

CHAPTER

# 15

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**Status report  
on Part D**

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## Status report on Part D

### Chapter summary

Each year the Commission provides a status report on Part D to:

- provide information on beneficiaries' access to prescription drugs—including enrollment figures and beneficiary survey results—program costs, and the quality of Part D services; and
- analyze changes in plan bids, premiums, benefit designs, and formularies.

Part D is now in its eighth year. In 2011, Medicare spent about \$60 billion for the Part D program, accounting for over 10 percent of total Medicare outlays. In 2012, over 30 million Medicare beneficiaries were enrolled in Part D, with about 63 percent of Part D enrollees in stand-alone prescription drug plans (PDPs) and the remaining 37 percent in Medicare Advantage–Prescription Drug plans (MA–PDs). In 2013, a total of 1,033 PDPs are offered nationwide along with 1,627 MA–PDs. MA–PD enrollees are much more likely than those in PDPs to receive basic and supplemental benefits combined in their drug plan. Most enrollees report high satisfaction with the Part D program.

**Access to prescription drug coverage**—In 2012, nearly 65 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 9 percent received their drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. CMS reports that, in 2010, about 17 percent of beneficiaries received their drug coverage through other sources and 10

### In this chapter

- Part D enrollees' access to prescription drug benefits
- Benefit offerings for 2013
- Costs of Part D
- Use of generic drugs
- Quality in Part D
- Role of competition in Part D
- Relationship between medical and drug spending

percent had no drug coverage or coverage less generous than Part D. Beneficiaries with no creditable coverage tended to be healthier, on average. More than half reported not joining Part D because they did not take enough medications to need such coverage. Among Part D plan enrollees, 10.8 million individuals (about 34 percent) received the low-income subsidy (LIS).

***Benefit offerings for 2013***—The number of plan offerings remained stable between 2012 and 2013. Sponsors are offering slightly fewer stand-alone PDPs (a decrease of just under 1 percent) and 6 percent more MA-PDs than in 2012. Beneficiaries will continue to have between 23 and 38 PDPs to choose from, depending on where they live, along with many MA-PDs. MA-PDs continue to be more likely than PDPs to offer enhanced benefits that include some coverage in the gap. For 2013, slightly more premium-free PDPs are available to enrollees who receive the LIS; 331 plans qualify compared with 327 in 2012. In most regions, LIS enrollees will continue to have many premium-free plans available. In two regions, Florida and Nevada, only two plans qualified as premium free in each region.

***Part D spending***—Between 2007 and 2011, Part D spending increased from \$46.7 billion to \$60 billion (an average annual growth of about 7 percent), and CMS expects it will have reached \$62 billion in 2012. These expenditures include the direct monthly subsidy plans receive for their Part D enrollees, reinsurance paid for very-high-cost enrollees, premiums and cost sharing for LIS enrollees, and payments to employers that continue to provide drug coverage to their Medicare beneficiary retirees. In 2011, LIS payments continued to be the largest single component of Part D spending, while Medicare's reinsurance payments were the fastest growing component. Changes made by the Patient Protection and Affordable Care Act of 2010 to gradually close the coverage gap likely contributed to the higher growth in reinsurance payments between 2010 and 2011.

***Change in Part D bids and premiums***—While the average costs for basic Part D benefits are expected to remain stable (a growth of less than 1 percent) between 2012 and 2013, plan sponsors are expecting significant changes in costs for individual components: a decrease of over 9 percent for the direct subsidy and an increase of about 14 percent for the reinsurance component. In 2013, the base beneficiary premium is about the same as in 2012 (\$31). It reflects the basic portion of the benefit and does not include premiums for enhanced, or supplemental, benefits. The actual premium paid depends on the beneficiary's choice of plan.

***Role of competition in Part D***—Part D uses a competitive design to give plan sponsors incentives to offer beneficiaries attractive prescription drug coverage while

controlling growth in drug spending. Plans that are able to manage drug spending and bid more competitively are supposed to be rewarded with higher enrollment than plans that do not. We find that a higher share of enrollees have switched plans voluntarily in recent years than was reported by CMS during the first few years of the program. ■



**TABLE  
15-1**

**Parameters of the defined standard benefit increased, 2006–2013**

	2006	2012	2013
Deductible	\$250.00	\$320.00	\$325.00
Initial coverage limit	2,250.00	2,930.00	2,970.00
Annual out-of-pocket spending threshold	3,600.00	4,700.00	4,750.00
Total covered drug spending at annual out-of-pocket threshold	5,100.00	6,730.39*	6,954.52*
Maximum amount of cost sharing in the coverage gap	2,850.00	3,727.50	3,763.75
Minimum cost sharing above annual out-of-pocket threshold:			
Copay for generic/preferred multisource drug prescription	2.00	2.60	2.65
Copay for other prescription drugs	5.00	6.50	6.60

Note: \*Total covered drug spending at annual out-of-pocket threshold depends on the mix of brand and generic drugs filled during the coverage gap. The amounts for 2012 and 2013 are for an individual not receiving Part D’s low-income subsidy who has no other sources of supplemental coverage.

Source: CMS, Office of the Actuary.

Each year since 2006, the Commission has provided a status report on Medicare’s Part D program and made recommendations as necessary. To monitor the ability of the program—under its competitive approach—to meet Medicare goals of maintaining beneficiary access while holding down program spending, we examine several performance indicators: beneficiaries’ access to prescription drugs (including data on enrollment and changes in Part D plan benefit designs and formularies for 2013), program costs, and quality of services.

## Background

Medicare’s payment system for Part D is very different from its prospective payment and fee-for-service payment systems for Part A and Part B services. For Part D, Medicare uses competing private plans to deliver prescription drug benefits; instead of setting prices administratively, Medicare’s payments to Part D plans are based on bids submitted by plan sponsors.

### Benefit structure

Medicare defines a standard Part D benefit structure with parameters that change at the same rate as the annual change in beneficiaries’ average drug expenses (Table 15-1). For 2013, the defined standard benefit includes a \$325 deductible and 25 percent coinsurance until the enrollee reaches \$2,970 in total covered drug spending. Enrollees exceeding that spending total face a coverage gap up to an annual threshold of \$4,750 in out-of-pocket (OOP)

spending that excludes cost sharing paid by most sources of supplemental coverage, such as employer-sponsored policies. Enrollees with drug spending exceeding that amount pay the greater of either \$2.65 to \$6.60 per prescription or 5 percent coinsurance.

Before 2011, enrollees exceeding the initial coverage limit were responsible for paying the full discounted price of covered drugs (usually without reflecting manufacturers’ rebates) up to the annual OOP threshold. Because of changes made by the Patient Protection and Affordable Care Act of 2010 (PPACA), beginning in 2011, beneficiaries in the coverage gap face reduced cost sharing for both brand-name and generic drugs in the coverage gap.<sup>1</sup> In 2013, cost sharing for drugs filled during the gap phase is 47.5 percent for brand-name drugs and 79 percent for generic drugs.<sup>2</sup> An individual with no other sources of drug coverage reaches the \$4,750 limit at \$6,954.52 in total drug expenses (the sum of the enrollee’s spending plus spending the Part D plan covers).<sup>3</sup>

### Formularies

In Part D, each plan sponsor uses one or more formularies—lists of drugs the plan covers and the terms under which it covers them—to manage the cost and use of prescription drugs.<sup>4</sup> When designing formularies, sponsors attempt to strike a balance between providing enrollees with access to medications and controlling growth in drug spending, which they accomplish by negotiating drug prices and dispensing fees with pharmacies and rebates with pharmaceutical manufacturers, and by managing enrollees’ utilization. Part D sponsors rely on clinicians—generally physicians

**TABLE 15-2**

**Over 70 percent of Medicare beneficiaries received drug coverage through Part D plans or RDS in 2012**

	Beneficiaries	
	In millions	Percent of Medicare enrollment
Medicare enrollment	50.7	100%
Part D enrollment		
Part D plans	32.7	64.5*
Plans receiving RDS**	4.5	8.9
Total Part D	37.2	73.4

Note: RDS (retiree drug subsidy). Totals may not sum due to rounding.  
 \*About 40 percent in prescription drug plans and 24 percent in Medicare Advantage–Prescription Drug plans.  
 \*\*Excludes federal government and military retirees covered by either the Federal Employees Health Benefit Program or the TRICARE for Life program.

Source: MedPAC based on Table IV.B8 and Table V.B3 of the 2012 annual report of the Boards of Trustees of the Medicare trust funds.

and pharmacists who participate on a pharmacy and therapeutics committee—when deciding which drugs to list. Sponsors also select the cost-sharing tier for each listed drug (if using a tiered formulary structure) and determine whether to apply any utilization management tools, such as prior authorization, subject to CMS review and approval. In constructing formularies, sponsors consider both clinical and financial factors (such as how tier-placement decisions might affect sponsors’ rebates from drug manufacturers). Making all medications readily accessible at preferred (i.e., relatively low) levels of cost sharing can lead to a monthly plan premium that is high relative to a sponsor’s competitors, whereas an overly restrictive formulary may keep a plan’s premium competitive but may make the plan less attractive to potential enrollees because it covers a limited number of drugs.

**Part D enrollees’ access to prescription drug benefits**

Implementation of the Part D program in 2006 increased the share of beneficiaries who have some drug coverage from 75 percent before Part D to about 90 percent.<sup>5</sup> In

general, Part D has improved Medicare beneficiaries’ access to prescription drugs. All individuals have access to Part D plan options, and many continue to receive drug coverage through former employers.

**In 2012, over 70 percent of Medicare beneficiaries were in Part D plans or employer plans receiving Medicare’s retiree drug subsidy**

In 2012, nearly 65 percent of an estimated 50.7 million Medicare beneficiaries were enrolled in Part D plans. This share has grown since the program began in 2006, with Medicare Advantage (MA) plans accounting for more than half of the growth in Part D enrollment between 2006 and 2012. An additional 9 percent of Medicare beneficiaries received their drug coverage through employer-sponsored plans that received Medicare’s retiree drug subsidy (RDS) (Table 15-2).<sup>6</sup> Some beneficiaries receive their drug coverage through other sources of creditable coverage, including the Department of Veterans Affairs, TRICARE (the Department of Defense’s health benefit for retired military members), and other payers.<sup>7</sup>

About 10 percent of beneficiaries had no drug coverage or coverage less generous than Part D’s standard benefit in 2010, the most recent year for which data are available. Research indicates that beneficiaries who do not enroll in Part D tend to be healthier and have lower drug spending (see text box).

In 2012, about 11 million individuals, or 34 percent of Part D enrollees, received the low-income subsidy (LIS). Of them, nearly 7 million were dually eligible for Medicare

**TABLE 15-3**

**Part D enrollment by plan type and LIS status, 2012**

	Plan type		
	All Part D	PDP	MA-PD
Beneficiaries (in millions)	31.5	19.7	11.7
By LIS status			
LIS	10.8	8.3	2.5
Non-LIS	20.6	11.4	9.2

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]). Totals may not sum due to rounding.

Source: MedPAC based on monthly Part D enrollment data as of April 2012 (<https://www.cms.gov/MCRAdvPartD/EnrolData/>).



## Characteristics of Medicare beneficiaries with no creditable drug coverage

The share of Medicare beneficiaries who have no drug coverage or coverage less generous than Part D's defined standard benefit (not creditable coverage) has remained at around 10 percent since the Part D program began in 2006.<sup>8</sup> To compare the characteristics of beneficiaries with no creditable drug coverage to those with creditable coverage, we relied on responses from Medicare beneficiaries in the 2010 Medicare Current Beneficiary Survey.

Beneficiaries with no creditable coverage differ from those enrolled in Part D in many respects. For example, among beneficiaries with no creditable coverage, there is a higher concentration of beneficiaries in the 65-year to 74-year age range and fewer beneficiaries age 75 or older compared with Part D enrollees (Table 15-4, p. 340). There are fewer racial and ethnic minorities

among beneficiaries with no creditable coverage compared with Part D enrollees. Overall, beneficiaries with no creditable coverage tended to have higher socioeconomic status than beneficiaries enrolled in Part D, with higher proportions reporting college and postgraduate education and an annual income of more than \$25,000.

A greater proportion of beneficiaries with no creditable coverage rated their health as excellent (26 percent) compared with beneficiaries enrolled in Part D (13 percent) and beneficiaries with the retiree drug subsidy and other creditable coverage (18 percent and 19 percent, respectively). The share of beneficiaries without creditable coverage reporting having had prescriptions for medications that they did not obtain

*(continued next page)*

and Medicaid. Another 4 million qualified for the LIS either because they received benefits through the Medicare Savings Program or the Supplemental Security Income program or because they were determined to be eligible by the Social Security Administration after applying directly to that agency. Among LIS beneficiaries, more than three-quarters (8.3 million) were enrolled in stand-alone prescription drug plans (PDPs) and the rest (2.5 million) were in Medicare Advantage–Prescription Drug plans (MA–PDs) (Table 15-3). CMS randomly assigns most LIS beneficiaries to PDPs that qualify as premium-free plans, unless the beneficiary chooses a plan that is different from the assigned plan. As a result, a much smaller share of LIS beneficiaries are enrolled in MA–PDs.

### Distribution of enrollment varies across regions

Part D enrollment varies geographically. In 2011, enrollment ranged between 39 percent and 70 percent of Medicare beneficiaries across the 34 PDP regions (Table 15-5, p. 341). Part D enrollment tends to be lower in states with large employers that receive Medicare's RDS—Michigan and Alaska, for example. In most regions, Medicare beneficiaries received their drug coverage through Part D plans or through drug coverage provided by former employers that receive the RDS. Between 2010 and 2011, most regions experienced a reduction in the share of beneficiaries receiving drug

coverage through former employers, with a corresponding increase in the share of beneficiaries enrolled in Part D plans. The reductions were generally small, ranging from 1 percent to 3 percent, with the exception of region 14 (Ohio), where the reduction was 11 percent. In region 5 (Delaware–District of Columbia–Maryland), region 7 (Virginia), and region 34 (Alaska), less than 65 percent of beneficiaries were in Part D plans or in plans receiving the RDS. In these regions, a higher proportion of Medicare beneficiaries may have received drug coverage from other sources, such as the Federal Employee Health Benefits Program or the Indian Health Service.

Most beneficiaries have access to many PDPs and MA–PDs. In general, MA–PD enrollment is high in regions with higher MA penetration. For example, in 2011, more than 45 percent of Part D enrollees were in MA–PDs in parts of the West (Arizona, California, Colorado, Idaho, Nevada, Utah) and in Florida, Hawaii, and New York. By comparison, in other parts of the Northeast, Midwest, and central states, less than 20 percent of Part D enrollees were in MA–PDs.

The number of beneficiaries receiving Part D's LIS also varies considerably by region. In 2011, the share of Part D enrollees receiving the LIS ranged from 27 percent in the upper Midwest and several central western states to 62 percent in Alaska (Table 15-5, p. 341). The number

## Characteristics of Medicare beneficiaries with no creditable drug coverage (cont.)

was comparable to that for Part D enrollees (nearly 7 percent compared with 6 percent).

Of the beneficiaries with no creditable coverage, survey responses indicate that slightly over 40 percent had some drug coverage, while the remainder did not indicate having had any drug coverage in 2010 (data

not shown). When asked why they did not enroll in a Medicare prescription drug plan, slightly over half with no drug coverage responded that they did not have enough prescriptions to need such a plan, or they would not benefit from enrolling in Part D. Seventeen percent reported cost as a reason for not enrolling in a Part D plan.<sup>9</sup> ■

**TABLE  
15-4**

**Characteristics of Medicare beneficiaries by type of drug coverage, 2010**

	No creditable coverage	Creditable coverage		
		Part D	RDS	Other coverage
<b>Demographic characteristics</b>				
Age				
64 or younger	15%	20%	4%	14%
65-74	51	40	45	48
75-84	22	28	36	26
85 or older	11	12	14	11
Female	55	60	54	37
Race				
White	87	81	92	88
African American	8	12	7	8
Asian/other	4	4	1	3
Hispanic	3	2	1	2
Education*				
Less than high school	20	29	13	14
High school graduate	27	29	29	27
Postsecondary education	29	26	28	35
College graduate	12	9	15	13
Postgraduate	11	6	15	10
Income				
\$25,000 or less	43	62	29	29
\$25,001-\$50,000	49	32	59	61
\$50,001 or more	7	5	11	10
Unknown	<1	1	1	1
<b>Health/medications</b>				
Self-rated health				
Excellent	26	13	18	19
Very good/good	54	58	65	60
Fair/poor	20	28	17	21
Medications prescribed but not obtained	7	6	3	3

Note: RDS (retiree drug subsidy). Totals may not sum due to rounding.

\*Postsecondary education includes individuals with certificates from vocational and other technical schools, associate's degrees, or some college education but no diploma. One percent or fewer did not indicate the highest level of education achieved.

Source: MedPAC analysis of 2010 Medicare Current Beneficiary Survey Access to Care file.

**TABLE  
15-5**

**Part D enrollment varies widely across regions, 2011**

PDP region	State(s)	Percent of Part D enrollment					
		Percent of Medicare enrollment		Plan type		Subsidy status	
		Part D	RDS	PDP	MA-PD	LIS	Non-LIS
1	ME, NH	57%	11%	84%	16%	47%	53%
2	CT, MA, RI, VT	60	16	70	30	43	57
3	NY	62	18	54	46	45	55
4	NJ	54	21	80	20	35	65
5	DE, DC, MD	48	17	86	14	41	59
6	PA, WV	65	12	56	44	33	67
7	VA	54	9	78	22	36	64
8	NC	60	15	74	26	42	58
9	SC	56	16	73	27	44	56
10	GA	62	9	67	33	43	57
11	FL	63	12	52	48	35	65
12	AL, TN	62	12	65	35	45	55
13	MI	50	30	72	28	39	61
14	OH	66	13	68	32	30	70
15	IN, KY	63	12	79	21	38	62
16	WI	57	13	61	39	32	68
17	IL	57	19	87	13	38	62
18	MO	64	10	69	31	35	65
19	AR	62	7	79	21	45	55
20	MS	66	5	87	13	53	47
21	LA	63	13	64	36	49	51
22	TX	57	14	69	31	45	55
23	OK	60	7	79	21	38	62
24	KS	63	6	84	16	29	71
25	IA, MN, MT, NE, ND, SD, WY	67	8	74	26	27	73
26	NM	64	6	61	39	39	61
27	CO	59	12	50	50	29	71
28	AZ	62	10	45	55	32	68
29	NV	58	10	50	50	29	71
30	OR, WA	60	10	57	43	31	69
31	ID, UT	59	9	55	45	27	73
32	CA	70	9	50	50	39	61
33	HI	67	4	41	59	29	71
34	AK	39	26	99	1	62	38

Note: PDP (prescription drug plan), RDS (retiree drug subsidy), MA-PD (Medicare Advantage-Prescription Drug [plan]), LIS (low-income subsidy). Definition of regions based on PDP regions used in Part D.

Source: MedPAC analysis of Part D enrollment data from CMS.

of beneficiaries who receive Part D's LIS is related to many factors, such as underlying rates of poverty and health status in each region, the degree to which a state's Medicaid program reaches out to enroll eligible individuals, and the criteria states use to determine

eligibility for their Medicaid programs. For example, states can increase the number of residents eligible for the Medicare Savings Program by not counting certain types of assets or sources of income in their eligibility criteria for Medicaid benefits.

**TABLE  
15-6**

**MA-PD enrollees more likely to be in enhanced plans with no deductible, 2012**

	PDP		MA-PD	
	Number (in millions)	Percent	Number (in millions)	Percent
Total	17.5	100%	8.5	100%
Type of benefit				
Defined standard	1.0	5	0.1	1
Actuarially equivalent*	13.2	75	0.5	6
Enhanced	3.3	19	7.9	94
Type of deductible				
Zero	7.3	42	7.5	88
Reduced	1.8	11	0.8	9
Defined standard**	8.3	48	0.2	2

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). The MA-PD enrollment described here excludes employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Totals may not sum due to rounding.

\*Includes "actuarially equivalent standard" and "basic alternative" benefits.

\*\*\$320 in 2012.

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

**Distribution of enrollment across plan types**

Access to prescription drugs can be affected by the type of plan one chooses. Most Part D enrollees are in plans that differ from Part D's defined standard benefit; these plans are actuarially equivalent to the standard benefit or are enhanced in some way. Actuarially equivalent plans have the same average benefit value as defined standard plans but a different benefit structure.<sup>10</sup> For example, a plan may use tiered copayments (e.g., charging \$5 per generic drug and \$50 for a brand-name drug) that can be higher or lower for a given drug compared with the 25 percent coinsurance under the defined standard benefit. Alternatively, instead of having a deductible, a plan may use a cost-sharing rate higher than 25 percent. Once a sponsor offers at least one plan with basic benefits in a region or a service area, it may also offer a plan with enhanced benefits—basic and supplemental benefits combined, with a higher average benefit value—by including, for example, lower cost sharing, coverage in the gap, and an expanded drug formulary that includes non-Part D-covered drugs.<sup>11</sup> Since Medicare does not subsidize supplemental benefits, enrollees must pay the full premium for any enhanced benefits.

In 2012, 75 percent of PDP enrollees had basic coverage that was actuarially equivalent to the defined standard

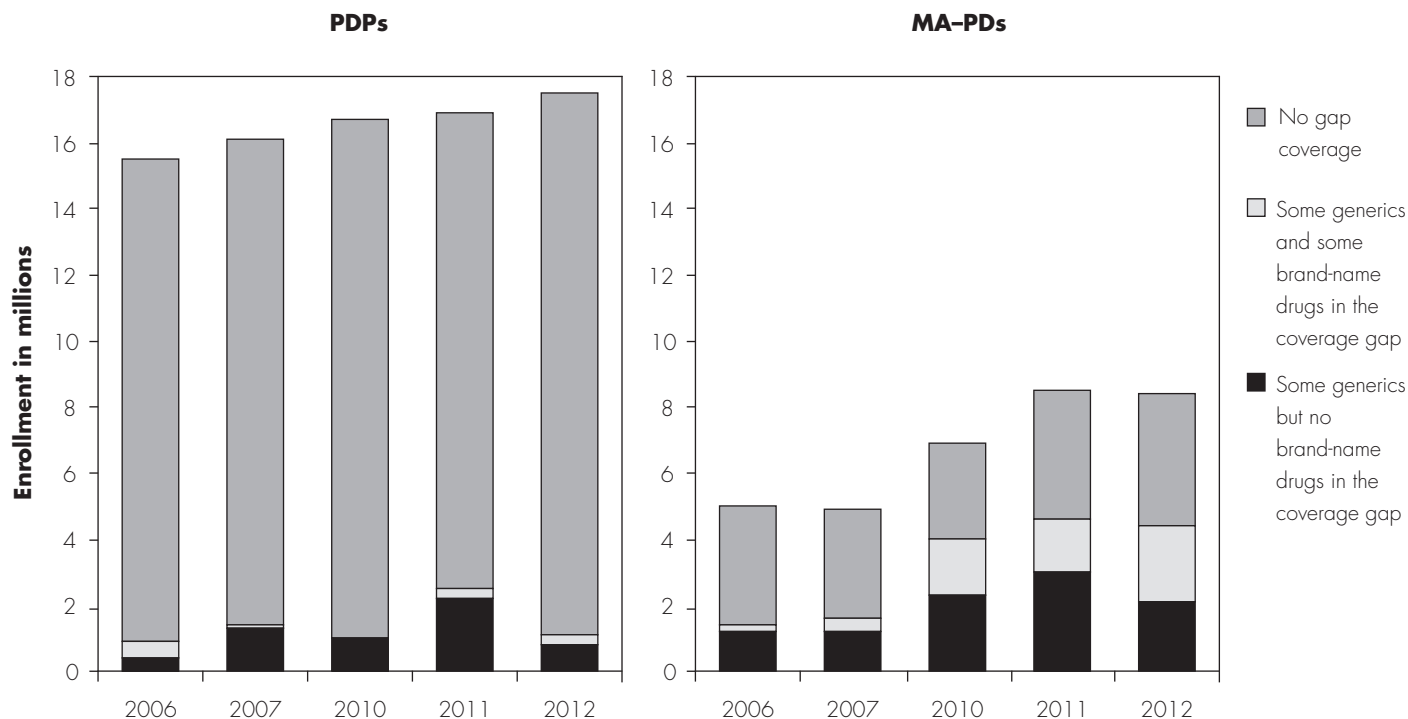
benefit, most with tiered copayments. Another 19 percent of PDP enrollees had enhanced benefits—the typical enhancement being a lower deductible rather than benefits in the coverage gap beyond what is required by PPACA. Five percent were in defined standard plans. MA-PD enrollees were predominantly in plans that used copayments, with 99 percent in actuarially equivalent or enhanced plans (Table 15-6).

Enrollees in stand-alone PDPs are more likely to have a deductible in their plans' benefit design than enrollees in MA-PDs. In 2012, slightly more than half of PDP enrollees paid no deductible or a lower deductible than was prescribed in the defined standard benefit; the remaining enrollees were in plans with the standard \$320 deductible. By comparison, 98 percent of MA-PD enrollees had a reduced deductible or no deductible at all (Table 15-6), which reflects the ability of MA-PDs to use MA (Part C) rebate dollars to supplement benefits or lower premiums.<sup>12</sup>

The ability of MA-PDs to use Part C rebate dollars to enhance their Part D benefits affects the difference between PDPs and MA-PDs in the availability of benefits in the coverage gap (Figure 15-1). In 2012, 6 percent of PDP enrollees (about 1 million beneficiaries)

**FIGURE 15-1**

**PDP enrollees are less likely to have benefits in the coverage gap**



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]).

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

were in plans that offered benefits in the coverage gap beyond what is required by PPACA. However, over 40 percent of PDP enrollees received Part D’s LIS, which effectively eliminated their coverage gap. By comparison, 52 percent of MA-PD enrollees were in plans offering gap coverage. About half of these enrollees were in plans that covered some generics but not brand-name drugs in the gap.

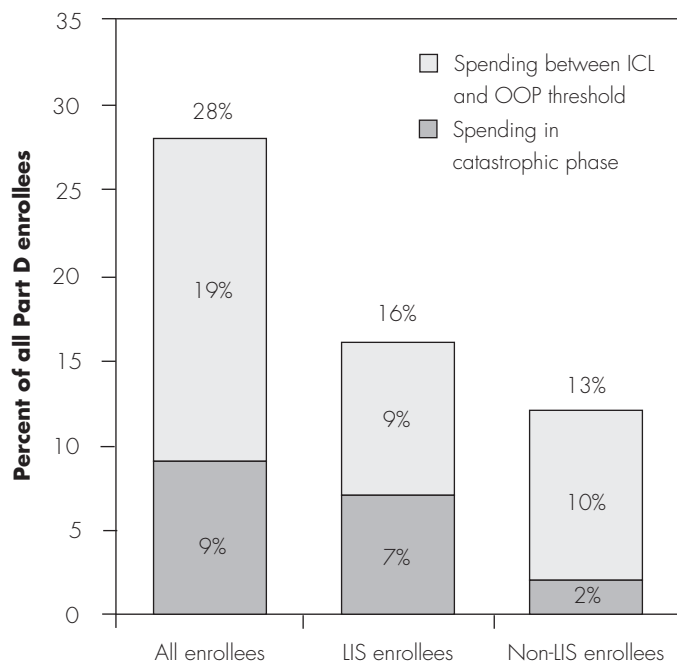
**Use of Part D benefits and share of enrollees reaching the coverage gap**

Prescription drugs are used widely by Medicare beneficiaries. According to the Commission’s analysis of 2010 prescription drug event data taken from Part D claims, about 93 percent of Part D enrollees filled at least one prescription during the year. Enrollees filled an average of 4.2 prescriptions per month, with considerably higher average utilization among those who received the LIS (5.1 per month) than among beneficiaries who did not (3.7 per month).

In 2010, about 28 percent of Part D enrollees had spending high enough to put them in the coverage gap, a decrease from over 30 percent in previous years (Figure 15-2, p. 344). Part D enrollees who entered the coverage gap in 2010 faced 100 percent of the plan’s negotiated price of the drug for prescriptions filled in the coverage gap, unless they were in a plan that provided some benefits in the gap or were an LIS enrollee, for whom the gap is eliminated. LIS enrollees accounted for more than half of the enrollees with spending high enough to reach the coverage gap (nearly 4.7 million, or about 16 percent of all Part D enrollees). Slightly over 2.6 million, or about 9 percent of Part D enrollees, had spending high enough to reach Part D’s catastrophic coverage phase. About 2 million of them (7 percent of Part D enrollees) received the LIS.

**Most Part D enrollees have good access to prescription drugs**

Surveys indicate that beneficiaries enrolled in Part D are generally satisfied with the Part D program and with their

**FIGURE  
15-2****Part D enrollees with spending  
in the coverage gap and  
catastrophic phase, 2010**

Note: ICL (initial coverage limit), OOP (out-of-pocket), LIS (low-income subsidy). For LIS enrollees, the cost-sharing subsidy effectively eliminates the coverage gap. In 2010, Part D enrollees reached the ICL at \$2,830 in gross drug spending. If they had no supplemental coverage, enrollees reached the annual OOP threshold at \$4,550 of OOP spending. Some non-LIS enrollees who reached the catastrophic phase of the benefit may have had some gap coverage. Sums may not add to totals due to rounding.

Source: MedPAC analysis of Part D prescription drug event data and Part D denominator file from CMS.

plans (Department of Health and Human Services 2010, Keenan 2007, *Medical News Today* 2009, PRNewswire 2010, Weems 2008). Our analysis of the 2010 Medicare Current Beneficiary Survey shows that most enrollees are satisfied with the drug benefit (94 percent) and think the level of coverage meets their medication needs (95 percent). The level of satisfaction does not vary significantly by plan type (PDP vs. MA–PD) or by enrollees’ LIS status (Table 15-7).

Most Part D enrollees appear to have good access to prescription drugs. In 2010, more than 80 percent were satisfied with the drugs listed on plan formularies and 95 percent had good access to pharmacies (Table 15-7). Slightly over 10 percent were dissatisfied with the list of covered drugs, while the remainder (between 6 percent and 8 percent) indicated that they did not know or had

no experience related to the question (data not shown). Only 6 percent reported having had prescriptions for some medications they did not obtain during the year. Cost was the main reason for not obtaining medications for both PDP and MA–PD enrollees and for non-LIS enrollees, accounting for about 40 percent of those who did not obtain medications. A smaller share of LIS enrollees reported cost as the main reason for not obtaining medications. Between 20 percent and 30 percent of enrollees reported that they chose not to obtain medications because they were concerned about reactions to the medications, the medication was not necessary, or they did not think the medication would help.

Other measures of access include plan formularies and pharmacy network requirements. The trend toward sponsors’ use of preferred and nonpreferred networks, since 2010, may have a larger effect on access to prescription drugs for individuals residing in rural areas than for those residing in urban areas. We will continue to monitor the plans’ use of tiered networks and the effects on beneficiaries’ access to medications. In the future, we will look at exceptions and appeals processes to evaluate the effectiveness of these processes in ensuring access to needed medications.

## Benefit offerings for 2013

Beneficiaries will continue to have many choices of Part D plans in each region. However, each year, a subset of beneficiaries is affected by the entry and exit of plans resulting from decisions by plan sponsors or CMS not to renew contracts. Changes in business strategies also affect plan benefits that are available in a given region.

## Number of plans remains stable in 2013

Between 2012 and 2013, the number of stand-alone PDPs decreased by just under 1 percent—from 1,041 to 1,033—while the number of MA–PDs increased by 6 percent—from 1,541 to 1,627 (Figure 15-3).<sup>13</sup> The number of plans offered has fluctuated over the years. The largest reduction in the number of plans occurred between 2010 and 2011. It was primarily the result of CMS’s policies that intended to differentiate more clearly between basic and enhanced benefit plans and to discourage plans with low enrollment.<sup>14</sup> In 2013, Medicare beneficiaries continue to have many plans to choose from, ranging from 23 PDP options in Hawaii and Alaska to 38 PDP options in the Pennsylvania–West

**TABLE  
15-7**

**Part D enrollees' access to prescription drugs, 2010**

	All Part D	Plan type		Subsidy status	
		PDP	MA-PD	LIS	Non-LIS
Percent:					
Satisfied with drug coverage	94%	94%	95%	96%	94%
Confident the level of coverage meets needs	95	94	96	94	95
Satisfied with plan list of drugs covered*	83	82	84	84	82
Satisfied with the ease of finding pharmacy that accepts drug plan*	95	95	93	94	95
With medication(s) not obtained	6	6	5	8	5

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), LIS (low-income subsidy).  
 \*A small share of respondents refused to respond, indicated that they did not know the answer to the question, or had no experience related to the question. Between 6 percent and 8 percent of respondents did not answer the question about the plan list of drugs. Between 4 percent and 5 percent did not answer the question about the ease of finding a pharmacy that accepts the drug plan.

Source: MedPAC analysis of 2010 Medicare Current Beneficiary Survey Access to Care file.

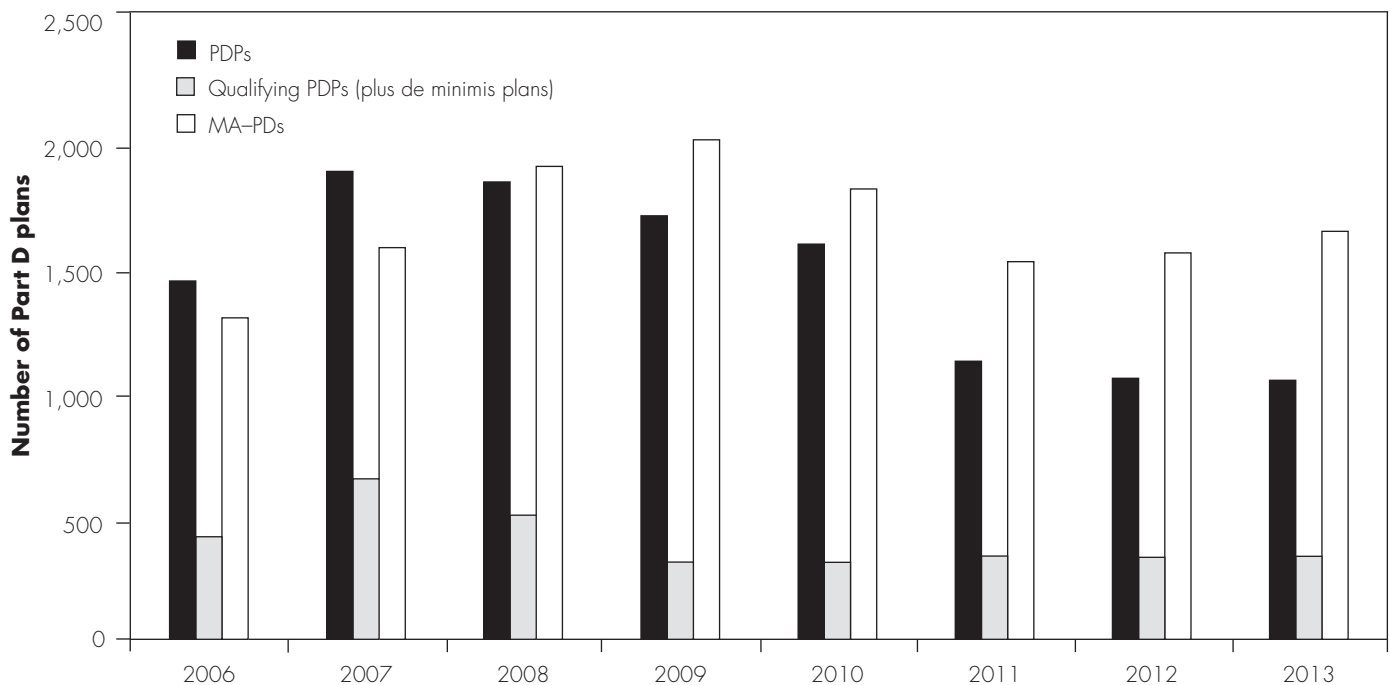
Virginia region, along with MA-PD options in most areas of the country. The number of MA-PDs available to a beneficiary varies by the county of residence, with a typical county having between 5 and 10 MA-PD plans

to choose from. A handful of counties have no MA-PD plans available.

In 2013, 331 PDPs are available to LIS enrollees with no premium, compared with 327 in 2012 (Figure 15-

**FIGURE  
15-3**

**Number of Part D plans remains stable between 2012 and 2013**



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Qualifying PDPs are plans for which low-income subsidy (LIS) enrollees pay no premium because the plans' premiums are at or below a regional premium threshold. De minimis plans are plans that CMS permitted to retain their LIS enrollees because the plan premium was within a certain variance from the regional LIS premium threshold.

Source: CMS landscape and plan report files.

3). Most regions continue to have many premium-free plans available. However, in two regions (Florida and Nevada), only two premium-free plans are available in each region. About 2.7 million LIS enrollees were in plans that do not qualify as premium free in 2013 (Hoadley et al. 2012). As of October 2012, CMS estimated that it will have reassigned about 850,000 LIS enrollees to different plans because their previous plan's premium no longer falls below the 2013 threshold. About 90 percent of the reassigned LIS enrollees will be in plans offered by different sponsors (Centers for Medicare & Medicaid Services 2012b). LIS enrollees who selected a plan that differed from their randomly assigned plan are not reassigned.

### **Notable changes for 2013 in benefit design**

Beneficiaries are encouraged to reexamine their options from time to time. In addition to the annual change in plan availability and premiums charged, most plans make some changes annually to their benefit offerings—such as deductible amounts and plan formularies that can directly affect access to and affordability of medications.

#### **Benefit designs**

For the 2013 benefit year, the structure of drug benefits for both stand-alone PDPs and MA-PDs held fairly steady. As in previous years, a smaller share of PDPs have no deductible (45 percent) compared with MA-PDs (86 percent). More than half of PDPs continue to charge a deductible in 2013, with most charging the defined standard amount (\$325).

In 2013, more PDPs are offering gap coverage beyond that required by PPACA than in 2012—34 percent compared with 26 percent. The extent of coverage in the gap varies from plan to plan. In previous years, a majority of PDPs that offered gap coverage limited their coverage to generic medications. In 2013, about half of PDPs that offer gap coverage include some brand-name drugs in the coverage gap. By contrast, the share of MA-PDs with gap coverage held steady at about 50 percent in 2013. Among MA-PDs that offer gap coverage, a slightly larger share includes some brand-name drugs in the coverage gap (55 percent) in 2013 than in 2012 (52 percent). But most of this brand coverage includes only a few brand-name drugs, typically less than 10 percent of brand-name drugs listed on the formulary.

As a result of changes made by PPACA, the coverage gap will be gradually phased out by 2020, and supplemental

benefits to provide coverage during the gap phase of the benefit will become less important over time. In 2013, the basic Part D benefit will cover 21 percent of the cost of generic drugs and 2.5 percent of the cost of brand-name drugs in the gap phase. The 50 percent discount paid by pharmaceutical manufacturers for brand-name drugs further reduces the beneficiary's cost sharing for brand-name drugs to about 47.5 percent.<sup>15</sup>

#### **Plan formularies**

Under contract with the Commission, researchers from NORC at the University of Chicago and from Social & Scientific Systems analyzed Part D formulary data for 2013. CMS generally requires that plan formularies include at least two drugs in each therapeutic category and class unless only one drug is available. For this analysis, drugs are defined at the level of chemical entities—a broad grouping that encompasses all of a chemical's forms, strengths, and package sizes—that combine brand-name and generic versions of specific chemicals (Medicare Payment Advisory Commission 2008).

The number of drugs that sponsors list on a formulary is one way to measure beneficiaries' access to prescription drugs under Part D. A plan's use of utilization management tools—such as its processes for obtaining nonformulary exceptions, prior authorization, quantity limits, and step therapy requirements—is another way to measure access.<sup>16</sup> However, these measures of access are imperfect. For example, formularies that list fewer drugs could still provide adequate access to appropriate medications. In some cases, unlisted drugs are covered through the nonformulary exceptions process. Other factors, such as the amount of cost sharing, can significantly affect beneficiaries' access to medications, regardless of the size of the formulary. Finally, utilization management tools, if used appropriately, can reduce the use of inappropriate medications. Plans are required to establish exceptions and appeals processes to ensure that their formularies do not impede access to needed medications. The relative ease or burden associated with the exceptions process varies from plan to plan. We intend to look into how well the exceptions and appeals processes are working to ensure that beneficiaries continue to have access to the medications they need.

For the seven largest nationwide PDPs, which accounted for over 60 percent of the enrollment in stand-alone PDPs in 2012, the shares of all distinct chemical entities (drugs) listed on their formularies remained stable or saw modest



**TABLE  
15-8**

**Formularies for stand-alone PDPs with highest 2012 enrollment**

Stand-alone PDPs with the highest 2012 enrollment	Enrollment, 2012 (in millions)	Percent of drugs on formulary		Percent of formulary drugs with any utilization management*	
		2012	2013	2012	2013
AARP MedicareRx Preferred	4.0	92%	92%	34%	21%
SilverScript Basic**	3.5	76	77	46	40
Humana Walmart-Preferred Rx Plan	1.5	85	83	40	48
Humana Enhanced	1.4	94	89	41	49
First Health Part D Premier	0.9	83	80	39	40
WellCare Classic	0.9	69	74	30	34
HealthSpring Prescription Drug Plan	0.6	81	79	43	42

Note: PDP (prescription drug plan). Enrollment figures are for September 2012 and exclude employer plans and U.S. territories. The number of drugs on the formulary for 2012 is 1,180; for 2013, the number is 1,174.

\*Any utilization management includes the use of prior authorization, quantity limits, and step therapy requirements.

\*\*CVS Caremark acquired Community CCRx Basic in 2011. In 2013, three plans—CVS Caremark Value, Community CCRx Basic, and Health Net Orange Option 1—all operated by CVS Caremark Corporation were consolidated into one plan to form SilverScript. Figures for 2012 are for Community CCRx Basic, which was the largest of the three plans by enrollment in 2012.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

changes between 2012 and 2013 (Table 15-8). Among the top seven PDPs, four plans—Humana Walmart-Preferred Rx Plan, Humana Enhanced, First Health Part D Premier, and HealthSpring Prescription Drug Plan—saw a decrease in the share of drugs listed in 2013.

The use of utilization management tools in Part D—including quantity limits, step therapy, and prior authorization—has grown in the past few years. Sponsors use such tools for drugs that are expensive, potentially risky, or subject to abuse, misuse, and experimental use. They are also often used to encourage the use of lower cost therapies. Between 2012 and 2013, among the top seven PDPs, four increased the share of drugs on plan formularies with some type of utilization management, while three decreased the share. In 2013, among the top seven PDPs, those operated by Humana Inc. (Humana Walmart-Preferred Rx Plan and Humana Enhanced) have the highest share of drugs with utilization management.

**Costs of Part D**

To monitor Part D’s costs, we examine aggregate program spending, trends in plans’ bid amounts and enrollees’ premiums, plans’ cost-sharing requirements, per capita spending, and trends in the prices at the pharmacy counter.

In our analysis of the 2009 Part D prescription drug event data, we found that beneficiaries with spending high enough to reach the catastrophic phase of the benefit filled more prescriptions, on average, and the cost of each prescription tended to be higher because more of them were for brand-name drugs. We also found that over 80 percent of beneficiaries with high drug spending received Part D’s LIS, which pays for cost-sharing amounts above the statutorily set copayment. This subsidy may limit how well plan sponsors can manage drug spending for those individuals—for example, by limiting plans’ ability to use reduced cost sharing to encourage the use of generic drugs when available. In our March 2012 report, we recommended that the Congress give the Secretary the authority to provide stronger financial incentives to use lower cost generics when they are available (Medicare Payment Advisory Commission 2012b).

**Aggregate program costs**

Medicare pays plan sponsors three major subsidies on behalf of each enrollee in their plans:

- *Direct subsidy*—Medicare makes a monthly payment to plans, which is set as a share of the national average bid for Part D basic benefits, adjusted for the risk of the individual enrollee.

**TABLE  
15-9**

**Medicare's reimbursement amounts for Part D on an incurred basis**

	Calendar year					
	2007	2008	2009	2010	2011	2012*
<b>In billions of dollars</b>						
Direct subsidy	\$18.1	\$17.7	\$18.9	\$19.7	\$20.0	\$21.6
Reinsurance	8.0	9.4	10.1	11.2	13.9	14.8
Low-income subsidy	16.8	18.0	19.6	21.0	22.3	22.8
Retiree drug subsidy	3.9	3.8	3.9	4.0	3.7	2.8
<b>Total</b>	<b>\$46.7</b>	<b>\$48.9</b>	<b>\$52.4</b>	<b>\$55.9</b>	<b>\$60.0</b>	<b>\$62.0</b>
<b>Annual percentage change</b>						
Direct subsidy	2.7%	-2.0%	6.5%	4.5%	1.5%	8.1%
Reinsurance	33.0	17.8	7.1	10.7	24.1	6.4
Low-income subsidy	11.1	7.6	8.5	7.4	6.2	2.1
Retiree drug subsidy	2.4	-3.3	3.5	1.8	-5.5	-25.1
<b>Total</b>	<b>10.0</b>	<b>4.7</b>	<b>7.1</b>	<b>6.6</b>	<b>7.3</b>	<b>3.4</b>

Note: The numbers above reflect reconciliation amounts. Most enrollees paid premiums directly to Part D plans, and those amounts are not included above. On a cash basis, the Boards of Trustees estimate that premiums paid by enrollees totaled \$4.1 billion in 2007, \$5 billion in 2008, \$6.3 billion in 2009, \$6.5 billion in 2010, \$7.7 billion in 2011, and \$8.7 billion in 2012. Totals may not sum due to rounding.

\*Estimated by CMS Office of the Actuary.

Source: MedPAC based on Table IV.B10 of the 2012 annual report of the Boards of Trustees of the Medicare trust funds.

- **Reinsurance**—Medicare subsidizes 80 percent of drug spending above an enrollee's annual OOP threshold. Reinsurance reduces risk for Part D sponsors by providing greater federal subsidies for the highest cost enrollees.
- **LIS**—Medicare pays the plan to cover expected cost sharing and premiums for enrollees eligible for the subsidy.

Direct and reinsurance subsidies combined cover 74.5 percent of the cost of basic Part D benefits, on average.<sup>17</sup> In addition to these subsidies, Medicare establishes symmetric "risk corridors" separately for each plan to limit its overall losses or profits. Under risk corridors, Medicare limits plans' potential losses and gains by financing a portion of any costs that are higher than expected or by recouping a portion of profits that are higher than expected.

**Low-income subsidy continues to be the largest single share of Part D costs**

Between 2007 and 2011, incurred reimbursements for Part D (including spending for the RDS) grew from \$46.7

billion to \$60 billion (Table 15-9). In 2011, the total was made up of \$20 billion in direct subsidy payments to plans, \$13.9 billion in payments for individual reinsurance, \$22.3 billion for the LIS, and \$3.7 billion in RDS payments. CMS's Office of the Actuary estimated that Part D spending would be about \$62 billion in 2012 (Boards of Trustees 2012).

In 2011, LIS payments continued to be the largest component of Part D spending. Moreover, substantial portions of other categories were spent on behalf of LIS enrollees. Because these individuals tend to use more medications than other Part D enrollees, a disproportionate share of spending for the direct subsidy and for individual reinsurance also reflects benefits for LIS enrollees.

**Individual reinsurance has been the fastest growing component of Part D spending**

Medicare payments for individual reinsurance have grown considerably faster than other components of Part D spending, increasing at an average annual rate of nearly 15 percent between 2007 and 2011, compared with 7 percent for overall Part D spending. Between 2010 and 2011,

## Gradual phase-out of the coverage gap

The Patient Protection and Affordable Care Act of 2010 (PPACA) gradually phases out the coverage gap. In 2020, when the phase-out is completed, enrollees' cost sharing in the coverage gap will be 25 percent—the same share as in the initial coverage phase of the defined standard benefit.<sup>2</sup>

The law uses different approaches to reduce cost sharing in the coverage gap for brand-name drugs and generic drugs. For brand-name drugs, manufacturers that want to continue including their products in the Part D program must sign contracts with CMS to participate in the coverage gap discount program. Since 2011, manufacturers have been required to provide Part D enrollees with a 50 percent discount for brand-name drugs while enrollees are in the coverage gap. Between 2013 and 2020, Part D will cover an increasing share of the cost of the drugs filled in the coverage gap until the enrollees' cost sharing reaches 25 percent (Table 15-10). A different phase-in schedule applies to generic drugs. The Part D benefit covered 7 percent when phase-out of the coverage gap began in 2011. The share

covered by the Part D benefit increases gradually until the enrollees' cost sharing is reduced to 25 percent in 2020 (Table 15-10).

In addition to the reduction in the cost-sharing amounts in the coverage gap, two changes made by PPACA will likely have the effect of increasing the share of Part D enrollees who reach the catastrophic phase of the benefit. First, the portion of the cost of the drugs in the coverage gap paid by manufacturers counts toward Part D's annual out-of-pocket (OOP) threshold.<sup>18</sup> Second, PPACA temporarily reduces the annual rate of growth in Part D's OOP threshold between 2014 and 2019. On the other hand, the reduction in OOP costs would tend to lengthen the time it takes to meet the OOP threshold, reducing the number of non-LIS beneficiaries who reach the catastrophic phase of the benefit. These changes may affect beneficiaries' decisions about the type of drug therapy they choose (e.g., brand-name drugs vs. generic drugs). We intend to analyze the impact of the changes made by PPACA once the data become available. ■

**TABLE  
15-10**

**Phase-in of reduced cost sharing for brand-name and generic drugs**

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Brand-name drugs	50%	50%	47.5%	47.5%	45%	45%	40%	35%	30%	25%
Generic drugs	93	86	79	72	65	58	51	44	37	25

Note: The actual cost-sharing amount for brand-name drugs in the coverage gap depends on the amount of dispensing fee charged by a plan since the portion covered by the Part D benefit (2.5 percent in 2013) applies to both the ingredient cost and the dispensing fee, while the 50 percent manufacturer discount applies only to the ingredient cost.

Source: MedPAC based on CMS. <http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11522-P.pdf>.

payments for individual reinsurance grew by 24 percent, a rate much higher than the growth rates for direct subsidy payments (1.5 percent) and for LIS payments (about 6 percent) (Table 15-9).

Multiple factors likely contribute to the growth in reinsurance spending. Our analysis of 2009 drug utilization for Part D enrollees with high spending suggests that growth in reinsurance spending is driven, in large part, by the volume of prescriptions filled rather than by the use of higher priced products that have

few, or no, therapeutic substitutes (Medicare Payment Advisory Commission 2012b). Two changes made by PPACA likely contributed to the even higher growth for reinsurance payments between 2010 and 2011 (see text box). First, beginning with the 2011 benefit year, pharmaceutical manufacturers are required to offer a 50 percent discount on brand-name drugs filled by non-LIS enrollees in the coverage gap, thereby reducing beneficiary cost sharing for brand-name drugs by half in 2011. Since the manufacturer discounts for brand-name drugs count

**TABLE  
15-11****National average bid and components of average prospective monthly payments per enrollee for basic coverage**

	2008*	2009	2010	2011	2012	2013
<b>Amount in dollars</b>						
National average monthly bid						
Base beneficiary premium	\$27.93	\$30.36	\$31.94	\$32.34	\$31.08	\$31.17
Monthly payment to sponsors	52.59	53.97	56.39	54.71	53.42	48.47
Subtotal	80.52	84.33	88.33	87.05	84.50	79.64
Expected individual reinsurance	29.01	34.73	36.92	39.77	37.38	42.60
Total average benefit cost	109.53	119.06	125.25	126.82	121.88	122.24
<b>Annual percent change</b>						
National average monthly bid						
Base beneficiary premium	2.1%	8.7%	5.2%	1.3%	-3.9%	0.3%
Monthly payment to sponsors	-0.9	2.6	4.5	-3.0	-2.4	-9.3
Subtotal	0.1	4.7	4.7	-1.4	-2.9	-5.8
Expected individual reinsurance	8.2	19.7	6.3	7.7	-6.0	13.9
Total average benefit cost	2.1	8.7	5.2	1.3	-3.9	0.3

Note: These amounts reflect averages based on bids to provide basic Part D benefits; they do not net out subsequent reconciliation amounts with CMS. They were calculated from bids by plans to provide the defined standard benefit or actuarially equivalent basic benefits, as well as the portion of enhanced Part D coverage attributable to basic benefits. Enrollees in plans with enhanced coverage must pay the full price of benefits that supplement basic coverage. The combination of monthly payments to plans and expected payments for individual reinsurance make up 74.5 percent of total average monthly benefit costs. Bids are fully weighted by prior year enrollment.

\*CMS used its general demonstration authority to calculate these values using 60 percent enrollment weighting and 40 percent weighting as in the 2006 approach.

Source: MedPAC based on CMS releases of Part D national average monthly bid amounts and base beneficiary premiums for 2008 through 2013, as well as other data provided by CMS.

toward the OOP threshold, individuals taking brand-name medications will reach the catastrophic phase of the benefit without having spent the full amount specified by the OOP threshold. Second, the gradual phase-down of cost sharing for generic drugs filled by Part D enrollees in the coverage gap began in 2011. As a result, cost sharing dropped from 100 percent to 93 percent for generic drugs filled by enrollees in the coverage gap.

### Decrease in retiree drug subsidy payments likely to continue

The number of Medicare beneficiaries who receive primary prescription drug coverage through former employers has been decreasing, from over 7 million in 2006 to about 6 million in 2011. The largest drop (9 percent) occurred between 2010 and 2011, resulting in a 5.5 percent decrease in spending for the RDS. Employers

no longer offering drug coverage to their retirees typically move their Medicare-eligible members to Part D.

Before 2013, the subsidy provided employers with two tax advantages. First, the RDS payments were and continue to be nontaxable income for employers. Second, employers had been allowed to treat the prescription drug expenses for which they receive the subsidy as a tax-deductible cost of doing business, making these subsidies worth more to the employers than the actual subsidy amounts paid. As of 2013, PPACA no longer allows employers to deduct expenses for which they receive the subsidy.<sup>6</sup> This change may accelerate the decline in beneficiaries receiving prescription drug coverage through former employers.

### National average bid

Between 2012 and 2013, national average costs for basic Part D benefits are projected to grow by less than 1 percent (Table 15-11). During this period, the monthly payment to

sponsors (i.e., the direct subsidy component) is projected to decrease by over 9 percent, while the reinsurance component is expected to grow by about 14 percent. The higher growth in the reinsurance component of the bid between 2012 and 2013 may, in part, be due to the expectation that the gradual phase-out of the coverage gap under PPACA will result in higher reinsurance costs.

Growth in expected per capita benefit costs for Part D has fluctuated. The expected growth in benefit costs was 5 percent between 2009 and 2010 and 1 percent between 2010 and 2011. For 2012, the expected costs were projected to decrease by 4 percent (Table 15-11). Although year-to-year trends in the national average bid provide some information about costs of the drug benefit, those trends are an imperfect measure of spending. Since bids are projections of sponsors' estimated costs and not actual costs, reconciliation at the end of the year could result in a higher or lower trend in spending for Part D.

### **Average Part D premium**

In 2013, the base beneficiary premium is \$31.17, a slight increase from \$31.08 in 2012. The actual average monthly premium in 2013 differs from the base beneficiary premium since it depends on the beneficiary's plan choice. The base beneficiary premium reflects the basic portion of the benefit (the portion that does not include premiums for enhanced, or supplemental, benefits). The actual premium paid by individual beneficiaries is higher or lower depending on their selected plan's bid (Medicare Payment Advisory Commission 2012a).

As a result of changes made by PPACA, the premium subsidy for higher income beneficiaries is lower than the statutorily defined subsidy of 74.5 percent. Similar to the income-related premium for Part B, the reduced subsidy applies to individuals with an annual adjusted gross income greater than \$85,000 and to couples with an adjusted gross income greater than \$170,000. A beneficiary whose income exceeds the threshold amount pays an income-related monthly adjustment amount in addition to the normal Part D premium paid to a plan. The adjustment amount varies based on income, ranging from \$11.60 to \$66.60 per month in 2013. About 1.14 million beneficiaries were subject to the reduced premium subsidy in 2012.<sup>19</sup>

### **Plans' cost-sharing requirements**

Cost-sharing requirements have generally been rising over the years. For plan sponsors, cost sharing plays an

important role in attracting potential enrollees (or retaining current enrollees) while managing drug utilization to remain competitive. From an enrollee's perspective, cost sharing can have a significant effect on access to and affordability of their medications.

### **Changes in cost sharing for the top seven PDPs vary across plans for 2013**

In 2013, changes in cost-sharing requirements for the top seven nationwide PDPs based on enrollment in 2012 are modest for the most part, with a few notable exceptions. The stability of the copayments and coinsurance amounts from year to year is, in part, due to CMS's formulary review process. During the review process, CMS determines, for example, whether there are plans that appear to be outliers and require that the cost-sharing amounts be brought in line with those of other plans.

Four of the top seven PDPs lowered cost sharing for generic drugs, while one plan (WellCare Classic) increased cost sharing from \$0 to \$6. Two plans—Humana Enhanced and First Health Part D Premier—increased cost sharing for brand-name drugs, while the rest tended to keep cost sharing at about the same level as in 2012 (Table 15-12, p. 352). Some enrollees in SilverScript Basic, a consolidated plan previously consisting of three separate plans, may experience significant change in their OOP spending as some will be changing from fixed copayments to coinsurance.<sup>20</sup>

For 2013, Humana Walmart-Preferred Rx Plan introduced a specialty tier with a 25 percent coinsurance, which is higher than its cost sharing for preferred brands (20 percent) but lower than its cost sharing for nonpreferred brands (35 percent). Typically, for actuarially equivalent plans, coinsurance amounts for specialty tiers are restricted to no more than 33 percent, which tends to be lower than the cost-sharing amounts for nonpreferred brands. Of the top seven PDPs, two plans—First Health Part D Premier and HealthSpring Prescription Drug Plan—do not have a specialty tier.

From an enrollee's perspective, cost-sharing requirements for specialty-tier drugs can be high until the enrollee reaches the catastrophic phase of the benefit. In addition, under CMS's regulations, enrollees may not appeal specialty-tier cost sharing as they can for other drugs, such as those on tiers for nonpreferred brands. Because drugs on specialty tiers are often used to treat serious chronic illnesses, such as rheumatoid arthritis and multiple

**TABLE  
15-12**

**Cost-sharing amounts for stand-alone PDPs with highest 2012 enrollment**

Stand-alone PDPs with the highest 2012 enrollment	Enrollment, 2012 (in millions)	Generic		Preferred brand		Nonpreferred brand		Specialty	
		2012	2013	2012	2013	2012	2013	2012	2013
AARP MedicareRx Preferred*	4.0	\$4/\$8	\$3/\$5	\$41	\$40	\$95	\$85	33%	33%
SilverScript Basic**	3.5	\$2	\$2	25%	23.5%	46%	45%	25%	25%
Humana Walmart-Preferred Rx Plan*	1.5	\$1/\$5	\$1/\$4.5	20%	20%	35%	35%	N/A	25%
Humana Enhanced*	1.4	\$7	\$2/\$5	\$38	\$41	\$73	\$90	33%	33%
First Health Part D Premier	0.9	\$5	\$1	20%	25%	36%	45%	26%	N/A
WellCare Classic	0.9	\$0	\$6	\$41	\$42	\$95	\$94	25%	33%
HealthSpring Prescription Drug Plan	0.6	25%	25%	25%	25%	25%	25%	N/A	N/A

Note: PDP (prescription drug plan). Enrollment figures are for September 2012 and exclude employer plans and U.S. territories. When plans vary cost-sharing amounts across regions, we report unweighted median cost-sharing amounts.

\*Indicates plans with two tiers, preferred and nonpreferred, for generic drugs in 2012 and/or 2013.

\*\*CVS Caremark acquired Community CCRx Basic in 2011. In 2013, three plans operated by CVS Caremark Corporation—CVS Caremark Value, Community CCRx Basic, and Health Net Orange Option 1—were consolidated into one plan to form SilverScript. Figures for 2012 are for Community CCRx Basic, which was the largest of the three plans by enrollment in 2012.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

sclerosis, patients who need these drugs can face relatively high cost sharing for medications on top of significant OOP costs for their medical care. From a sponsor's perspective, high-cost drugs may be used more widely than the evidence of their effectiveness supports, and higher coinsurance may temper their use. Some sponsors may use a specialty tier if most of their competitors also use one to limit the risk of attracting enrollees who take very expensive drugs.

### Pharmacy networks and cost-sharing requirements

Part D plans contract with pharmacies to fill prescriptions for their enrollees. Plans are required to contract with any pharmacy that agrees to the terms of the contract. However, pharmacies may choose not to do business with the plan. Any pharmacy that contracts with a drug plan is considered to be in the plan's network (in-network), whereas any others are considered out-of-network. In-network pharmacies can be further classified as preferred or nonpreferred pharmacies. While the medicines covered by all in-network pharmacies must be the same, the corresponding cost-sharing amounts may depend on the classification of the pharmacy within the plan's network. In recent years, a growing number of plan sponsors have chosen to offer preferred pharmacies in their network, with potentially significant price differentials for beneficiaries (see text box). Sponsors' use of preferred and nonpreferred

networks may have a larger effect on access to prescription drugs for individuals residing in rural areas than for those residing in urban areas.

In general, plans do not cover drugs bought from out-of-network pharmacies. Exceptions may include the following: (1) the beneficiary does not live reasonably close to an in-network pharmacy, (2) the beneficiary is traveling, and (3) the in-network pharmacy does not have the drug in stock. In such situations, the plan must cover the prescription but can require higher cost sharing—for example, by requiring the beneficiary to pay the difference in the price the plan would pay to an out-of-network pharmacy compared with an in-network pharmacy. To ensure that beneficiaries have adequate access to in-network pharmacies, plans are required to meet the statutorily defined network adequacy requirement.<sup>21</sup> (Network adequacy for plans with preferred and nonpreferred pharmacies is based on access to both types of pharmacies since they are all considered in-network.) Because of these restrictions, plans' networks are usually wide. Eighty-three percent of PDPs contract with over 95 percent of pharmacies in their respective regions. Only one plan lists less than 70 percent of the pharmacies in its area as in-network.

## Use of preferred pharmacy networks by Part D plans

Plans that have preferred pharmacy networks are a small but growing portion of all Part D plans. For this analysis, plans are considered to have “true” preferred networks if the network includes both preferred and nonpreferred pharmacies and there is differential cost sharing for preferred and nonpreferred pharmacies.<sup>22</sup> The stratification of cost sharing for beneficiaries in plans with preferred networks is such that copayments and coinsurance are less for an in-network pharmacy than for an out-of-network pharmacy and are less for preferred in-network pharmacies than for nonpreferred in-network pharmacies. In 2012, six plans offered preferred networks with corresponding differences in cost sharing. These plans accounted for 12.5 percent of prescription drug plan enrollment (Table 15-13) and 3 percent of Medicare Advantage–Prescription Drug plan enrollment (data not shown). For all such plans, no more than one-third of in-network pharmacies are preferred (i.e., have the lowest cost-sharing amounts).

CMS rules establish that the viability of a pharmacy network with preferred and nonpreferred pharmacies is conditional on cost sharing that is not “so significant as to discourage enrollees in certain areas (rural areas or inner cities, for example) from enrolling in that Part D plan” (Centers for Medicare & Medicaid Services 2011). Different plans have interpreted this rule in different ways. Most have cost-sharing differentials between preferred and nonpreferred pharmacies ranging from \$5 to \$10 for generics and from 0 percentage point to 19 percentage points for brand-name drugs.<sup>23</sup> The impact of these costs, especially for beneficiaries who are unaware of or do not understand the distinction between preferred and nonpreferred pharmacies, may be significant. Although the population affected by the tiered pharmacy network in 2012 was relatively small, many more beneficiaries could be affected in the coming years. At least five plans had announced the addition of preferred pharmacies in 2013 at the time this analysis was conducted. Depending on how many beneficiaries choose to enroll in those plans, they could represent a sizeable share of Part D enrollees. ■

**TABLE  
15-13**

**Enrollment in PDPs with preferred and nonpreferred pharmacies, 2012**

	Share of all PDP enrollment	Average share of pharmacies that the plan lists as preferred
Humana Walmart-Preferred	8.0%	7.7%
First Health Part D Value Plus	2.0	24.0
Aetna CVS	1.9	13.8
BlueMedicare Rx-Option 1 (FL)	0.3	30.6
CVS Caremark Plus	0.3	13.1
Rite Aid EnvisionRxPlus	0.0	12.0
Total	12.5	

Note: PDP (prescription drug plan). Average shares of pharmacies are weighted by the number of pharmacies in each region and include only regions where the plan is offered.

Source: Analysis of formularies submitted to CMS conducted by NORC/Social & Scientific Systems for MedPAC.

### Per capita spending and use

Under Part D, payments to plans are based on the average of the bids plan sponsors submit to CMS each year. The bids are intended to reflect the expected costs for a Medicare beneficiary of average health; CMS adjusts payments to plans based on the actual health status of each

of the plan’s enrollees. The actual costs of the program may be higher or lower than the prospective payments CMS makes to plans based on the bids.

Between 2007 and 2010, the average per capita spending for Part D–covered drugs for MA–PD enrollees has been consistently lower than that for stand-alone PDP

**TABLE  
15-14**

**Average per capita spending and use per month for Part D-covered drugs, 2007-2010**

**Part D spending and utilization per enrollee**

	Average spending				AAGR, 2007-2010		Average number of prescriptions				AAGR, 2007-2010 (in percent)
	2007	2008	2009	2010	In dollars	In percent	2007	2008	2009	2010	
All Part D	\$212	\$221	\$228	\$231	\$6	2.9%	3.9	4.1	4.1	4.2	2.3%
By plan type											
PDP	239	250	260	265	9	3.6	4.1	4.3	4.4	4.4	2.3
MA-PD	151	162	169	172	7	4.4	3.4	3.6	3.7	3.8	3.3
By LIS status											
LIS	301	324	339	348	16	4.9	4.6	4.9	5.0	5.1	3.2
Non-LIS	156	159	163	163	2	1.4	3.4	3.6	3.6	3.7	2.7

Note: AAGR (average annual growth rate), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), LIS (low-income subsidy). Part D prescription drug event (PDE) records are classified into plan types based on the contract identification on each record. For purposes of classifying the PDE records by LIS status, monthly LIS eligibility information in Part D's denominator file was used to classify the PDE records by LIS status. Estimates are sensitive to the method used to classify PDE records to each plan type and LIS status. Gross drug spending includes all payments to pharmacies, including payments by drug plans, Medicare's LIS, and beneficiary out-of-pocket spending. Prescriptions standardized to a 30-day supply.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

enrollees—by about \$90 per member per month. The average per capita spending for LIS enrollees has been about double that of non-LIS enrollees, with the difference between the two groups growing over time (Table 15-14).

Growth in average per capita spending slowed from 3.6 percent in the past few years to 1.5 percent in 2010—a trend consistent with that of general drug costs measured in national health expenditures. Between 2007 and 2010, spending for non-LIS enrollees remained relatively flat (1.4 percent growth) compared with LIS enrollees (4.9 percent growth). The difference in growth in per capita spending between LIS and non-LIS enrollees is due to higher growth in the average cost per prescription and higher growth in the average number of prescriptions filled by LIS enrollees. Although the growth in per capita drug spending among MA-PD enrollees was greater than for stand-alone PDP enrollees (4.4 percent compared with 3.6 percent), the average growth was lower for MA-PD enrollees in terms of the dollar increase (\$7 compared with \$9).

**Part D drug prices**

Most plan sponsors do not negotiate drug prices directly with pharmaceutical manufacturers. Instead, sponsors engage in two separate negotiations:

- The first involves pharmacies or a network of pharmacies over the prices the plan will pay them for drug ingredient costs and dispensing fees.
- The second involves the terms under which manufacturers pay retrospective rebates.

The average manufacturer rebate as a percentage of total prescription drug costs increased from less than 9 percent to 11.3 percent between 2006 and 2010 (Boards of Trustees 2012). In general, plan sponsors do not receive rebates from manufacturers of generic drugs, which accounted for about three-quarters of the prescriptions dispensed under Part D in 2010. The CMS Office of the Actuary reports that “many brand-name prescription drugs carry substantial rebates, often as much as 20–30 percent” but expects the rebates to decrease as some of the drugs with the highest Part D rebate amounts lose patent protection in the next several years (Boards of Trustees 2012). Plan sponsors tend to use rebate revenues to offset plans’ benefit spending (reducing plan



premiums) rather than lowering the price of prescriptions at the pharmacy counter. As a result, drug prices measured in this section do not reflect the outcomes of the rebate negotiations.

Part D plan sponsors have had mixed success at influencing drug prices. They have been successful at encouraging enrollees to use generic alternatives when available (Congressional Budget Office 2010, Office of Inspector General 2007). Plan sponsors regularly use cost-sharing differentials to encourage enrollees to use lower priced products such as generic drugs and brand-name drugs placed on preferred brand tiers. But sponsors have had less success at controlling the growth in prices for unique drug and biologic products.

To track drug prices, the Commission contracted with researchers at Acumen, LLC, to construct a series of volume-weighted price indexes (Figure 15-4, p. 356). The indexes do not reflect retrospective rebates from manufacturers but do reflect the prices sponsors and beneficiaries pay to pharmacies at the point of sale (including ingredient costs and dispensing fees).

Measured by individual national drug codes (NDCs), Part D drug prices rose by an average of 23 percent cumulatively between January 2006 and December 2010.<sup>24</sup> At the same time, Part D sponsors have had success at encouraging enrollees to switch from brand-name drugs to generic substitutes. As measured by a price index that takes this substitution into account, Part D prices grew cumulatively by 2 percent between January 2006 and December 2010.<sup>25</sup> Therefore, nongeneric drug prices appear to be growing aggressively. For drugs with few or no generic substitutes, prices have grown rapidly. Prices for biologics, for example, increased by 43 percent over the same period (data not shown).<sup>26</sup> The increase in prices was the same even after generic substitution was taken into account.

For most drug classes, CMS requires plan formularies to cover at least two drugs in every therapeutic class and key drug type that are not therapeutic substitutes unless only one drug is approved for that class. This policy is intended to protect beneficiaries who need a drug that is the only one available to treat a certain condition and allows competition in classes with multiple products. For six drug classes, CMS requires Part D plans to cover “all or substantially all” drugs in the class. Those classes are antineoplastics, antidepressants, antipsychotics, antiretrovirals, anticonvulsants, and immunosuppressants used by transplant patients. Although plans can charge

higher cost sharing for drugs in these classes—for example, by placing them on tiers for nonpreferred brands—plans may have limited ability to influence utilization of these classes of drugs.

As measured by individual NDCs, prices for drugs in the six protected classes showed a trend similar to that for all Part D drugs, rising by a cumulative 21 percent over the five-year period (Figure 15-4, p. 356). This growth is influenced heavily by two classes of drugs: antidepressant medications, which account for about half of the volume in the six classes and had many generics on the market during this period, and anticonvulsants, which account for about a quarter of the volume and also had generic alternatives available during the same period.

Our price index for the individual NDCs of antidepressant and anticonvulsant drugs fell by nearly 6 percent and 17 percent, respectively, during the five-year period (data not shown). Growth in the price index for immunosuppressants has slowed in recent years due to generic entries in 2009. Other classes are made up almost entirely of brand-name drugs, and the prices of these products grew rapidly, ranging from nearly 30 percent for antiretrovirals to over 60 percent for antineoplastics.<sup>27</sup>

When protected class drugs were grouped to take generic substitution into account, their prices fell by a cumulative 2 percent over the five-year period. Thus, despite the drugs’ protected status, plan sponsors appeared to have had success at moving enrollees toward generics for these drugs when generic substitutes were available. However, it is possible that the drugs’ protected status may limit plan sponsors’ ability to negotiate rebates from manufacturers in classes in which one brand-name drug can be a therapeutic substitute for another brand-name drug. We lack rebate information to test this hypothesis.

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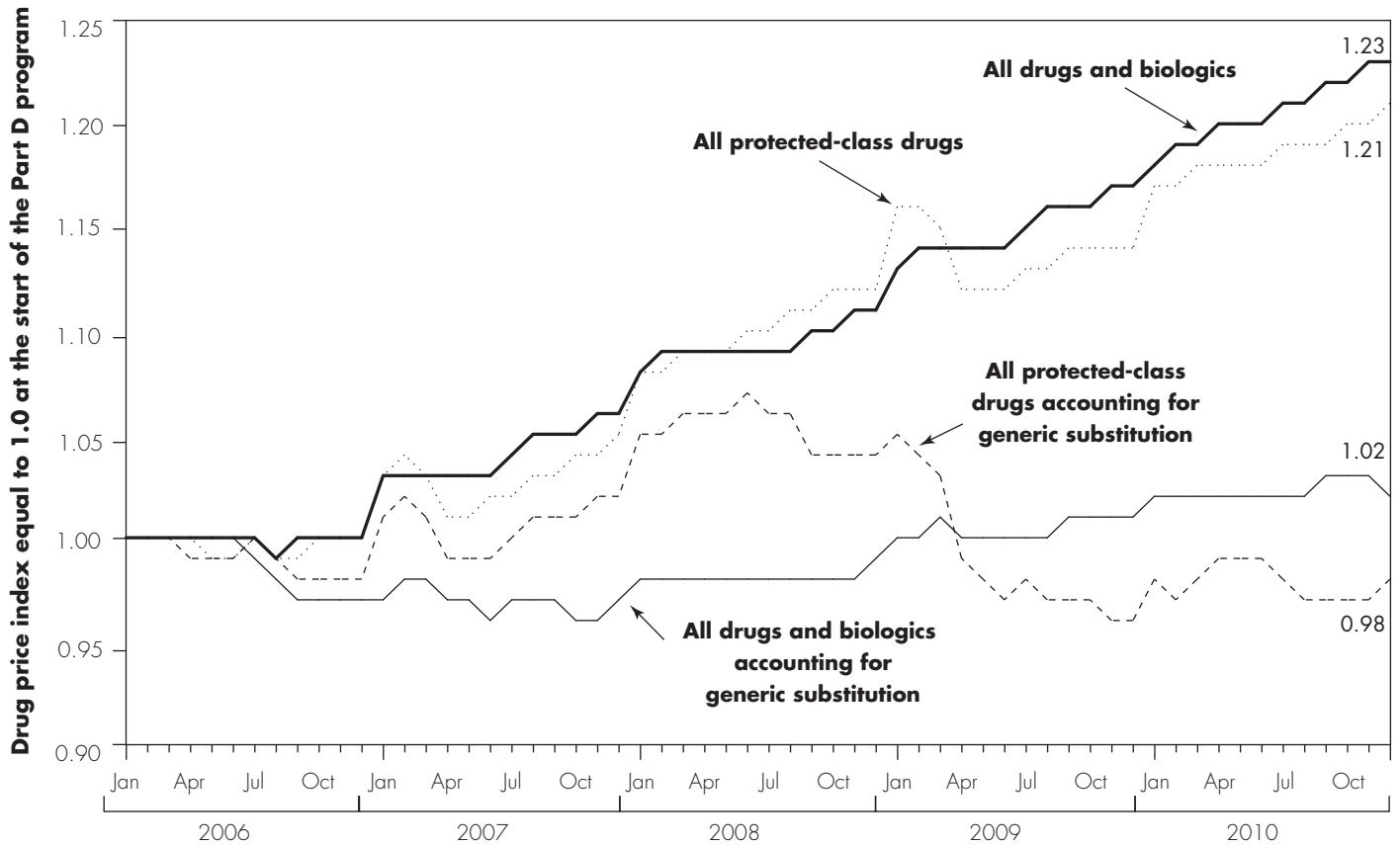
## Use of generic drugs

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Generic substitution can result in significant reductions in spending. The Commission’s set of volume-weighted indexes shows that, when taking into account generic substitution, prices for Part D drugs grew cumulatively by just 2 percent between January 2006 and December 2010, while the prices of individual drugs (measured by NDCs) grew by 23 percent, on average, during the same period. The Congressional Budget Office estimates that, in 2007, dispensing generic drugs rather than their brand-name counterparts reduced total prescription drug costs for

**FIGURE  
15-4**

**Availability of generics, rather than protected status,  
key to slower price growth under Part D**



Note: Chain-weighted Fisher price indexes.

Source: Acumen, LLC, analysis for MedPAC.

Part D by about \$33 billion (Congressional Budget Office 2010). Even so, for the same year, the Congressional Budget Office estimates that Part D could have saved an additional \$900 million if all prescriptions for multiple-source brand-name drugs had instead been filled with their generic counterparts and an additional \$4 billion if generics had been dispensed as therapeutic substitutes.

The use of generic medications has increased. According to the Commission's analysis, the overall average generic dispensing rate (GDR) increased from 61 percent in 2007 to 74 percent in 2010 (Table 15-15). During this period, some of the most popular brand-name drugs lost patent protection so there were more opportunities for generic substitution. GDRs vary across different groups of beneficiaries. For example, MA-PD enrollees are more likely to use generic drugs than enrollees in PDPs. Between 2007 and 2010, MA-PDs consistently exceeded

the GDR for PDPs by about 5 percentage points. LIS enrollees have had a consistently lower GDR than non-LIS enrollees, and that difference grew between 2007 and 2010 from 2 percent to 5 percent.

Multiple factors likely contribute to the higher or lower GDRs among groups of beneficiaries. For example, differences in health status may limit the opportunity for clinically appropriate therapeutic substitutions for some beneficiaries. There may be differences in the prescribing behavior of physicians who are part of a managed care organization and those who are not. Some of the difference in GDRs between PDPs and MA-PDs reflects the fact that most LIS enrollees are in PDPs. Since LIS enrollees are more likely to be disabled and tend to have a greater disease burden than non-LIS enrollees, they may have different medication needs. At the same time, since one of the key tools plan sponsors use to manage drug

**TABLE  
15-15****Generic dispensing rate by plan type and LIS status, 2007-2010**

	2007	2008	2009	2010
All Part D	61%	67%	70%	74%
By plan type				
PDP	60	66	69	72
MA-PD	66	71	74	77
By LIS status				
LIS	60	65	68	71
Non-LIS	62	69	72	76

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Shares are calculated as a percent of all prescriptions standardized to a 30-day supply. Generic dispensing rate is defined as the proportion of drugs dispensed that are generics. Part D drug event records are classified as PDP or MA-PD records based on the contract identification on each record.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

spending—using cost-sharing differentials between drugs on different tiers to encourage enrollees to use lower cost drugs—is not available to manage the drug spending of LIS enrollees, sponsors have limited ability to manage spending for this population.

## Quality in Part D

CMS collects quality and performance data for Part D plans to monitor sponsors' operations and help beneficiaries choose among plans. CMS relies on several sources for these data—the Consumer Assessment of Healthcare Providers and Systems survey, agency monitoring of plans, data furnished by sponsors, and claims information (Centers for Medicare & Medicaid Services 2012c). For 2013, 18 metrics are grouped into four domains (Centers for Medicare & Medicaid Services 2012a):

- drug plan customer service (five measures);
- member complaints, problems getting services, and improvement in the drug plan's performance (four measures);

- member experience with the drug plan (three measures); and
- patient safety and accuracy of drug pricing (six measures).

The star ratings on Medicare's web-based Plan Finder for MA-PDs are based on 49 measures, including measures that assess the quality of medical services provided under Part C (i.e., the MA program) in addition to the measures used to assess the quality of prescription drug (Part D) services provided. Similar to the 2012 plan ratings, the 2013 plan ratings put more emphasis on patient safety and appropriate medication use, such as the use of medications with a high risk of serious side effects and the percentage of enrollees obtaining medications that are recommended to treat selected conditions. CMS aggregates individual scores for each of the measures (18 for PDPs and 49 for MA-PDs) on the Plan Finder under a 5-star system; 5 stars mean excellent performance and 1 star reflects poor performance. CMS presents star ratings that combine individual scores in each domain as well as a summary rating that represents overall performance.

For 2013, ratings for both stand-alone PDP and MA-PD sponsors range from 2 stars to 5 stars. Weighted by enrollment, the average star rating among PDP sponsors is 3.3, compared with 2.96 for 2012, and the average among MA-PD sponsors is 3.66, compared with 3.44 for 2012 (Centers for Medicare & Medicaid Services 2012a). Ratings for contracts (only stand-alone PDPs that are eligible to receive LIS autoassignments) range from 2.5 stars to 4 stars; no 5-star plans are available. Compared with last year, fewer LIS plans have ratings below 3 stars, indicating potential improvement in quality. However, because of the addition of two new Part D measures in 2013 (measure of drug plan quality improvement and accuracy of prices on plan finder) and because plan ratings are determined relative to other plans, 2013 Part D plan ratings are not directly comparable to other years.

## Role of competition in Part D

Medicare's payment system for Part D uses competing private plans to deliver prescription drug benefits. When designing Part D, policymakers envisioned that plans would compete for enrollees based on their premiums, formularies, quality of services, and network of pharmacies. Medicare's payments to plans are based on bids submitted by plan sponsors, and Part D requires

## Voluntary switchers

Each year, Part D enrollees have an opportunity to reevaluate their Part D plan selection for the coming year during the annual open enrollment period. Although some low-income subsidy (LIS) enrollees choose plans on their own, many are randomly assigned to prescription drug plans (PDPs) with premiums that are below the regional thresholds (i.e., premium free to beneficiaries receiving the LIS). We limited our analysis of plan switching to non-LIS enrollees to ensure that the change in plans reflected a voluntary switch rather than random assignments by CMS. We further restricted our analysis to exclude individuals enrolled in employer group plans and individuals who switched plans due to plan terminations or service area reductions.

Between 2009 and 2010, 13.6 percent of the non-LIS enrollees in our analysis voluntarily switched plans. Younger enrollees were more likely than older enrollees to switch plans, with about 16 percent of enrollees between 65 and 69 years old switching compared with 11 percent of enrollees 80 years or older (Table 15-16). White enrollees were more likely than non-White enrollees to switch plans. Hispanic enrollees were less likely than non-Hispanic enrollees to switch plans. Gender did not affect the rate of switching (data not shown). Enrollees residing in nonmetropolitan areas were more likely (17 percent) to switch plans than enrollees residing in metropolitan areas (13 percent). The results were similar for the 2010–2011 period.

The share of enrollees who voluntarily switched plans differed between Medicare Advantage–Prescription Drug plan (MA–PD) enrollees (15 percent) and PDP enrollees (13 percent) between 2009 and 2010 but not between 2010 and 2011 (13 percent of enrollees in both plan types). For the two plan types (PDP and

**TABLE  
15-16**

### Non-LIS beneficiaries who voluntarily switched plans, 2009–2011

	2009–2010	2010–2011
All non-LIS enrollees	13.6%	13.0%
By age		
64 or younger	14	14
65–69	16	15
70–74	14	14
75–79	13	12
80 or older	11	10
By race		
White	14	13
African American	12	12
Asian/other	11	13
Hispanic	10	10
By urbanicity		
Metropolitan	13	12
Micropolitan	17	16
Rural	17	16
By plan type		
PDP	13	13
MA–PD	15	13

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). The figures in the table exclude individuals enrolled in employer group plans and those enrolled in terminated plans or plans that experienced service area reductions.

Source: MedPAC analysis of Medicare enrollment and Part D denominator files.

MA–PD), most switchers—90 percent of MA–PD enrollees and about 80 percent of PDP enrollees—changed to plans of the same plan type (data not shown). ■

sponsors to bear insurance risk for the benefit spending of their enrollees. The idea was for competition among plans to provide strong incentives for plan sponsors to manage drug use and keep spending growth in check. Plans that are able to manage drug spending and bid more competitively are supposed to be rewarded with higher enrollment than plans that do not.

During the first few years of the program, according to CMS, only about 6 percent of non-LIS Part D enrollees switched plans voluntarily each year. A low rate of switching among beneficiaries could reflect general satisfaction with their plan choices or difficulty in choosing plans. Beneficiaries may be reluctant to switch plans if they face transition issues arising from changes

to formularies, benefit structure, and administrative processes. If beneficiaries are unwilling to switch, even when faced with significant premium increases, sponsors will have less of an incentive to compete on premiums and control drug spending. On the other hand, if enough beneficiaries switch plans to maximize coverage of their medications, it could increase costs for the plans and in turn increase Medicare spending for Part D, as Medicare subsidizes a significant portion of Part D benefit costs.

On the basis of the Commission's analysis of enrollment data, we find that a higher share of enrollees than was reported earlier has switched plans voluntarily—13.6 percent between 2009 and 2010 and 13 percent between 2010 and 2011 (see text box).<sup>28</sup> Although many beneficiaries who participated in our focus groups found the annual open enrollment process for selecting or changing plans to be confusing, more beneficiaries reported using the Internet to research and compare plan options than in previous years. Several participants knew about the Medicare Plan Finder and CMS's star rating system (Hargrave et al. 2012). Some beneficiaries reported

researching their plan options regularly to compare cost-sharing amounts and the formulary status of specific medications, although researching their plan options did not always lead beneficiaries to switch plans.

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## **Relationship between medical and drug spending**

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Policymakers and health services researchers have given much attention to the relationship between drug spending and medical spending. The results of studies that examined this relationship have been mixed (e.g., McWilliams et al. 2011, Stuart et al. 2013, Zhang et al. 2009). Our analysis of the patterns of service use for Part A and Part B of Medicare and for Part D across metropolitan statistical areas showed no consistent relationship between medical service use and drug use (Suzuki and Zabinski 2010). We may not have been able to observe the relationship between medical and drug spending because that study aggregated Part D spending to the level of a metropolitan statistical area. For future work, the Commission will investigate the relationship between medical and drug spending at the individual beneficiary level and explore whether better adherence to drugs used for certain conditions reduces Medicare Part A and Part B spending. ■

## Endnotes

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- 1 PPACA eliminates the coverage gap by (1) requiring pharmaceutical manufacturers to offer a 50 percent discount on brand-name drugs filled during the coverage gap, (2) gradually phasing down cost sharing for generics and brand-name drugs, and (3) reducing the OOP threshold on true OOP spending over the 2014 to 2019 period.
- 2 PPACA requires pharmaceutical manufacturers of brand-name drugs to provide a 50 percent discount for drugs filled while beneficiaries are in the coverage gap. In 2013, the Part D benefit provides coverage of 2.5 percent for brand-name drugs, reducing the cost sharing for drugs filled during the coverage gap to about 47.5 percent in 2013. The actual cost-sharing amount for brand-name drugs in the coverage gap depends on the amount of dispensing fee charged by a plan since the 2.5 percent covered by the Part D benefit applies to both the ingredient cost and the dispensing fee, while the 50 percent manufacturer discount applies only to the ingredient cost.
- 3 The amount of total covered drug spending at which a beneficiary meets the annual OOP threshold depends on the existence of other sources of supplemental coverage and the mix of brand-name and generic drugs an individual fills during the coverage gap. The 2013 amount of total drug expenses at the annual OOP threshold of \$6,954.52 is for an individual not receiving Part D's low-income subsidy and without other sources of supplemental coverage, assuming that expenses for brand-name drugs account for 85.6 percent of total drug spending in the coverage gap.
- 4 Often plan sponsors often use the same formulary across multiple plans they operate; furthermore, sponsors cannot apply different formularies to enrollees in a given plan.
- 5 The prescription drug coverage beneficiaries had before 2006 may or may not have been as generous as the Part D benefit. Since the implementation of Part D, 90 percent of beneficiaries have drug coverage that is at least as generous as the Part D basic benefit.
- 6 If an employer agrees to provide primary drug coverage to its retirees with an average benefit value that is equal to or greater than 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. Under PPACA, employers would still receive the RDS on a tax-free basis, but beginning in 2013, they can no longer deduct prescription drug expenses for which they receive the subsidy as a cost of doing business (but they can still deduct prescription drug expenses not covered by the subsidy).
- 7 Creditable coverage refers to prescription drug benefits, through sources such as a former employer that are at least as generous as the standard Part D benefit.
- 8 Based on CMS presentations and publications (e.g., a 2007 presentation by Cynthia Tudor, Director, Medicare Drug Benefit Group, before the National Health Policy Forum; CMS Management Information Integrated Repository data as of January 2008; CMS Management Information Integrated Repository data as of February 2009; and 2010 enrollment information).
- 9 These responses are not mutually exclusive. Individuals could list both "not taking enough prescriptions" and "too expensive" as reasons for not enrolling in Part D.
- 10 Medicare allows plan sponsors to offer two types of plans that have the same average benefit value as the defined standard benefit. The first type, which CMS calls actuarially equivalent, uses the same deductible as the defined standard benefit but has different cost sharing during the plan's initial coverage phase. The second type, called basic alternative, allows insurers to use a lower deductible than the defined standard benefit, different cost sharing, and a modified initial coverage limit. Because they have the average benefit value as the defined standard benefit, in this chapter, we refer to both types as actuarially equivalent benefits.
- 11 Enhanced benefit plans that include coverage in the gap must provide coverage in the gap beyond what is required by PPACA.
- 12 Under the Part C payment system, which is used to pay MA plans, a portion (between 67 percent and 73 percent in 2012) of the difference between the plan's benchmark payment and its bid for providing Part A and Part B services is referred to as Part C rebate dollars. The rebate dollars can be used to supplement benefits or lower premiums for services provided under Part C or Part D.
- 13 Two PDPs have withdrawn from Part D since CMS released revised landscape files in October of 2012, which was used for our analysis for this chapter.
- 14 CMS allows a sponsor to offer multiple plans in any given service area only if those offerings are substantially different from one another. To be considered "substantially different," for 2013, plans must have a difference of at least \$23 per month in a beneficiary's expected monthly OOP costs between basic and enhanced plans. If a sponsor is offering two enhanced plans in the same service area, in 2013, the second enhanced plan must have a higher value than the first.

- with a difference of at least \$12 in a beneficiary's expected monthly OOP costs between the two enhanced plan offerings.
- 15 The actual cost-sharing amount for brand-name drugs will depend on the amount of dispensing fee charged by a plan since the 2.5 percent covered by the Part D benefit applies to both the ingredient cost and the dispensing fee, while the 50 percent manufacturer discount applies only to the ingredient cost.
  - 16 Prior authorization refers to requirements for preapproval from a plan before coverage. Quantity limits refer to a plan limiting the number of doses of a particular drug covered in a given time period. Under step therapy, plans require the enrollee to try specified drugs before moving to other drugs.
  - 17 Lower subsidy rates apply to higher income beneficiaries. For more information, refer to the section on enrollee premiums.
  - 18 Manufacturer discounts may also affect employers' decisions about retiree drug coverage. If an employer provides a gap coverage that wraps around the Part D benefit, the discount is calculated as 50 percent of a beneficiary's cost-sharing amount after taking into account the gap coverage offered by the employer.
  - 19 Based on CMS's estimate as of September 30, 2012.
  - 20 In 2013, three plans—CVS Caremark Value, Community CCRx Basic, and Health Net Orange Option 1 (all operated by CVS Caremark Corporation)—were consolidated into one plan to form SilverScript. In 2012, CVS Caremark Value used copays (\$6 for generics, \$45 for preferred brands, and \$95 for nonpreferred brands), while Community CCRx Basic used both copays (\$2 for generics) and coinsurance (25 percent for preferred brands and 46 percent for nonpreferred brands).
  - 21 At least 90 percent of urban beneficiaries must live within 2 miles of an in-network pharmacy, at least 90 percent of suburban beneficiaries must live within 5 miles, and at least 70 percent of rural beneficiaries must live within 15 miles.
  - 22 Several plans report having preferred pharmacies in their network, but they either consider all in-network pharmacies as preferred or have no cost-sharing differential between preferred and nonpreferred pharmacies.
  - 23 Cost-sharing amounts are for region 12 (Alabama–Tennessee region), with the exception of one plan that was offered only in region 11 (Florida). Plans have slight differences in cost sharing from region to region.
  - 24 An individual NDC uniquely identifies the drug's labeler, drug, dosage form, strength, and package size. Because each specific drug often is available in different dosages, strengths, and package sizes, the same drug typically has many different NDCs.
  - 25 For this index, Acumen grouped NDCs that are pharmaceutically identical, aggregating prices across drug trade names, manufacturers, and package sizes. As a result, brand-name drugs are grouped with their generics if they exist, and the median price more closely reflects the degree to which market share has moved between the two.
  - 26 Because most biologics are injected or infused directly into the patient, they are more likely to be covered under Medicare Part B. Consequently, biologics account for a relatively small share of gross Part D spending. Based on the Commission's analysis of 2007 Part D data, spending on biologics totaled approximately \$3.9 billion, or about 6 percent of gross Part D spending.
  - 27 An antineoplastic drug (Armidex) with about 20 percent market share lost its patent in the summer of 2010. As a result, the price index that takes into account generic substitution dropped during the latter half of 2010 but does not appear to have significantly affected the price index measured at the individual NDC level.
  - 28 The Commission's estimate of the share of enrollees who voluntarily switched plans may not be directly comparable to the 6 percent reported by CMS because of methodological differences.

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