

HCSC Provider Newsletter January 2008

Medicare Part D Pharmacy Updates

Strategies to Avoid Medicare's Part D Coverage Gap

The Medicare Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for people on Medicare, known as Part D, that went into effect in 2006. The drug benefit is offered through stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans, such as HMOs, that cover all Medicare benefits including drugs. For 2008, Part D plans are allowed to offer either a defined standard benefit, an alternative equal in value ("actuarially equivalent"), or a plan with enhanced benefits. The standard benefit in 2008 has a \$275 deductible and 25% coinsurance up to an initial coverage limit of \$2,510 in total drug costs, followed by a coverage gap (the so-called "doughnut hole") where enrollees pay 100% of their drug costs until they have spent a total of \$4,050 out of pocket, excluding the Part D premium paid to the plan. Once out-of-pocket costs exceed \$4,050 enrollees pay 5% of total drug costs.

The coverage gap was included by Congress in the Part D program because the cost of providing continuous coverage with no gap would have exceeded the budgetary limit imposed by the legislation when the Medicare drug benefit was established. In 2008, the coverage gap totals \$3,216 for plans offering the standard Medicare Part D benefit; by 2016, it is projected to exceed \$6,000. Nationally, most PDPs, however, do not help pay for prescriptions in the coverage gap. Among the 29% of PDPs with some gap coverage, all but one plan covers generic drugs only. About half of the PDPs with gap coverage in 2008 are covering only "preferred" or "some" generics. The increase in the share of MA-PD plans offering gap coverage is mainly among plans covering all generics and "some" brand-name drugs in the gap. In 2007, as in 2006, more than 80% of Part D enrollees (both PDP and MAPD plans) had no gap coverage. As a consequence, nearly 4.2 million Medicare beneficiaries reached the coverage gap threshold in 2006, the first year of the program. If history is a reliable guide (i.e. only about 10% of beneficiaries switched plans from 2006 to 2007) there will not be a significant change in volume of beneficiaries reaching the coverage gap threshold 2008 as well. One reason for the low volume of beneficiary plan changes from year to year is the additional beneficiary cost-sharing that plans charge to provide these and other extra benefits. For example, PDPs that provide gap coverage have monthly premiums that are about double that of PDPs with no gap coverage. In 2008, average monthly premiums are \$63.29 for PDPs that offer some gap coverage, \$30.14 for PDPs with basic benefits and no gap coverage, and \$31.97 for PDPs with enhanced benefits but no gap coverage. Lastly, if that was not enough of a strain on the budget of the average Medicare beneficiary, the Part D plan member is still required to pay the monthly Part D premiums even as they struggle to pay for their medications out-of-pocket while in the coverage gap.

While federal assistance is available to help the poorest patients with Part D plan cost sharing, including premiums, deductibles and co-pays, those who fall just above the poverty guidelines and cannot get extra help sometimes simply stop taking their medications, cut their dose in half to stretch their supply of medication further, or rack up big credit card debt to pay for them.

Despite the general unpopularity of the coverage gap with older consumers, some experts see a positive public policy trend evolving. Because the existence of the coverage gap may require a Medicare enrollee to pay more than \$3,200 out of their own pocket during the gap period, the strategy is helping to curb growth in the nation's drug spending by encouraging the use of low-cost generic drugs. By the first quarter of 2007, the generic dispensing rate in Medicare Part D programs was 61.5% while some plans report rates closer to 70% and higher.

A generic drug is manufactured and sold by a company other than the original patent holder. "A" rated generic medications (bioequivalent to the brand-name drug) must meet the same rigid standards as the brand-name drug but because the manufacturer is not attempting to recoup research and development costs and pay for expensive marketing campaigns the cost of generic medications based on conservative estimates is 60% less than brand-name medications. Some of the recent entries into the generic drug market include some former popular brand-name products such as: simvastatin (ZOCOR), sertraline (ZOLOFT), amlodipine (NORVASC), zolpidem (AMBIEN), risperidone (RISPERDAL), cetirizine (ZYRTEC) and carvedilol (COREG). Others expected in 2008 include: DEPAKOTE, LAMICTAL, DYNACIRC,

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TOPAMAX, IMITREX and ALTACE. It has been reported that in 2006 and 2007 alone, Medicare Part D drug costs could be reduced nationally by \$5 billion due to patents exclusivity expiring on just eleven major branded pharmaceuticals.

Less preferable strategies employed by some physicians to prevent patients from falling into the coverage gap include a) switching to potentially less-effective but cheaper alternatives, b) use of samples, c) pharmaceutical assistance programs and d) utilizing over-the counter (OTC) medications. All of these alternatives have significant drawbacks and may present unacceptable options for physicians and their patients. As noted above, for those patients with limited financial resources the choice between essentials such as food and expensive medications may lead many to forego needed medical therapies. Patients and providers may find that they have to compromise on a less effective therapy (e.g. Aspirin in place of PLAVIX) when non-adherence to the gold standard medication is the most likely outcome. Samples are also commonly used to provide patients with short term therapies or test a patient's tolerance to a new therapy without taking the risk of having to discard a 30 day supply of an expensive medication. Certainly the use of samples fills a therapy niche that helps many patients. However, providers often run the risk that their patient becomes stabilized on a medication that is not available on their formulary, or requires trials of therapeutically equivalent alternatives or is simply too expensive to be continued once the supply of samples is exhausted. Pharmaceutical assistance programs are commonly available for selected medications from most manufacturers for those patients who meet rigid acceptance criteria. However, the application process can often be quite confusing and cumbersome, especially for older patients and many drugs are simply not available. Additional information on pharmaceutical assistance can be found at the respective company website. Lastly, there are OTC medications (e.g. PRILOSEC, ibuprofen, etc.) that can reasonably replace similar prescription medications in some cases but these examples of therapeutic interchanges are limited and can not replace important maintenance medications for many chronic diseases such as hypertension, diabetes, and hyperlipidemia.

A study by Express Scripts, the pharmaceutical benefits manager, found that 23% of those who fell into the coverage gap in 2006 could have avoided it by utilizing generics to reduce their out-of-pocket drug costs. Such planning, though, requires that patients talk to providers about their ability to afford their medications as prescribed by their provider. Many people can be expected to avoid such personal discussions and many physicians never broach the subject with their patients. Recent studies found that 80% of patients wished that their providers would discuss the cost of medications but less than one in five doctors did. With the fear of falling into the coverage gap ever present, providers need to be diligent in their review of their patient's medication therapies. In many instances, cost effective formulary alternatives are readily available for beneficiaries without a noticeable loss of efficacy. Local retail pharmacists and medical personnel at your patient's health plan can be a great resource to help keep your patient out of the coverage gap that older Americans love to hate.

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