



The Medicare Drug Benefit: How Good Are the Options?

Overview

Under the new Medicare Part D prescription drug benefit, California's 4.2 million Medicare beneficiaries are presented with 164 different drug plans.¹ In any given county, beneficiaries may be faced with choosing among as many as 71 plans. Such a range of drug plans presents each Medicare beneficiary with a complex array of considerations and comparisons within the overall process of selecting a plan.

Most beneficiaries must choose between two different plan types: stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PDs). In a few counties, beneficiaries with certain chronic conditions, or those who are dual-eligible for both Medicare and Medi-Cal, may enroll in a special needs plan (SNP), which is a managed care plan specifically designed to serve their particular needs. In addition to choosing the plan type, beneficiaries must compare the numerous features of each specific plan, including which drugs are covered, prior authorization (PA) requirements and appeal procedures, premiums, and copayment amounts. Moreover, most drug plans have three or four levels—or tiers—of cost-sharing for different drugs and for different forms of the same drug (e.g., generic or brand name); some plans have as many as eight cost-sharing tiers. Beneficiaries must weigh these features based on their own circumstances, including consideration of their future health needs. And they may have to repeat this process periodically, reevaluating their enroll-

ment decision in light of changes in their drug usage as well as cost and coverage modifications made by their current plan and its competitors.

The purpose of this issue brief is to address two sets of questions: First, does it matter which plan a beneficiary chooses? The brief examines different features of plans operating in California to establish the variations among them and whether the differences are meaningful. The analysis also seeks to determine any relationships between plan features, such as whether plans with low premiums cover fewer drugs or charge higher copayments. Second, is coverage for dual-eligibles better or worse under Medicare Part D than with Medi-Cal, or does it depend on the specific plan in which the dual-eligible is enrolled? This question is especially important since most dual-eligibles who did not choose a plan themselves were randomly assigned to PDPs that offer a premium at or below the statewide average.

Among the positive findings of the issue brief are:

- Despite predictions of a lack of choice under the drug benefit, Medicare beneficiaries in California have a wide array of drug plans from which to choose—between 50 and 71, depending on the county.
- Federal protections for certain drug classes have led to more extensive coverage by all plans for drugs in protected classes than in unprotected classes.

- Plans that are available to dual-eligibles at no cost appear to offer drug coverage that is similar to other plans.

Other key findings that should be of concern to policymakers and consumer advocates include:

- There are meaningful differences in coverage among the plans, yet these differences can be difficult for beneficiaries and their advocates to sort out. Each plan employs a different mixture of several utilization controls and cost-reduction devices, including premiums, deductibles, cost-sharing, prior authorization, step therapy, and generic substitution.² Moreover, most differences in plan features are not correlated with one another.
- Many dual-eligible beneficiaries, even if they are properly enrolled in a drug plan, have coverage that is inferior to their coverage under Medi-Cal for the four classes analyzed. Moreover, dual-eligibles who were automatically and randomly enrolled into a plan by the Centers for Medicare and Medicaid Services (CMS) may receive very different coverage depending on the plan in which they were enrolled.
- For these reasons, both Medicare-only and dual-eligible beneficiaries may find themselves enrolled in a plan that is not the best option for them.

Implementation of the new drug benefit has just begun, so some issues raised in this brief cannot be fully answered until the plans have operated for a longer period of time. In particular, the full impact of the new plans on beneficiary drug access and utilization will not be known until plans and CMS collect and disseminate utilization data.

Despite the limit on available data at this early date, all the variations in plan coverage and structures point to the need for California policymakers and

beneficiary advocates to continue monitoring implementation of the new drug benefit and assisting beneficiaries to enroll in the plan most appropriate for their health needs. Some of California's dual-eligibles have already experienced difficulty in obtaining their prescription drugs and state officials have responded by providing them with an emergency supply of medications. California officials should consider allocating funds to supplement the Medicare drug benefit if sustained access problems are identified and provide additional assistance with beneficiary decision-making, especially for dual-eligibles and other vulnerable populations.

For its part, the federal government should continue to monitor the effects of its regulations and policy guidance as program data becomes available, as well as develop new forms of beneficiary information and assistance. In particular, CMS should consider establishing performance measures regarding the plans as a way to further assist beneficiaries in choosing among plans. CMS should also gauge the impact of its automatic enrollment system on drug access for dual-eligible beneficiaries. And because of the great variety among plans, it should consider standardizing the procedures by which beneficiaries, and the physicians and pharmacists who assist them, request prior authorization and coverage exceptions.

Methodology

The first section of this brief examines coverage of four classes of drugs—antipsychotics, antiretrovirals, antihypertensives, and anticholesterols—to assess differences in coverage among California plans. The specific anticholesterol and antihypertensive medications analyzed are the subsets dyslipidemics and renin-angiotensin-aldosterone system inhibitors. The United States Pharmacopeia's (USP) Comprehensive Drug Listing was used to identify the prescription drugs within the classes.

In cases where brand name and generic drugs have the same active ingredient and preparation, the analysis compared coverage across all of these drugs. The comparative data reflects the best positioning (i.e., lowest cost-sharing tier placement) among all such comparable drugs. For example, if a plan includes coverage of one version of a medication on its lowest tier and another version of the same drug on a higher tier, the lower tier drug was considered for purposes of coverage and cost analysis.

Coverage of these drug classes was analyzed using Avalere Health's DataFrame™ tool, which captures data from the CMS "plan finder" Web site, which in turn have been submitted by Medicare prescription drug plans. This analysis was based on plan data publicly available on October 22, 2005. Plans may change their benefit offerings, so the data presented in this issue brief may not precisely reflect changes made since that date.

The second section of the analysis attempts to address a significantly different set of issues, and so uses a different methodology. It evaluates coverage of brand name and generic drugs, plus overall drug coverage, for ten specific plans offered in Los Angeles County. Each drug, both brand name and generic, was treated as distinct, even if they had the same active ingredient. Furthermore, different drug preparations (e.g., oral versus injectable) of the same active ingredients, and combination drugs, were considered as separate drugs. Data for this section came from a combination of sources: Avalere Health's DataFrame™ tool, information on individual plan Web sites, and the CMS formulary finder as of January 16, 2006. It should be noted that there were instances in which a plan's published formulary—list of covered drugs—did not include a particular drug, while the CMS formulary finder for that plan did list the drug as covered. When such discrepancies were found, this analysis

used the data from CMS's formulary finder, though it is possible that the CMS tool contains some errors. For readers' reference, each table or figure in the brief specifically notes whether the data came from Avalere Health's DataFrame™ tool, the CMS formulary finder, or the specific plan Web sites.

Extent of Drug Coverage

CMS granted Medicare drug plans considerable flexibility in designing their formularies and in placing certain restrictions on drug utilization, both to ensure appropriate use and to contain costs. Plans had the option of following the model drug classification system developed by USP or developing their own classification system. CMS required plans to include on their formularies at least two drugs in each therapeutic category or class. And through policy guidance, CMS designated six drug categories as "protected," meaning that it expects plans to cover "all or substantially all" available drugs; CMS issued this guidance in response to concerns that restrictions on these particular drugs are more likely than in other categories to cause adverse health care outcomes.

To evaluate the effect of CMS formulary mandates and guidance, this section examines coverage of commonly prescribed medicines in four drug classes: two drug categories that were designated as protected and two that were not. It compares plans' coverage in these categories among the different plan types (PDPs, MA-PDs, and SNPs) and between PDPs that qualify for dual-eligible auto-enrollment and PDPs that do not. The section also uses these four categories to assess the potential impact on dual-eligible beneficiaries of their transition from Medi-Cal to the new drug benefit.

The four drug classes selected for analysis, each addressing common, serious illnesses among California's Medicare population, are:

Protected Categories

- **Antipsychotics**, used to treat psychotic conditions such as schizophrenia. This is the most extensively prescribed class of drugs for California dual-eligible beneficiaries.³ Individual drugs in this class have markedly different effects on different people, so physicians carefully tailor drug regimens for patients—a process that can be lengthy and difficult. Once a patient with a psychotic condition has been stabilized with these drugs, even a small change in preparation, dosage, or other aspect of use can destabilize the patient, which can result in disruption of the drug regimen and adverse health events. For these reasons, clinicians and beneficiary advocates argue that it is extremely important that Medicare beneficiaries who use antipsychotic drugs are able to continue their treatment exactly as currently prescribed.

- **Antiretrovirals**, used to treat HIV. CMS established special protection status for this drug class because the population it treats is clinically vulnerable to changes in drug coverage. In particular, and unlike its guidance for other protected classes, CMS restricted plans' use of prior authorization (PA) for all but one antiretroviral drug.

Unprotected Categories

- **Antihypertensives and anticholesterol drugs** are two subclasses of cardiovascular agents. Antihypertensives and anticholesterol drugs help regulate blood pressure and reduce cholesterol, addressing two leading factors in heart disease. These medicines are both extremely important and heavily used: heart disease was the leading cause of death for Californians aged 65 and above in 2002,⁴ and these subclasses include some of the most highly prescribed drugs from the Medicare Drug Discount Card Program.⁵

Although CMS did not designate these subclasses as protected, it has indicated that it will closely monitor several of these drugs⁶ and will evaluate plans' tiered cost-sharing structures and other utilization management tools to ensure beneficiaries have appropriate access to them.

Comparing the Coverage

Coverage by Category

As a result of CMS's directive regarding protected drug classes, Medicare drug plan coverage of antipsychotics and antiretrovirals in California is more comprehensive than coverage of the two unprotected classes of cardiovascular agents, as indicated in Table 1. On average, Medicare drug plans in California cover 87 percent of antipsychotics and 98 percent of antiretrovirals, compared to 63 percent of antihypertensives and anticholesterol drugs.

However, even within the protected classes there is variability in Medicare drug plan coverage for specific drugs. Most plans cover all antiretrovirals, averaging 22.6 out of 23 drugs, compared to an average of 18.3 out of 21 antipsychotic drugs (see Table 1). This average for antipsychotics indicates that some Medicare drug plans may not be appropriate for certain Medicare beneficiaries who require specific drugs in this protected class.

The presence of a drug on a plan's formulary, however, is not the only measure of a beneficiary's access to that drug. Under CMS regulations and guidance documents, Medicare drug plans are permitted to place utilization restrictions on certain drugs. On average, Medicare plans place prior authorization restrictions on only 2 percent of antiretroviral drugs but on 10 percent of antipsychotics. So, even though antipsychotics are a protected class, they have a higher prior authorization rate than the two unprotected classes considered in this analysis, as shown in Table 1.

Table 1: Comparison of Formulary Coverage Across Different Types of California Plans and Medi-Cal
All figures are averages as of October 22, 2005.

| | Medi-Cal | Auto-Enrollment PDPs (10 plans) | Other PDPs (37 plans) | MA-PDPs (107 plans) | SNPs (10 plans) | All Medicare Drug Plans (164 plans) |
|---|-----------------|---------------------------------|-----------------------|---------------------|-----------------|-------------------------------------|
| Premium* | — | \$18.60 | \$35.50 | \$10.00 | \$19.10 | \$16.83 |
| Deductible* | — | \$105.00 | \$86.50 | \$23.40 | \$225.00 | \$54.90 |
| Number of Tiers | — | 4.1 | 3.6 | 4.0 | 4.0 | 3.9 |
| Number of Drugs on Formulary | — | 1,508 | 1,452 | 1,469 | 1,510 | 1,470 |
| PROTECTED CLASSES | | | | | | |
| Antipsychotics (21 drugs) | | | | | | |
| Number of Drugs Covered | 20 | 18.1 | 17.7 | 18.5 | 18.2 | 18.3 |
| Number of Drugs NOT Covered | 1 | 2.9 | 3.3 | 2.5 | 2.8 | 2.7 |
| Percentage of Drugs Covered in First Tier | — | 38% | 39% | 37% | 39% | 38% |
| Percentage of Drugs Covered in Second Tier | — | 29% | 30% | 22% | 26% | 25% |
| Percentage of Drugs Covered in Third Tier or Higher | — | 20% | 14% | 28% | 22% | 24% |
| Percentage of Drugs Requiring Prior Authorization | 0% | 11% | 5% | 12% | 13% | 10% |
| Antiretrovirals (23 drugs) | | | | | | |
| Number of Drugs Covered | 23 | 22.3 | 22.4 | 22.7 | 22.9 | 22.6 |
| Number of Drugs NOT Covered | 0 | 0.7 | 0.6 | 0.3 | 0.1 | 0.4 |
| Percentage of Drugs Covered in First Tier | — | 3% | 0% | 0% | 9% | 1% |
| Percentage of Drugs Covered in Second Tier | — | 66% | 68% | 50% | 59% | 56% |
| Percentage of Drugs Covered in Third Tier or Higher | — | 30% | 29% | 49% | 32% | 42% |
| Percentage of Drugs Requiring Prior Authorization | 4% [†] | 0% | 2% | 3% | 3% | 2% |
| NON-PROTECTED CLASSES | | | | | | |
| Antihypertensives (12 drugs) | | | | | | |
| Number of Drugs Covered | 12 | 8.3 | 8.7 | 8.5 | 9.1 | 8.6 |
| Number of Drugs NOT Covered | 0 | 3.7 | 3.3 | 3.6 | 2.9 | 3.5 |
| Percentage of Drugs Covered in First Tier | — | 23% | 21% | 23% | 24% | 23% |
| Percentage of Drugs Covered in Second Tier | — | 25% | 29% | 18% | 22% | 21% |
| Percentage of Drugs Covered in Third Tier or Higher | — | 21% | 22% | 30% | 47% | 40% |
| Percentage of Drugs Requiring Prior Authorization | 8% | 5% | 3% | 9% | 10% | 7% |
| Anticholesterol drugs (20 drugs) | | | | | | |
| Number of Drugs Covered | 14 | 12.8 | 12.3 | 11.3 | 12.3 | 11.7 |
| Number of Drugs NOT Covered | 6 | 7.2 | 7.7 | 8.7 | 7.7 | 8.3 |
| Percentage of Drugs Covered in First Tier | — | 30% | 28% | 25% | 28% | 26% |
| Percentage of Drugs Covered in Second Tier | — | 14% | 14% | 14% | 18% | 15% |
| Percentage of Drugs Covered in Third Tier or Higher | — | 20% | 19% | 17% | 16% | 17% |
| Percentage of Drugs Requiring Prior Authorization | 0% | 6% | 5% | 8% | 14% | 6% |

*Dual-eligibles and other low-income beneficiaries generally pay no or reduced premiums and deductibles.

[†]All other antiretroviral drugs can only be prescribed to treat HIV.

Source: Avalere Health analysis of DataFrame™.

Medicare Coverage vs. Medi-Cal Coverage

Approximately one million of California’s Medicare beneficiaries have transitioned from Medi-Cal’s prescription drug coverage to Medicare drug plans. Although these dual-eligible beneficiaries pay no deductible or monthly premium for their Medicare drug plans, they are responsible for copays of \$1 to \$5, an increase from Medi-Cal’s non-mandatory \$1 copay for all prescription drugs.

Drug coverage under fee-for-service Medi-Cal for the four drug classes analyzed here is more comprehensive than average coverage by each type of Medicare drug plan.⁷ For example, only 1 out of 21 antipsychotic drugs is not covered on Medi-Cal’s preferred drug list (PDL), compared to an average of 2.7 such drugs on Medicare drug plans’ formularies. (Technically, all drugs are covered on the Medi-Cal formulary, if the physician deems them medically necessary, via the Treatment Authorization Review [TAR] process.) Similarly, Medi-Cal coverage is significantly more complete for cardiovascular agents than the average coverage offered by Medicare plans. These data indicate that some dual-eligible beneficiaries may experience disruptions in their drug coverage after transitioning to the Medicare prescription drug benefit. However, depending on their drug regimen, many dual-eligibles will find that their Medicare drug plan provides adequate coverage for the drugs they are currently taking.

Coverage among Plan Types

The average number of covered drugs within the classes reviewed for this brief varies only slightly across the different types of Medicare drug plans. This suggests that the type of plan beneficiaries enroll in may not be important in securing access to a broad range of drugs. Coverage among PDPs is somewhat better than coverage among MA-PDs, since on average MA-PDs place more drugs on higher

cost-sharing tiers and require prior authorization for more drugs than do PDPs. For example, in the hypertensives category, MA-PDs on average require prior authorization for 8 percent of drugs, compared to an average of 7 percent across all types of Medicare plans. This same relatively small magnitude of difference holds true in each of the four categories of drugs analyzed here.

The average total number of drugs covered by the plans is also similar, although auto-enrollment PDPs and SNPs tend to cover slightly more drugs in many drug classes than other plan types. It is worth noting that on average both types of PDPs offered in California—those eligible to receive dual-eligibles and those not eligible—offered similar coverage in the four analyzed drug categories. Consumer advocates had expressed concerns that dual-eligibles, one of the most vulnerable groups of Medicare beneficiaries, would be assigned to plans that offered generally poorer coverage than other stand-alone PDPs or MA-PDs. At least in terms of the number of common drugs covered, such a difference does not appear to exist in California.

Coverage among Individual Plans

Although average coverage is similar across all types of Medicare drug plans, there is great variation in the number of drugs covered by individual plans. As shown in Table 2 (highlighting the highest, lowest, and median levels of plan elements for each of the four types of Medicare drug plans), the number of drugs on plans’ formularies varies from 530 to 3,360. There are also great differences among plans in their use of utilization controls. For example, one auto-enrollment plan requires prior authorization for eight antipsychotic drugs while others do not require prior authorization for any drugs in the same class.

The total number of drugs covered by a plan may be a significant factor in evaluating whether a plan will best serve a beneficiary's needs. Knowing whether a plan covers the specific drugs a beneficiary is currently taking is the most important and immediate concern in choosing a plan. But beneficiaries may also want to consider whether a plan is likely to meet their future health care needs as well. Over time, beneficiaries may develop illnesses or conditions that call for new medications. Enrolling in a plan that covers a high total number of drugs may lessen the

likelihood of needing to switch plans in the future. This may be particularly important for Medicare beneficiaries enrolled in managed care, because switching drug plans may also necessitate changes in their overall medical coverage, which in turn may mean changes in doctors and other providers, and in various aspects of cost-sharing.

The enormous variation in coverage offered by auto-enrollment PDPs could have a significant impact on dual-eligible beneficiaries. Because CMS randomly

Table 2: Range of Coverage Offered by Medicare Drug Plans in California

All figures are averages as of October 22, 2005.

| | Medi-Cal | Auto-Enrollment PDPs | | | Other PDPs | | | MA-PDs | | | SNPs | | |
|---|-----------------|----------------------|--------|---------|------------|---------|---------|---------|-----|-------|---------|-----|---------|
| | | High | Low | Med | High | Low | Med | High | Low | Med | High | Low | Med |
| Premium* | — | \$23.22 | \$5.41 | \$20.04 | \$66.08 | \$11.25 | \$34.79 | \$50.84 | \$0 | \$11 | \$23.25 | \$0 | \$22.33 |
| Deductible* | — | \$250 | \$0 | \$25 | \$250 | \$0 | \$0 | \$250 | \$0 | \$0 | \$250 | \$0 | \$250 |
| Tiers | — | 5 | 3 | 4 | 5 | 2 | 4 | 8 | 2 | 4 | 5 | 3 | 4 |
| Drugs on Formulary | NA [†] | 3,360 | 626 | 1,267 | 2,773 | 626 | 1,516 | 3,360 | 817 | 1,056 | 3,360 | 530 | 1,056 |
| Antipsychotics (21 drugs) | | | | | | | | | | | | | |
| Drugs Covered | 20 | 21 | 15 | 18 | 21 | 12 | 18 | 21 | 15 | 19 | 21 | 10 | 20 |
| Drugs Covered in First Tier | — | 47% | 24% | 40% | 57% | 0% | 48% | 57% | 0% | 33% | 52% | 19% | 48% |
| Drugs Requiring PA | 0% | 38% | 0% | 2.4% | 24% | 0% | 0% | 57% | 0% | 10% | 33% | 0% | 10% |
| Antiretrovirals (23 drugs) | | | | | | | | | | | | | |
| Drugs Covered | 23 | 23 | 19 | 23 | 23 | 18 | 23 | 23 | 22 | 23 | 23 | 22 | 23 |
| Drugs Covered in First Tier | — | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 0% | 91% | 0% | 0% |
| Drugs Requiring PA | 4% [‡] | 4% | 0% | 4% | 4% | 0% | 0% | 4% | 0% | 4% | 4% | 0% | 4.3% |
| Antihypertensives (12 drugs) | | | | | | | | | | | | | |
| Drugs Covered | 12 | 12 | 5 | 8 | 12 | 3 | 9 | 12 | 5 | 8 | 12 | 6 | 9 |
| Drugs Covered in First Tier | — | 25% | 17% | 25% | 25% | 0% | 25% | 25% | 0% | 25% | 33% | 17% | 25% |
| Drugs Requiring PA | 8.3% | 35% | 0% | 0% | 16.7% | 0% | 0% | 25% | 0% | 8.3% | 25% | 0% | 8% |
| Anticholesterol drugs (20 drugs) | | | | | | | | | | | | | |
| Drugs Covered | 14 | 20 | 7 | 10 | 20 | 6 | 10 | 20 | 4 | 9 | 20 | 9 | 10 |
| Drugs Covered in First Tier | — | 30% | 25% | 30% | 35% | 0% | 30% | 35% | 0% | 25% | 4% | 25% | 30% |
| Drugs Requiring PA | 0% | 45% | 0% | 0% | 5% | 0% | 0% | 45% | 0% | 5% | 45% | 0% | 5% |

*Dual-eligibles enrolled in these plans do not pay the premium or deductible.

†Technically, all drugs are covered on the Medi-Cal formulary if the physician deems them medically necessary via the Treatment Authorization Review (TAR) process. However, many drugs require prior authorization under Medi-Cal's PDL, which covers approximately 600 drugs. There are over 8,000 total Part D drugs; however, that number includes many drugs for which multiple generic versions exist.

‡All other antiretroviral drugs can only be prescribed to treat HIV.

Notes: "Med" is median. "PA" is prior authorization. The values shown in any given column (e.g., MA-PDs High) do not represent any single plan; rather, each value may represent a different plan.

Source: Avalere Health analysis of DataFrame™.

assigned dual-eligibles to these plans, some dual-eligibles may arbitrarily receive significantly poorer drug coverage than others. CMS also intends to facilitate enrollment for certain non-dual-eligible low-income beneficiaries on May 1, 2006;⁸ these beneficiaries, too, may receive drastically different drug benefits depending on the plan in which they are enrolled. These disparities among plans raise doubts about the appropriateness of random auto assignment policies for dual-eligibles. And while dual-eligibles are permitted to change plans on a monthly basis, there is little information as yet about how often they will actually do so. Given these problems, it appears that the method for assigning dual-eligible beneficiaries to drug plans does not provide a consistent level of benefits to this vulnerable group of beneficiaries.

Distinguishing Plan Choices

In order to take a closer look at the differences among plans, this section analyzes ten specific Medicare

plans that offer coverage in the Los Angeles area (which has 71 total Medicare drug plans, the most offerings of any California county). Ten representative plans were chosen, and include PDPs, MA-PDs, and SNPs. The factors considered when selecting plans for comparison were whether they: are eligible for auto-enrollment; are offered on a nationwide or more limited basis; and provide additional benefits beyond the standard benefit structure. Plans were selected with a range of premiums and covered drugs.

Table 3 lists the ten specific plans and their major characteristics. The categories of comparison include:

- “Eligible for Auto-Enrollment” (for PDPs), which refers to whether CMS auto-enrolls dual-eligible beneficiaries into those plans. In order to be eligible for auto-enrollment, a PDP must have a monthly plan premium below the region’s benchmark (\$23.25 in California for 2006). This

Table 3: Plans’ Geographic Regions, Cost Sharing, and Drug Coverage

| | Features | Offered... | No Deductible | Coverage in Gap | High Drug Coverage |
|--|-------------------------------------|----------------------------|---------------|-----------------|--------------------|
| PDP PLANS | Eligible for Auto-Enrollment | Nationwide | | | |
| PDP 1 – Cignature Rx Complete | | ✓ | ✓ | ✓ | ✓ |
| PDP 2 – Prescription Pathway Gold | | | ✓ | | |
| PDP 3 – WellCare Signature | ✓ | ✓ | ✓ | | |
| PDP 4 – Humana Standard | ✓ | | | | ✓ |
| MA-PD PLANS | No Drug Premium | in Most Counties | | | |
| MA-PD 1 – Kaiser Permanente Senior Advantage | ✓ | ✓ | ✓ | | |
| MA-PD 2 – Aetna Golden Medicare Premier | ✓ | | ✓ | ✓ | ✓ |
| MA-PD 3 – Secure Horizons Classic Plan II | | | ✓ | | |
| MA-PD 4 – Freedom Blue Plan I | | ✓ | ✓ | | ✓ |
| SNP PLANS | SNP Type | in Several Counties | | | |
| SNP 1 – Positive Healthcare Partners | HIV/AIDS | | | | |
| SNP 2 – Health Net Seniority Plus Amber | Dual-eligibles | ✓ | | | ✓ |

Note: The organizations sponsoring these ten plans also offer other Medicare drug plans. This analysis is not an evaluation of particular organizations, but only of individual plans. Also, this analysis should not be viewed as an endorsement of any particular plan over another. Choosing a plan should depend on each beneficiary’s medical conditions and specific drug needs, and on the beneficiary’s preferences and concerns regarding plan differences.

Source: Avalere Health research from the Landscape of Local Plans, released by the Centers for Medicare and Medicaid Services (CMS) (available at www.medicare.gov/medicarerreform/map.asp). High drug coverage status obtained using the CMS Medicare Formulary Finder Tool (available at www.medicare.gov). The list of top 100 Medicare drugs lists only the drug’s active chemical ingredient. The chemical ingredient was matched with the brand name drug, and searched using the CMS formulary finder, which lists which drugs have available generics.

category may be considered a proxy for low-premium plans.

- “Offered Nationwide” refers to the geographic availability of a PDP. Plans with a check-mark are offered nationwide; the others are not offered in every state.
- “Offered in Most Counties” shows whether an MA-PD plan is available in 30 or more California counties (check-marked) or in less than ten counties (including Los Angeles).
- “Offered in Several Counties” shows whether a SNP is available in more than just Los Angeles County (check-marked).
- “No Deductible” indicates whether the plan benefit waives the standard plan’s annual deductible requirement of \$250.
- “Coverage in Gap” shows whether the plan offers any drug coverage during the standard benefit’s gap in coverage in which beneficiaries are responsible for 100 percent of their total drug costs. Some plans offer coverage of generic or brand name drugs in the gap as part of an “enhanced benefit.” For 2006, the gap begins when total drug spending (i.e. beneficiary plus plan spending) equals \$2,250 (equivalent to \$750 in beneficiary out-of-pocket spending under the standard benefit). The gap ends when total spending reaches the catastrophic limit for 2006 of \$5,100 (equivalent to \$3,600 in out-of-pocket spending), after which plans pay 95 percent of covered drug costs.
- “High Drug Coverage” is based on the number of drugs a plan covers out of the top 100 Medicare drugs.⁹ Plans with high coverage among the PDPs are those with more than 95 of the top 100 drugs. MA-PDs with high drug coverage are those with over 90 of the top 100. The criteria

are different for PDPs and MA-PDs because PDPs on average cover more of the top 100 drugs than do MA-PDs.

Coverage of Generic Drugs

In addition to restricting the number of available drugs, many plans combine broad coverage of generics with tiered copayments in order to control utilization. Of the top 100 Medicare drugs, 59 are available as generics; of these, each of the ten representative plans covers at least 52 generics (88 percent).¹⁰ And all seven of the ten representative plans that have tiered cost-sharing use their tiering system to promote generic utilization over the use of brands. They do so by including generic drugs on tiers with little or no cost-sharing while placing brand name drugs on tiers with higher cost-sharing. For the seven plans chosen with tiered copayments, the highest copay for generic drugs is \$10, while the lowest copay for brand name drugs is \$20. Generic utilization is also encouraged among the low-income subsidy beneficiaries; even though most low-income subsidy beneficiaries have fixed copays of between \$1 and \$5 in 2006, they pay \$2 more for brand name drugs.

Table 4 provides the cost-sharing structure for each of the ten plans. Every plan with fixed-dollar copays charges a lower cost for generics than for brand name drugs. Three plans charge a co-insurance rate, instead of copays, for all of their covered drugs; the co-insurance amount is based upon a percentage of the drug’s cost. Many plans charge coinsurance rather than a fixed copay for specialty drugs, typically injectable and other very high-cost drugs such as genomic and biotech products. There is also a “non-preferred brand” tier in which the highest fixed copay is charged for brand name drugs.

Table 4: Cost Sharing Offered by the 10 Representative Plans in Los Angeles County

| Plan | Premium | Number of Drugs on Formulary as of 10/22/05 | Tier 1 | Tier 2 | Tier 3 | Tier 4 | Tier 5 |
|---------|---------|---|----------------------------|---------|--------------|--------|--------|
| PDP 1 | \$42.63 | 2,175 | \$5.00 | \$30.00 | \$50 | | |
| PDP 2 | \$49.62 | 1,523 | \$4.00 | \$29.00 | 25% | | |
| PDP 3 | \$18.04 | 626 | \$0.00 | \$0.00* | \$69 | \$69 | 32% |
| PDP 4 | \$5.41 | 1,450 | 25% | 25% | 25% | 25% | |
| MA-PD 1 | \$0.00 | 911 | \$10.00 | \$30.00 | | | |
| MA-PD 2 | \$0.00 | 2,773 | \$2.00 | \$20.00 | \$40 | | |
| MA-PD 3 | \$23.00 | 1,056 | \$8.50 | \$26.70 | 50% | 33% | |
| MA-PD 4 | \$7.00 | 894 | \$10.00 | \$30.00 | Not Covered† | 25% | 25% |
| SNP 1 | \$18.37 | 530 | One Tier: 25% Co-Insurance | | | | |
| SNP 2 | \$14.28 | 3,360 | One Tier: 25% Co-Insurance | | | | |

Tier Key

- Generics
- Preferred Brand Name
- Non-Preferred Brand Name
- Preferred Specialty
- Non-Preferred Specialty

*PDP 3 has the same cost sharing for preferred and non-preferred generics.

†Non-formulary drugs

Sources: Information from the Medicare plan finder tool (available at www.medicare.gov). The number of drugs on formulary: Avalere Health analysis of DataFrame™.

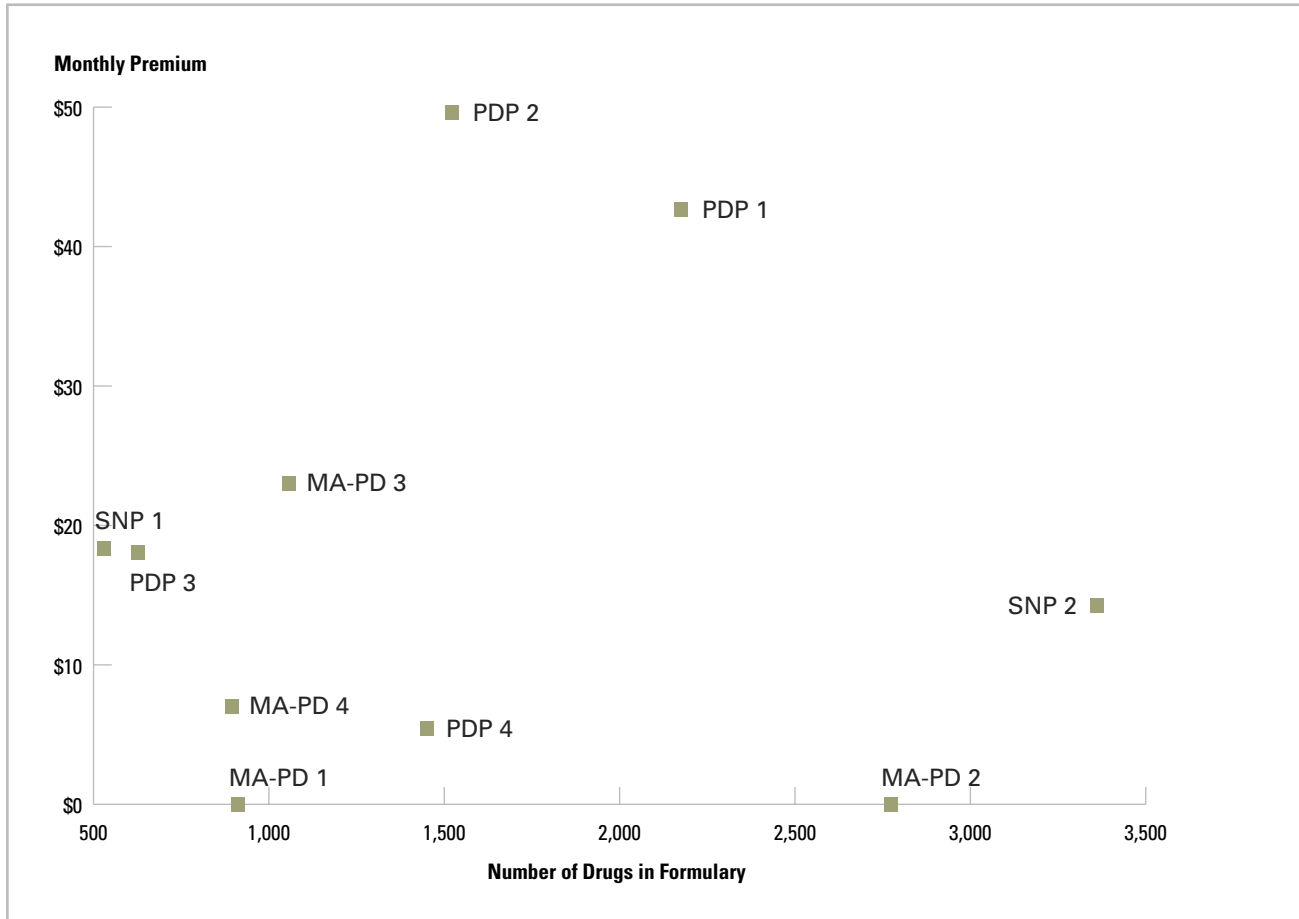
Variation among the Ten Plans

In addition to differences in cost-sharing structures, the ten representative plans vary greatly in other ways. However, there appears to be no simple correlation between one distinguishing element of a plan and any other element. For example, Figure 1 displays the range of the ten plans’ premiums (organized from lowest to highest) mapped against the number of drugs on each plan’s formulary. There appears to be little relation between plans’ premiums and the number of drugs they cover: the most expensive plan does not cover the most drugs; and one of the lowest-premium plans (MA-PD 2) covers more total drugs than any other plan except one SNP available only to dual-eligibles. On the other hand, it should be noted that high-premium plans may offer better coverage in other ways, such as providing some coverage within the coverage gap, reducing the standard deductible, or providing other enhanced benefits.

In an effort to help beneficiaries evaluate plan options, CMS provides data (through the Medicare Web site plan finder tool) on plans’ coverage of the top

100 Medicare drugs. A plan’s coverage of the drugs a beneficiary is currently taking is clearly the most important immediate selection criterion. But, at least notionally, information about tier coverage of the top 100 drugs may help beneficiaries choose a plan that is also likely to cover drugs they may need in the future. Analysis done for this issue brief suggests that coverage for the top 100 drugs does indeed provide a reasonable indication of plan coverage for drugs, generally, and for specific important and commonly used medicines. Table 5, which lists the ten plans in descending order based on data from CMS showing the number of top 100 Medicare drugs on the formulary, demonstrates that plans covering a high percentage of the top 100 drugs also tend to cover a high percentage of the drugs within four key classes: antiretrovirals, antipsychotics, and the cardiovascular agents. However, the relationship is not entirely reliable, as a comparison of PDP 4 and MA-PD 2 illustrates. Both PDP 4 and MA-PD 2 cover all, or essentially all, of the top 100 Medicare drugs. But this masks important differences between the two plans. PDP 4 covers fewer drugs on its formulary compared to MA-PD 2 (1,450 and

Figure 1: Number of Drugs Covered on Formulary, by Plan and Premium



Source: The number of drugs on formulary: Avalere Health analysis of DataFrame™ as of October 22, 2005. Premium information is from Avalere Health research from the Medicare plan finder tool (available at www.medicare.gov).

2,773, respectively), yet it covers many more drugs in the four key drug classes (73 and 57, respectively) without prior authorization (PA) or step therapy (ST). In the ten representative plans, there does not appear to be any relationship between plan premiums and their offering of enhanced coverage, represented by coverage in the coverage gap within which beneficiaries in standard plans are responsible for 100 percent of their drug costs. Of the nine plans for which there was available information, only PDP 1 and MA-PD 2 offer some coverage within the coverage gap. The other seven plans offer no coverage in the gap, though six of the seven plans' premiums fall between those of the two plans that do offer gap coverage (see Table 4 for plan premiums).¹¹

Restrictions on Brand Name Drugs

In addition to limiting brand name drugs on their formularies, most plans restrict coverage of brand names through prior authorization, step therapy and generic substitution, all to encourage the use of generics by their plan enrollees. To illustrate several different such approaches, Figure 2 compares coverage provided by three of the representative plans for certain brand name drugs which have available generics. The figure shows such coverage for three key drug classes (not including antiretrovirals, which are almost all covered and have very few generics available). Each of the other plans, too, uses one of these three approaches.

Table 5: Drug Coverage by the Ten Plans

| Plan | Top 100 Drugs Covered as of 11/15/05 | Drugs on Formulary as of 10/22/05 | Drugs Covered in the Four Classes | |
|---------|--------------------------------------|-----------------------------------|-----------------------------------|---------------------------------|
| | | | 10/22/05 | without PA or ST, as of 2/10/06 |
| SNP 2 | 100 | 3,360 | 76 | 56 |
| MA-PD 2 | 100 | 2,773 | 73 | 57 |
| PDP 1 | 99 | 2,175 | 70 | 70 |
| PDP 4 | 99 | 1,450 | 66 | 73 |
| PDP 2 | 92 | 1,523 | 57 | 58 |
| MA-PD 4 | 92 | 894 | 53 | 56 |
| PDP 3 | 88 | 626 | 52 | 52 |
| SNP 1 | 84 | 530 | 51 | 45 |
| MA-PD 3 | 82 | 1,056 | 60 | 53 |
| MA-PD 1 | 71 | 911 | 49 | 54 |

Source: The number of top 100 drugs covered and the number of top 100 drugs covered without PA or ST are from CMS' Landscape of Local Plans, available at www.medicare.gov/medicarereform/mapdpdocs/PDPLandscape.pdf for PDPs, and www.medicare.gov/medicarereform/mapdpdocs/MALandscape.pdf for MA-PDs. The number of drugs on formulary and covered in the four classes come from Avalere Health analysis of DataFrame™. The data for the number of drugs covered in the four classes without PA or ST is from Avalere Health's analysis of plan formularies (for eight of the 10 plans) and the Medicaid prescription drug Formulary Finder tool, available from CMS (www.medicare.gov).

Certain plans (in Figure 2, MA-PD 1) encourage enrollees to use generics by simply covering very few brand drugs at all. Other plans (SNP 2 on the figure) cover all of the brand name drugs but use prior authorization, step therapy and generic substitution to control their utilization. Still other plans (PDP 4 in Figure 2) cover many brand name drugs without restriction. While there is no clear pattern among the plans on exactly how they do so, it is evident that every plan uses some tools to encourage its enrollees to use generic drugs in order to reduce the plan's costs.

Exceptions and Appeals Processes

For beneficiaries who need access to particular drugs that require prior authorization or are not covered on the formulary, the exceptions and appeals process ultimately will be an important factor in evaluating drug plans. At this time, however, there is not enough information about the differences among plans' appeals processes to evaluate them across the plans. Where information is available on this topic on plan Web sites, the descriptions of formulary exemption and grievance processes were essentially the same for all ten plans, closely mirroring general CMS requirements (described in detail in the California HealthCare Foundation issue brief *The Medicare*

Drug Benefit: Implications for Chronic Disease Care).

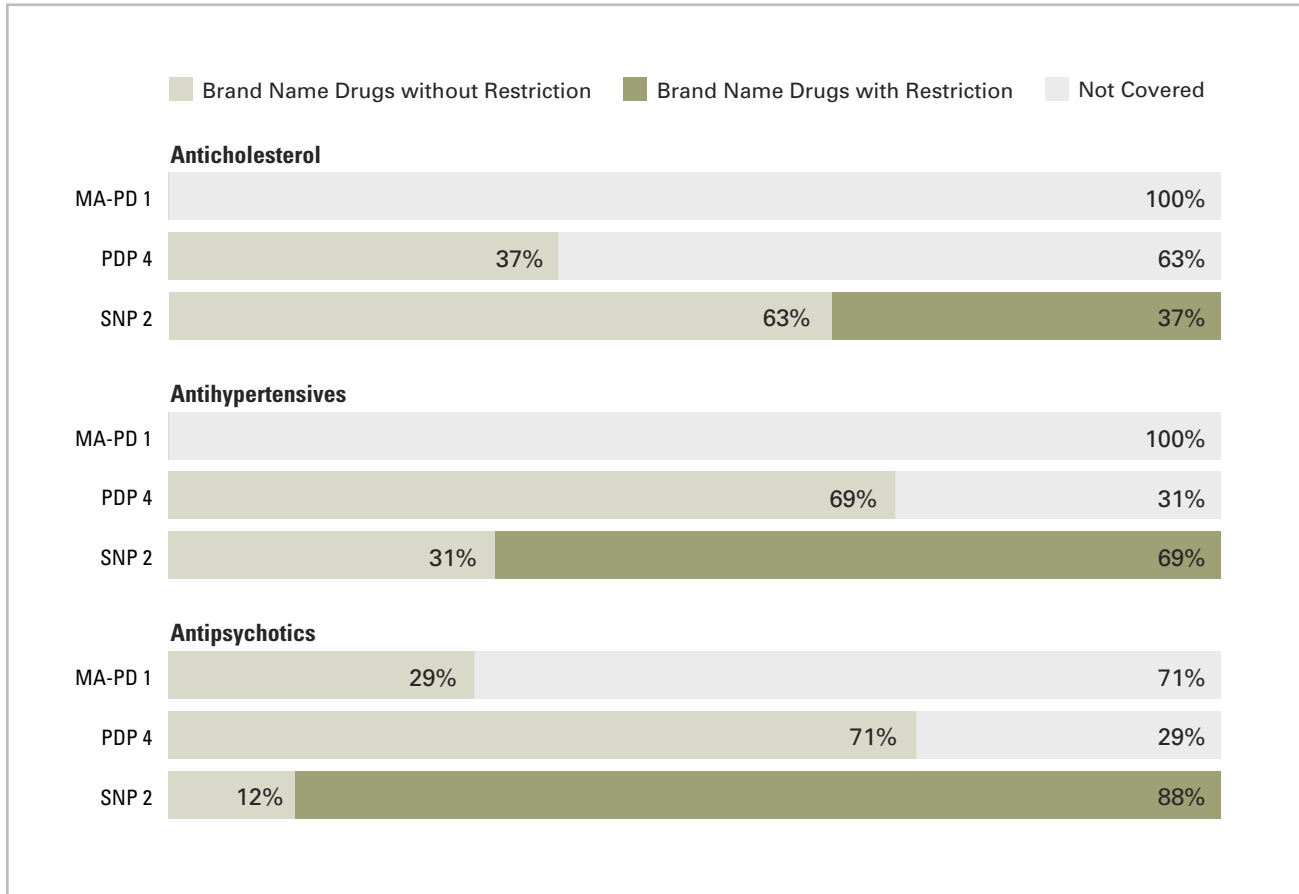
More research will be needed to assess the differences among plans' exceptions and appeals processes once more beneficiaries, their physicians, and pharmacists have actually navigated plans' individual processes.

Findings and Policy Recommendations

This analysis finds significant variation in coverage among California's many new Medicare prescription drug plans. This variation may be especially significant for dual-eligibles, who were randomly assigned to PDPs which qualified for auto-enrollment. Some dual-eligibles are enrolled in plans that offer drug coverage similar to their previous Medi-Cal coverage. Although copays will be higher, a few may even find that their access to drug coverage has increased, depending on the particular plan. However, many dual-eligibles are enrolled in PDPs that offer more limited drug coverage than Medi-Cal did, and their access to medically-necessary drugs may be impeded as a result.

The many differences among plans will likely prove challenging to most beneficiaries when attempting to determine the most appropriate plan for their particular circumstances. To make an informed

Figure 2: Restrictions and Non-Coverage, for Brand Name Drugs with Generic Equivalents as of 1/16/05



Note: Figure measures whether prior authorization, step therapy or generic substitution is required.

Source: Avalere Health research from the Medicare plan finder tool, (available at www.medicare.gov) and plan Web sites.

choice, beneficiaries must not only compare premiums and deductibles but also investigate the plans' formularies, tiering structure, copays, prior authorization, and step therapy requirements, and decide which of these factors are most important to them. Although most of this information is available to beneficiaries through CMS-sponsored print, Internet, and telephone sources, its sheer complexity will likely make it difficult to meaningfully compare plans without a significant amount of consumer education and individualized decision support.

When choosing among plans, beneficiaries should attempt to consider not only coverage of their current medications but also their future prescription drug

needs. In this regard, they can view each plan's coverage of the 100 most common Medicare drugs, as well as prior authorization rules and other restrictions. Changes in drug needs that are not met by the plan in which a beneficiary is enrolled can be ameliorated through the beneficiary's right to switch plans on a regular basis. In order to ensure enrollment in the most appropriate plan, beneficiaries will need to reevaluate their plan choice periodically.

Policymakers at both the federal and state level will need to be vigilant during the first few years of the implementation of this benefit to address difficulties beneficiaries may experience. Medicare drug plans, CMS, state officials, and consumer advocacy groups

should consider providing further assistance as beneficiaries navigate the Medicare prescription drug benefit, such as:

- **DHS and consumer advocates must provide support for dual-eligibles and other low-income beneficiaries in choosing or switching plans.**

Dual-eligible beneficiaries and beneficiaries residing in institutional settings may switch plans monthly; other beneficiaries may switch during the yearly open enrollment period, from November 1 to December 15. Beneficiaries whose current plan does not provide adequate coverage may use these enrollment periods to choose a better plan option. However, the differences among the many plans in California are extremely complex. So, beneficiaries will need ongoing reliable assistance evaluating the differences when choosing a new plan. They may also need assistance negotiating the switch-in-enrollment process itself.

- **The California legislature should consider providing wrap-around coverage for Medi-Cal beneficiaries transitioning to the Medicare drug benefit.**

The wide variety in drug benefits offered by Medicare drug plans, plus the randomness of the auto-enrollment process for dual-eligibles and the higher copays they face, means there is the potential for many people to end up in plans which limit or deny their access to important drugs. These limits are in addition to the losses in health status suffered by the beneficiaries themselves. Many states have responded to this problem by coordinating with the Medicare prescription drug benefit to provide assistance with cost-sharing and drug coverage. California has previously considered implementing a state pharmacy assistance program and currently operates other discount drug programs.

Policymakers should consider providing wrap-around coverage for dual-eligible and other low-income beneficiaries, which ultimately may benefit the state financially.

- **DHS should monitor CMS requirements and plan guidance.**

CMS can alter many of the formulary requirements and guidance currently directed at plans. California policymakers should evaluate how effective these regulations and policy pronouncements are in ensuring that beneficiaries receive adequate access in the program's first year. At the end of 2006, California officials may want to recommend that CMS keep all the current protections in place, or strengthen them if beneficiaries turn out not have sufficient drug access. It should be noted, however, that while greater access to drugs provided by the Medicare program will ensure continuity of care for dual-eligibles, it might also have a financial impact on California through the "maintenance of effort" or "clawback" requirement if overall per capita costs increase.¹²

- **CMS should evaluate plans using performance measures which can help beneficiaries select the best plans.**

CMS should establish and disseminate a series of metrics to evaluate the quality of different aspects of coverage, including extent of coverage for beneficiaries with particular chronic illnesses, ease of navigating and success rates of appeals processes, ability to sort through plan information, and quality outcomes. CMS might also provide specific guidance to help beneficiaries understand what coverage differences between plans would mean for their particular health care requirements.

- **CMS should require plans to use a standardized process for exceptions, grievances and prior authorization requests.** Under current CMS regulations, plans have broad flexibility in designing their own forms and processes for beneficiary grievances and requests for exceptions and prior authorization. Given the many plan offerings, especially in California, it is likely that practitioners, pharmacists, beneficiaries, and their advocates will have difficulty navigating the multitude of plans' processes. To lessen this complexity, CMS should mandate that plans follow common processes and provide standard forms for use by practitioners and beneficiaries when filing a grievance or request for an exception or prior authorization.
- **CMS and the state should monitor the impact of random assignment on drug coverage for, and utilization of other services by, dual-eligibles.** DHS should evaluate whether dual-eligibles are having difficulty accessing drugs, and thereby experiencing negative health outcomes, with their new coverage. Especially to the extent that dual-eligibles lose access to drugs that reduce other, higher-cost medical services, the State of California would face higher costs when Medi-Cal pays for the more expensive care. Similarly, CMS should monitor whether dual-eligibles are managing to switch plans in response to coverage problems; if not, CMS might consider directly assisting dual-eligibles to switch plans. If problems arise in significant numbers, CMS should modify or abandon its random assignment policy and instead assign beneficiaries to plans based, in part, on health status (a change that might require federal legislation). This might include matching dual-eligibles' current drug use with plans that cover those drugs. CMS might also consider requiring greater consistency of coverage among

auto-enrollment plans to help ensure that all dual-eligible beneficiaries receive comparable drug benefits.

Conclusion

The landscape of the new Medicare Part D prescription drug benefit in California includes a wide array of plans. And while the great number of plans provides a measure of choice to beneficiaries, it also presents them with a complex and difficult selection process. Federal protection for specific drug classes enhances coverage of key drugs for many beneficiaries with certain serious or chronic illnesses. But many other beneficiaries may find that their plan offers the same drug that they have been taking but at a high out-of-pocket cost to the beneficiary. This problem is particularly acute for dual-eligible beneficiaries who have been automatically enrolled in a plan. For dual-eligibles, the cost to them of drugs under the new Medicare plan is higher than it was under Medi-Cal. And some may find that the plan in which CMS has enrolled them does not cover drugs they need, leading to a break in their drug regimen, with potentially serious and expensive health consequences, unless and until they can locate a better plan and switch to it.

In response to these potential problems, CMS, the State of California, consumer advocates and the drug plans themselves must continue to be vigilant in overseeing the transition of Medicare beneficiaries to the new plans. In particular, they must closely monitor the quality of coverage provided to dual-eligibles: that population has high health vulnerability; their demographics make it more difficult for them, on average, to sort through plan options; they have less financial resources to cushion coverage gaps; and most of the financial cost of poor health consequences will be borne by the state. To the extent such monitoring discloses significant coverage problems,

especially for dual-eligibles and other vulnerable populations, CMS should be willing to change regulations and policy guidance, and the State of California should establish systems to assist beneficiaries with plan selection and switching processes, and consider providing extra drug coverage assistance.

AUTHORS

Chiquita White, Elizabeth Hinshaw, Eli Sprecher, and Jonathan Blum of Avalere Health LLC, based in Washington, D.C.

ENDNOTES

1. Based on data from the Centers from Medicare and Medicaid Services, January 2006.
2. Plans heavily promote the use of generic drugs over brand name drugs through a variety of methods, including tiered copays, formulary limits, and drug utilization restrictions. Extensive use of generics could help contain overall Medicare prescription drug costs.
3. Interview with DHS official, October 2005 and CMS Statistical Compendium: Medicare Pharmacy Benefit Use and Reimbursement in 1999.
4. According to the Centers for Disease Control (CDC),
5. The Medicare Drug Discount Program was a precursor to, and has been superseded by, the Medicare Part D drug benefit.
6. Statins and ACE inhibitors, which are antihypertensive and anticholesterol drugs, are listed among CMS's list of the 40 drug groups most commonly prescribed to Medicare beneficiaries.
7. The Medi-Cal List of Contract Drugs is a preferred drug list (PDL) containing over 600 drugs.
8. During a March 8, 2006 Operational User Group Call, CMS announced that the facilitated enrollment effective date has been moved up from June 1 to May 1 in order to get beneficiaries into Part D systems sooner.
9. The list of top 100 Medicare drugs refers to total number of prescriptions. The list is based on the Medicare drug discount card experience and is produced by CMS. Many Medicare beneficiaries, including all dual-eligibles, did not participate in the drug discount card program.
10. Source: Avalere Health research using the CMS Medicare Formulary Finder Tool (available at www.medicare.gov). The list of top 100 Medicare drugs lists only the drug's active chemical ingredient. The chemical ingredient was matched with the brand name drug, and searched using the CMS formulary finder, which lists which drugs have available generics.
11. Source: Avalere Health research based on the Medicare plans finder tool (available at www.medicare.gov).
12. The clawback formula is based in part on increases in Part D per capita spending.

For more background on the Medicare drug benefit and its implications for California—including other issue briefs in this series—visit the California HealthCare Foundation's Web site at www.chcf.org/topics/healthinsurance/drugbenefit.