number of parent organizations. Several of those organizations offer both stand-alone prescription drug plans (PDPs) and Medicare Advantage-Prescription Drug plans (MA-PDs). For example, United and PacifiCare (which merged in 2006) had 29 percent of the 15.5 million enrollees in PDPs and 21 percent of the 5.0 million enrollees in MA-PDs. Similarly, Humana had a considerable portion of both markets: 22 percent of PDP enrollees and 18 percent of MA-PD enrollees.

Chart 11-12. In 2006, most Part D enrollees were in plans that distinguished between preferred and nonpreferred brands and include specialty tiers

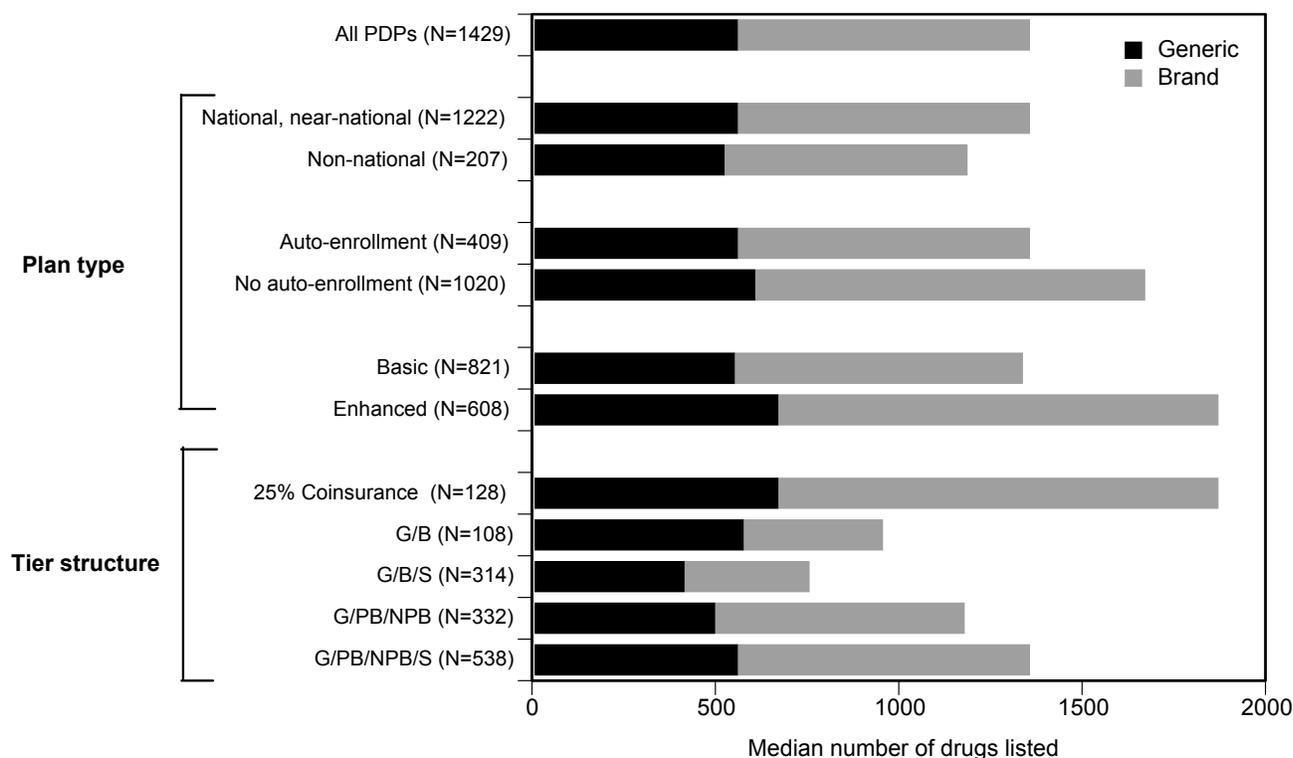
Plan characteristics	25% coinsurance, all tiers	Generic/brand		Generic/preferred brand/ nonpreferred brand		Other	Total
		Without specialty tier	With specialty tier	Without specialty tier	With specialty tier		
All Part D plans	17%	6%	14%	13%	50%	1%	100%
All PDPs	22	2	17	13	46	1	100
National, near national	16	1	12	10	40	0	79
Non-national	6	<0.5	5	3	6	1	21
Auto-enrollment	21	1	15	7	33	1	78
No auto-enrollment	<0.5	1	1	7	13	<0.5	22
Basic	22	1	16	9	35	1	83
Enhanced	0	1	1	4	11	0	17
All MA-PDs	2	20	5	13	60	<0.5	100
Local HMO	2	18	4	10	47	1	82
Local PPO	<0.5	1	<0.5	1	1	<0.5	4
Regional PPO	<0.5	<0.5	<0.5	<0.5	1	0	1
PFFS	<0.5	<0.5	<0.5	0	12	0	12
Basic	2	9	1	3	10	1	26
Enhanced	<0.5	10	3	8	52	1	74

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). Enrollment numbers are as of July 1, 2006. The group of PDPs analyzed here excludes employer-only plans, plans offered in U.S. territories, and plans with no enrollment. The group of MA-PDs excludes employer-only plans, demonstration programs, 1876 cost plans, plans offered in U.S. territories, and plans with no enrollment. Auto-enrollment refers to PDPs that were eligible for automatically enrolled beneficiaries based on low-income status. Cost-sharing structures are for before the initial coverage limit of Part D. A specialty tier generally includes expensive products and unique drugs and biologicals, such as biotechnology drugs, for which enrollees may not appeal for lower cost-sharing amounts. Benefits labeled basic include Part D's standard benefit design as well as benefits that are actuarially equivalent to standard benefits. Enhanced plans include supplemental coverage. Numbers may not sum to 100 percent due to rounding.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- In 2006, nearly 65 percent of Part D enrollees were in plans with formularies that distinguished between preferred and nonpreferred brands (13 percent without a specialty tier plus 50 percent with a specialty tier). Twenty percent of enrollees were in plans that distinguished only between brand name and generic drugs (6 percent without a specialty tier plus 14 percent with a specialty tier). About 17 percent of enrollees face 25 percent cost sharing for all covered drugs.
- Almost 60 percent of enrollees in stand-alone prescription drug plans (PDPs) (13 percent without a specialty tier and 46 percent with one) and nearly 75 percent of enrollees in Medicare-Advantage Prescription Drug (plans) (MA-PDs) (13 percent without a specialty tier and 60 percent with one) were in plans with the generic, preferred, and nonpreferred brand structure.
- Enrollees in PDPs that used flat, 25 percent cost sharing were more likely to be in plans offered nationally or near nationally, providing basic coverage, and qualified to receive auto-assigned enrollees. Enrollees in enhanced plans almost never faced this structure.

Chart 11-13. In 2006, the median PDP enrollee was in a plan that listed more than 1,300 drugs

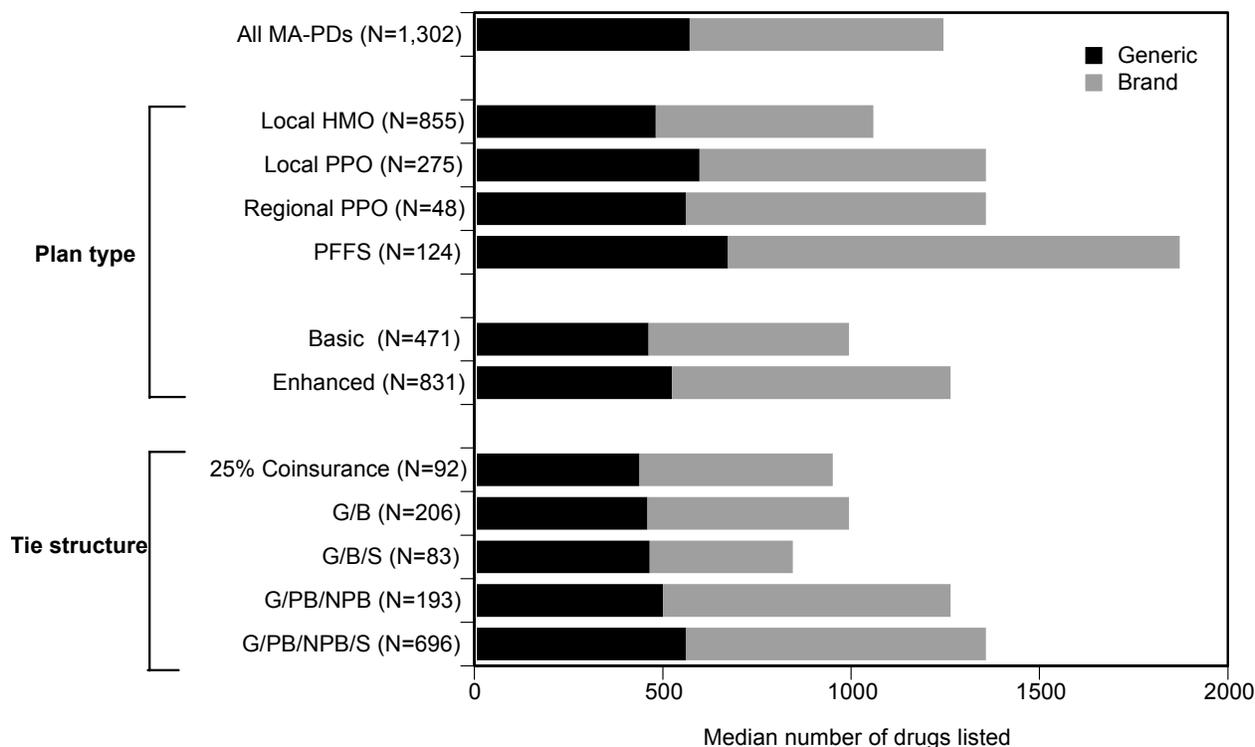


Note: PDP (prescription drug plan), G (generic), B (brand), PB (preferred brand), NPB (nonpreferred brand), S (specialty). Occasionally, plans list some generic drugs on brand tiers and vice versa. Plans with "other" tier structures are not displayed. The PDPs described here exclude employer-only plans offered in U.S. territories. Cost-sharing structures are for before the initial coverage limit of Part D. A specialty tier generally includes expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- In 2006, enrollees in stand-alone prescription drug plans (PDPs) generally had a formulary that listed more than 1,300 drugs. About 60 percent of those listings were brand-name drugs while the remaining 40 percent were generic.
- The median enrollee in a national or near-national PDP generally had slightly more drugs listed on their plan's formulary than the median enrollee in a non-national plan. Enrollees in plans that qualified for auto-enrollees tended to have fewer drugs listed on their plans' formularies than plans that did not qualify for auto-enrollees.
- Enrollees in plans that used a flat, 25 percent coinsurance structure tended to have the most drugs listed on their plans' formularies. Enrollees in plans with only one brand-name tier typically had fewer drugs listed on their plans' formularies than enrollees in plans that distinguished between preferred and nonpreferred brand-name drugs.
- The number of drugs on a plan's formulary does not necessarily represent beneficiary access to medications. Beneficiaries may access coverage for unlisted drugs through the plan's nonformulary exceptions process and may be denied coverage for listed drugs through prior authorization approval requirements.

Chart 11-14. In 2006, the median MA–PD enrollee was in a plan that listed more than 1,200 drugs



Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), G (generic), B (brand), PB (preferred brand), NPB (nonpreferred brand), S (specialty). Occasionally, plans list some generic drugs on brand tiers and vice versa. Plans with “other” tier structures are not displayed. The MA–PDs described here exclude demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Cost-sharing structures are for before the initial coverage limit of Part D. A specialty tier generally includes expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- In 2006, enrollees in Medicare Advantage–Prescription Drug plans (MA–PDs) generally had a formulary that listed more than 1,200 drugs. About 55 percent of those listings were brand-name drugs while the remaining 45 percent were generic.
- The median enrollee in private fee-for-service MA–PDs tended to have a larger number of drugs listed on their plan’s formularies than did the median enrollee in preferred provider organizations and local HMOs.
- Enrollees in plans that distinguished between preferred and nonpreferred brand-name drugs tended to have more drugs listed on their plans’ formularies than did enrollees in plans with only one brand-name tier or plans that used flat, 25 percent coinsurance.
- The number of drugs on a plan’s formulary does not necessarily represent beneficiary access to medications. Beneficiaries may access coverage for unlisted drugs through the plan’s nonformulary exceptions process and may be denied coverage for listed drugs through prior authorization approval requirements.

Chart 11-15. The number of drugs listed in a therapeutic category available to the median enrollee depends on therapeutic class size and regulation

Plan type	For the median enrollee, the percent of drugs listed by selected therapeutic class			
	Cholinesterase inhibitors (antidementia agents)	Dyslipidemics (anticholesterol agents)	Opioid analgesics (narcotic pain relievers)	Atypical nonphenothiazines* (atypical antipsychotics)
Total drugs in class:	4	20	61	6
Plan type:				
PDPs	100%	80%	69%	100%
MA-PDs	75	80	59	100

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Occasionally plans list some generic drugs on brand tiers and vice versa. The population of MA-PDs described here excludes demonstration programs, 1876 cost plans, employer-group plans, and plans offered in U.S. territories.

*Under CMS regulation, plans are required to list all drugs in the atypical antipsychotic category.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- For the median enrollee, the number of drugs listed within a therapeutic class of their plan's formulary can vary widely. That number depends on both regulatory coverage rules as well as the size of the class of drugs available within the marketplace.
- In classes with fewer drugs available, plans typically list a larger share of them. Conversely, when there are more drugs available in a given class, plans are able to negotiate better prices by listing only selected drugs on their formulary, particularly when there are overlapping products.
- In classes for which CMS requires that plans cover all or substantially all drugs, enrollees' plans predictably list a larger share of drugs.

Chart 11-16. Most enrollees are in Part D plans that target prior authorization to selected categories

Therapeutic category	For the median enrollee, the percent of listed drugs subject to prior authorization, among plans ever using prior authorization	
	PDPs	MA-PDs
All drugs	7%	8%
Atypical antipsychotics*	33	20
Dyslipidemics	15	17
Immune suppressants*	86	86
Metabolic bone disease agents	17	17
Molecular target inhibitors*	50	50
Opioid analgesics	9	10
Oral hypoglycemics	5	8
Proton pump inhibitors	50	67
Renin-angiotensins	4	4
Reuptake inhibitors*	5	5

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Atypical antipsychotics (antipsychotics, nonphenothiazines); dyslipidemics (anticholesterol agents); immune suppressants (includes rheumatoid arthritis agents); metabolic bone disease agents (bone-loss inhibitors); molecular target inhibitors (selected anticancer drugs); opioid analgesics (narcotic pain relievers); oral hypoglycemics (blood sugar level); proton pump inhibitors (stomach acid reducers); renin-angiotensins (selected hypertension drugs); reuptake inhibitors (selected anti-depressants). The population of PDPs described here excludes those offered in U.S. territories. The population of MA-PDs described here excludes demonstration programs, 1876 cost plans, employer-group plans, and plans offered in U.S. territories.
*Plans are able to apply prior authorization to new-start enrollees—those not already taking a drug in these categories.

Source: National Opinion Research Center/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 1, 2006.

- Most Part D enrollees are in plans that apply utilization management tools to selected drugs. These tools include prior authorization (plans require preapproval before coverage), step therapy (enrollees must try specified drugs before moving to other drugs), and quantity limits (plans limit the number of doses of a particular drug covered in a given time period).
- Plans use these tools for drugs that are expensive, potentially risky, subject to abuse, misuse, or experimental use, or to encourage use of lower-cost therapies.
- All prescription drug plans (PDPs) and almost all Medicare Advantage-Prescription Drug plans (MA-PDs) (98 percent) use prior authorization for at least one drug on their formularies. The median enrollee is in a plan that applies prior authorization to 7 percent to 8 percent of the drugs on its formulary. Step therapy is less commonly used among Part D plans and those that use it do so for a smaller proportion of drugs.
- In the class of proton pump inhibitors (PPIs), which have low-cost and over-the-counter drugs among the choices, the median enrollee is in a plan that typically applies prior authorization to half (PDPs) and two-thirds (MA-PDs) of its listed PPIs.
- PDPs and MA-PDs that use prior authorization typically require it for most of the drugs in the immune suppressant category that includes expensive rheumatoid arthritis drugs. Plans are likely applying prior authorization restrictions in this category (and several other categories) to assist in determining whether the drugs should be covered under Part B instead of Part D.

Web links. Drugs

- Chapters in several of MedPAC's Reports to the Congress provide information on the Medicare Part D program, as does MedPAC's Payment Basics series.

http://www.medpac.gov/chapters/Jun07_Ch07.pdf

http://www.medpac.gov/chapters/Mar07_Ch04.pdf

http://www.medpac.gov/publications%5Ccongressional_reports%5CJun06_Ch07.pdf

http://www.medpac.gov/publications%5Ccongressional_reports%5CJun06_Ch08.pdf

http://www.medpac.gov/publications%5Ccongressional_reports%5CJune05_ch1.pdf

http://www.medpac.gov/publications%5Ccongressional_reports%5CJune04_ch1.pdf

http://www.medpac.gov/publications/other_reports/Sept06_MedPAC_Payment_Basics_PartD.pdf

- Analysis of Medicare spending on Part B drugs can be found in MedPAC's January 2007 and January 2006 reports to the Congress.

http://www.medpac.gov/documents/Jan07_PartB_mandated_report.pdf

http://www.medpac.gov/publications/congressional_reports/Jan06_Oncology_mandated_report.pdf

- A Kaiser Family Foundation fact sheet, last updated in November 2006, provides information on the Medicare Part D benefit.

<http://www.kff.org/medicare/7044.cfm>

- A Kaiser Family Foundation analysis of formularies and other features of Medicare Part D plans.

<http://www.kff.org/medicare/7589.cfm>

- A Kaiser Family Foundation fact sheet on low-income assistance under the Medicare Part D benefit.

<http://www.kff.org/medicare/med062804oth.cfm>

- CMS information on Part D enrollment.

http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage

