

Access to Pharmaceuticals Under Part D

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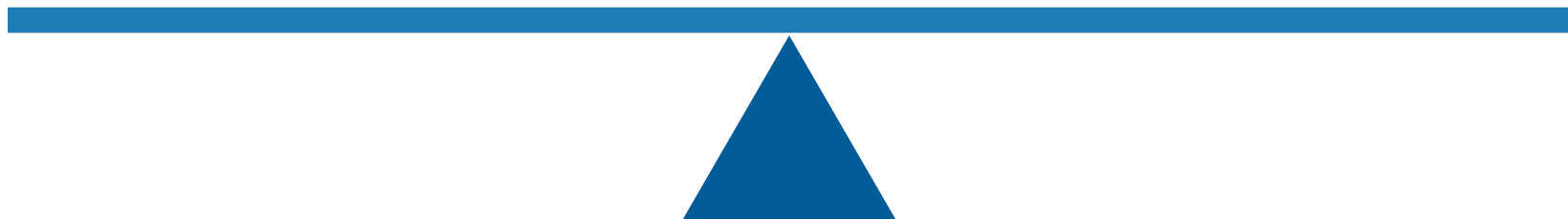
Competing Goals: Access and Cost Control

“CMS seeks to implement a strategy to ensure that formularies and pharmacy benefit management are consistent with effective practices in drug benefit management today.”

- CMS Strategy for Affordable Access to Comprehensive Drug Coverage 2006

Cost Control

Access



Plan Sponsors Took Advantage of Flexibility in Statute and Regulations

- 9% of PDPs and 13% of MA-PD plans offer the standard benefit
- 66% of PDPs and 76% of MA-PD plans offer a \$0 or reduced deductible
- 15% of PDPs and 24% of MA-PD plans offer coverage in the gap
- 99% of Part D plans use multiple cost-sharing tiers – 4-tier benefit structures are most common
- 48% of PDPs and 56% of MA-PD plans use a specialty tier
- Formulary size varies from 1,017 to 5,398 for PDPs and 756 to 8,461 for MA-PD plans
- Plans generally complied with the “all or substantially all” mandate for 6 protected classes, but 5 of these classes are still subject to prior authorization or step therapy restrictions
- It is as yet unclear how stringently plans are applying their appeals and exceptions criteria

Coverage Gap in The Press



"Medicare: Americans falling into cost gap"

- Jonathan Ellis, August 3, 2006



"Health Costs: Dodge the Doughnut Hole"

- Laurie McGinley, August 27, 2006



"More patients fall into a hole in drug benefit"

- Richard Wolf, August 26, 2006



"Medicare drug coverage gap leaves many seniors broke, or skipping medication"

- Monica Hatcher, August 6, 2006



"Medicare Beneficiaries Confused and Angry Over Gap in Drug Coverage"

- Robert Pear, July 30, 2006



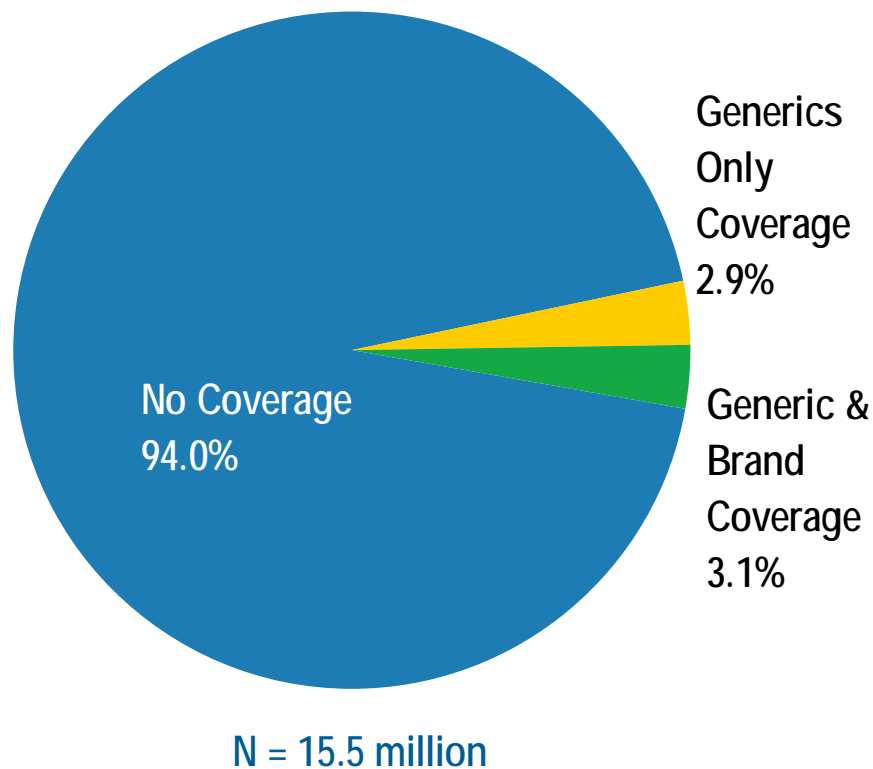
"Millions of Seniors Facing Medicare 'Doughnut Hole'"

- Christopher Lee and Susan Levine, September 25, 2006



Most PDP Enrollees Have No Gap Coverage

Percent of Enrollment in PDPs Offering Coverage in the Gap



Most PDPs did not offer coverage in the gap; plans that did had higher premiums

Example:

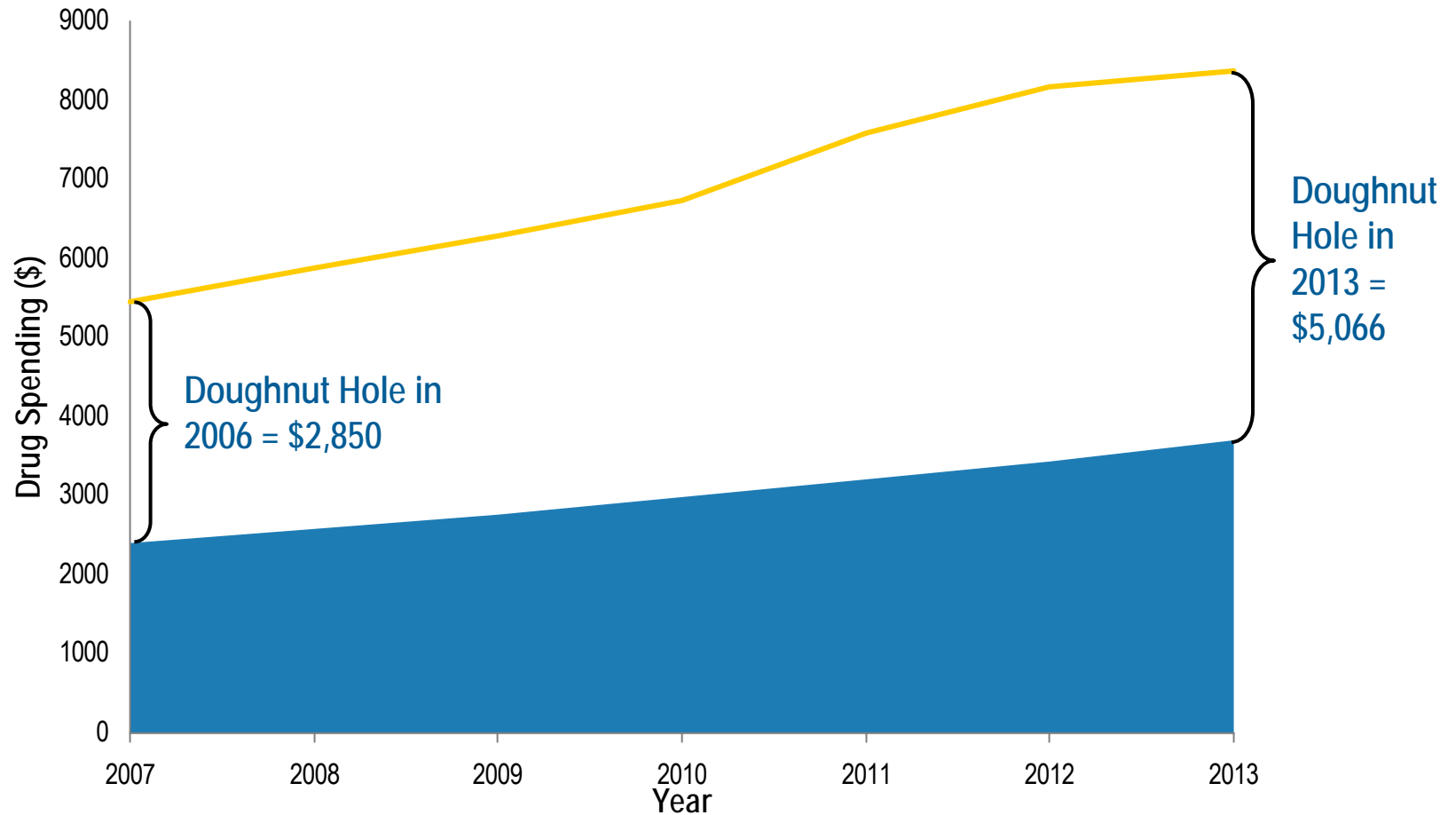
Humana Standard (\$1.87 – \$17.06)

Humana Complete (\$38.70 - \$73.17)

Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Plan benefit and formulary design data from April 2006. Enrollment data from July 2006. Analysis excludes lives in PDPs with fewer than 10 enrollees, lives in employer/union only Part D plans, and lives in the U.S. territories.



Size of Coverage Gap Increases Dramatically Over Time

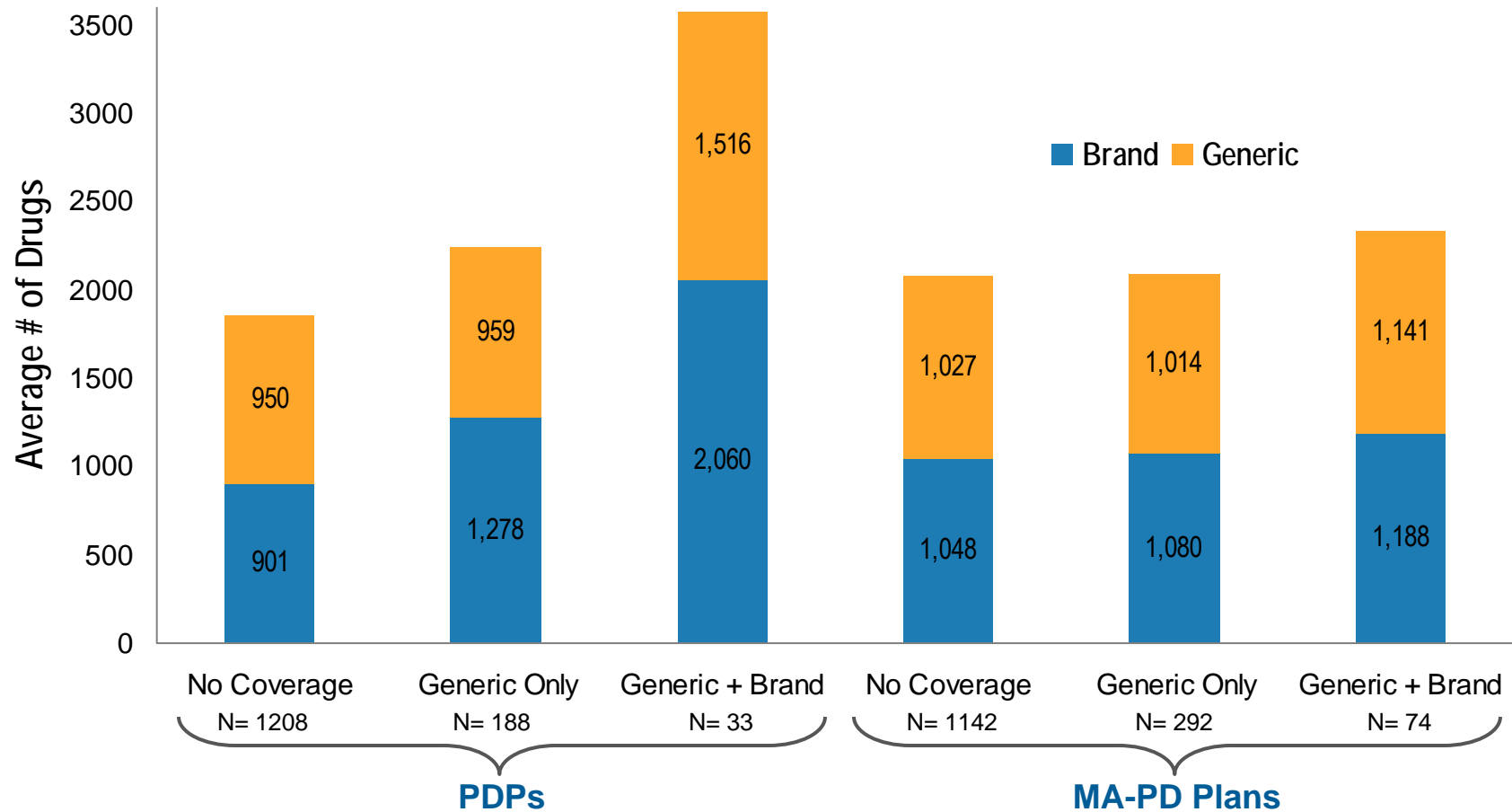


*Assumes that growth in drug costs significantly exceeds CPI.

Source: 2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table V.C2., p. 165.



Plans With Gap Coverage Have Larger Formularies

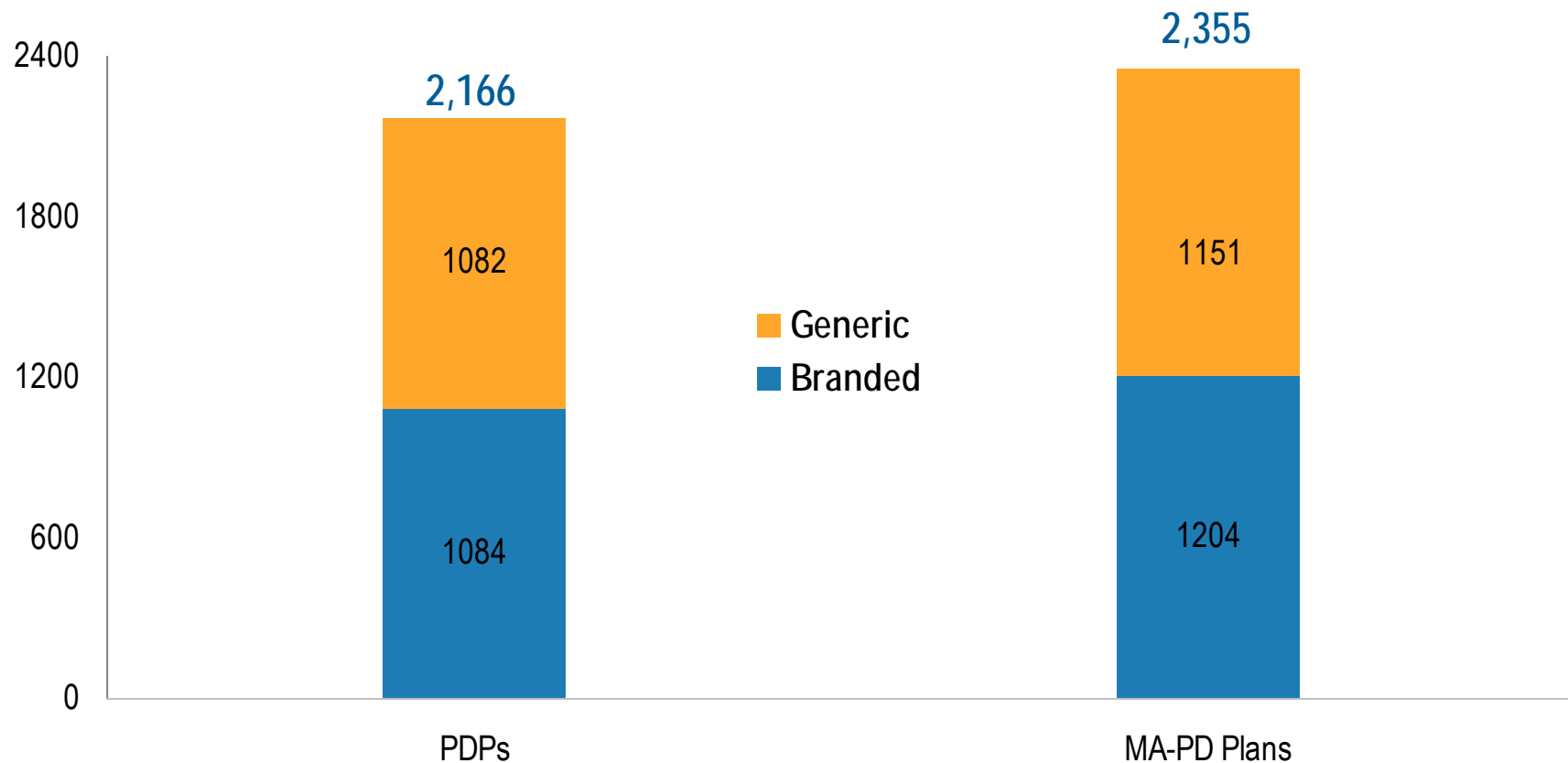


Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Data from February 2006.



On Average, Part D Plans Cover 2,263 Drugs

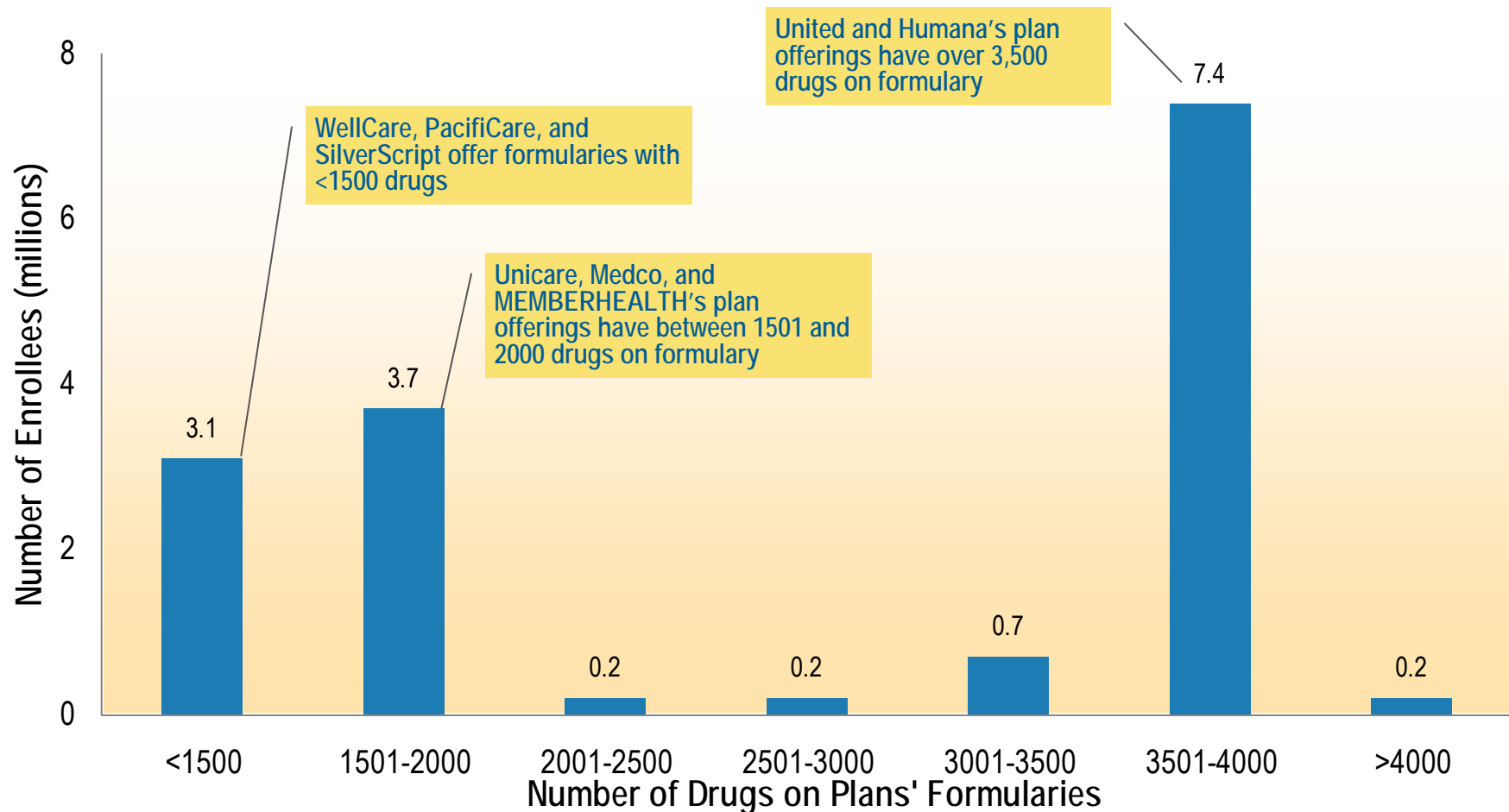
On average, MA-PD plans cover slightly more drugs than PDPs. For both plan types, branded products make up over half of the formulary.



Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features.
Data from July 27, 2006.



Plans With Robust Formularies Captured a Significant Portion of PDP Lives



Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Plan benefit and formulary design data from April 2006. Enrollment data from July 2006. Analysis excludes lives in PDPs with fewer than 10 enrollees, lives in employer/union only Part D plans, and lives in the U.S. territories.



Utilization Management in Part D



PDPs Use Utilization Management Techniques At Higher Rates than MA-PD Plans Do

	PDPs		MA-PD Plans	
	Number of Drugs	Percentage of Drugs	Number of Drugs	Percentage of Drugs
Total Drugs Covered	2166	100%	2355	100%
Prior Authorization	211	10%	186	8%
Quantity Limits	229	11%	175	7%
Step Therapy	12	<1%	14	<1%

At least 11% of drugs are subject to a utilization management tool in PDPs

Step therapy is used sparingly by both PDPs and MA-PD plans

Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Data from July 27, 2006.



4-Tier Structures Most Common Among Part D Plans— More Than Is Typical in Commercial Plan Designs

Number of Tiers in Plan	PDPs		MA-PD Plans	
	Number of Plans	Percentage of Plans	Number of Plans	Percentage of Plans
1 Tier	13	<1%	30	2%
2 Tiers	110	8%	256	17%
3 Tiers	535	37%	222	15%
4 Tiers	500	35%	783	52%
5 Tiers	270	19%	198	13%
6 Tiers	1	<1%	11	<1%
7 Tiers	0	0%	5	<1%
8 Tiers	0	0%	4	<1%

Four tier structures most common among Part D plans

PDPs have between 1 and 6 tiers

- Average 3.6 tiers

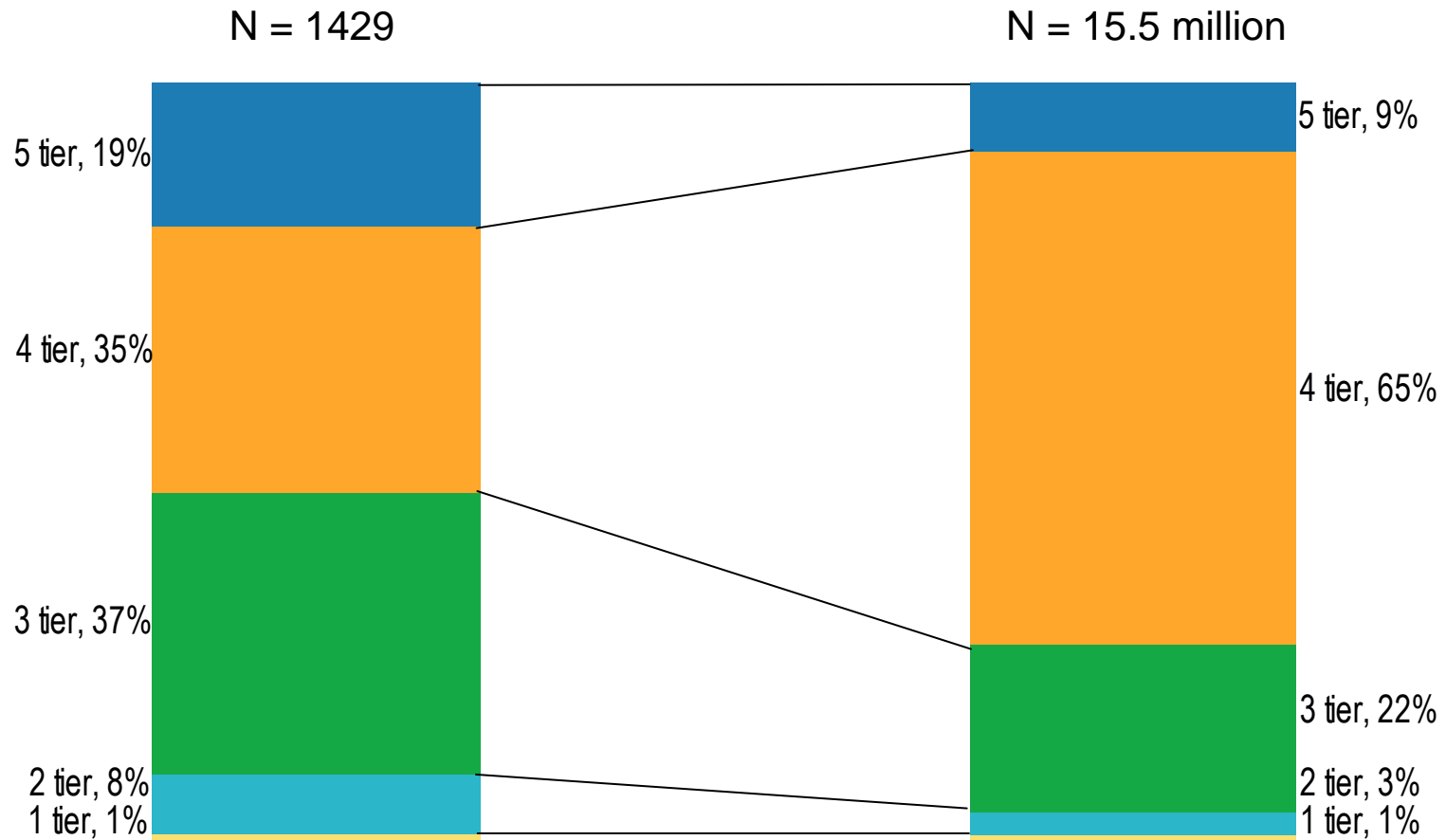
MA-PD plans have up to 8 tiers

- Average 3.6 tiers

Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Data from July 27, 2006.



Most Beneficiaries in PDPs Are in Plans With Four or More Tiers



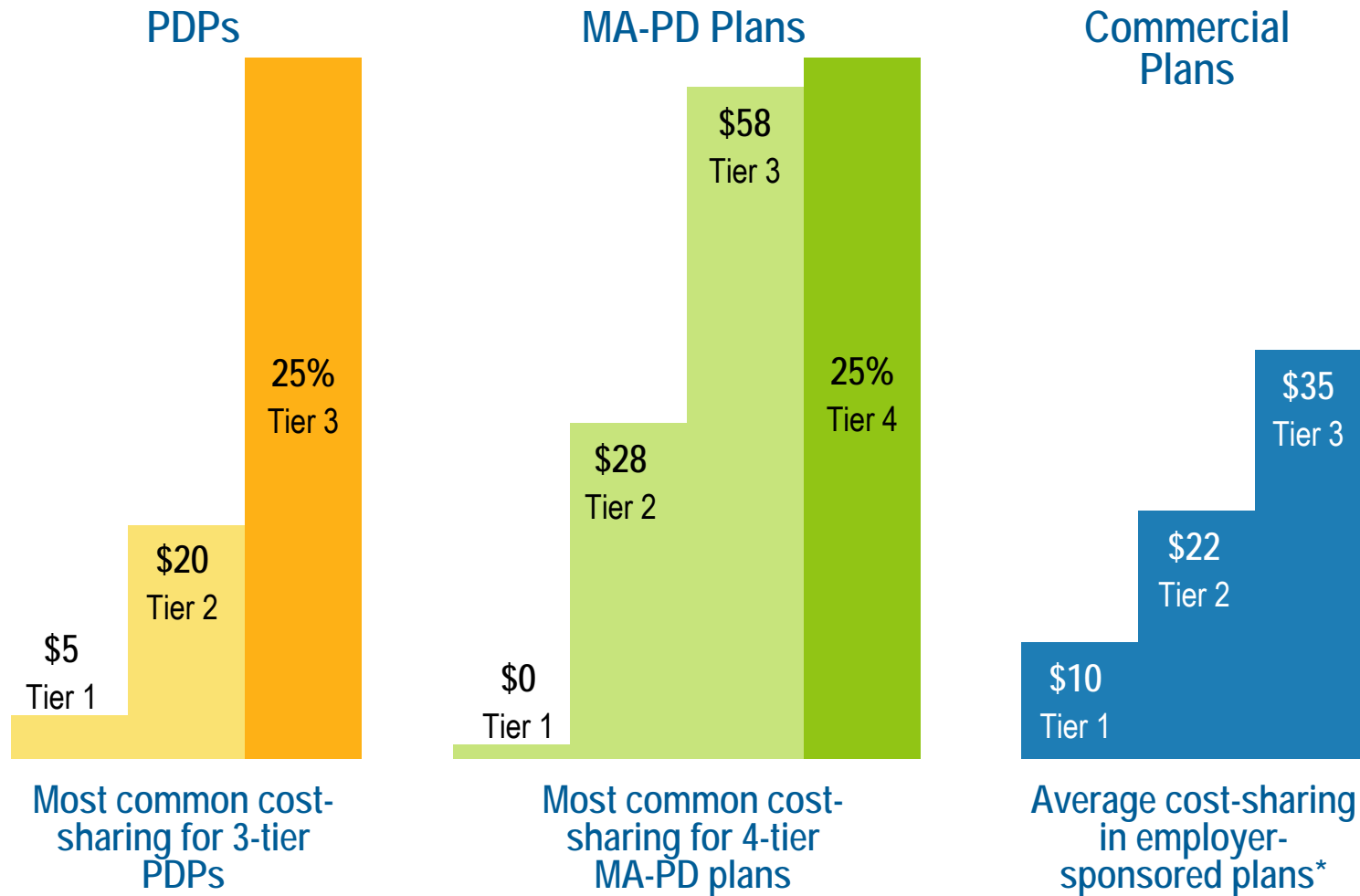
Percent of PDPs With Different Tiering Structures

Percent of Enrollment in PDPs With Different Tiering Structures

Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Plan benefit and formulary design data from April 2006. Enrollment data from July 2006. Analysis excludes lives in PDPs with fewer than 10 enrollees, lives in employer/union only Part D plans, and lives in the U.S. territories.



Part D Plans Tend to Have Larger Spreads Between Cost-Sharing Requirements on the First and Second Tiers



Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Data from July 27, 2006.

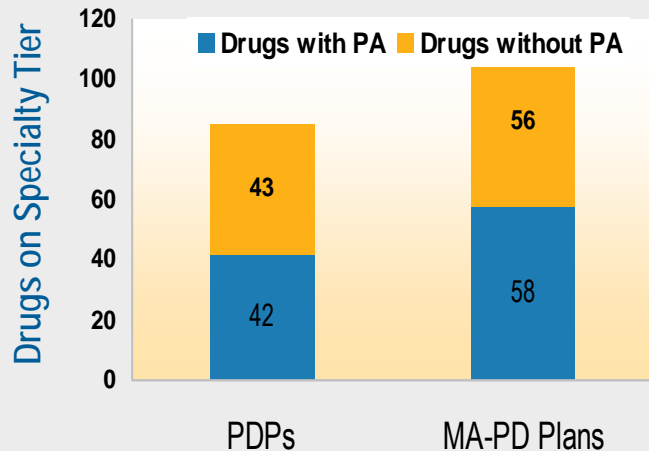
* Kaiser Family Foundation. Employer Health Benefits. 2005 Annual Survey.



Average Specialty Tier Holds 4-6% of Covered Drugs

- Plans typically place fewer than 200 drugs on specialty tier
 - » PDPs place 4% of covered drugs
 - » MA-PD plans place 6% of covered drugs
 - » But, a few plans place drugs on specialty tier at over twice this rate

Treatment of Drugs on Specialty Tiers



- Average number of drugs on specialty tier = 100
- Drugs on specialty tiers have higher cost-sharing and higher rates of prior authorization relative to the rest of plans' formularies
- An average of 8 specialty tier drugs are subject to quantity limits on PDP formularies, and 13 on MA-PD plan formularies.

20 Most Common Drugs Found on Specialty Tiers

Cancer

Neupogen
Tarceva
Intron-A
Gleevec
Sandostatin

Multiple Sclerosis

Avonex
Copaxone
Betaseron

Rheumatoid Arthritis

Humira
Remicade
Enbrel

Anemia

Procrit
Aranesp

Hep C

Peg-Intron
Pegasys
Intron-A

Other

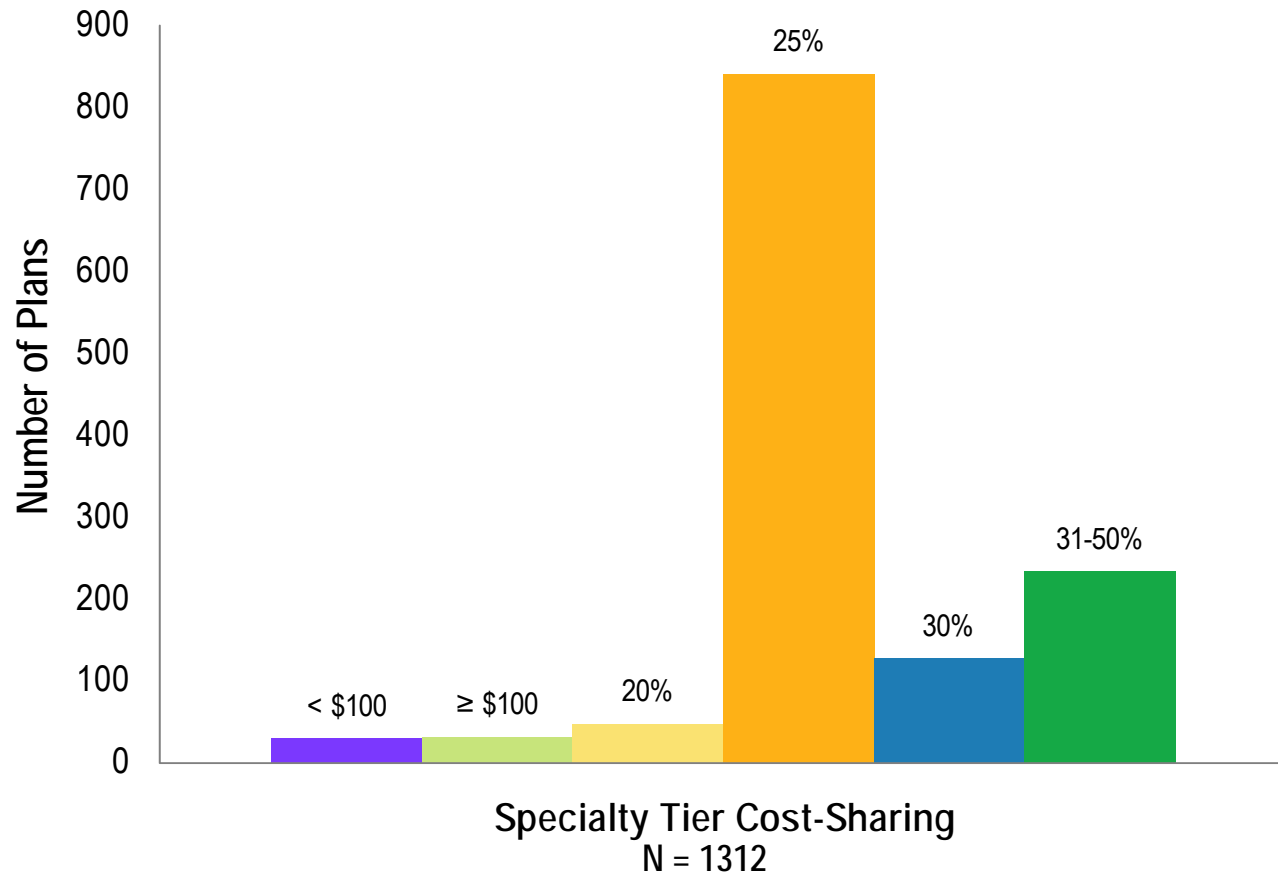
Fabrazyme
Fuzeon
Cerezyme
Tracleer

These drugs are on over 70% of specialty tiers

Many drugs found on specialty tiers are eligible for Part B coverage in certain situations

Very few drugs found on specialty tiers are generics

Cost-Sharing on Specialty Tiers Typically Is High



Almost all plans use percentage coinsurance on specialty tier

Fewer than 5% of plans use copays

MA-PD plans are more likely to use copays

Most plans without specialty tiers use flat copays on every tier, with highest tier at \$25-60

Coverage of the Protected Classes in Part D

	On Formulary	% with PA	% with QL	Most Common Cost-sharing
HIV/AIDS	100%	0%	4%	\$20-30
Antidepressants	76%	3%	37%	\$20-30
Antipsychotics	100%	15%	37%	\$20-30
Antineoplastics	75%	10%	4%	\$20-30

Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Data from April 2006.



■■■ Cost-Sharing Case Study: Cancer

- Wide variation in out-of-pocket spending, depending on type of cancer diagnosis and drug regimen prescribed
- Part D low income subsidies are highly beneficial for those who qualify
- Part B supplemental coverage important protection – does not exist for Part D out-of-pocket costs
- Since beneficiaries most likely are not choosing plans based on expectation of cancer diagnosis, they may be “stuck” with high cost-sharing if they are diagnosed mid-year and are enrolled in a plan without gap coverage



Access in Part D: 2007 and Beyond

- Lower base beneficiary premium in 2007, but premium increases expected over time
- Plan participation relatively stable in 2007 but market consolidation expected in future
- Diminishing variability in benefit design
- Increasing utilization management
- Continued importance of generics
- Increasing cost-sharing
- “Feedback loop” between commercial and Part D benefit structures



Access Questions For The Future

- Did beneficiaries choose the “optimal” plan for them?
- What effect will the November 2006 and November 2008 elections have on the stability of Part D?
- What effect is Part D having on access to drugs for duals, LTC residents, and other Medicare subpopulations?