Access to Pharmaceuticals Under Part D

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“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
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

- No Coverage: 94.0%
- Generics Only Coverage: 2.9%
- Generic & Brand Coverage: 3.1%

N = 15.5 million

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

*Doughnut Hole in 2006 = $2,850*

*Doughnut Hole in 2013 = $5,066*

*Assumes that growth in drug costs significantly exceeds CPI.
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, 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

<table>
<thead>
<tr>
<th></th>
<th>PDPs</th>
<th>MA-PD Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number of Drugs</td>
<td>Percentage of Drugs</td>
</tr>
<tr>
<td><strong>Total Drugs Covered</strong></td>
<td>2166</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Prior Authorization</strong></td>
<td>211</td>
<td>10%</td>
</tr>
<tr>
<td><strong>Quantity Limits</strong></td>
<td>229</td>
<td>11%</td>
</tr>
<tr>
<td><strong>Step Therapy</strong></td>
<td>12</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>

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

Four tier structures most common among Part D plans

<table>
<thead>
<tr>
<th>Number of Tiers in Plan</th>
<th>PDPs</th>
<th>MA-PD Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Plans</td>
<td>Percentage of Plans</td>
<td>Number of Plans</td>
</tr>
<tr>
<td>1 Tier</td>
<td>13</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>2 Tiers</td>
<td>110</td>
<td>8%</td>
</tr>
<tr>
<td>3 Tiers</td>
<td>535</td>
<td>37%</td>
</tr>
<tr>
<td>4 Tiers</td>
<td>500</td>
<td>35%</td>
</tr>
<tr>
<td>5 Tiers</td>
<td>270</td>
<td>19%</td>
</tr>
<tr>
<td>6 Tiers</td>
<td>1</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>7 Tiers</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>8 Tiers</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Tier Type</th>
<th>Percent of PDPs</th>
<th>Percent of Enrollment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5 tier</td>
<td>19%</td>
<td>9%</td>
</tr>
<tr>
<td>4 tier</td>
<td>35%</td>
<td>65%</td>
</tr>
<tr>
<td>3 tier</td>
<td>37%</td>
<td>22%</td>
</tr>
<tr>
<td>2 tier</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>1 tier</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

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

- **PDPs**
  - Tier 1: $5
  - Tier 2: $20
  - Tier 3: 25%

- **MA-PD Plans**
  - Tier 1: $0
  - Tier 2: $28
  - Tier 3: $58
  - Tier 4: 25%

- **Commercial Plans**
  - Tier 1: $10
  - Tier 2: $22
  - Tier 3: $35

Most common cost-sharing for 3-tier PDPs

Most common cost-sharing for 4-tier MA-PD plans

Average cost-sharing in employer-sponsored plans*

Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features.

Data from July 27, 2006.

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.

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

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

Source: Avalere Health analysis using DataFrame™, a proprietary database of Medicare Part D plan features. Data from February 2006.
## Coverage of the Protected Classes in Part D

<table>
<thead>
<tr>
<th>Class</th>
<th>On Formulary</th>
<th>% with PA</th>
<th>% with QL</th>
<th>Most Common Cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV/AIDS</td>
<td>100%</td>
<td>0%</td>
<td>4%</td>
<td>$20-30</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>76%</td>
<td>3%</td>
<td>37%</td>
<td>$20-30</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>100%</td>
<td>15%</td>
<td>37%</td>
<td>$20-30</td>
</tr>
<tr>
<td>Antineoplastics</td>
<td>75%</td>
<td>10%</td>
<td>4%</td>
<td>$20-30</td>
</tr>
</tbody>
</table>

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
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?