THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE PART D 2009 DATA SPOTLIGHT

SPECIALTY TIERS

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JUNE 2009

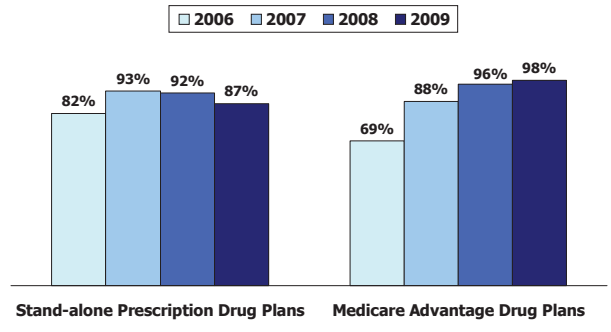
Medicare Part D prescription drug plans establish formularies that list the specific drugs they cover and the level of cost sharing charged to Medicare enrollees. Plans can offer a "standard" benefit with 25 percent coinsurance for all covered drugs or a benefit with tiered cost sharing. In practice, most plans use tiers with different cost-sharing amounts for generic, preferred, and non-preferred drugs, and also include an additional "specialty" tier for very high cost and unique drugs. According to guidelines from the Centers for Medicare & Medicaid Services (CMS), only drugs costing more than $600 per month in 2009 may be placed on a specialty tier. Some plans also have a separate tier for certain injectible drugs, which tend to be relatively expensive.[1] This Part D Data Spotlight examines use of the specialty tier, based on the authors' analysis of data from CMS. This research is part of a broader series of data spotlights analyzing Medicare Part D plans in 2009 and key trends since 2006.[2]

Most Beneficiaries in Plans with Specialty Tiers

In 2009, the vast majority of Part D enrollees are in plans with a specialty or injectible drug tier, including 87 percent of those in stand-alone prescription drug plans (PDP) and 98 percent of those in Medicare Advantage Prescription Drug (MA-PD) plans with tiered cost sharing (Exhibit 1).[3] Since 2006, the share of Part D enrollees in plans using specialty tiers has increased. Part D plans are not required to grant exception requests for specialty tier drugs, so beneficiaries must pay the full cost-sharing amount for these high-cost drugs, even if no other similar treatment is available.

Exhibit 1

Share of Enrollment in Medicare Part D Plans with Tiered Cost Sharing Using Specialty Tiers, 2006-2009



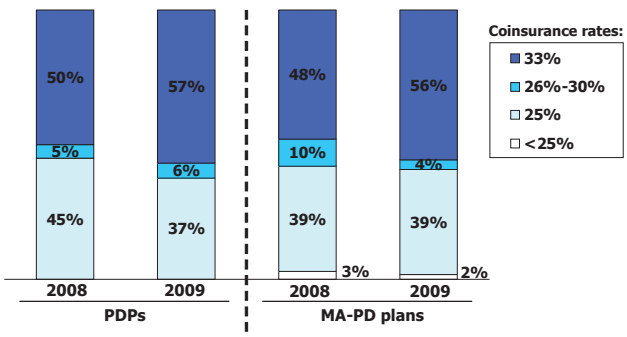
NOTE: Estimates weighted by enrollment in each year.
SOURCE: Georgetown/NORC analysis of data from CMS for MedPAC and the Kaiser Family Foundation.

Cost Sharing for Specialty Tier Drugs

Just as more plans are using specialty tiers, more are also opting to charge higher coinsurance for drugs on the specialty tier during the initial coverage period (before the coverage gap, when enrollees pay the full cost of their prescriptions). In 2009, more than half of all Part D enrollees in plans with a specialty tier were subject to 33 percent coinsurance for specialty tier drugs (Exhibit 2). Since 2006, the number of national PDPs charging 33 percent coinsurance for specialty tier drugs has increased considerably, when only four of the 35 national or near-national PDPs charged this rate (not shown). While coinsurance for specialty tier drugs is generally limited to 25 percent, CMS allows plans a higher level if offset by a lower deductible.[4]

Exhibit 2

Share of Enrollment in Medicare Part D Plans with Specialty Tiers, by Specialty Tier Coinsurance Rate, 2008-2009



NOTE: Estimates weighted by enrollment in each year. Analysis excludes small share of plans with copayments for specialty tiers (0.1% of PDPs and 2% of MA-PD plans). Analysis of MA-PD plans excludes Special Needs Plans.
SOURCE: Georgetown/NORC analysis of data from CMS for MedPAC and the Kaiser Family Foundation.

Most plans without a specialty tier use designs with 25 percent coinsurance or higher for specialty drugs placed on preferred or non-preferred tiers, which can lead to higher cost sharing than if they used a specialty tier. For example, the Humana Standard PDP has specialty drugs on formulary tiers with either 25 percent or 45 percent coinsurance.

Drugs Assigned To Specialty Tiers

Although CMS guidelines specify that only drugs costing more than $600 per month in 2009 may be placed on a specialty tier, some cost considerably more, often over $1,000 per month. Typically, Part D plans assign a relatively small number of such high-cost drugs to specialty and injectible tiers: on average, 135 drugs (12 percent of covered drugs) are on a specialty tier among PDPs with a specialty tier, and nearly the same share in MA-PD plans, according to analysis for the Medicare Payment Advisory Commission. Since 2007, the share of covered drugs placed on the specialty tier has been stable.

To illustrate use of the specialty tier among Part D plans, we analyzed tier placement and cost sharing for ten common specialty drugs in the 44 PDPs offered in all or nearly all regions in 2009 (representing 89 percent of all PDPs nationwide).[5] Of these 44 PDPs, most (38 PDPs) use a specialty tier. Of the ten specialty drugs, seven (Copaxone, Enbrel, Humira, Procrit, Thalomid, Tracleer, and Truvada) are listed on specialty tiers by at least three-fourths of the

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38 national PDPs with specialty tiers (Exhibit 3). By contrast, just seven of the 38 PDPs placed Sensipar (used to treat problems associated with the parathyroid) on a specialty tier. Most plans with specialty tiers also apply utilization management (UM) tools such as prior authorization to manage use of these drugs. All but three of the ten specialty drugs have UM restrictions in more than half the national PDPs when they are listed on formulary.

Exhibit 3: Coverage of Top Specialty Drugs in National PDPs, 2009

Drug (Use)	Among Plans with a Specialty Tier: Covered on Specialty Tier	Among Plans with a Specialty Tier: Covered on Other Tier	Covered by Other Plans	Not Covered	% of PDPs using UM when on formulary
Copaxone (Multiple sclerosis)	38		6		82%
Enbrel (Rheumatoid arthritis)	38		6		89%
Humira (Rheumatoid arthritis)	38		6		89%
Kaletra (HIV)	16	22	6		27%
Procrit (Anemia)	32	6	5	1	100%
Reyataz (HIV)	17	21	6		27%
Sensipar (Hyperparathyroidism)	7	31	6		52%
Thalomid (Cancer)	36	2	6		73%
Tracleer (Pulmonary arterial hypertension)	36	2	6		68%
Truvada (HIV)	29	9	6		14%

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

Exhibit 4: Cost sharing for Top Specialty Drugs in National PDPs, 2009

Drug	Average Full Cost	Minimum Cost Sharing	Average Cost on Specialty Tier	Maximum Covered Cost Sharing
Copaxone	$1,976	$466	$602	$858
Enbrel	$1,521	$359	$464	$840
Humira	$759	$180	$232	$315
Kaletra	$738	$23	$228	$406
Procrit	$2,306	$25	$710	$773
Reyataz	$897	$20	$276	$319
Sensipar	$686	$20	$220	$379
Thalomid	$6,271	$1,485	$1916	$3,474
Tracleer	$4,938	$1,097	$1512	$2,773
Truvada	$925	$35	$285	$509

NOTE: Amounts rounded to neared dollar.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

BENEFICIARY COSTS FOR COMMON SPECIALTY DRUGS

The placement of a drug on a specialty tier has dramatic cost implications for enrollees. For example, Kaletra and Truvada (used to treat HIV) have a total monthly cost of $738 and $925, respectively, for the specific dosage in our analysis (Exhibit 4). When these drugs are covered on a preferred tier (in 16 and three of the national PDPs, respectively), monthly cost sharing can be as low as $23 or $35 in the initial coverage period. However, when on a specialty tier, monthly cost sharing is typically $228 and $285, respectively – nearly ten times as much. Regardless of the cost-sharing amounts enrollees pay during the initial coverage period, however, those who take expensive specialty tier drugs are likely to reach the coverage gap early in the year since the gap is reached after total drug spending of $2,700 in 2009; enrollees who can afford to pay the full cost of their drugs during the gap are likely to reach catastrophic coverage at about the same time (based on paying a total of $4,350 out of pocket).

POLICY ISSUES

The increasing use of specialty tiers limits Part D plan liability for expensive drugs, but increases costs for some beneficiaries and has consequences for government spending. Enrollees face relatively high costs for specialty drugs, except for those receiving low-income subsidies, for whom the government pays much of the costs for specialty drug use. Plan incentives to manage specialty drug costs are attenuated during the coverage gap (when plans face no liability) and catastrophic coverage (where reinsurance from the government helps to limit liability). Thus, specialty drugs are a significant driver of Part D program costs to the government.

High cost sharing during the initial coverage period for specialty tier drugs can be a concern to beneficiaries who rely on these drugs to treat their medical conditions (unless they qualify for low-income subsidies). Plans typically increase specialty tier cost sharing from the standard 25 percent coinsurance rate in exchange for reducing the standard deductible to maintain actuarial equivalence. As a result, while many enrollees could save up to $295 in 2009 with no deductible, a smaller number who take specialty tier drugs could face much higher costs. Policymakers may want to consider the distributional effects of allowing these plan design elements to be traded off against each other in calculating actuarial equivalence. Oversight will be important to ensure that plan use of specialty tiers does not violate non-discrimination rules that prohibit plans from discriminating against individuals based on medical condition.

Relatively high specialty tier coinsurance rates also result in wide variations across plans in beneficiary costs for the same drug, depending on tier placement. This may create selection issues if beneficiaries who take 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. These selection effects may help to explain why nearly all plans have adopted a specialty tier. It will be important to assess the extent to which specialty tiers in Part D plans may influence prescribing practices, cost-related adherence, and patient outcomes.

[1] CMS has not set a specific limit for injectible drugs when plans place these drugs on a separate "injectible" tier.
[2] 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.
[3] This measure includes only beneficiaries enrolled in plans for which we were able to categorize tiers. Beneficiaries whose plans did not have a clear tier structure – either because it was a defined benefit or because it did not fall into a typical pattern of tiers – were not included in the calculation. Plans use varying labels for tiers, so this count is based on the authors' assessment of whether tiers appear to be specialty tiers.
[4] CMS, "Medicare Part D Manual, Chapter 6, Part D Drugs and Formulary Requirements," March 9, 2007.
[5] We used data on the top 100 drugs by total cost, based on the prescriptions filled in 2006 in all Part D plans, and selected from that list drugs that appear on a specialty tier for at least one plan. The top 100 list was compiled by CMS from 2006 Part D claims data; available at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/08_PartDData.asp.