

**Medicare Part D:
An Assessment of Plan Performance and
Potential Savings**

A Report Prepared for the Pharmaceutical Care Management Association

January 2007

Table of Contents

Executive Summary	i
Savings in Medicare PDPs	1
• Medicare PDP Discounts Higher than Originally Estimated	
• Medicare PDP Premiums Lower than Forecasted	
• Substantial Savings for Medicare Beneficiaries	
• Savings in Medicare PDPs Comparable to FEHBP	
• Medicare PDPs Projected to Save Hundreds of Billions of Dollars	
Potential Savings from Generic Drugs in Medicare.....	6
• PBM Best Practice Solutions Encourage the Use of Generic Drugs	
• Billions in Estimated Savings from Increased Use of Generics in Medicare Part D	
Conclusion.....	8
Appendix: Methodology.....	9

Executive Summary

With two decades of experience in negotiating and administering drug benefits, Pharmacy Benefit Managers (PBMs) are playing a central role in the new Medicare Part D prescription drug benefit. Unlike the way PBMs manage benefits in the commercial market, PBMs managing benefits under Part D must design Prescription Drug Plan (PDP) offerings that both comply with Medicare's unique program requirements and also attract individual beneficiaries to enroll. At the same time, many of the PBM cost management tools available to PDPs, including formularies, generic utilization programs, pharmacy networks, and mail-service pharmacies are similar to tools available in the commercial sector. The use of these tools in Medicare is guided by statute, regulation, and beneficiary plan choice.

The design of Medicare Part D was intended to foster competition between plans, lower costs for beneficiaries, and reduce the burden on the federal government.

Estimated savings achieved by Medicare PDPs in 2006 are greater than savings originally estimated by the Centers for Medicare and Medicaid Services (CMS) and the Congressional Budget Office (CBO). These savings are comparable to savings achieved by Federal Employee Health Benefit (FEHBP) plans that serve 3 million federal employees and Members of Congress. Still more savings would be possible if PDPs were able to expand the use of PBM tools, including best practices adopted by top-performing employer-sponsored plans that encourage the use of generic drugs in place of brands.

Major findings:

- **PDPs achieved higher savings—an estimated 29 percent relative to unmanaged drug expenditures in 2006—than the 15 percent savings originally forecasted by CMS or the 20 percent forecasted by CBO.**
- **PDPs are achieving savings comparable to the savings achieved by FEHBP plans which, like Medicare PDPs, are typically managed by PBMs.**
- **PDPs saved Medicare and its beneficiaries an estimated \$30 billion in 2006 and will save a projected \$469 billion over the 2006-2015 period if current performance is maintained.**
- **For each percentage point increase in overall generic utilization, Part D drug spending falls by an estimated \$12 billion over the 2007 to 2015 period.**
- **If PDPs were able to increase their generic dispensing rate by 5 percentage points, savings could increase by \$58 billion over the 2007 to 2015 period.**

Savings in Medicare PDPs

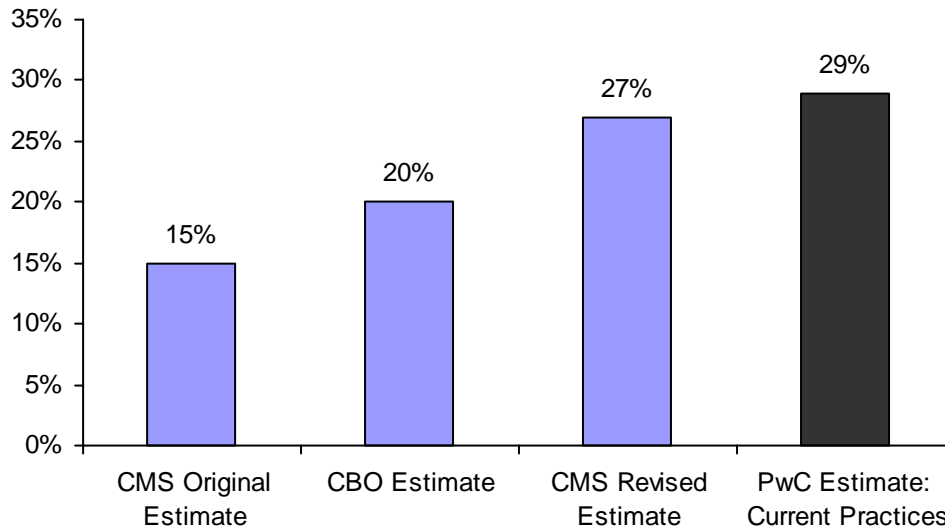
On January 1, 2006, the Medicare Part D program began providing drug coverage to Medicare beneficiaries through private prescription drug plans (PDPs). Official government estimates of the program were based on assumptions about how the program would operate in practice. PricewaterhouseCoopers, at the request of the Pharmaceutical Care Management Association, examined the latest information on the prescription drug plans, their benefit designs, and premiums. Our findings with respect to discounts, premiums, and savings to beneficiaries are presented below.

Medicare PDP Discounts Higher than Originally Estimated

Both the Congressional Budget Office (CBO) and the Centers for Medicare and Medicaid Services (CMS) assumed that the PDPs would, on average, save more from cost management techniques than is typical of current employer plans.¹ Overall, CBO assumed that PDPs would achieve savings in 2006 of approximately 20 percent relative to an unmanaged benefit. CMS originally assumed that plans would achieve about 15 percent in 2006 but subsequently increased its assumed savings to 27 percent.² Based on our analysis, PricewaterhouseCoopers estimates that PDPs are achieving actual savings for Medicare and its beneficiaries of 29 percent relative to unmanaged drug benefits (Exhibit 1).

Exhibit 1: Higher-than-expected Savings Achieved by Medicare PDPs

PDP savings relative to unmanaged drug expenditures



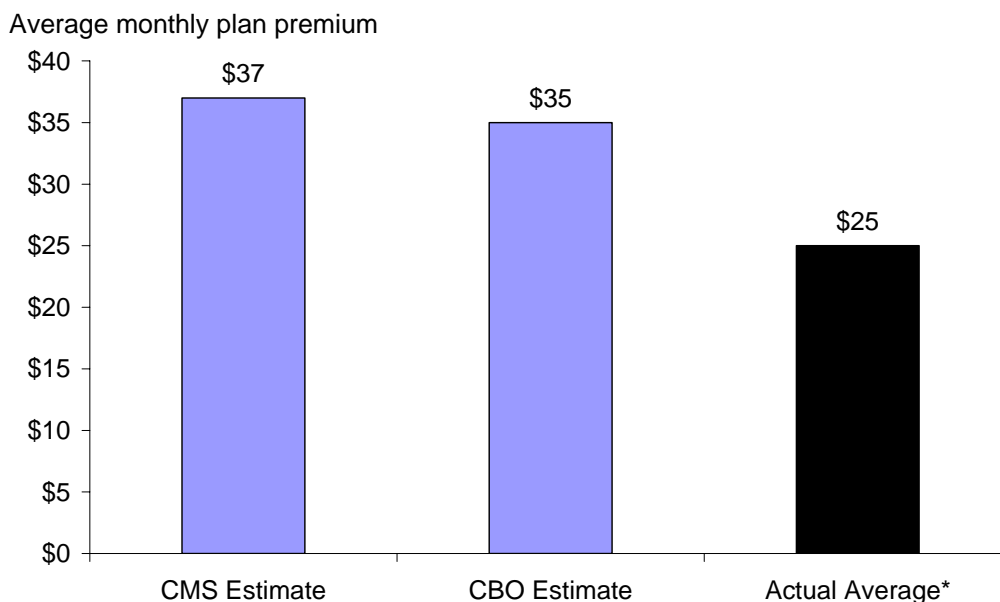
¹ Whether this assumption turns out to be the case in practice depends on what CMS allows plans to do in practice. The MMA itself was vague on important areas such as the number of therapeutic categories, restrictions on formularies, network pharmacies, mail order, therapeutic substitution, and other techniques for holding down prescription drug costs. Details were added by CMS in a series of regulations and guidances.

² Originally, CMS assumed that discounts would rise to 23 percent in 2010. CBO assumed that discounts would rise to 25 percent by 2016.

Medicare PDP Premiums Lower than Forecasted

Another early indication of the actual savings achieved under the PDPs is the average monthly premium level under the plans. Average premiums for PDPs were lower than estimated by CBO and CMS at the time of enactment. Specifically, CBO estimated that the average monthly premium charged to beneficiaries in 2006 would be \$35 and CMS estimated \$37. The average premium appears to be about \$25, significantly lower than the original estimates. (Exhibit 2)

Exhibit 2: Lower-than-expected Monthly Premiums in Medicare PDPs



*Actual average as reported by CMS

Lower premiums not only imply less spending by Medicare beneficiaries, but also lower overall federal budgetary costs. Both CBO and CMS have subsequently lowered their estimates of Medicare spending over the past year.

Deeper-than-expected discounts in the Medicare prescription drug benefit have also prompted CMS to lower their estimates for national prescription drug expenditures. According to CMS, the introduction of the Medicare prescription drug benefit slows projected prescription drug expenditure growth nationwide—both public and private—from 8.0 percent to 7.7 percent in 2006.³

³ Borger, C., “Health Spending Projections Through 2015: Changes On The Horizon,” *Health Affairs*, vol. 25(2), February, 2006.

Substantial Savings for Medicare Beneficiaries

Overall, Medicare beneficiaries who have enrolled in Part D are saving a substantial amount on their drug costs. According to CMS:

- Beneficiaries choosing the lowest-cost PDP available in their area can save an average 57 percent off of their drug costs—with a maximum savings of up to 71 percent.⁴
- Even those choosing from the range of lower-cost plans can save 49 percent annually—and the mid-priced (or, “median”) PDP can provide savings of up to 42 percent off of the costs they would pay without this coverage.⁵

Savings in Medicare PDPs Comparable to FEHBP

Our analysis of PDPs showed that Medicare PDPs achieve savings comparable to savings in the Federal Employees Health Benefits Plan (FEHBP), the program used by about 3 million federal employees as well as Members of Congress. Drug benefits under FEHBP are typically managed by PBMs and achieve savings similar to most employer-sponsored plans. In comparing FEHBP to Medicare PDPs, PricewaterhouseCoopers' analysis revealed:

⇒ *PDPs and FEHBP plans achieve comparable savings levels—29 percent and 28 percent respectively vs. unmanaged drug expenditures.*

On balance, PDPs are managed to roughly the same degree as FEHBP plans. PDPs for Florida Medicare beneficiaries have a median of 2.5 tiers each compared to 3.0 for Florida FEHBP enrollees.⁶ The typical Medicare plan has about 16 percent of the surveyed branded drugs on the preferred tier of its formulary compared to 21 percent in the FEHBP plans. Copays are slightly higher in the PDPs as compared to the FEHBP plans—\$23 compared to \$20. The PDP plans, however, appeared to utilize step therapy less than the FEHBP plans.

⁴ Centers for Medicare and Medicaid Services, “Medicare Drug Coverage Provides Significant Price Discounts and Savings,” March 2, 2006, available at <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1791>

⁵ Ibid.

⁶ We use the median as our “average” measure in all cases to eliminate the impact of outliers.

Medicare PDPs Projected to Save Hundreds of Billions of Dollars

PBM tools and techniques used by Medicare PDPs will save the Medicare program and its beneficiaries hundreds of billions of dollars in the first 10 years of operation. Compared to what drug expenditures under the Part D program would be without pharmacy benefit management, PDPs saved Medicare and its beneficiaries 29 percent, or an estimated \$30 billion in 2006 and a projected \$469 billion from 2006 to 2015 (Exhibit 3).

Exhibit 3: Savings Resulting from Medicare PDPs Using PBM Tools
(billions of dollars)

	2006	2007	2008	2009	2010	2006-2015
Unmanaged* Drug Expenditures by Part D enrollees	\$105.0	\$114.3	\$124.8	\$136.4	\$149.4	\$1,642
Total Drug Expenditures by Medicare Part D Enrollees**	\$75.0	\$81.7	\$89.1	\$97.4	\$106.7	\$1,173
Total Savings Achieved by Medicare Part D Plans	\$30.0	\$32.7	\$35.6	\$39.0	\$42.7	\$469.0

Source: PricewaterhouseCoopers analysis, 2006.

* Unmanaged drug expenditures are equivalent to retail pharmacy purchases with no pharmacy benefit management support.

** Total drug expenditures on Part D include both the government share and the share paid by Medicare beneficiaries in the form of premiums, copayments/coinsurance, and other out-of-pocket costs. Part D enrollees include individuals covered by PDPs or MA-PDPs.

Total expenditures in Exhibit 3 reflect amounts directly paid by beneficiaries and amounts paid by the government under Part D. Under the standard Part D benefit, the federal government subsidies cover approximately 40 percent of total spending.

Part D was designed to foster competition between plans in attracting beneficiaries, whether through low premiums, alternative cost sharing, or other plan characteristics. Plans are allowed flexibility in designing benefit packages as long as they are “actuarially equivalent” to the standard benefit package, which allows plans to design plans that balance

drug savings with access to drugs. Medicare beneficiaries choose from competing plans based on benefits, deductibles, and monthly premiums.

Congress also designed Medicare Part D to encourage competition between prescription drug products by exempting Medicare Part D from the calculation of Medicaid best price. Medicaid best price is used to calculate rebates that manufacturers are statutorily required to pay the Medicaid program. Medicaid's best price is generally the lowest price available from the manufacturer to any private sector purchaser in the United States. The best price must reflect certain financial concessions, such as discounts, that are available to drug purchasers.

According to CBO, manufacturers are less willing to give large discounts to private-sector purchasers because they must give the same discounts to Medicaid. Similarly, manufacturers would be less likely to provide significant discounts to Medicare PDPs if Medicaid best price provisions applied. CBO estimated that if a Medicaid best price provision applied to Medicare, the costs of the program would have been \$18 billion higher during the initial ten years of the program.⁷ The exemption of Part D from Medicaid best price encourages manufacturers to give PDPs their largest discounts.

⁷ Congressional Budget Office, Letter to Honorable William Thomas, Chairman, Committee on Ways and Means, U.S. House of Representatives, July 27, 2002.

Potential Savings from Generic Drugs in Medicare

Generic drugs cost between 30 to 80 percent less than equivalent branded products.⁸ In addition, generic drugs are also frequently effective therapeutic alternatives to more expensive brand-name prescription drugs. As a result, a 1 percent increase in generic use can result in a 1 percent decrease in overall drug costs.

PBM Best-Practice Solutions Encourage the Use of Generic Drugs

To increase the use of generics, PBMs implement a variety of programs. Programs vary by company, but can include advising plan sponsors to adopt tiered cost sharing that encourages the use of generics, outreach to patients and doctors with information on available generic drugs, vouchers for free samples of generic drugs, providing samples of generic drugs to physicians, and waiving the first-copayment for prescriptions filled with generic drugs. Best practices with regard to generic drugs include:

- Generic drugs are in a lower tier with lower cost sharing as compared to branded drugs.
- Patients are required to pay the difference between the cost of the branded drug and the equivalent generic drug.
- Pharmacists remind patients that more cost-effective generic alternatives are available and request physicians to authorize the generic drug, if medically appropriate.
- Only generic drugs are covered in certain therapeutic classes when appropriate. For example, in the proton-pump inhibitors (PPI) class, where many generics are available and medically effective, only generic drugs are covered.

Billions in Estimated Savings from Increased Use of Generics in Medicare Part D

The implementation of PBM best practices with regard to generic drugs is guided by statute, regulation, and beneficiary plan choice. Potentially large savings would be available to the Medicare program and its beneficiaries if plans were able to use best practices tools to encourage the clinically appropriate use of generic drugs in place of brands. As with employer plans, Medicare Part D would still have “grievance and appeals” mechanisms in place whereby patients that require a branded medication out of medical necessity can appeal to have it covered.

- ⇒ For each percentage point increase in overall generic utilization, Part D drug spending falls by an estimated \$12 billion over the 2007 to 2015 period.
- ⇒ If PDPs were able to increase their generic dispensing rate by 5 percentage points, savings could increase by \$58 billion over the 2007 to 2015 period.

⁸ Generic Pharmaceutical Industry Association, “About Generics,” Accessed April 6, 2006, available at <http://www.gphaonline.org/Content/NavigationMenu/AboutGenerics/Statistics/Statistics.htm>

Conclusion

Congress designed Medicare Part D in a way that was intended to foster competition, lower costs for beneficiaries, and to reduce the burden on the federal government. Evidence suggests that PDPs have met cost-savings expectations within this framework. PDPs saved Medicare and its beneficiaries an estimated \$30 billion in 2006. If current performance is maintained, PDPs will save a projected \$469 billion over the 2006-2015 period. Additional savings could be realized during the same period if PDPs implement best practice solutions to increase the utilization of generic drugs in place of brands.

Appendix: Methodology

The Pharmaceutical Care Management Association (PCMA) commissioned a study by PricewaterhouseCoopers to address the question of whether the new prescription drug benefit management system created by the MMA is achieving savings as predicted. Our findings in this study are based on a wide range of methods including review of previous studies, analysis of the legislation and regulations issued under the MMA, interviews with PBM officials, and a survey of prescription drug plans. In addition to the interviews, we researched current trend reports publicly available on the various PBMs' websites. We also utilized the findings from our previous report for PCMA, "The Value of Pharmacy Benefit Management and the National Cost Impact of Proposed PBM Legislation," for the calculated savings level. Finally, we discussed all of our findings with internal PricewaterhouseCoopers actuaries who work with employers and health plans.

What follows are details on the interview of PBM officials and our survey of prescription drug plans.

Survey of PDPs and FEHBP Plans

To compare the savings achieved under Medicare PDPs to typical employers, we researched national PDPs as well as regional PDPs (in Florida) with the drug benefit offered under FEHBP. We compared the structure of formularies, utilization management techniques, and pricing policies. In addition, we compared the likely level of savings from typical employer-sponsored plans.

To determine the cost management strategies used by PDPs, we surveyed six national PDP plans as well as regional plans in Florida. Specifically, we collected the following information:

- We reviewed the standard information on PDP and Federal Employers Health Benefit Plans (FEHBP) offered in Florida that was publicly available.
- For each plan, we summarized information including the deductible amount, number of tiers in the formulary, copay amounts by tier, and evidence about other management tools such as generic substitution, step therapy, therapeutic substitution, appeals, and open/closed formulary.
- We also obtained, from private sources, the top five therapeutic categories for retirees, which included drugs for anticholesterol, gastric, and 3 heart treatment categories. We used the two most-prescribed categories (anticholesterol drugs and gastric medications) as well as calcium channel blockers. The three categories are about 15 percent of all drugs used by retirees.
- We recorded which of the 48 drugs in the 3 categories were in the "preferred tier" in each health plan. In other words, if a plan had two drugs from each of the three categories, it would score "6" on an index that ranged in levels from 0 to 48. (It is possible to have less than 6, since some plans may have chosen a drug with generic substitutes as one of only two preferred drugs in a category.)
- Based on this information, PricewaterhouseCoopers summarized the counts by therapeutic category for each plan.

Structured Interviews with Industry Experts

We interviewed six industry experts to gather evidence of typical practices in employer-sponsored plans as well as their views on the impact of the regulations on PDP practices. The executives came from different parts of the PBM organizations ranging from clinical services to public affairs in their orientation. We developed a master list of questions but we eliminated questions that were not germane to a specific interviewee's specialization. The interviews provided the information on which to base our description of typical practices and their ability to reduce prescription drug costs.