Advising the Congress on Medicare issues

Status report on Part D, with focus on beneficiaries with high drug spending

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Medicare beneficiaries' access to prescription drug benefits in 2011

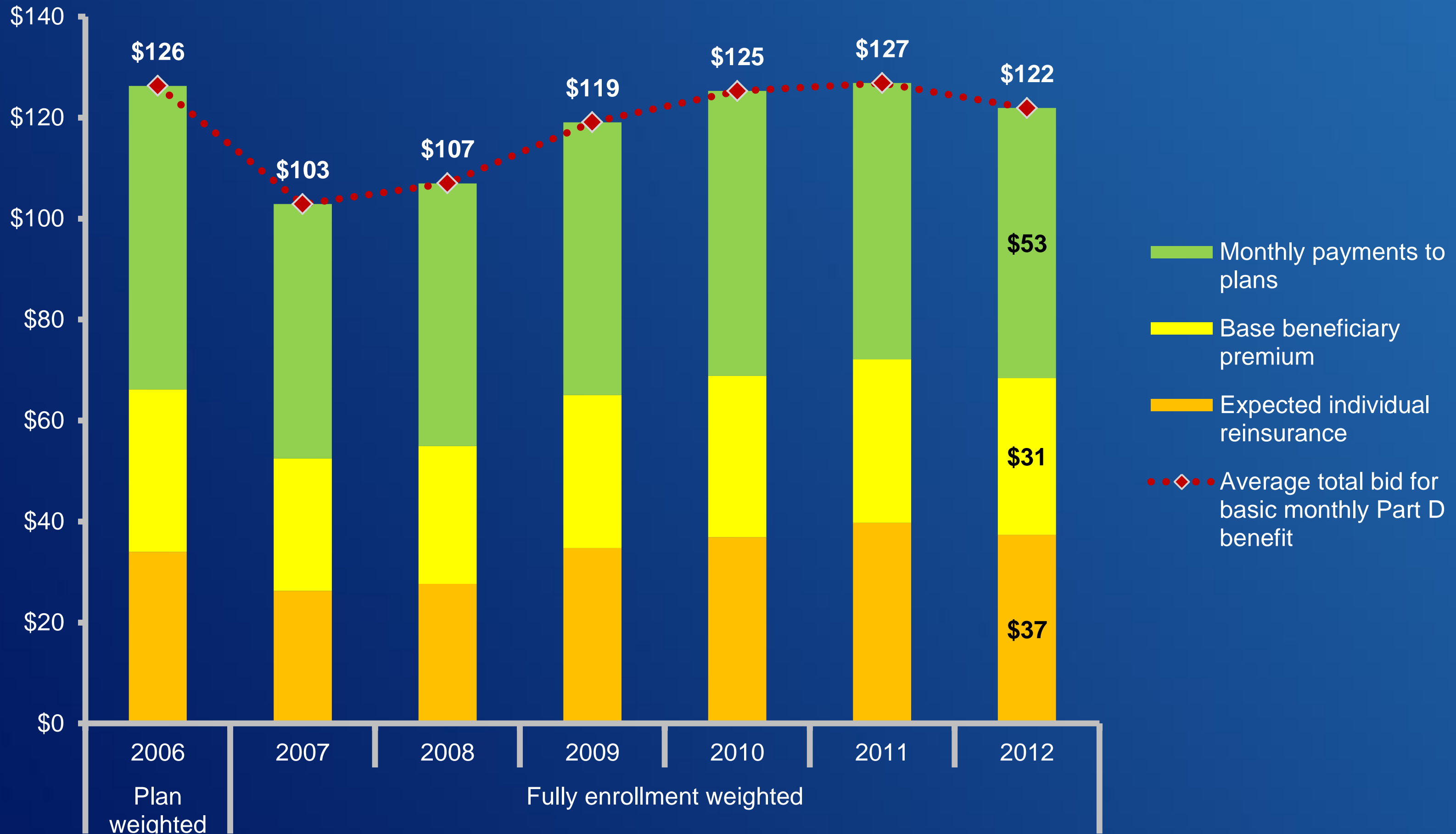
- Beneficiaries appear to have good access to prescription drugs
  - All individuals have access to many Part D plans
  - Many continue to receive coverage through former employers
- Survey indicates Part D enrollees are generally satisfied

Part D enrollment and plan offerings, 2011-2012

- Patterns of Part D enrollment similar to previous years
  - About 2/3 in stand-alone PDPs, 1/3 in MA-PDs
  - 80% of LIS enrollees are in PDPs
  - More MA-PD enrollees have enhanced benefits (e.g., coverage in the gap)
- About the same number of plans available in 2012
- Fewer PDPs offering gap coverage than in 2011
  - Gradual phase-out of the coverage gap will make this less important over time

MEDPAC Source: MedPAC based on of CMS landscape and plan report files and enrollment data.

Lower bids for basic Part D benefits in 2012



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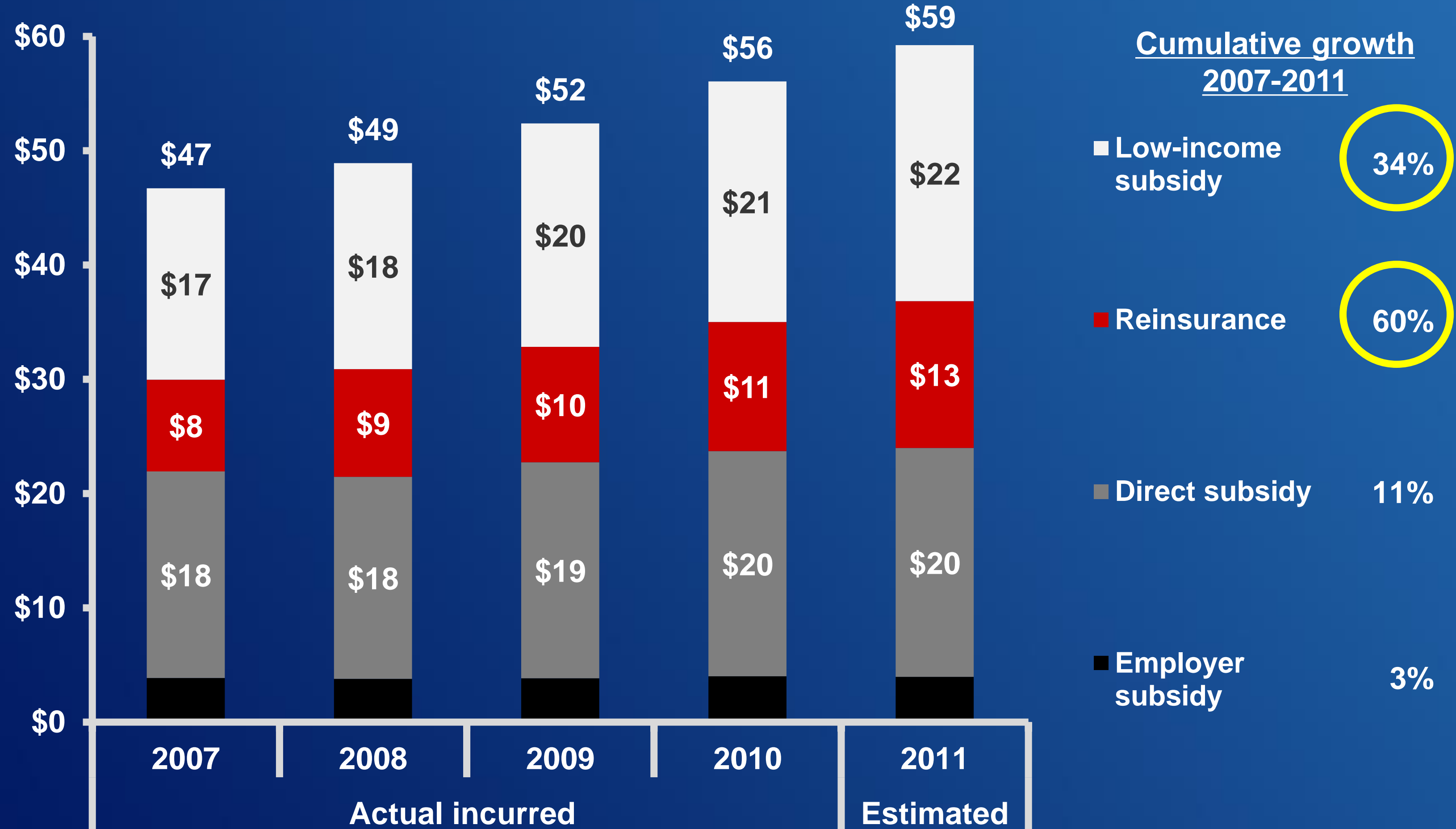
Source: MedPAC based on CMS releases of Part D national average monthly bid amounts and base beneficiary premiums for 2006 through 2012.

LIS and reinsurance payments have grown much faster than direct subsidy payments



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Note: Totals may not sum to 100 percent due to rounding.

Source: MedPAC based on Table IV.B.10 of the Medicare Board of Trustees' report for 2011.

Key findings from the analysis of high-cost beneficiaries

- Characteristics of high-cost beneficiaries
  - Majority receive Part D's low-income subsidy
  - Fill more prescriptions and spend more per prescription
  - Use more brand-name drugs
- Structure LIS cost sharing to encourage beneficiaries to choose generic drugs when available
  - Reduction in program spending
  - Should not affect access to needed medications

The role of low-income cost-sharing subsidy

Hypothetical plan A	Cost sharing	Non-LIS beneficiary	LIS beneficiary*	
		OOP	OOP	LIS program
Tier1: generic drugs	$7	$7	$1.10	$5.90
Tier 2: preferred brand-name drugs	$40	$40	$3.30	$36.70
Tier 3: other brand-name drugs	$80	$80	$3.30	$76.70
Tier 4: specialty drugs	30%	30% of the cost	$3.30	30% of the cost minus $3.30

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*Copay amounts are for 2011, and applies to non-institutionalized LIS beneficiaries with incomes at or below 100% of poverty.

LIS beneficiaries take more drugs and spend more per prescription, 2009

DATA ARE PRELIMINARY AND SUBJECT TO CHANGE

	LIS beneficiaries		Non-LIS beneficiaries	
# of beneficiaries, millions	10.9	(38%)	17.8	(62%)
Aggregate utilization:				
Gross drug spending, billions	$40.5	(55%)	$33.2	(45%)
# of prescriptions, millions	597	(45%)	740	(55%)
Average # of prescriptions per beneficiary per month	5.0		3.6	
Average spending per prescription	$68		$45	

Note: Prescription standardized to a 30-day supply.

Source: MedPAC analysis of 2009 Part D prescription drug event data and MBD/CMS Medicare Entitlement file.

Generic use tends to be lower for LIS beneficiaries, 2009

DATA ARE PRELIMINARY AND SUBJECT TO CHANGE

% generic prescriptions by therapeutic classes	LIS beneficiaries	Non-LIS beneficiaries	Percentage point difference (LIS – non-LIS)
Antihyperlipidemics	56%	63%	-7
Diabetic therapy	53%	67%	-14
Antihypertensive therapy agents	70%	73%	-3
Peptic ulcer therapy	66%	76%	-10
Asthma/COPD therapy agents	11%	6%	5
Antidepressants	74%	80%	-6
Calcium & bone metabolism regulator	53%	63%	-8
Total, all therapeutic classes	68%	72%	-4

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Note: COPD (chronic obstructive pulmonary disease). Components may not sum due to rounding. Therapeutic classification based on the First DataBank Enhanced Therapeutic Classification System 1.0. Prescriptions standardized to a 30-day supply.

Source: MedPAC analysis of 2009 Part D prescription drug event data and Part D denominator file.

Providing stronger incentive to use generics when available

- Use cost differential to make generic drugs relatively more attractive
  - Ensure access to needed medications
  - Take into account variations in plan formulary structures
- Cost-sharing policy would not apply to dual-eligibles residing in institutions (about 13% of LIS enrollees)
- Provide incentives to plans to encourage their enrollees to use generic drugs

Example of a change to LIS cost-sharing structure to encourage generic drug use

Drug class with generic substitute(s)	
Current LIS cost-sharing	
Generic drug	$1.10
Brand drug A	$3.30
Brand drug B	$3.30
Alternative LIS cost-sharing	
Generic drug	$0
Brand drug A	$6.00
Brand drug B	$6.00

- No change in cost-sharing amounts for drugs in a class with no generic substitutes.

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Notes: N/A (not applicable). *Copay amounts are for 2011, and applies to non-institutionalized LIS beneficiaries with incomes at or below 100% of poverty.

Examples of effects of higher generic use by LIS enrollees subject to copays in 2009

- Antihyperlipidemics ($2.2 billion in spending)
  - $1.8 billion (83%) for brands
  - An increase in GDR to 63% (GDR for non-LIS enrollees) would reduce:
    - Spending for Low-income cost-sharing subsidy by over 10% (> $100 million)
    - Plan costs by over 10% (> $100 million)
- For 7 of the top 15 classes by spending ($12.8 billion, or 40% of spending)
  - Reduce Part D spending by over 10 percent (> $1.3 billion) if generic use increased to non-LIS level
- Lower Part D spending would:
  - Lower payments for low-income cost-sharing subsidy
  - Lower bids (direct subsidy payments) and beneficiary premiums
  - If fewer beneficiaries reach the catastrophic phase, it would lower payments for individual reinsurance

Issues for discussion

- What cost-sharing amounts are appropriate for people with limited incomes?
- Are there other (non-financial) ways to encourage the use of generic drugs?
- Next step:
  - The next draft will have additional information on plan formularies, drug prices, and quality ratings.

Policy option

- Modify Part D copayment amounts specified in law for Medicare beneficiaries with incomes at or below 135 percent of poverty to further encourage the use of generic drugs when available in a given therapeutic class.
- Secretarial review of the therapeutic classes periodically to determine an appropriate classification for implementing the policy.