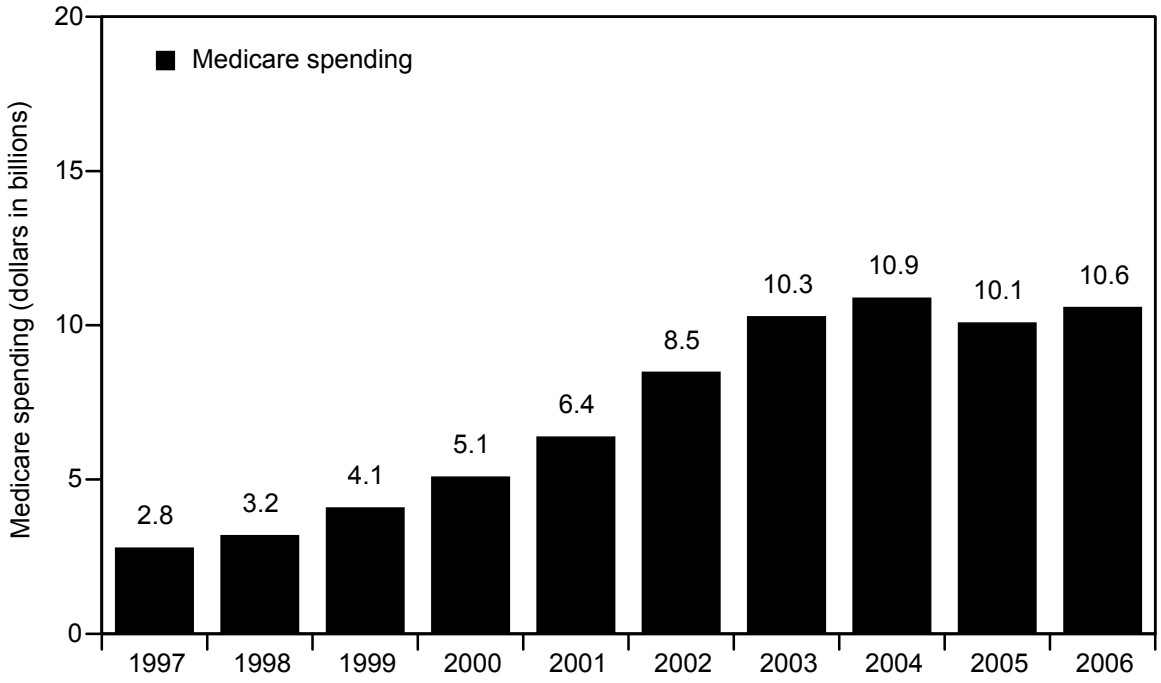
SECTION 11

Drugs

Chart 11-1. Medicare spending for Part B drugs



Source: MedPAC analysis of unpublished CMS data.

- MedPAC estimates that spending for Part B drugs totaled $10.6 billion in 2006.
- Medicare spending on Part B drugs increased at an average rate of 25 percent per year from 1997 to 2003. Since then the rate has moderated. In 2005, spending declined by 7.8 percent compared with 2004. Spending increased 4.7 percent in 2006 but remained below 2004 levels.
- This total does not include drugs provided through outpatient departments of hospitals or to patients with end-stage renal disease in dialysis facilities. MedPAC estimates that payments for separately billed and pass-through drugs provided in hospital outpatient departments equaled about $3 billion in 2006. We estimate that freestanding and hospital-based dialysis facilities billed Medicare an additional $2.8 billion for drugs.
- In 2005, the Medicare payment rate changed from one based on the average wholesale price to 106 percent of the average sales price.

Chart 11-2. Top 10 drugs covered by Medicare Part B, by share of expenditures, 2006

Drug name	Clinical indications	Competition	Percent of spending	Rank in 2005
Darbepoetin alfa	Anemia	Sole source	10.6%	1
Rituximab	Non-Hodgkin's lymphoma	Sole source	6.9	3
Non-ESRD erythropoietin	Anemia	Multisource biological	6.4	2
Infliximab	Rheumatoid arthritis, Crohn's disease	Sole source	5.6	4
Pegfilgrastim	Cancer	Sole source	5.1	5
Bevacizumab	Cancer	Sole source	4.3	6
Levalbuterol	Asthma and other lung conditions	Sole source	3.5	not on list
Unclassified drugs	N/A		3.1	N/A
Oxaliplatin	Cancer	Sole source	2.9	9
Docetaxel	Cancer	Sole source	2.6	not on list

Note: ESRD (end-stage renal disease), N/A (not applicable). This chart has been updated since the printed version of this data book was published.

Source: MedPAC analysis of 2005 Medicare claims data from CMS and unpublished Food and Drug Administration data.

- Medicare covers about 650 outpatient drugs under Part B, but spending is very concentrated. The top 10 drugs account for about 51 percent of all Part B drug spending.
- Spending for new drugs dominates the list. Of the top nine listed drugs covered by Medicare in 2006, eight received Food and Drug Administration approval in 1997 or later. Drugs too new to have their own codes (unclassified drugs) accounted for 3 percent of all Part B drug spending.
- Treatment for cancer dominates the list—seven out of the top nine listed drugs treat cancer or the side effects associated with chemotherapy. This is because most cancer drugs must be administered by physicians, a requirement for coverage of most Part B drugs.

Chart 11-3. Part D enrollment and other sources of drug coverage

	Millions as of January 16, 2008	Percent of all eligible Medicare beneficiaries
Enrollment that leads to Medicare program spending:		
Beneficiaries receiving LIS*		
Full dual eligibles	6.2	14%
MSP and SSI recipients	1.7	4
Other individuals determined eligible by SSA	1.5	3
Other enrollees in stand-alone PDPs (excluding LIS)	9.5	21
Other enrollees in MA–PDs (excluding LIS)	6.6	15
Individuals covered by Medicare RDS	6.7	15
Subtotal	32.1	73
Enrollment that does not lead to Medicare program spending:		
FEHB, TRICARE, VA, and active workers	5.5	12
Total	37.5	85
Additional sources of creditable coverage**	~2	5

Note: LIS (low-income subsidy), MSP (Medicare Savings Program), SSI (Supplemental Security Income), SSA (Social Security Administration), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), RDS (retiree drug subsidy), FEHB (Federal Employees Health Benefits program), VA (Department of Veterans Affairs). TRICARE is the health program for military retirees and their dependents. Columns may not sum due to rounding.
* Includes approximately 7.9 million PDP enrollees and 1.5 million MA–PD enrollees.
** Drug coverage of equal or greater value to Part D benefits through other sources such as state pharmaceutical assistance programs.

Source: CMS Management Information Integrated Repository.

- As of January 2008, CMS estimated that 32.1 million of the 44 million Medicare beneficiaries (73 percent) were either signed up for Part D plans or had prescription drug coverage through employer-sponsored coverage under Medicare's retiree drug subsidy (RDS). (If an employer agrees to provide primary drug coverage to its retirees with an average benefit value that is equal or greater in value to 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.)
- About 9.4 million beneficiaries (21 percent) receive extra help with premiums and cost sharing through Part D's low-income subsidies (LISs). Of these individuals, 6.2 million are dually eligible to receive Medicare and all Medicaid benefits offered in their state. Another 3.2 million qualified for extra help either because they receive benefits through the Medicare Savings Program or Supplemental Security Income Program, or they were determined eligible by the Social Security Administration after applying directly to that agency. Among all LIS beneficiaries, about 7.9 million (18 percent) are enrolled in stand-alone prescription drug plans (PDPs) and 1.5 million (3 percent) are in Medicare Advantage–Prescription Drug plans (MA–PDs).
- Other enrollees in stand-alone PDPs numbered 9.5 million, or 21 percent of all Medicare beneficiaries. Another 6.6 million enrollees (15 percent) are in MA–PDs. Individuals whose employers receive Medicare's RDS numbered 6.7 million, or 15 percent. Those groups of beneficiaries directly affect Medicare program spending.
- Other Medicare beneficiaries have creditable drug coverage, but that coverage does not affect Medicare program spending. For example, 5.5 million beneficiaries (12 percent) receive drug coverage through the Federal Employees Health Benefits program, TRICARE, the Department of Veterans Affairs, or current employers because the individual is still an active worker. CMS estimates that another 2 million individuals have other sources of creditable coverage.

Chart 11-4. Defined standard benefit parameters increase over time

	2006	2007	2008
Deductible	$250.00	$265.00	275.00
Initial coverage limit	2,250.00	2,400.00	2,510.00
True out-of-pocket spending limit	3,600.00	3,850.00	4,050.00
Total covered drug spending at true out-of-pocket limit	5,100.00	5,451.25	5,726.25
Minimum cost sharing above true out-of-pocket limit			
Copay for generic/preferred multisource drug prescription	2.00	2.15	2.25
Copay for other prescription drugs	5.00	5.35	5.60

Note: Under Part D's defined standard benefit, the enrollee pays the deductible and then 25 percent of covered drug spending (75 percent paid by the plan) until total covered drug spending reaches the initial coverage limit. The enrollee then reaches the coverage gap where she must pay 100 percent of covered drug spending until she reaches the true out-of-pocket limit. "True out of pocket" refers to the fact that cost sharing paid by most sources of supplemental coverage does not count toward this limit. The enrollee pays nominal cost sharing above the limit.

Source: CMS 2007. *Notification of changes in Part D payment for calendar year 2008*. CMS 2006. *Medicare Part D benefits parameters for standard benefit: Annual adjustments for 2007*.

- The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 specified a defined standard benefit structure for 2006 that included a $250 deductible, 25 percent coinsurance on covered drugs until the enrollee reaches $2,250 in total covered drug spending, and then a coverage gap in which the enrollee is responsible for the full discounted price of covered drugs until their true out-of-pocket spending reaches $3,600. ("True out of pocket" refers to the fact that cost sharing paid by many sources of supplemental coverage does not count toward this $3,600 out-of-pocket spending limit.) A person with no other source of drug coverage that supplements Part D would reach this $3,600 true out-of-pocket limit at $5,100 in total drug spending (i.e., the combination of the enrollee's spending plus spending that the Part D plan covered). Enrollees with drug spending even higher than that amount would pay just $2 to $5 per prescription.

- The parameters of this defined standard benefit structure increase over time at the same rate as the annual increase in average total drug expenses of Medicare beneficiaries. Benefit parameters for 2006, 2007, and 2008 are shown in the chart above.

- Within certain limits, sponsoring organizations may offer Part D plans that have the same actuarial value as the defined standard benefit but a different benefit structure. For example, a plan may use tiered copayments rather than 25 percent coinsurance. Or a plan may have no deductible but use cost-sharing requirements that are equivalent to a rate higher than 25 percent. Both defined standard benefit plans and plans that are actuarially equivalent to the defined standard benefit are known as "basic benefits."

- Once a sponsoring organization offers at least one plan with basic benefits within a prescription drug plan region, it may also offer a plan with enhanced benefits—basic and supplemental coverage combined.

Chart 11-5. Characteristics of Medicare PDPs

	2007				2008	
	Plans		Enrollees [a]		Plans	
	Number	Percent	Number (in millions)	Percent	Number	Percent
Totals	1,866	100%	16.1	100%	1,824	100%
Type of organization						
National [b]	1,507	80	13.9	86	1,589	87
Near-national [c]	149	8	0.6	4	0	0
Other	210	11	1.7	10	235	13
Type of benefit						
Defined standard	219	12	2.9	18	217	12
Actuarially equivalent [d]	760	41	9.9	61	682	37
Enhanced	887	48	3.3	20	925	51
Type of deductible						
Zero	1,127	60	8.6	54	1,065	58
Reduced	157	8	0.5	3	150	8
Defined standard [e]	582	31	7.0	43	609	33
Drugs covered in the gap						
Some generics but no brand name drugs	511	27	1.3	8	528	29
Some generics and some brand name drugs	27	1	0.1	1	1	<0.5
None	1,328	71	14.7	91	1,295	71

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Sums of percentage may not add to totals due to rounding.
[a] Number of enrollees as of July 2007.
[b] Reflects total numbers of plans for the 17 organizations with at least one PDP in all 34 PDP regions.
[c] Totals for organizations offering 30 or more PDPs across the country, but without one in each PDP region.
[d] Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.
[e] $265 in 2007 and $275 in 2008.

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

- Part D drew about the same number of stand-alone prescription drug plans (PDPs) into the field for 2008 as in 2007. Plan sponsors are offering 1,824 PDPs in 2008 compared with 1,866 in 2007.
- In 2008, 87 percent of all PDPs were offered by sponsoring organizations that had at least one PDP in each of the 34 PDP regions across the country. In 2007, plans offered by those national sponsors accounted for 86 percent of all PDP enrollment.
- Sponsors are offering a slightly larger proportion of PDPs with enhanced benefits (basic plus supplemental coverage) for 2008 and a slightly smaller proportion of benefits with the same average value as the standard benefit but with alternative benefit designs (called actuarially equivalent benefits).
- About the same proportion of PDPs include some benefits in the coverage gap for 2008 as in 2007. Nearly all plans with some gap coverage limit that coverage to generic drugs; 29 percent offer generics only while 1 percent of plans offer generics and brand name drugs. Among those plans that provide coverage for brand name drugs, most limit the benefit to preferred drugs.
- In 2007, 91 percent of PDP enrollees were in plans that offered no additional benefits in the coverage gap; just under half were beneficiaries who receive Part D's low-income subsidies (LISs). As LIS enrollees do not face a coverage gap, the number of beneficiaries who face 100 percent coinsurance is considerably smaller than 91 percent. In addition, many enrollees were unlikely to exceed the initial coverage limit for drug spending.

Chart 11-6. Average Part D premiums

	2007 enrollment in millions	Average 2007 premium weighted by 2007 enrollment	Estimated average 2008 premium*	Difference between 2007 and 2008 average premium	Percentage change in weighted average premium
PDPs					
Basic coverage	12.8	$24.05	$28.32	$4.27	18%
Enhanced coverage	3.3	40.42	45.43	5.01	12
Any coverage	16.1	27.39	31.81	4.42	16
MA–PDs**					
Basic coverage	1.0	16.86	20.72	3.86	23
Enhanced coverage	4.0	8.68	10.51	1.83	21
Any coverage	5.0	10.35	12.59	2.24	22
All plans					
Basic coverage	13.8	23.52	28.15	4.63	20
Enhanced coverage	7.3	23.09	25.61	2.52	11
Any coverage	21.1	23.37	27.28	3.91	17

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. The MA–PDs and enrollment described here exclude employer-only plans and plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans.
*Premiums are the weighted average using July 2007 enrollment. New plans entrants are credited with no enrollment. Almost 99 percent of July 2007 PDP enrollees and about 96 percent of MA–PD enrollees that were in the scope of our analysis were in 2007 plans that could be matched to 2008 plans. Note that some beneficiaries chose to enroll in a different plan or were automatically reassigned to a different plan for 2008.
**Reflects the portion of MA plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage. MA–PD premiums reflect rebate dollars (75 percent of the difference between a plan's payment benchmark and its bid for providing Part A and Part B services) that were used to offset Part D premium costs. Note that lower average premiums for enhanced MA–PD plans reflect a different mix of sponsoring organizations and counties of operation than MA–PDs with basic coverage.

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

- On average, Part D enrollees pay $27 per month in 2008, up nearly $4 or 17 percent from 2007.
- The average PDP enrollee pays about $32 per month, compared with $27 in 2007—a 16 percent increase.
- Medicare Advantage–Prescription Drug plans (MA–PDs) can lower the part of their monthly premium attributable to Part D using rebate dollars—75 percent of the difference between the plan's payment benchmark and its bid for providing Part A and Part B services. MA–PDs may also enhance their Part D benefit with rebate dollars. Many MA–PDs use rebate dollars in these ways, resulting in more enhanced offerings and lower average premiums compared with PDPs.
- The portion of MA premiums attributable to prescription drug benefits increased for 2008, with the average MA–PD enrollee paying nearly $13 per month compared with $10 in 2007 (22 percent higher).

Chart 11-7. Characteristics of MA–PDs

	2007				2008	
	Plans		Enrollees [a]		Plans	
	Number	Percent	Number (in millions)	Percent	Number	Percent
Totals	1,622	100%	5.0	100%	1,932	100%
Type of organization						
Local HMO	947	58	3.7	75	1,025	53
Local PPO	274	17	0.3	7	353	18
PFFS	367	23	0.8	16	520	27
Regional PPO	34	2	0.1	2	34	2
Type of benefit						
Defined standard	84	5	0.1	1	79	4
Actuarially equivalent [b]	321	20	1.0	19	132	7
Enhanced	1,217	75	4.0	80	1,721	89
Type of deductible						
Zero	1,461	90	4.7	95	1,665	86
Reduced	38	2	0.1	1	45	2
Defined standard [c]	123	8	0.2	3	222	11
Drugs covered in the gap						
Some generics but no brand name drugs	450	28	1.2	25	661	34
Some generics and some brand name drugs	76	5	0.4	8	327	17
None	1,096	68	3.3	67	944	49

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), PPO (preferred provider organization), PFFS (private fee-for-service). The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Sums of percentages may not add to totals due to rounding.

[a] Numbers of enrollees as of July 2007.

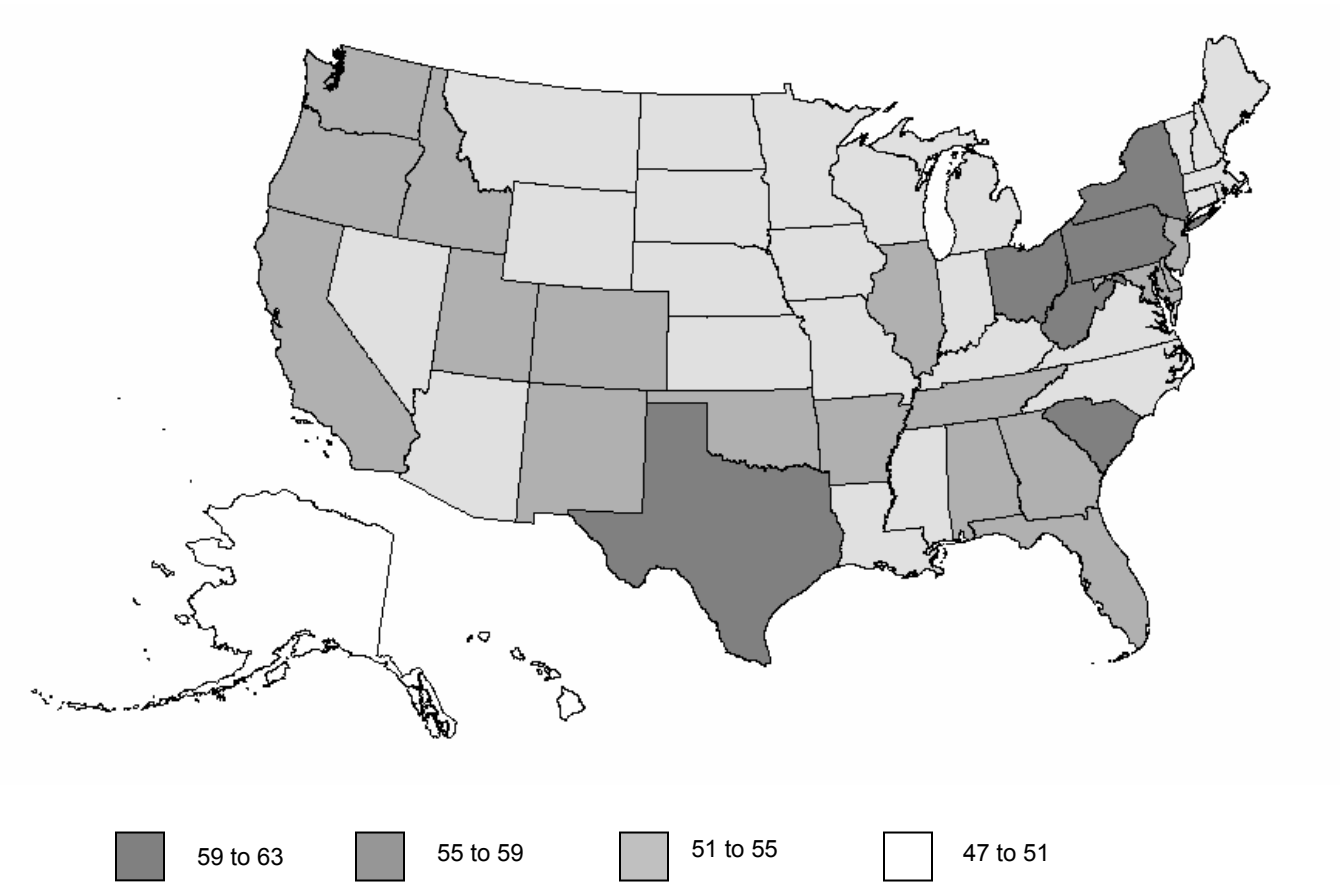
[b] Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.

[c] $265 in 2007 and $275 in 2008.

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

- There were more MA–PDs in 2008 than in 2007. Sponsors are offering 1,932 MA–PDs compared with 1,622 the year before (about 19 percent more). Although local HMOs offer the most MA–PD plans, there were sizable increases in the number of drug plans offered by preferred provider organizations and private fee-for-service (PFFS) plans. PFFS plans made up 27 percent of all (unweighted) offerings in 2008 compared with 23 percent in 2007.
- A larger share of MA–PDs than PDPs offer enhanced benefits (compare Chart 11-7 with Chart 11-5). In 2007, 48 percent of all PDPs had enhanced benefits compared with 75 percent of MA–PDs. In 2008, 51 percent of PDPs were enhanced compared with 89 percent of MA–PDs. In 2007, enhanced MA–PDs attracted 80 percent of total MA–PD enrollment.
- Most MA–PD plans have no deductible: 90 percent of MA–PD offerings in 2007 and 86 percent in 2008. MA–PDs with no deductible attracted about 95 percent of total MA–PD enrollment in 2007.
- MA–PDs are more likely than PDPs to provide some additional benefits in the coverage gap, although mostly for generics. In 2007, 32 percent of MA–PDs included some gap coverage—28 percent with some generics but no brand name drugs and 5 percent with some generics and some brand name drug coverage. Those plans accounted for 33 percent of MA–PD enrollment.
- For 2008, 51 percent of MA–PDs provide some gap coverage (34 percent with some generics but no brand name drugs, and 17 percent with some generics and some brands).

Chart 11-8. Geographic distribution of PDPs in 2008

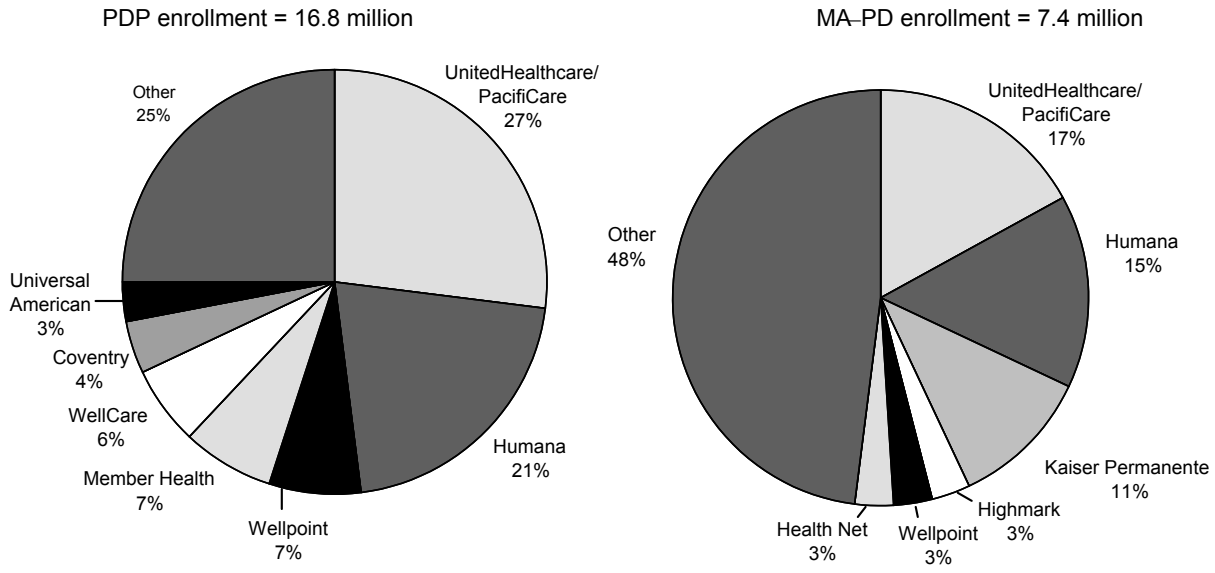


Note: PDP (prescription drug plan). The PDPs shown here exclude employer-only plans and plans offered in U.S. territories.

Source: MedPAC analysis of CMS plan benefit package and landscape data.

- The number of stand-alone prescription drug plans (PDPs) stayed fairly steady around the country, with the median number of plans offered in each region at 53 compared with 55 in 2007.
- Alaska had the fewest stand-alone plans with 47. The Pennsylvania–West Virginia region had the most with 63 PDPs.

Chart 11-9. Distribution of 2007 Part D enrollees by organization

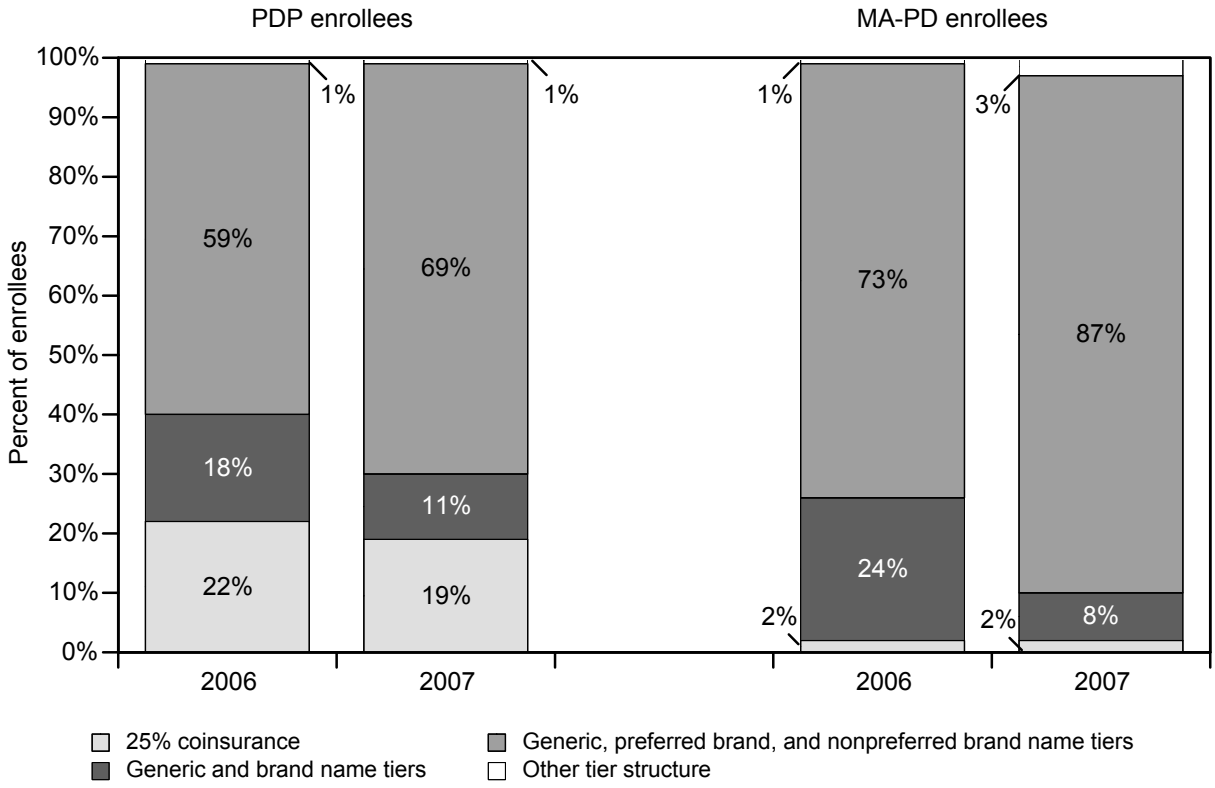


Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Data are as of July 2007.

Source: MedPAC based on CMS enrollment data.

- As of July 2007, Part D enrollment was concentrated among plans offered by a small number of parent organizations. Several of those organizations offer both stand-alone prescription drug plans (PDPs) and Medicare Advantage–Prescription Drug plans (MA–PDs). For example, UnitedHealthcare and PacifiCare (which merged in 2006) had 27 percent of the 16.8 million enrollees in PDPs and 17 percent of the 7.4 million enrollees in MA–PDs. Similarly, Humana had a considerable portion of both markets: 21 percent of PDP enrollees and 15 percent of MA–PD enrollees.

Chart 11-10. In 2007, most Part D enrollees were in plans that charged higher copayments for nonpreferred brand name drugs



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Percentages are weighted by enrollment. PDPs exclude employer-only groups and plans offered in U.S. territories. MA–PDs exclude employer-only groups, demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Plans with one generic and one brand name tier have lower cost sharing for generic drugs. Plans that distinguish between preferred and nonpreferred brands tend to have the lowest cost sharing for generic drugs, somewhat higher copays for preferred brand name drugs, and the highest cost sharing for nonpreferred brands. Many plans also include a specialty tier that applies to expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

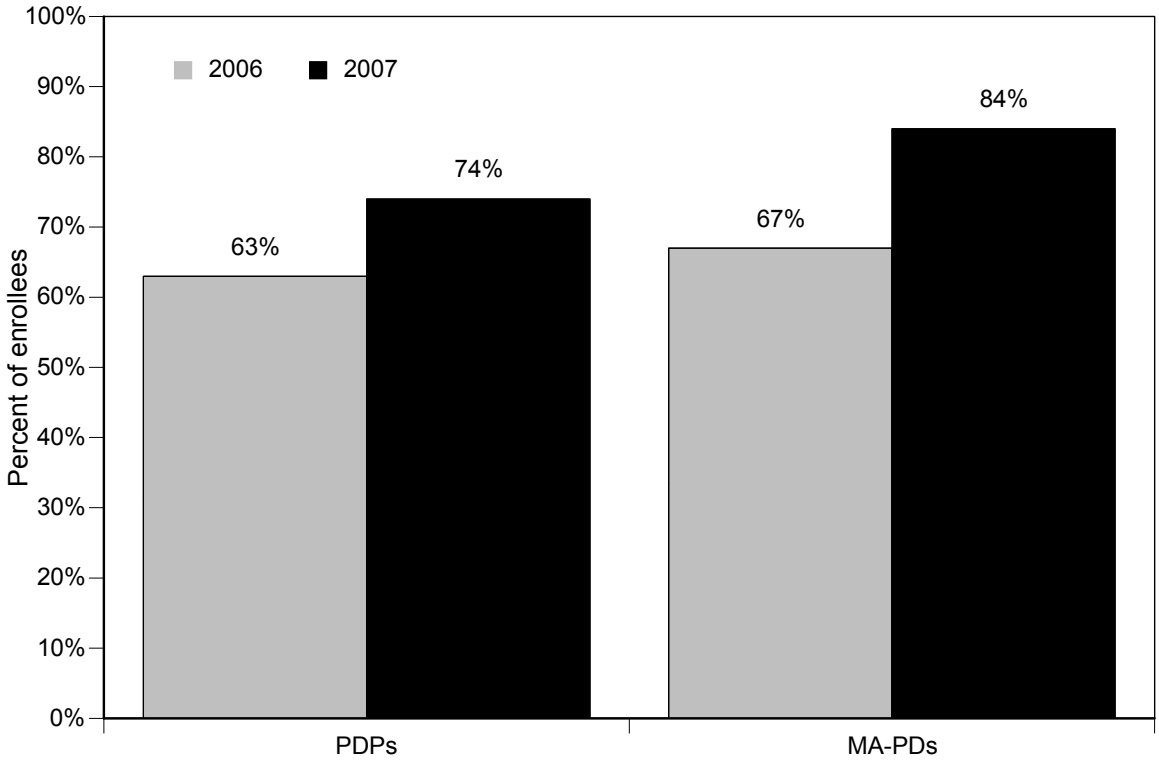
Source: MedPAC sponsored NORC/Georgetown University analysis of formularies submitted to CMS for January 2006 and January 2007.

- The share of beneficiaries enrolled in plans that distinguish between preferred and nonpreferred brand name drugs grew between 2006 and 2007. Among PDPs, 69 percent of enrollees were in such a plan in 2007, compared with 59 percent in 2006. Similarly, 87 percent of MA–PD enrollees were in such a plan in 2007, up from 73 percent in 2006.

- For enrollees in either PDPs or MA–PDs that distinguished between preferred and nonpreferred brand name drugs, the median copay in 2007 was $28 to $29 for a preferred brand and $60 for a nonpreferred brand. The median copay for generic drugs was $5.

- In 2007, about 19 percent of PDP enrollees and 2 percent of MA–PD enrollees were in plans that charged 25 percent coinsurance for all covered drugs after the plan's deductible, up to its initial coverage limit. Enrollees in these PDPs who receive Part D's low-income subsidies paid nominal copays per prescription rather than 25 percent coinsurance.

Chart 11-11. More enrollees were in Part D plans that used specialty tiers in 2007



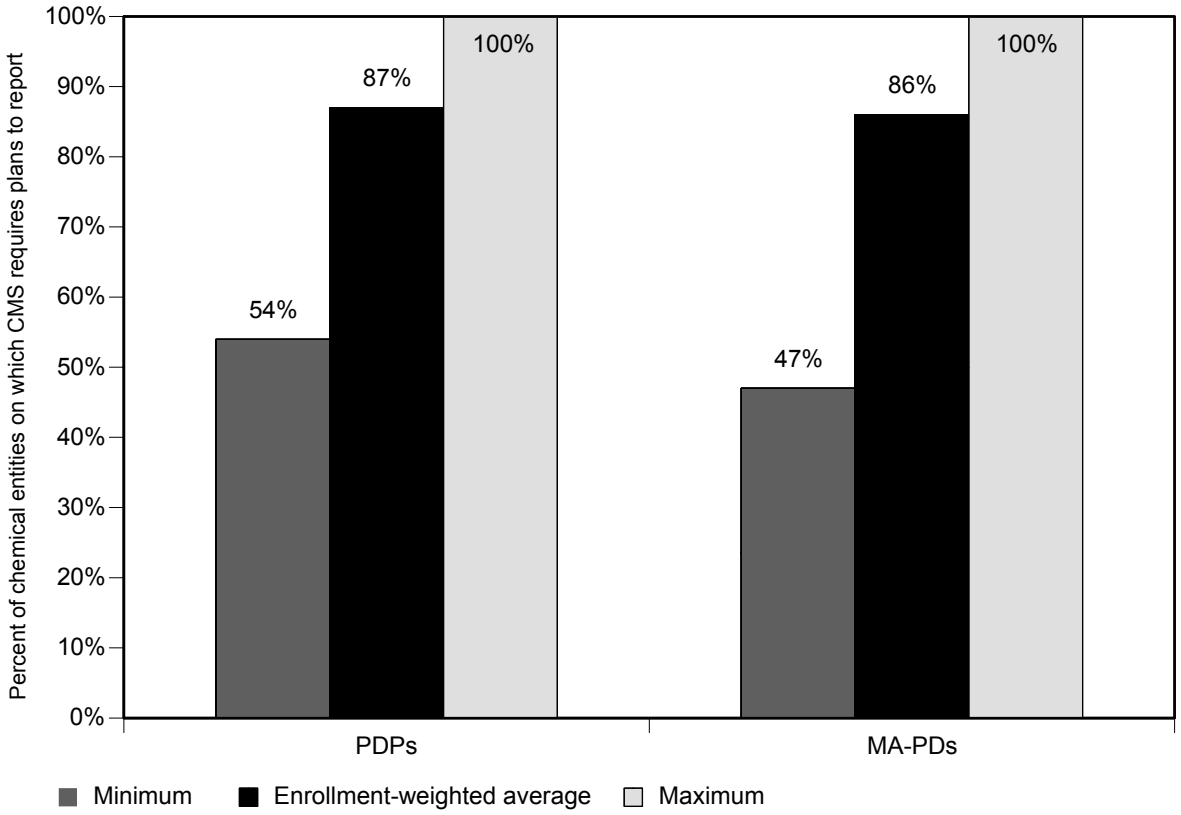
Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Percentages are weighted by enrollment. PDPs exclude employer-only groups and plans offered in U.S. territories. MA–PDs exclude employer-only groups, demonstration programs, 1876 cost plans, and plans offered in U.S. territories. Specialty tiers apply to expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

Source: MedPAC-sponsored NORC/Georgetown University analysis of formularies submitted to CMS for January 2006 and January 2007.

- Generally, plans use specialty tiers for expensive products, unique drugs, and biologicals. For 2007, CMS allowed plans to place drugs on a specialty tier if the drug's negotiated price exceeded $500 per month. Cost-sharing requirements for specialty-tier drugs can be high (at least 25 percent of the plan's negotiated price) until the beneficiary reaches the catastrophic levels of spending in Part D's benefit that limit out-of-pocket spending. Under CMS regulations, enrollees may not appeal cost sharing for drugs on specialty tiers as they can for other drugs such as those on nonpreferred brand tiers.

- The share of enrollees in plans that use specialty tiers rose between 2006 and 2007. Among PDP enrollees, 74 percent were in such plans in 2007, and 84 percent of MA–PD enrollees were in plans with a specialty tier. The median PDP enrollee paid 30 percent coinsurance for specialty-tier drugs, while the median MA–PD enrollee paid 25 percent.

Chart 11-12. PDPs and MA–PDs listed similar numbers of drugs on their formularies in 2007



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). PDPs exclude employer-only groups and plans offered in U.S. territories. MA–PDs exclude demonstration programs, 1876 cost plans, employer-only groups, and plans offered in U.S. territories. Values reflect the percent of distinct chemical entities listed within CMS's file of reference national drug codes.

Source: MedPAC-sponsored NORC/Georgetown University analysis of formularies submitted to CMS for January 2007.

- In 2007, enrollees in stand-alone PDPs and MA–PDs had similar numbers of drugs listed on their plans' formularies. The average PDP enrollee was in a plan that listed 87 percent of all distinct chemical entities on which CMS requires plans to report, while the average MA–PD was in a plan listing 86 percent.

- The number of drugs listed on any given plan's formulary can vary considerably, from around 50 percent of reportable drugs for plans with the tightest formularies to 100 percent for some of the most popular plans.

Chart 11-13. The average percent of drugs listed in each therapeutic category depends on therapeutic class size and regulation

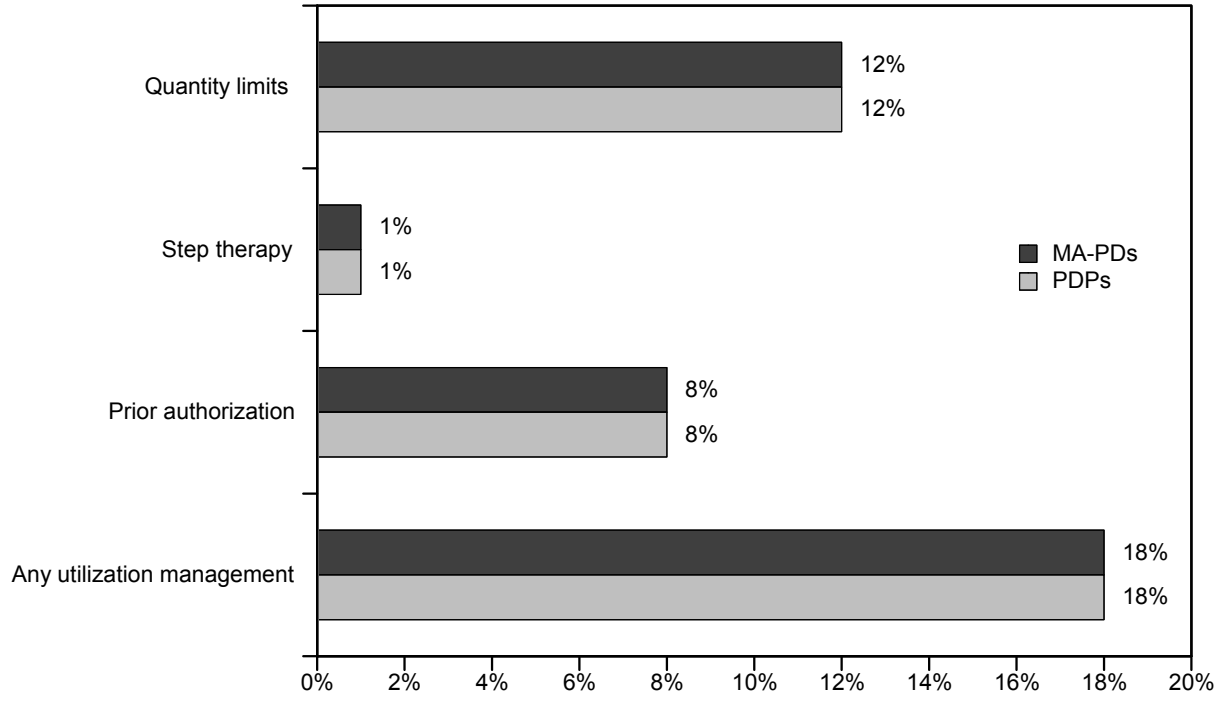
	Total drugs in class	Average percent of drugs listed	
		PDPs	MA–PDs
Selected protected classes:*			
Anticonvulsants	19	95%	100%
Antidepressants	24	100	100
Antipsychotics	18	94	94
Selected other classes:			
Analgesics	69	77	81
Antibacterial	119	77	81
Antivirals**	43	93	93
Cardiovascular	141	84	86
Gastrointestinal	37	78	81
Glucose regulators	37	86	86
Respiratory	48	83	88
Combination drugs (multiclass)	95	56	64

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). PDPs exclude employer-only groups and plans offered in U.S. territories. MA–PDs exclude demonstration programs, 1876 cost plans, employer-only groups, and plans offered in U.S. territories. Values reflect the percent of distinct chemical entities listed within CMS's file of reference national drug codes.
*Under CMS regulation, plans are required to list all or substantially all drugs in these classes.
**This class includes some protected drugs (those to treat HIV/AIDS) as well as unprotected drugs.

Source: NORC/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 2007.

- The percent of drugs listed within a therapeutic class of a plan's formulary can vary widely. That number depends on both regulatory coverage rules as well as the size of the class of drugs available within the marketplace.
- In classes with fewer drugs available, plans typically list a larger share of them. Conversely, when there are more drugs available within a given class, plans are able to negotiate better prices by listing only selected drugs on their formulary, particularly when there are overlapping products.
- In classes for which CMS requires that plans cover all or substantially all drugs, plans predictably list a larger share of drugs. For example, in the class of antidepressants, the average PDP and the average MA–PD typically list all of the available drugs.

Chart 11-14. PDPs and MA–PDs applied utilization management tools similarly in 2007



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). PDPs exclude employer-only groups and plans offered in U.S. territories. MA–PDs exclude demonstration programs, 1876 cost plans, employer-only groups, and plans offered in U.S. territories. Values reflect the percent of listed chemical entities that are subject to utilization management, weighted by plan enrollment. Quantity limits mean that plans limit the number of doses of a drug available to the enrollee in a given time period. Step therapy refers to a requirement that the enrollee try specified drugs first before moving to other drugs. Prior authorization means that the enrollee must get preapproval from the plan before coverage.

Source: MedPAC-sponsored NORC/Georgetown University analysis of formularies submitted to CMS for January 2007.

- The number of drugs listed on a plan's formulary does not necessarily represent beneficiary access to medications. Plans' processes for nonformulary exceptions, prior authorization (preapproval from plan before coverage), quantity limits (plans limit the number of doses of a particular drug covered in a given time period), and step therapy requirements (enrollees must try specified drugs before moving to other drugs) can have a strong influence on access to certain drugs. For example, unlisted drugs may be covered through the nonformulary exceptions process, which may be relatively easy for some plans and more burdensome for others. Alternatively, on-formulary drugs may not be covered in cases in which a plan does not approve a prior authorization request. Also, a formulary's size can be deceptively large if it includes drugs that are no longer used in common practice.

- In 2007, the average enrollee in either a stand-alone prescription drug plan or Medicare Advantage prescription drug plan would have had similar experiences with respect to utilization management. The average enrollee was in a plan that used quantity limits on 12 percent of listed chemical entities (referred to hereafter as drugs), used step therapy for 1 percent of listed drugs, and required prior authorization for about 8 percent of listed drugs. Altogether, about 18 percent of listed drugs were subject to some form of utilization management for the average enrollee.

Web links. Drugs

- Chapters in several of MedPAC's Reports to the Congress provide information on the Medicare Part D program, as does MedPAC's Payment Basics series.

  http://www.medpac.gov/chapters/Mar08_Ch04.pdf
  http://www.medpac.gov/chapters/Mar08_Ch05.pdf
  http://www.medpac.gov/chapters/Jun07_Ch07.pdf
  http://www.medpac.gov/chapters/Mar07_Ch04.pdf
  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch07.pdf
  http://www.medpac.gov/publications/congressional_reports/Jun06_Ch08.pdf
  http://www.medpac.gov/publications/congressional_reports/June05_ch1.pdf
  http://www.medpac.gov/publications/congressional_reports/June04_ch1.pdf
  http://www.medpac.gov/documents/MedPAC_Payment_Basics_07_PartD.pdf

- Analysis of Medicare spending on Part B drugs can be found in MedPAC's January 2007 and January 2006 reports to the Congress.

  http://www.medpac.gov/documents/Jan07_PartB_mandated_report.pdf
  http://www.medpac.gov/publications/congressional_reports/Jan06_Oncology_mandated_report.pdf

- A series of Kaiser Family Foundation fact sheets data spotlights provide information on the Medicare Part D benefit.

  http://www.kff.org/medicare/rxdrugbenefit.cfm

- CMS information on Part D enrollment

  http://www.cms.hhs.gov/MCRAdvPartDEnrolData/