Medicare Prescription Drug Benefit Symposium

Specialty Tier Overview and Analyses

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Discussion Topics

- Specialty Tier Overview
- Specialty Tier Analyses
  - Analysis of Specialty Tier Utilization and Expenditures
  - Analysis of Out-of-Pocket Costs

Specialty Tier Overview

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- What is the Specialty Tier?
  - Part D formulary tier designated for high cost drugs
  - Current eligibility threshold limit of $600/month
  - Exempt from tiering exceptions

- Purpose of the Specialty Tier
  - Limit the cost sharing of high cost medications to the standard benefit
  - Allow plans to appropriately project drug costs and calculate risk
  - Allow for lower cost shares of non-specialty tier drugs
  - Promote a tiered copay structure for remaining brands

- Formulary Review Process
  - 3 Stages of Review
    - Stage 1: Includes evaluation of Categories and Classes, Six Classes of Clinical Concern, Common Medicare Drugs
    - Stage 2: Formulary Tier Review
      - Evaluate proposed specialty tier drugs for appropriateness
        - Part D plan negotiated price must be ≥ $600 per month
        - Split-tiering may occur for different strengths of a drug
    - Stage 3: Remaining Stage 1 and 2 Issues
      - Evaluate justifications for specialty tier placement
      - Evaluate additions to the specialty tier for appropriateness

- Common Specialty Tier Categories
  - Antineoplastics
    - Molecular Target Inhibitors
      - e.g. Gleevec [AWP ~$3,400-8,200/month]
  - Antivirals
    - Anti-HIV Agents
      - e.g. Fuzeon [AWP ~$2,800/month]
  - Immunological Agents
    - Immune Suppressants
      - e.g. Enbrel [AWP ~$1,800/month]

- Specialty Tier Drug vs. Specialty Product
  - Specialty tier placement for Part D is based solely on drug cost
  - Specialty product designation may relate to aspects such as:
    - Drug handling (e.g. special handling requirements for safety)
    - Drug distribution (e.g. restricted to certain facilities or physicians)
    - Drug manufacturing (e.g. biologics)
  - Part D analyses exclude specialty products covered by Part B

Specialty Tier Analyses

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Methodology

Data Sources

- 2006 Standard Analytical File (SAF) of PDE Data and 2007 PDE Data
- Medicare Beneficiary Database (MBD)
- 2006 and 2007 Part D Plan Benefit and Formulary Information
- Database of drug information derived from Medi-Span and First DataBank

Methodology (continued)

- Identified reference NDCs for 2007 specialty tier products using approved Part D sponsor formularies and plan benefit package information
- Created a specialty tier NDC dataset by using Medi-Span and First DataBank to map specialty tier reference NDCs to all possible NDCs
- Identified specialty tier products in 2006 and 2007 PDE data using NDCs from the specialty tier NDC dataset

Methodology (continued)

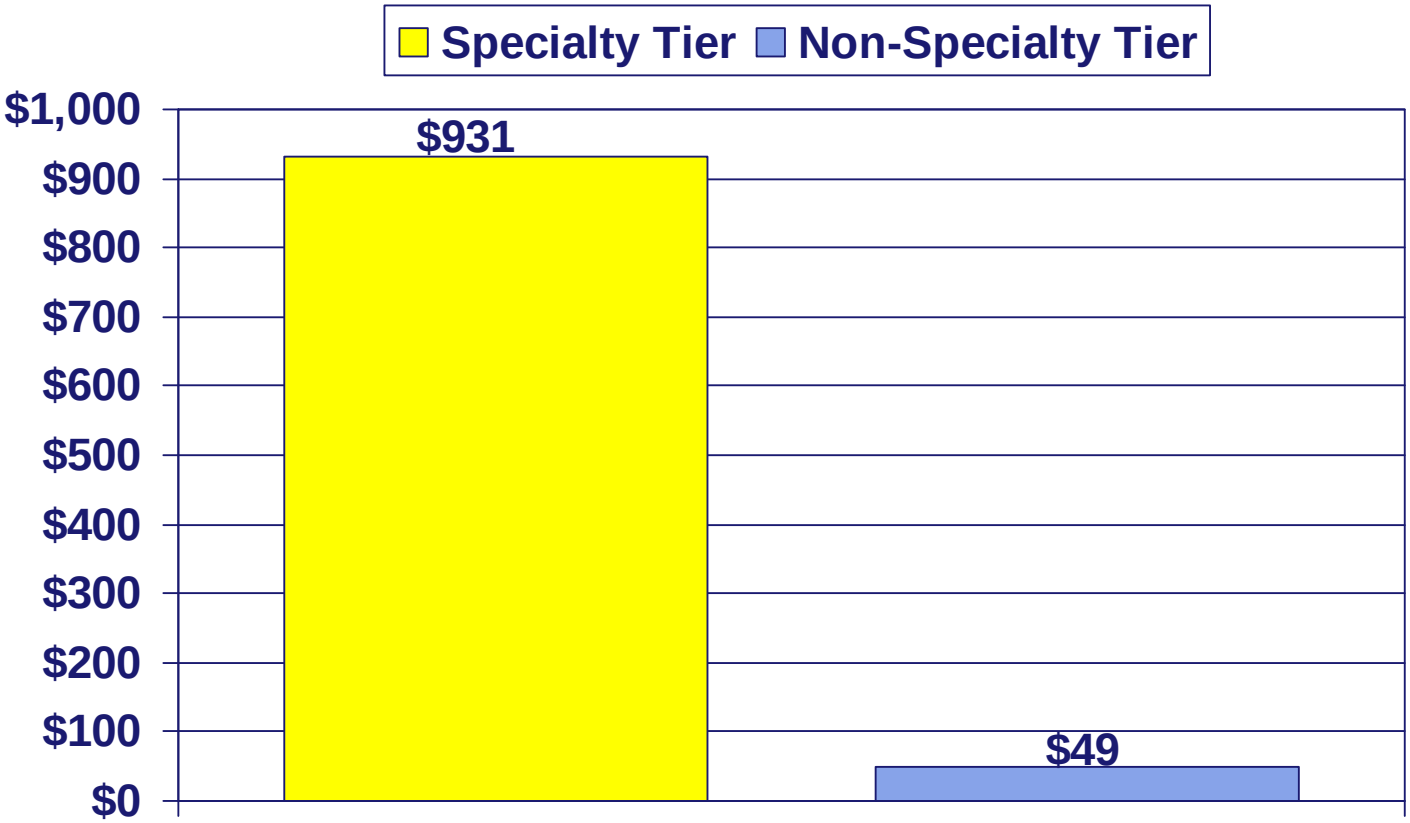
- PDE data
  - Broken out by beneficiary type (Non-LIS and LIS)
  - Used to determine the following for specialty and non-specialty tier products:
    - Number of 30-day prescription equivalents
      - Claims with > 1 month's supply/30 = # prescription equivalents
      - Claims with ≤ 1 month's supply = 1 prescription equivalent
    - Total gross drug costs
    - True Out-of-Pocket (TrOOP) costs (pre and post catastrophic)
    - Beneficiary Out-of-Pocket costs (pre and post catastrophic)
  - Used to identified the number of distinct beneficiaries who utilized a specialty tier product
    - Specialty Tier User: beneficiary enrolled at any time with at least one PDE record for a specialty tier drug

Analysis of Specialty Tier Drug Utilization and Expenditures

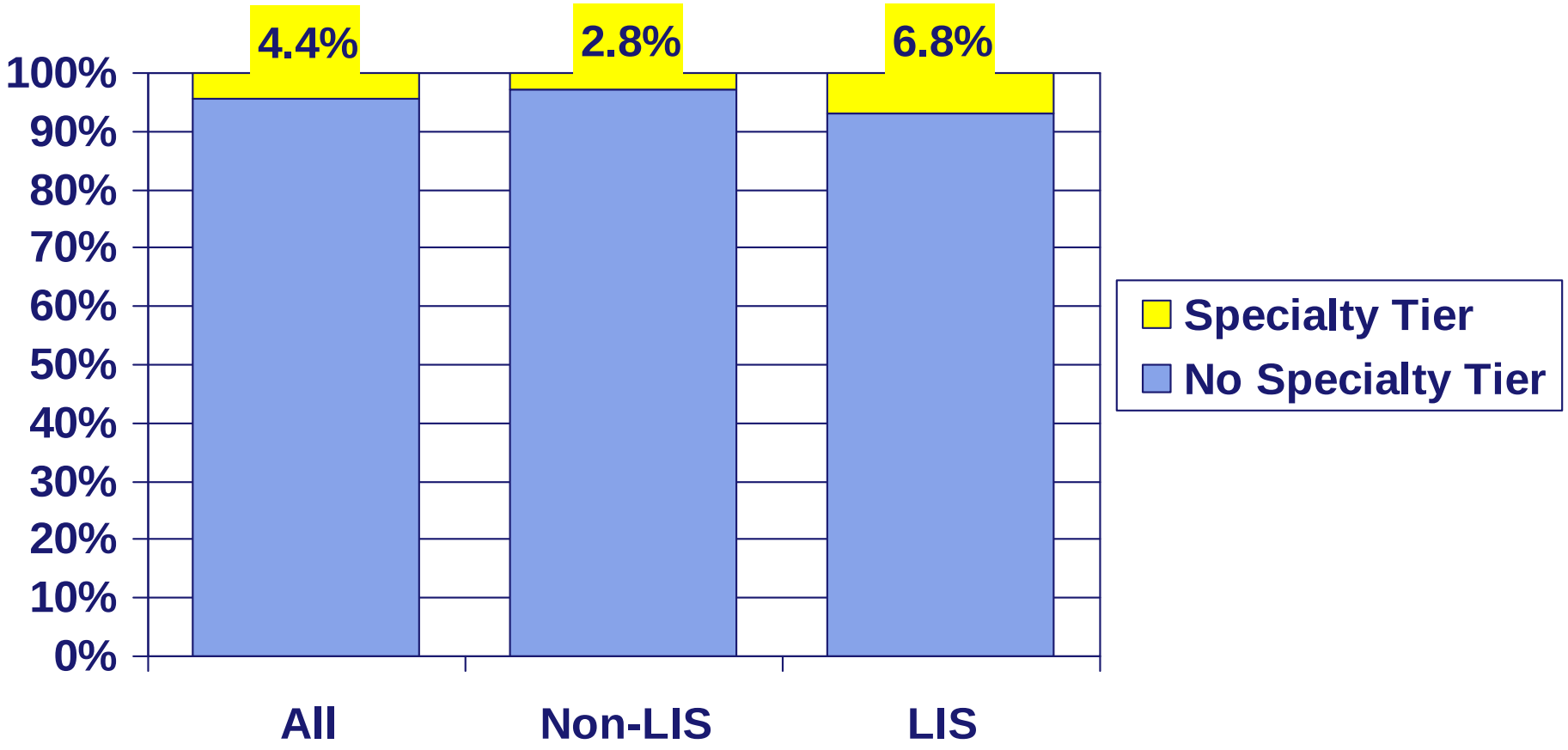
Utilization and Expenditure of Specialty Tier Drugs

- Overall only 4.4% of beneficiaries used specialty tier drugs in 2007.
  - 61% of beneficiaries using specialty tier drugs were LIS
- Specialty tier drugs represented only 0.6% of all 30-day prescription equivalents in 2007.
  - 72% of specialty tier 30-day prescription equivalents were for LIS beneficiaries
- Expenditures for specialty tier drugs in 2007 accounted for 9.5% of total gross drug costs.

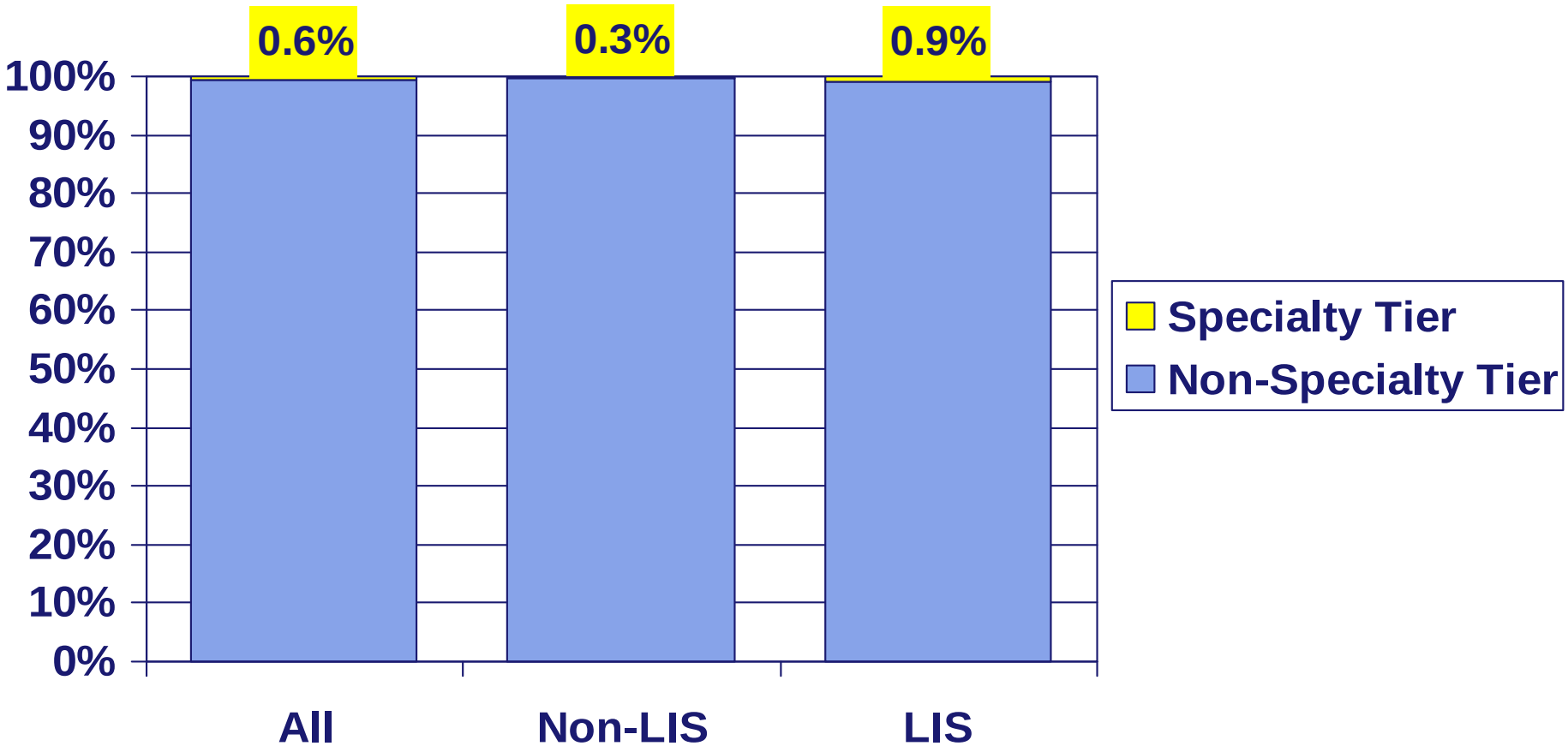
Average Cost of 30-day Prescription Equivalents for Specialty Tier vs. Non-Specialty Tier Drugs (2007)



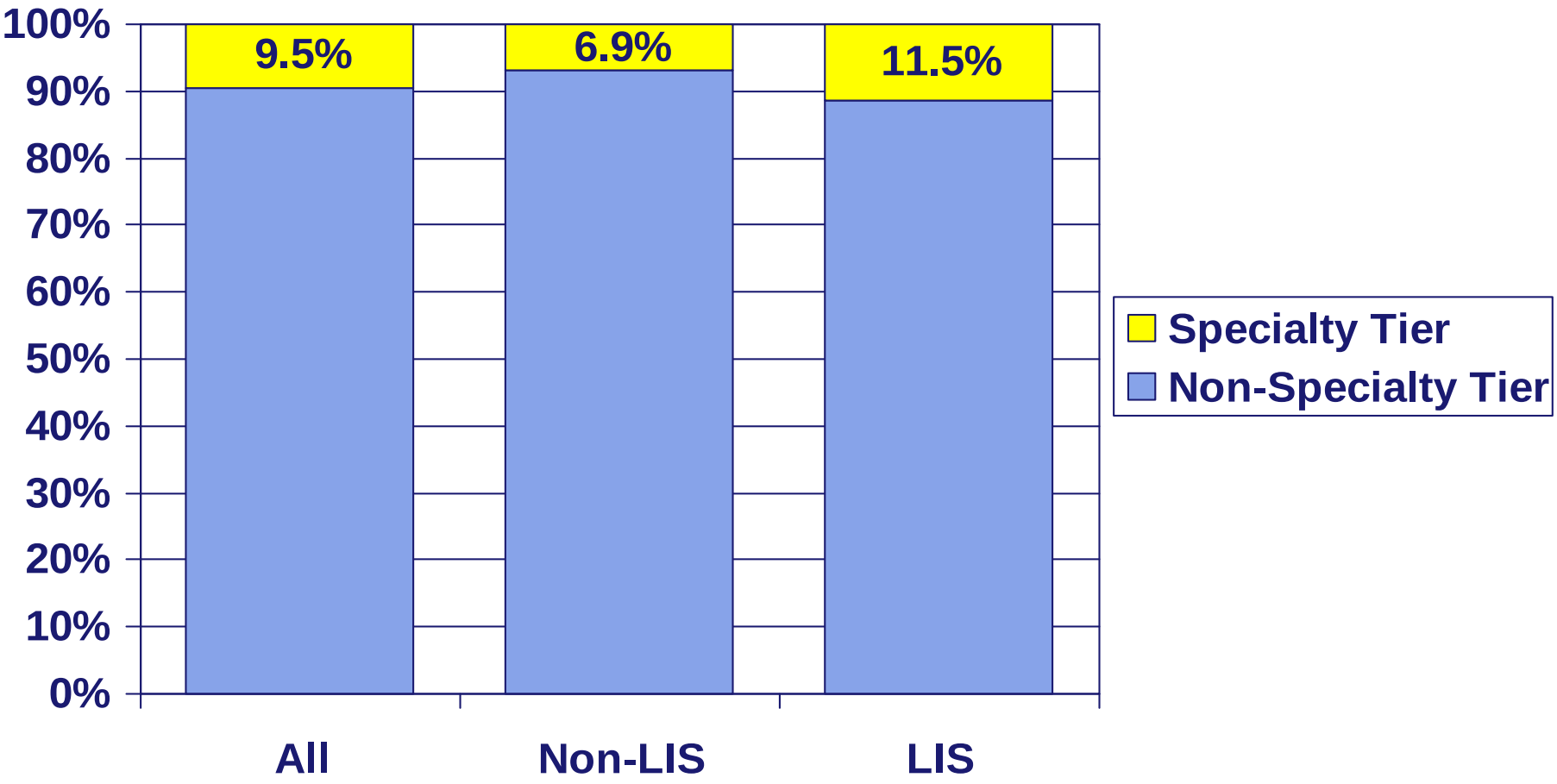
Proportion of Beneficiaries Utilizing Specialty Tier Drugs (2007)



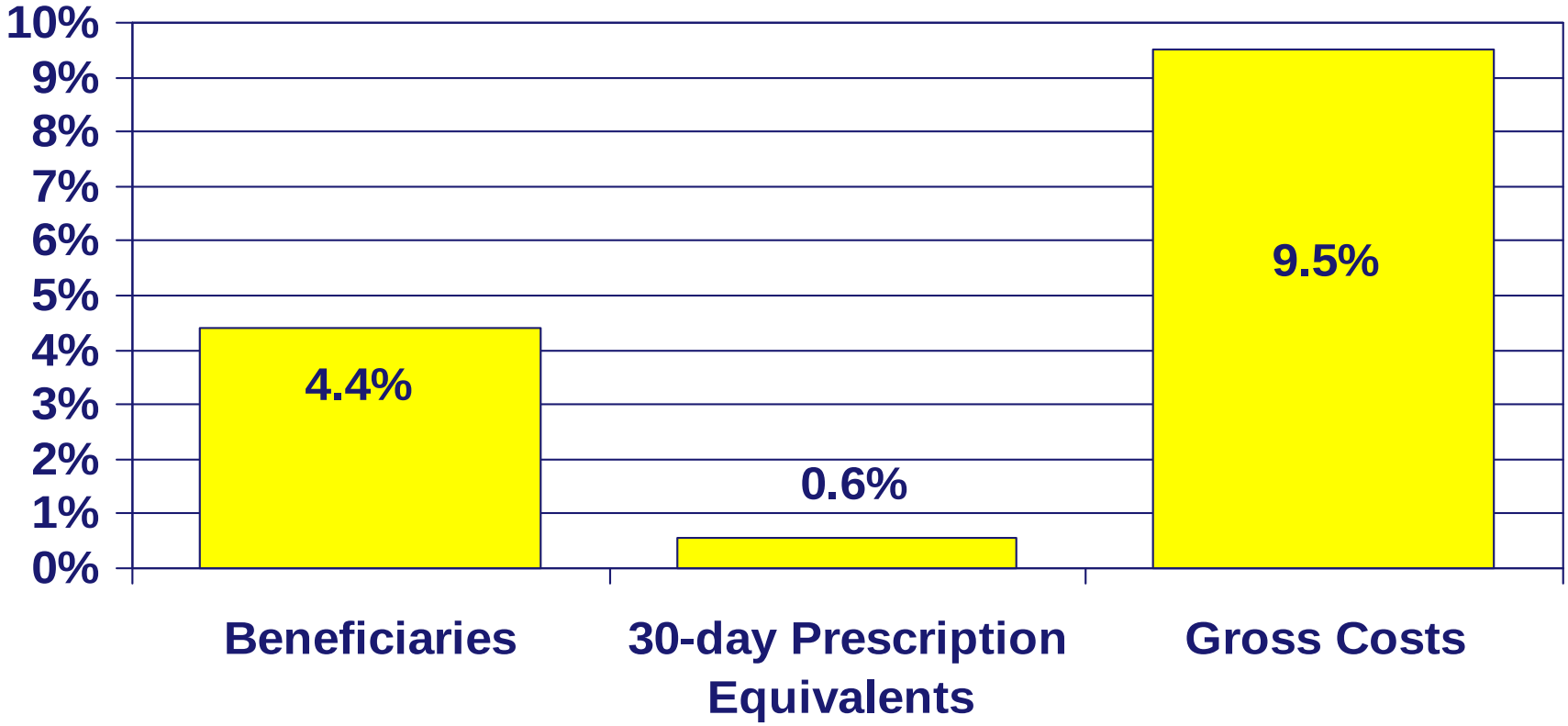
Proportion of Specialty Tier vs. Non-Specialty Tier 30-day Equivalent Prescriptions (2007)



Proportion of Total Gross Costs for Specialty Tier vs. Non-Specialty Tier Drugs (2007)



Comparison of Total Beneficiaries, 30-day Prescription Equivalents, and Gross Costs for Specialty Tier Drugs (2007)



Analysis of Out-of-Pocket Costs

Out-of-Pocket Costs

- True Out-of-Pocket (TrOOP) Costs
  - Eligible expenditures incurred by the enrollee or on behalf of the enrollee for Part D covered “formulary” medications
  - Determines when an enrollee’s catastrophic coverage begins
- Beneficiary Out-of-Pocket (OOP) Costs
  - TrOOP eligible costs incurred by the enrollee only

Out-of-Pocket Costs

- Specialty tier drug TrOOP costs for the entire coverage period did not exceed 25%.
- Out-of-Pocket costs for specialty tier drugs were less than non-specialty tier drugs.

Proportion of Total Gross Costs for Specialty vs. Non-Specialty Tier Drugs Attributable to TrOOP Costs* (2007)

TrOOP for All Beneficiaries	
Specialty Tier	Non-Specialty Tier
24.50%	42.90%

*TrOOP costs over the entire benefit

Proportion of Total Gross Costs for Specialty vs. Non-Specialty Tier Drugs Attributable to Beneficiary Out-of-Pocket (OOP) Costs* (2007)

	Beneficiary (OOP) Costs	
Beneficiary Type	Specialty Tier Drugs	Non-Specialty Tier Drugs
All	6.6%	18.8%
Non-LIS	19.6%	37.7%
LIS	0.5%	2.9%

*Costs over the entire benefit

Summary

- The Specialty tier provides both beneficiary and Part D sponsor protections.
- Specialty tier medications represent a limited number of drugs that are used by a small proportion of beneficiaries.
- Overall, specialty tier medications represent a minor proportion of all Part D 30-day prescription equivalents; however, these drugs are a moderate cost driver for Part D.
- In general, while non-LIS beneficiaries pay approximately 20% of the medication cost for specialty tier medications, when including all Medicare beneficiaries the average amount paid is much less.

Specialty Tier in Part D Bids

Specialty Tier in Part D Bids

- No separate specialty tier information was collected in the 2006 or 2007 BPT.
- The specialty drug tier was added to the BPT in 2008.
- Slides will focus on 2008 and 2009 bids
  - based on 2006 and 2007 plan experience
- Methods used by actuaries in bids likely different than those used in the PDE summary.

Overview of Part D Bids

	Allowed Cost PMPM	Reinsurance PMPM	Bid Amount (Enrollment Weighted)
2008	$219.56	$32.65	$79.30
2009	$240.94	$39.98	$84.33
Increase	9.7%	22.5%	6.3%

Specialty Drug Tier Bid Summary Data

	Share of Utilization	Allowed Cost per Script	Allowed Cost PMPM	Share of Total Allowed Cost
2008	0.31%	$1,188.43	$12.35	5.6%
2009	0.37%	$1,225.96	$16.47	6.8%
Increase		3.2%	33.4%	

Total Data for Beneficiaries Projected to Have Catastrophic Claims

	Share of Members	Share of Scripts	Share of Total Allowed Cost
2008	9.6%	24.0%	39.4%
2009	9.2%	22.8%	40.8%

Specialty Tier Data for Beneficiaries Projected to Have Catastrophic Claims

	Share of Utilization	Allowed Cost per Script	Reinsurance PMPM	Share of Reinsurance
2008	1.58%	$1,535.96	$5.93	18.2%
2009	1.93%	$1,648.96	$8.37	21.0%
Increase		7.4%	41.1%	

QUESTIONS?