

MEDICARE PART D 2008 DATA SPOTLIGHT: SPECIALTY TIERS

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Medicare Part D plans must establish a formulary that lists the specific drugs they cover and at what level of cost sharing. Although the law establishes a defined standard benefit with 25 percent coinsurance for covered drugs, most plans rely on the law's flexibility to offer a benefit with tiered cost sharing. Plans typically use different levels of cost sharing for generic, preferred, and non-preferred drugs. A growing number of plans include an additional "specialty" tier for very high cost and unique items, and some also have a separate tier for injectible drugs.

Part D enrollees have the right to request an exception to a plan's designation of a drug as non-preferred, but not for drugs on the specialty tier. In general, if an enrollee can establish that a non-preferred drug is medically necessary and no preferred drug would be as effective, the enrollee can pay the lower cost sharing that applies to the preferred drug. Plans are not required to grant exceptions requests for drugs on the specialty tier, however, so beneficiaries must pay the full cost-sharing amount for these high-cost drugs, even if no other drug is available.

This Part D Data Spotlight examines use of the specialty tier among Medicare stand-alone Prescription Drug Plans (PDPs), based on the authors' analysis of data from the Centers for Medicare and Medicaid Services (CMS) on the 47 unique, national plans in 2008, representing 88 percent of all PDPs nationwide. This research is part of a broader effort analyzing Medicare Part D plans in 2008 and key trends since 2006, with key findings summarized in a series of data spotlights.¹

SPECIALTY TIERS ARE USED BY MOST PLANS

Since 2006, the number of Medicare PDPs using specialty tiers has increased (Exhibit 1). In 2008, 41 of the 47 national PDPs include a tier for high-cost specialty or injectible drugs.² This represents almost a doubling of PDPs with specialty tiers since 2006. Of the other plans, five have a standard benefit design (25 percent coinsurance for all drugs) and one plan has coinsurance tiers of 30 percent for preferred drugs and 45 percent for non-preferred drugs. By contrast, only 7 percent of employer-sponsored plans in 2007 used fourth tiers, not all of which are specialty tiers.³

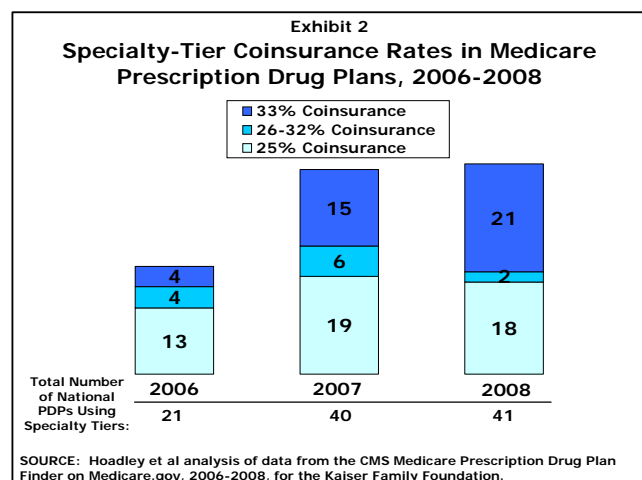
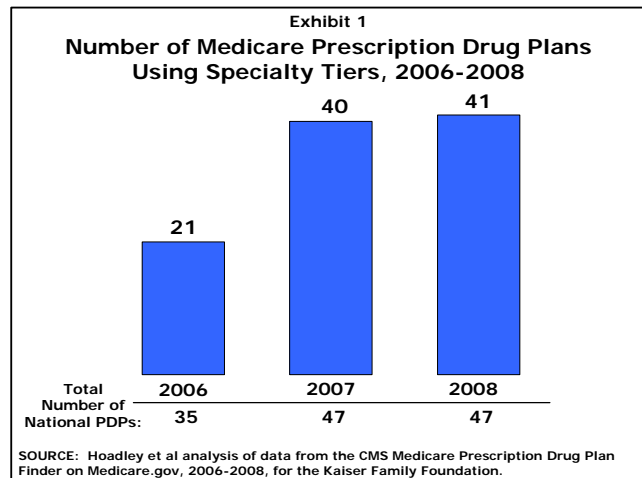
COST SHARING FOR SPECIALTY TIER DRUGS

Cost sharing for drugs on a specialty tier is generally limited to 25 percent coinsurance. However, CMS allows plans to have higher cost sharing for a specialty tier if offset by a lower deductible.⁴ Just as more plans are using specialty tiers, more are also opting to charge higher coinsurance for drugs on the specialty tier. In 2007 and 2008, more than half of the plans with a specialty tier charged more than 25 percent coinsurance for that tier (Exhibit 2). The number of national PDPs charging 33 percent coinsurance for drugs placed on the specialty tier has increased more than five-fold since 2006, from 4 to 21 national PDPs in 2008.

The placement of any drug on a specialty tier has cost implications for enrollees. For example, if a plan covers a brand-name drug with a total monthly cost of \$600, an enrollee might face an average flat dollar monthly copayment of \$30 if preferred, \$72 if non-preferred, or \$180 per month if the drug is covered on a specialty tier with a 30 percent coinsurance rate.

DRUGS ASSIGNED TO SPECIALTY TIERS

Beginning in 2007, CMS clarified that drugs may be placed on a specialty tier if they cost more than \$500 per month (increasing to \$600 in 2008). Some drugs placed on specialty tiers actually cost much more, often over \$1,000 per month. CMS has not set a comparable limit for drugs on a separate tier for injectible drugs. Typically, a limited number of drugs are assigned to specialty and injectible tiers. Analysis completed for the Medicare Payment Advisory Commission found that, on average, PDPs with a specialty tier in 2007 included 150 drugs on that tier, which was 12 percent of all covered drugs.⁵



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Using a selected list of 152 drugs, including frequently prescribed drugs, drugs that belong to certain commonly prescribed drug classes, and several high-cost drugs, we assessed use of specialty tiers and drug placement on these tiers in national PDPs in 2006, 2007, and 2008.⁶ All nine sample drugs with a monthly cost of over \$600 in 2008 appear on at least one plan's specialty tier. Of the 18 national or near-national plans that had specialty tiers in both 2006 and 2007, all but one increased the number of the 152 sample drugs assigned to that tier. The median number of sample drugs on the specialty tier was 4 in 2006 and 5 in both 2007 and 2008. Most plans kept the same drugs on their specialty tiers, though some plans added or removed drugs.

Of the ten drug groups in the sample, three include drugs that are listed on a specialty tier by more than one plan. The three tumor necrosis factor (TNF) inhibitors, used to treat rheumatoid arthritis, are almost always placed on a specialty tier when covered by plans with such a tier (Exhibit 3). Five hormonal agents used to treat

Exhibit 3: Selected Drugs Placed by National PDPs on Specialty Tiers in 2007-2008

Drug Group	Drugs Ever on Specialty Tier	2007			2008		
		Number of Plans (of 40) Placing Drug:			Number of Plans (of 41) Placing Drug:		
		On Specialty Tier	On Other Tier	Off Formulary	On Specialty Tier	On Other Tier	Off Formulary
TNF Inhibitors	Enbrel	36	3	1	40	1	0
	Humira	37	3	0	40	1	0
	Remicade	37	2	1	41	0	0
Hormonal Agents	Aredia	17	0	23	14	3	24
	Pamidromate	10	15	15	5	20	16
	Zometa	27	4	9	25	3	13
	Skelid	2	21	17	0	26	15
	Forteo	34	6	0	30	11	0
Calcium Channel Blockers	Nimotop	12	18	10	14	22	5

SOURCE: Hoadley et al analysis of data from the CMS Medicare Prescription Drug Plan Finder on Medicare.gov, 2007-2008, for the Kaiser Family Foundation.

osteoporosis, cancer, and Paget's disease are sometimes listed on specialty tiers, although less often in 2008 than in 2007. Nimotop, a calcium channel blocker prescribed for patients with ruptured cerebral aneurysms, is listed as a specialty drug by 14 of the national PDPs (about 40 percent of the plans that cover it). No other calcium channel blocker exceeds the \$600 cost threshold required for placement on a specialty tier in 2008.

POLICY ISSUES

The increasing use of specialty tiers has important implications for beneficiaries. Specialty tiers are one of the tools available to plans to limit their liability to pay for relatively expensive drugs, particularly because drugs placed on the specialty tier are not subject to exceptions requests from enrollees. Relatively high coinsurance rates for drugs on the specialty tier can translate into high out-of-pocket monthly costs for enrollees taking those drugs, and wide variations across plans in the amount an enrollee could pay, based on tier placement (preferred, non-preferred, or on a specialty tier). This could be of particular concern for individuals who are prescribed a specialty tier drug mid-year, when enrollees generally are not allowed to switch plans. More clear and consistent labeling of tiers and explanations of the distinctions between them on the Medicare Prescription Drug Plan Finder on Medicare.gov might help beneficiaries anticipate relatively high expenses for certain medications and make better decisions in choosing plans based on benefit design and formulary structure.

Some Part D plans have reduced the standard Part D deductible in order to maintain relatively higher cost sharing on the specialty tier to meet requirements of actuarial equivalence. In such plans, many enrollees could save up to \$275 annually from the eliminated deductible, while a smaller number who take drugs on the specialty tier would face higher costs. Policy makers may want to consider the distributional effects of allowing these two elements of plan design to be traded off against each other in calculations of actuarial equivalence.

The existence of specialty tiers may also create selection issues if beneficiaries who know they will be taking an expensive drug evaluate plans on the basis of cost sharing. Plans that place expensive drugs on a tier with flat dollar cost sharing are likely to attract a disproportionate number of beneficiaries using those drugs. Selection effects may in fact be driving nearly all plans to adopt specialty tiers and to assign more drugs to these tiers. Over time, it will be important to assess the extent to which specialty tiers may influence prescribing practices, cost-related adherence, and patient outcomes.

¹ Other Medicare Part D 2008 Data Spotlights, based on the authors' analysis of CMS data, are available at <http://www.kff.org/medicare/med102507pkg.cfm>.

² Plans use varying labels for these tiers; however, all 41 appear to meet the rules and requirements for specialty tiers.

³ "Kaiser/HRET Employer Health Benefits Annual Survey, 2007," Kaiser Family Foundation publication #7672, September 2007.

⁴ CMS, "Medicare Part D Manual, Chapter 6, Part D Drugs and Formulary Requirements" March 9, 2007.

⁵ Jack Hoadley, presentation at Medicare Payment Advisory Commission meeting, November 8, 2007.

⁶ For a list of the 152 drugs included in the sample, see "An In-Depth Examination of Formularies and Other Features of Medicare Drug Plans" (<http://www.kff.org/medicare/7489.cfm>).