THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE PART D 2009 DATA SPOTLIGHT

TEN MOST COMMON BRAND-NAME DRUGS

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JUNE 2009

Medicare Part D drug plans typically use formularies (lists of covered drugs), cost sharing, and utilization management techniques (prior authorization, step therapy, and quantity limits) to manage enrollees' use of drugs. As a result, access to and costs for a particular drug can vary widely from one Part D plan to another. Part D plans, enrollees, and the federal treasury may save money when beneficiaries use generic equivalents of brand-name drugs. For many commonly used brands, however, there are no generic drugs available as a therapeutic alternative in the same drug class. This Part D Data Spotlight focuses on Part D plan coverage of the ten brand-name drugs that were most commonly prescribed for Medicare beneficiaries in 2006 and lack generic equivalents in 2009. Findings are based on the authors' analysis of data for the 44 unique, national and near-national stand-alone prescription drug plans (PDPs) offered by 16 organizations in 2009 (representing 89 percent of all PDPs nationwide). This research is part of a broader series of data spotlights analyzing Medicare Part D plans in 2009 and key trends since 2006.[1]

The list of the top ten brand-name drugs is based on the number of prescriptions filled in 2006 in all Part D plans.[2] The list includes cholesterol-lowering and other cardiovascular medications; one drug for treating osteoporosis; two proton pump inhibitors (PPIs) used to treat gastrointestinal reflux and ulcers; an inhaled drug that treats asthma, emphysema, and other respiratory disorders; and medications used to treat dementia, depression, and bipolar disorder (Exhibit 1). Of the top ten drugs, two (Seroquel and Lexapro) are in a protected class, meaning that plans must cover them unless they have been granted permission not to by the Centers for Medicare & Medicaid Services (CMS).[3] At the time of our data collection, none of these ten drugs had direct generic equivalents, although some are in a class with a similar drug that is off-patent.

Exhibit 1: Top Ten Brand-Name Drugs, Ranked by Number of Prescriptions Filled in Part D Plans in 2006

Rank	Drug Name	Type of Drug	Median Posted Monthly Price*
1	Lipitor	Cholesterol	$86.29
2	Plavix	Cardiovascular	$141.82
3	Nexium	PPI	$159.81
4	Prevacid	PPI	$161.02
5	Lexapro	Depression	$82.66
6	Diovan	Cardiovascular	$67.54
7	Aricept	Dementia	$184.35
8	Seroquel	Atypical Anti-psychotic	$147.19
9	Actonel	Osteoporosis	$90.57
10	Advair Diskus	Respiratory	$192.38

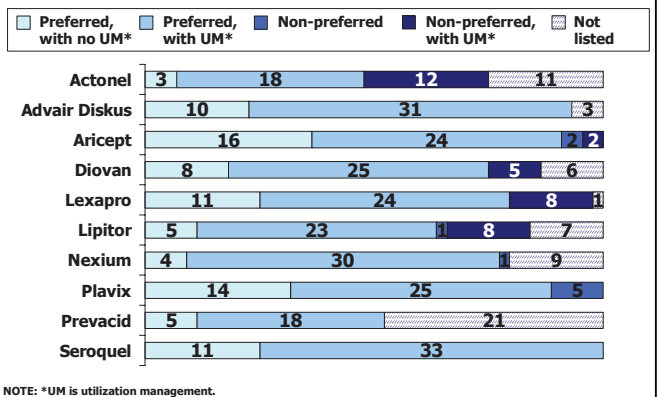
NOTE: *Median posted monthly price is based on prices listed on the Medicare Prescription Drug Plan Finder website as of February 2009.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

COVERAGE OF THE TOP TEN BRAND-NAME DRUGS

Of the top ten brands, three are covered by all national PDPs in 2009: Aricept, an Alzheimer's treatment; Plavix, to prevent blood clotting; and Seroquel, an anti-psychotic (Exhibit 2). Lexapro, in a protected class of antidepressants, is not listed on formulary by one national plan because CMS allows plans to list either Lexapro or Celexa (which is available in generic form). Among the top ten brands, Prevacid, a PPI, is not listed by nearly half of the national PDPs, most likely because it has considerable competition in its class (including Nexium and other off-patent drugs).

Exhibit 2

National Plans Covering Top Ten Brand-Name Drugs, by Preferred Status and Restrictions, 2009



NOTE: *UM is utilization management.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

COST SHARING FOR THE TOP TEN BRAND-NAME DRUGS

Cost sharing for each of the top ten brand-name drugs varies widely across plans. For half of these drugs, there is at least a four-fold difference between the minimum and maximum monthly cost-sharing amounts that enrollees face, even when the drugs are covered (Exhibit 3). For example, a beneficiary could pay as little as $22 per month for Aricept in one of the national PDPs but $88 per month in another. On-formulary cost sharing tends to be much higher when drugs are on a non-preferred tier than when on a preferred tier. Among the top brand drugs, Actonel, Lexapro, and Lipitor are most often placed on non-preferred tiers (Exhibit 2).

When drugs are not covered, the range in beneficiary out-of-pocket costs is even wider. For example, a beneficiary selecting a plan in which Advair Diskus is uncovered could pay as much as 13 times the minimum covered cost-sharing amount ($289 vs. $22 per month). Among the national PDPs, Nexium and Prevacid both have a maximum cost of just over $170 when not covered on a plan's formulary, compared to a minimum of $20 when covered. Out-of-pocket payments for drugs that are off-formulary do not count toward reaching catastrophic coverage.

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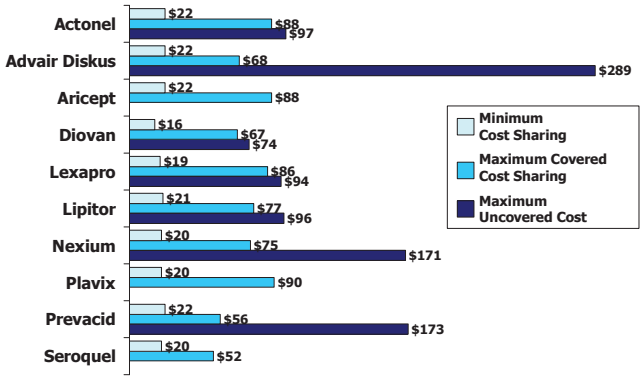
RESTRICTIONS ON COVERAGE OF THE TOP TEN BRANDS

Even for drugs on a Part D plan's formulary, cost-sharing requirements or utilization management (UM) restrictions – quantity limits, step therapy and prior authorization – may limit enrollees' access to a drug. National PDPs typically place the top ten brands on a preferred tier, sometimes with utilization management restrictions (Exhibit 2). About one-third of the national plans cover Plavix and Aricept on a preferred tier without restrictions. By contrast, only a few of the national plans cover the PPIs (Nexium and Prevacid), Actonel, and Lipitor without restrictions; each drug has generic and brand alternatives in its class.

Overall, PDPs apply UM criteria to only about one quarter of all drugs listed on their formularies.[4] The top ten brand-name drugs are subject to UM restrictions in at least half of the national and near-national plans that list them on formulary (Exhibit 4). Aricept and Plavix are least likely to be subject to UM.

Exhibit 3

Monthly Cost Sharing for Top Ten Brand-Name Drugs in National Plans, 2009



SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

Quantity limits, restricting how long a beneficiary can use a particular drug, the dosage that can be taken during a month, or the days' supply, are the most common utilization management tool for the top ten brands. Over half of the national plans placing any UM restriction on the top ten brand-name drugs use only a quantity limit. Lipitor and Nexium are most likely to have quantity limits among plans listing them on their formulary.

Exhibit 4: Number of National PDPs Applying Utilization Management to the Top Ten Brand-Name Drugs, 2009

Drug Name	Number of National PDPs Listing on Formulary	Number of National PDPs Listing on Formulary Applying:			
		Prior Authorization	*Quantity Limits*	*Step Therapy*	*Any UM*
Actonel	33	4	22	10	30
Advair Diskus	41	1	27	4	31
Aricept	44	0	26	0	26
Diovan	38	0	29	5	30
Lexapro	43	0	29	8	32
Lipitor	37	2	31	1	31
Nexium	35	0	29	3	30
Plavix	44	0	25	0	25
Prevacid	23	0	15	4	18
Seroquel	44	0	33	0	33

SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

Step therapy, generally requiring individuals to begin with a less aggressive or less expensive drug, is the next most common UM restriction for these ten drugs. Although this approach can be clinically appropriate, it can also be burdensome for both enrollees and physicians. Among the top ten drugs, plans are most likely to require beneficiaries to try another drug before covering Actonel, a change from 2008 that may be partly explained by the recently approved generic version of competitor Fosamax. Five or fewer plans require step therapy for Advair, Diovan, Lipitor, Nexium, and Prevacid – a decrease from 2008 for four of these drugs.[5] Step therapy is not used for three of the top ten brands (Aricept, Plavix, and Seroquel) in 2009.

Prior authorization is the least frequently used form of utilization management, perhaps because implementation requires an investment of plan resources in the review of prior authorization requests. Only three of the top ten brands have a prior authorization requirement in at least one of the national PDPs in 2009: Actonel, Advair, and Lipitor. Our analysis shows a reduction from 2008 in the use of prior authorization for certain drugs, when Nexium, Prevacid, and Aricept all required prior authorization in six or seven of the 47 national PDPs.

DISCUSSION

Our analysis reveals wide variation across Part D plans in the treatment of the top ten brand-name drugs, in terms of coverage, tier placement, cost sharing, and utilization management. These variations have important implications for beneficiaries' access to specific medications and out-of-pocket spending, underscoring the importance of medication-specific Part D plan comparisons.

The list of commonly used brand drugs is in continual flux as drugs lose patent protection. Of the top 20 brands used by Medicare beneficiaries enrolled in Part D plans in 2006, nine already have generic alternatives, and all but one of the rest (including nine of the ten drugs in this study) will lose patent protection within the next five years.[6] Shifting enrollees' utilization from brands to the new generic versions of these drugs could result in major savings for enrollees and the program.

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[1] Other Medicare Part D 2009 Data Spotlights, based on the authors' analysis of CMS data, are available at http://www.kff.org/medicare/med110608pkg.cfm.
[2] We used data compiled by CMS from 2006 Part D claims data on the top 100 drugs by total fills and subset that list to include only brand drugs for which no generic versions were on the market as of February 2009. Information available at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/08_PartDData.asp
[3] CMS guidance states that although Lexapro is in a protected class, plans may choose between covering it and citalopram (available as a generic).
[4] Presentation by Hoadley et al, Medicare Part D Benefit Designs and Formularies 2006-2009, Prepared for MedPAC, December 2008.
[5] We did not collect information on utilization management restrictions for Advair Diskus in 2008.
[6] There is no date for Advair because the FDA has not determined a standard for bioequivalence for inhaled corticosteroids in dry powder inhalers (Source: Medco Health, "Estimated Dates of Possible First Time Generic Rx-to-OTC Market Entry," Accessed at http://www.medcohealth.com/art/corporate/anticipatedfirsttime_generics.pdf, on March 19, 2009).