ONLINE APPENDIXES 13

Status report on Part D

ONLINE APPENDIX 13-A

Case study of the use of tiered pharmacy networks

TABLE 13A–1 **Most new enrollees lived close to at least one preferred pharmacy**

	Plan 1	Plan 2
Percent within close proximity to a preferred pharmacy	91%	70%
Percent within close proximity to a preferred pharmacy by LIS status		
LIS	88	62
Non-LIS	93	72
Percent within close proximity to a preferred pharmacy by urbanicity		
Urban	54	22
Suburban	98	69
Rural	93	81

Note: LIS (low-income subsidy). Close proximity (or convenient access) was defined as living within 2 miles of a preferred pharmacy in an urban area, within 5 miles in a suburban area, and within 15 miles in a rural area. ZIP codes were used to assign the urbanicity category to each beneficiary address: Urban is defined as an area in which the population density is greater than 3,000 individuals per square mile, suburban is defined as an area in which the population density is between 1,000 and 3,000 individuals per square mile, and rural is defined as an area in which the population density is less than 1,000 individuals per square mile.

Source: Acumen LLC analysis for MedPAC.

The Commission contracted with Acumen LLC to examine patterns in enrollment and prescription use for two PDPs offered by the same plan sponsor in different regions before and after the implementation of tiered pharmacy networks. Although the study had a limited scope, certain patterns may shed light on how tiered pharmacy networks may affect enrollees and Medicare.[1]

Most new enrollees lived within close proximity to a preferred pharmacy

Both PDPs noted sizable increases in enrollment after putting in place tiered pharmacy networks: after two years, over 90 percent of the plans' enrollees were new. A large percentage of new enrollees lived in close proximity to at least one preferred pharmacy (Table 13A-1). That share was higher among non-LIS than LIS enrollees and higher among those in suburban and rural areas than urban areas.

TABLE 13A–2 **Percent of enrollees who filled at least one prescription at a preferred pharmacy**

	Plan 1		Plan 2	
	Year 1	Year 2	Year 1	Year 2
All enrollment spells*	52%	49%	38%	34%
By LIS status				
LIS	34	33	21	19
Non-LIS	62	60	42	39
By urbanicity				
Urban	33	30	24	20
Suburban	50	46	34	29
Rural	55	52	42	38

Note: LIS (low-income subsidy). ZIP codes were used to assign the urbanicity category to each beneficiary address: Urban is defined as an area in which the population density is greater than 3,000 individuals per square mile, suburban is defined as an area in which the population density is between 1,000 and 3,000 individuals per square mile, and rural is defined as an area in which the population density is less than 1,000 individuals per square mile.
*An enrollment spell is defined as a 12-month period in which an individual was enrolled with a plan.

Source: Acumen LLC analysis for MedPAC.

Non-LIS enrollees were more likely than LIS enrollees to use preferred pharmacies

Two years after the PDPs put tiered pharmacy networks in place, about half of Plan 1's enrollees and roughly one-third of Plan 2's enrollees filled at least one prescription at a preferred pharmacy (Table 13A-2). In both plans, non-LIS enrollees were twice as likely as LIS enrollees to use a preferred pharmacy, and those in suburban and rural areas were more likely to use a preferred pharmacy than those in urban areas. Some of this difference reflects the fact that non-LIS enrollees were more likely to reside in an area with convenient access to a preferred pharmacy.

LIS enrollees' lower use of preferred pharmacies could also reflect differences in their financial incentives. For example, non-LIS beneficiaries who used preferred pharmacies filled more prescriptions, on average, than those who did not use a preferred pharmacy. That is, individuals who, because they have greater medication needs, are likely to save more from the lower cost sharing, were more likely to fill prescriptions at preferred pharmacies. This pattern was not as apparent among LIS beneficiaries. In addition, the average cost per prescription was higher among LIS enrollees who did not use preferred pharmacies, which suggests that the amount of Medicare's payments for the low-income cost-sharing subsidy could be lowered by encouraging these beneficiaries to use a preferred pharmacy. ■

Endnotes

1 Features likely to be unique to the selected plans include (1) a relatively small share of pharmacies designated as preferred, (2) a change in the benefit type from enhanced benefits to basic benefits, and (3) gaining the LIS benchmark status. The second and third features coincided with the implementation of the tiered pharmacy network by both plans.