

## **An In-Depth Examination of Formularies and Other Features of Medicare Drug Plans**

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## EXECUTIVE SUMMARY

As of January 2006, 42 million elderly and disabled people on Medicare have access to private plans that offer the new Medicare prescription drug benefit. Across the 50 states, there are a total of 1,429 stand-alone prescription drug plans (PDPs), in addition to 1,314 Medicare Advantage plans, that provide the new drug benefit. Coverage offered by these Medicare prescription drug plans must meet minimum federal standards. For example, plans are required to provide a standard drug benefit or one that is actuarially equivalent. At the same time, plans have flexibility to modify the standard drug benefit design and establish their own formularies, and also can offer enhanced benefit packages, subject to review and approval. The concept behind this choice-based approach is that Medicare beneficiaries, primarily seniors but also people with disabilities, will choose among competing drug plans to select the plan that is most likely to meet their individual needs.

With the proliferation of Medicare drug plans in 2006, the key questions for beneficiaries include which plans cover the specific drugs they take and how much they will pay out-of-pocket for these medications. The Centers for Medicare and Medicaid Services (CMS), the agency responsible for administering the new drug benefit, has created a number of tools to help beneficiaries compare key features of the plans available in their area, such as formularies, costs, and the use of utilization management tools.

This report examines the extent to which the new stand-alone prescription drug plans vary with respect to key features that are likely to be important to Medicare beneficiaries' access to medications and out-of-pocket costs. The study takes a detailed look at the drug coverage offered by 14 national and near-national organizations that account for a total of 1,222 of the 1,429 stand-alone drug plans available to beneficiaries nationwide. It looks at a sample of 152 generic and brand-name drugs, selected to include drugs commonly used by Medicare beneficiaries, such as those treating high cholesterol and high blood pressure, as well as some less common, high-cost drugs used to treat specific conditions such as osteoporosis and rheumatoid arthritis.

The study finds significant variation across plans with respect to formularies, cost sharing in the initial benefit period, and the application of utilization management tools. These differences could have significant implications for beneficiaries in terms of access to needed medications and out-of-pocket costs. They also underscore both the importance to beneficiaries of making *good* choices when selecting among competing Medicare prescription drug plans, and the challenges in choosing wisely when so many plan features vary.

### KEY FINDINGS

**Formularies.** All of the Medicare drug plans examined in this study use formularies to help manage drug utilization and costs, but the list of covered drugs differs across plans. These differences could have a substantial impact on enrollees with a preference, or current prescription, for one particular medication, in terms of out-of-pocket spending – unless they ask their physician to switch them to a drug that is on the plan's formulary.

- None of the 35 drug plans cover all 152 of the drugs in the sample. On average, the plans cover 81 percent of those drugs, ranging from 64 percent in the most restrictive formulary to 97 percent in the least restrictive.

- While all of the top 10 most commonly prescribed generic drugs are covered by 32 of the 35 plans, only 18 of the 35 plans cover all top 10 brand-name drugs. Among the top 10 drugs, the most frequently omitted – in favor of therapeutically similar alternatives – include Nexium, Diovan, and Plavix.
- Formulary comprehensiveness varies considerably by drug group. Averaged across all plans in the study, about 90 percent of antidepressants, beta blockers, and tumor necrosis factor inhibitors (used to treat rheumatoid arthritis) are covered on plan formularies, while only about 60 percent of hormonal agents (used to treat osteoporosis) and proton pump inhibitors (used to treat gastrointestinal problems) are covered.

**Cost Sharing and Tiering Structure.** The amount enrollees pay for covered drugs varies substantially across plans, due to variation in placement of covered drugs on separate cost-sharing tiers (e.g., tiers for generic vs. brand-name drugs, preferred vs. non-preferred drugs, or “specialty” drugs) and the amount plans charge for covered drugs based on their cost-sharing design for each tier.

- The amount enrollees pay for a given drug when it is covered on the plan’s formulary varies considerably across plans. An enrollee could pay from \$15 to \$62 for Norvasc (for high blood pressure), \$15 to \$66 for Fosamax (for osteoporosis), and \$15 to \$100 for Namenda (for Alzheimer’s). An even more dramatic example of this variation across plans is for Enbrel (for rheumatoid arthritis), with cost sharing that varies from a low of \$20 in one Medicare drug plan to \$1,276 in a plan that covers the drug but charges enrollees 75 percent of its cost.
- The most common cost-sharing arrangement is a three-tier system of copayments. Among the 21 plans with such arrangements, the median cost-sharing is \$5 for first-tier drugs, \$25 for second-tier drugs, and \$53 for third-tier drugs.
- Most of the 35 plans also use a “specialty tier,” primarily for relatively high-cost biotechnology or injectable drugs. Although CMS issued guidance encouraging plans not to charge beneficiaries more than 25 percent of the cost of these drugs, eight plans charge between 30 percent and 33 percent. For the specialty tier drugs in the study’s sample, beneficiaries would be required to pay between \$149 and \$450 for a one-month supply in plans that cover these drugs.
- There is relatively modest variation across plans – much less variation than other parameters in this analysis – in the negotiated price that enrollees pay for covered drugs when they are required to pay 100 percent of the cost (in the deductible and the coverage gap, or so-called “doughnut hole”).

**Utilization Management Tools.** Utilization management tools – prior authorization, quantity limits, and step therapy – are used by plans to help manage drug use and total costs. The application of such tools can be an important way for plans to steer beneficiaries to specific drugs as well as to control the use of certain drugs. Yet enrollees may not know whether these tools might create a real barrier to getting their medications until they first attempt to fill a prescription for a specific drug under their plan.

- Plans vary significantly in the type of utilization management tools they use to restrict enrollees’ access to specific drugs, and in the frequency these tools are applied. Four of the 35 plans use these tools on fewer than one in 10 of their covered drugs, while 13 plans do so on at least one in four covered drugs.

- Plans are more likely to apply quantity limits for covered drugs than to require step therapy, which is applied slightly more often than prior authorization requirements.
- At least half of the plans use one or more utilization management tools on five of the top 10 brand-name drugs, most often quantity limits. Restrictions are far less commonly used for the top 10 generic drugs.

## **DISCUSSION**

This study confirms considerable variation across plans with respect to virtually every key indicator, including the comprehensiveness of formularies, the treatment of covered drugs as preferred or non-preferred, the amount enrollees pay for covered drugs, and the application of utilization management tools. These differences reflect decisions made by the organizations that sponsor Medicare drug plans to encourage enrollees' use of generic drugs in lieu of comparable brand-name drugs, and the use of preferred over non-preferred brands. It is beyond the scope of this paper to assess whether or not these decisions are appropriate, but the findings underscore the importance for beneficiaries in making careful decisions when choosing among the many Medicare drug plans available to them.

Variation across Medicare drug plans could have a significant impact on beneficiaries' access to needed medications and their out-of-pocket expenditures over the course of a year. The potential impact of these variations is heightened by the fact that once beneficiaries enroll in a plan, they are generally locked into that choice for the remainder of the year. Without careful consideration of the ways in which plans differ, beneficiaries may find themselves paying hundreds, if not thousands, of dollars more to fill their prescriptions, depending upon the plan they select. For several commonly used brand-name drugs, enrollees could face a four-fold difference in cost sharing for a 30-day supply from one plan to another, even when the drug is covered by both plans and filled at a network pharmacy. The absence of any standardization for many features of drug plan benefit design, and even some of the basic terminology used to describe these plans, is likely to make apples-to-apples comparisons across plans more difficult for consumers.

Given the significant needs and vulnerabilities of the Medicare population, the findings of this study confirm the need for careful oversight to monitor plan compliance and minimize unnecessary complexity in the Medicare prescription drug plan marketplace. Such oversight is critical to secure protections for beneficiaries who are unable to compare key features of Medicare drug plans or to predict their future medication needs.

## INTRODUCTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a new voluntary prescription drug benefit for people on Medicare, known as Part D. The benefit, which took effect in January 2006, is available to beneficiaries who are enrolled in private plans that have been approved by the federal government to offer Medicare's new drug coverage. In most parts of the country, beneficiaries have a choice of at least 40 stand-alone prescription drug plans (PDPs) that offer coverage for prescription drugs only. Across the 34 regions established for Part D (excluding the territories), there are a total of 1,429 stand-alone drug plans available. Most beneficiaries can also choose to get drug coverage from Medicare Advantage plans that offer the drug benefit in addition to other Medicare benefits.

The MMA requires organizations offering drug plans to provide a standard benefit which is defined in the law<sup>1</sup>, but gives them flexibility to modify the benefit, establish formularies and cost-sharing amounts, and apply utilization management tools to covered drugs, such as prior authorization, quantity limits, and step therapy.<sup>2</sup> Plan designs are subject to the approval of the Centers for Medicare and Medicaid Services (CMS), the agency that administers the Medicare program. From a beneficiary perspective, the formulary, or list of covered drugs, is among the most important features of a Medicare drug plan. Another key concern for beneficiaries is how much they will pay at the pharmacy when they fill their prescriptions. Beneficiaries can evaluate these features of the Medicare drug plans available in their region to select one that is most likely to meet their individual needs.

CMS requires that organizations offering drug plans meet minimum standards to ensure that plan formularies cover a full range of medications needed by beneficiaries and are not designed to discriminate against certain types of beneficiaries or discourage their enrollment. Formulary guidelines issued by CMS in 2005 were based on a therapeutic classification scheme developed specifically for Medicare drug plans by the United States Pharmacopoeia (USP). These guidelines require a minimum number of drugs to be covered in each class and key drug type of the USP classification system, and coverage of all or substantially all drugs in six specified classes (anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immune suppressants). At the same time, CMS gives organizations latitude to modify their formularies, subject to review and approval.

CMS allowed each approved sponsor organization to offer up to three unique plan options in 2006 which could vary in benefit design, formulary, and utilization management tools. At least one plan offered by each organization must be actuarially equivalent to the standard benefit. Data released by CMS in the fall of 2005 provided basic information about these plans, including monthly premiums, deductible and cost-sharing amounts, and which drugs are covered on their formularies. At a basic level, the Medicare drug plans appear to be

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<sup>1</sup> The standard benefit defined in the MMA has a \$250 deductible and 25 percent beneficiary coinsurance in the initial benefit period. The initial benefit period ends after \$2,250 in total drug spending. From this point until catastrophic coverage begins (after a beneficiary incurs \$3,600 in out-of-pocket drug costs, which corresponds to \$5,100 in total drug costs under the standard benefit), the beneficiary pays 100 percent of drug costs; this gap in coverage is commonly referred to as the "doughnut hole." Organizations must either offer at least one plan with the standard benefit design or a plan design that is actuarially equivalent to this benefit.

<sup>2</sup> Plans can require the enrollee to show that a particular drug is medically necessary before granting permission to fill the prescription; limit the quantity of drugs that they cover over a certain period of time, such as limiting prescriptions to a certain number of pills each time the prescription is filled; and restrict coverage of a particular drug unless and until certain other drug therapies have been tried first.

similar to each other in many respects. Most plans do not replicate the standard benefit, but instead offer one that is actuarially equivalent. Most plans do not have a deductible or charge a flat 25 percent coinsurance rate. Most plans *do* have a gap in coverage, known as the “doughnut hole.” And all of the stand-alone drug plans cover a majority of the top 100 drugs commonly used by Medicare beneficiaries, according to CMS.

Underlying these similarities, however, this report shows there is a great deal of variation in Medicare’s new prescription drug plans. Specifically, this study takes a more detailed look at the drug coverage offered by the stand-alone prescription drug plans offered by 14 national and near-national organizations that sponsor PDPs, focusing on three key areas:

1. ***Formularies.*** How comprehensive are the Medicare drug plan formularies? To what extent do plans vary with respect to the specific drugs that they cover and the placement of drugs on preferred versus non-preferred tiers?
2. ***Cost Sharing.*** How much variation is there across plans in the amount enrollees pay for their medications during the initial coverage period and in the coverage gap (the so-called “doughnut hole”)?
3. ***Utilization Management Tools.*** To what degree do plans apply utilization management practices that affect access to certain drugs, and to what extent does the application of these tools vary across plans?

Variations in these three areas could have significant implications for enrollees in terms of out-of-pocket drug spending and access to needed medications. The potential impact of these variations is heightened by the fact that once beneficiaries enroll in a specific plan, they are generally locked into their chosen plan for the remainder of the year.



## METHODS<sup>3</sup>

### Overview of Medicare Drug Plans in This Analysis

Our analysis focuses on stand-alone prescription drug plans (PDPs) offered by the 14 national and near-national organizations that sponsor such plans in at least 31 of the 34 regions established by CMS (excluding the territories). **(See Appendix Table A1)** These 14 organizations each offer between one and four different plan designs for a total of 35 unique plan options. Typically the organizations establish a different benefit structure for each of the plan options, and some also offer a different formulary for one of their plan options.

Across the 34 regions throughout the country, the 14 organizations that sponsor stand-alone PDPs account for 1,222 plans – 86 percent of the 1,429 PDPs offered nationwide.<sup>4</sup> Our analysis excludes the remaining 14 percent of plans – mainly local plans offered in a single region or a smaller number of regions – due to limitations imposed by collecting drug coverage and price data from the CMS website. We do not examine prescription drug benefits offered by Medicare

Advantage prescription drug (MA-PD) plans, for similar reasons.

Organizations' benefit designs and formularies are normally unchanged across the regions, although some exceptions exist. For example, several organizations modify cost-sharing levels by a few dollars or a few percentage points from region to region, presumably to maintain compliance with actuarial equivalence requirements. For simplicity, we present our findings in terms of the 35 unique plan options offered by these 14 organizations that are available across the country, rather than counting each of these plan options separately for all of the regions in which they are offered.

### Benefit Design

The characteristics of the 35 plans that we analyzed, representing 86 percent of all PDPs nationwide, are similar to the universe of stand-alone prescription drug plans in terms of average premiums and benefit design. **(See Table 1)** The average 2006 unweighted premium among the

**Table 1: Comparison of National and Near-National Plans in This Analysis to All Plans Available Nationwide**

	National/ Near-National	
	Plans	All Plans
<b>Number of plans</b>	1,222	1,429
<b>Benefit design</b>		
Standard	5.2%	9.2%
Actuarially equivalent	49.2%	48.2%
Enhanced	45.7%	42.5%
<b>Average premium<sup>1</sup></b>	\$38.14	\$37.43
<b>Deductible amount</b>		
\$250.00	29.6%	33.8%
Partial (less than \$250)	8.2%	7.8%
No deductible	62.2%	58.4%
<b>Uses tiered cost sharing</b>	94.8%	90.8%
<b>Coverage in the gap<sup>2</sup></b>		
No gap coverage	83.6%	84.6%
Generic coverage only	13.8%	13.1%
Brand and generic coverage	2.5%	2.3%
<b>Initial coverage limit</b>		
Standard (\$2,250 in total drug costs)	87.3%	87.8%
Lower coverage limit	10.1%	9.5%
No coverage limit	2.5%	2.3%

NOTE: Territories are excluded from all calculations.

1: The Administration's FY 2007 Budget assumes a Part D premium of \$25 per month for 2006. The Administration's estimate is lower than the average reported in this table because it (a) reflects CMS estimates of expected higher enrollment in low-premium plans, (b) includes only the portion of the premium for enhanced plans that corresponds to the basic benefit, and (c) includes premiums for Medicare Advantage plans.

2: The coverage gap (or "doughnut hole") is from the end of the initial benefit period up to \$3,600 in out-of-pocket payments.

SOURCE: CMS landscape file (11-15-05). Statistics for national plans are based on all regional offerings of each plans and thus differ slightly for other results presented in the report.

<sup>3</sup> See Appendix A for a more detailed description of the study methodology.

<sup>4</sup> The 10 national organizations offer 882 (62 percent) of the 1,429 plans offered nationwide, and the four near-national firms offer another 340 plans (24 percent) nationwide.

plans analyzed for this study is \$38.14, compared with \$37.43 for the universe of PDPs nationwide. Only a small share of the PDPs in our sample (5%) and nationwide (9%) offer the standard drug benefit as defined in the MMA, but nearly half of our sample plans and the national plans offer a drug benefit that is actuarially equivalent to the standard. Close to half of the PDPs in our sample (46%) and nationwide (43%) offer an enhanced benefit package. Roughly six in 10 PDPs in our sample (62%) and nationwide (58%) do not have a deductible. More than eight in 10 PDPs in our sample (84%) and nationwide (85%) have a coverage gap (the so-called “doughnut hole”) and only a very small share of the plans that we studied (2.5%) and all PDPs nationwide (2.3%) provide coverage of both brand-name and generic drugs in the gap.

### Sample of Drugs in this Analysis

To analyze plan formularies and cost-sharing arrangements, we examined coverage of a pre-selected sample of 152 drugs that together represent nearly 60 percent of the total prescription drug volume for Medicare beneficiaries, as reported in the 2001 MCBS. **(See Appendix Table A2)** We limited our analysis to these 152 unique drugs because of the time demands in collecting data from the CMS Medicare.gov website.<sup>5</sup>

The sample includes drugs from 14 complete drug classes in the USP model formulary guidelines developed for and adopted by CMS as the standard drug classification system for Medicare drug plan formularies. We selected some classes based on the volume of drugs prescribed, such as cardiovascular drugs, and others based on cost, such as drugs used to treat osteoporosis and rheumatoid arthritis. For simplicity, we have arranged these drugs into 10 groups for this report. **(See Appendix Table A3)** To augment these groups, our sample also includes the top 10 brand-name drugs and the top 10 generic drugs used by beneficiaries (as determined by volume of prescriptions from the Medicare prescription drug discount card program)<sup>6</sup> and an additional set of commonly prescribed drugs that are listed on at least one of several lists of commonly prescribed drugs. Overall, our sample is almost evenly divided between generic (n=73) and brand-name (n=79) drugs.<sup>7</sup>

### Data Collection and Analysis

We collected three types of data for each drug from the Formulary Finder on the Medicare.gov website: whether a drug was on plan formularies, the cost-sharing tier for each covered drug, and whether utilization management tools (prior authorization, quantity limits, or step therapy) were applied.<sup>8</sup> These data were collected between late November and early December 2005.

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<sup>5</sup> CMS has since released public use files which may make it easier to download and analyze data for all covered drugs, across all PDP and MA-PD plans in the future.

<sup>6</sup> The list of most commonly prescribed drugs in the discount card program was provided by CMS to congressional staff, but was not made public available on the CMS website.

<sup>7</sup> In most cases, when both a generic and a brand-name version of the same drug are on the market, we included only the generic version on our list of drugs. However, in a few cases, we included the brand-name version to examine how likely plans are to include the brand-name drug when a generic equivalent is available. In these cases, the brand-name drug and the generic drug each count as one drug in the sample. In addition, we included both standard-release and extended-release versions of a few drugs and also counted each separately.

<sup>8</sup> In collecting data from the website [<http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp>], we specified the state of Maryland. We have determined, however, that the organizations offering these national and near-national plans used the same formularies in all regions.

To estimate beneficiary cost sharing for each drug, we collected information on plan benefit designs, including the copayments and coinsurance charged by each plan.<sup>9</sup> We used the Medicare Prescription Drug Plan Finder on the Medicare.gov website to identify each plan's negotiated price for purchases at retail pharmacies (the price charged to beneficiaries when in the deductible period and the coverage gap).<sup>10</sup> We used this information to calculate cost sharing in the initial coverage period. When drugs were on a tier with flat copayments, we applied the plan's copayment unless the plan's negotiated price was lower. In those cases, we set the beneficiary's cost as the lower of the two prices. Although plans are not required to follow this rule, it appears that this is how prices are reflected in the Plan Finder. When drugs were subject to coinsurance, we applied the coinsurance rate to the plan's negotiated price to estimate the amount a beneficiary would pay in the initial coverage period.

For each of the individual drugs in our sample, we determined the most common form and strength of each drug and the amount of a common month's supply. Dose and strength are needed to determine cost sharing for covered drugs and the price in the coverage gap. In general, we used the Plan Finder's preset values for the most common form and strength of each drug. Because the Plan Finder defaults to 30 pills for a standard month's supply, in some instances it was necessary to determine through various clinical sources which drugs were typically taken as a daily dose, several doses per day, or a single dose per week and modify our data collection accordingly. Negotiated price data were downloaded in December 2005. We rechecked prices for the top 10 brand-name and top 10 generic drugs in February 2006 to determine whether there had been changes in the intervening months that might negate any of our key findings. For this subset of drugs, we identified price changes for 69 percent of the data points (54 percent increases and 15 percent decreases). In general, these changes were very modest – across the 14 organizations in our study, the average negotiated price for this set of 20 drugs rose by \$1.47, or 3.4 percent.<sup>11</sup> Some of these price changes (in particular, the large increases or decreases) are likely to reflect corrections of errors in data that were posted on the Plan Finder, either in December or in February.<sup>12</sup> The findings presented in this report reflect the negotiated price data collected in December.

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<sup>9</sup> Information on benefit design (including cost sharing levels) was collected primarily from the Medicare.gov website and supplemented by information from plan websites where the Medicare.gov information was incomplete.

<sup>10</sup> To collect price information from the website [<https://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/Questions.asp>], we entered a specific zip code in Maryland, but did not select a specific pharmacy. We found that all organizations had a single price across different plan options.

<sup>11</sup> The average negotiated price increased for 12 of the 14 organizations and decreased for the other two; the largest increase for any organization was 9.8 percent.

<sup>12</sup> It appears that some pricing errors result from prices that are imputed by CMS, typically in cases where plans did not submit negotiated prices for off-formulary drugs.

## RESULTS

### COVERED DRUGS

**Our analysis finds substantial variations in plan formularies and the placement of covered drugs on tiers (preferred versus non-preferred versus specialty tier).**

All of the Medicare drug plans examined in this study use formularies to help manage drug utilization and costs, but there are significant differences across plans with respect to covered drugs.

- The Medicare drug plans that we analyzed cover, on average, 81 percent of the 152 drugs in our sample, ranging from 64 percent in the most restrictive formulary to 97 percent in the least restrictive formulary. No plan covers all 152 of the sample drugs; 43 percent of plans cover more than 80 percent. (*See Exhibit 1*)

- Roughly one-third (53) of the 152 sample drugs are covered by all the plans that we analyzed. This list is dominated by generic drugs. Nearly three-fifths (43) of the generic drugs on our list are covered by every drug plan that we analyzed, but only 10 of the 79 brand-name drugs in our sample are always covered.

- All of the top 10 most commonly prescribed generic drugs are covered by 32 of the 35 plans. Levothyroxine is the only one of the top 10 generics not covered by three plans.<sup>13</sup> In contrast, only 18 of the 35 plans cover all top 10 brand-name drugs and only two of the top 10 brand-name drugs are covered by all plans. The top 10 brand-name drugs most frequently omitted, in favor of therapeutically similar alternatives, include Nexium, Zocor, Diovan, and Plavix.

- Seven of the 14 national and near-national organizations use at least two different formularies for their different Medicare drug plan options.<sup>14</sup> For six of these organizations, the plan with the lowest premium covers fewer of our sample drugs than the same organization's higher-premium plans. For example, one company's lowest-premium plan covers 103 of the 152 drugs in our sample, while its higher-premium plans cover 141 of the 152 drugs.

**Exhibit 1: Number of Plans Covering 152 Sample Drugs and Top 10 Brand-Name and Generic Drugs**

	Cumulative Number of Plans	Cumulative Percent of Plans
<b>152 Sample Drugs</b>		
All 152	0	0%
More than 90%	13	37%
More than 80%	15	43%
More than 70%	27	77%
More than 60%	35	100%
<b>Top 10 Brand-Name and Generic Drugs</b>		
All Top 10 Brands	18	51%
All Top 10 Generics	32	91%

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

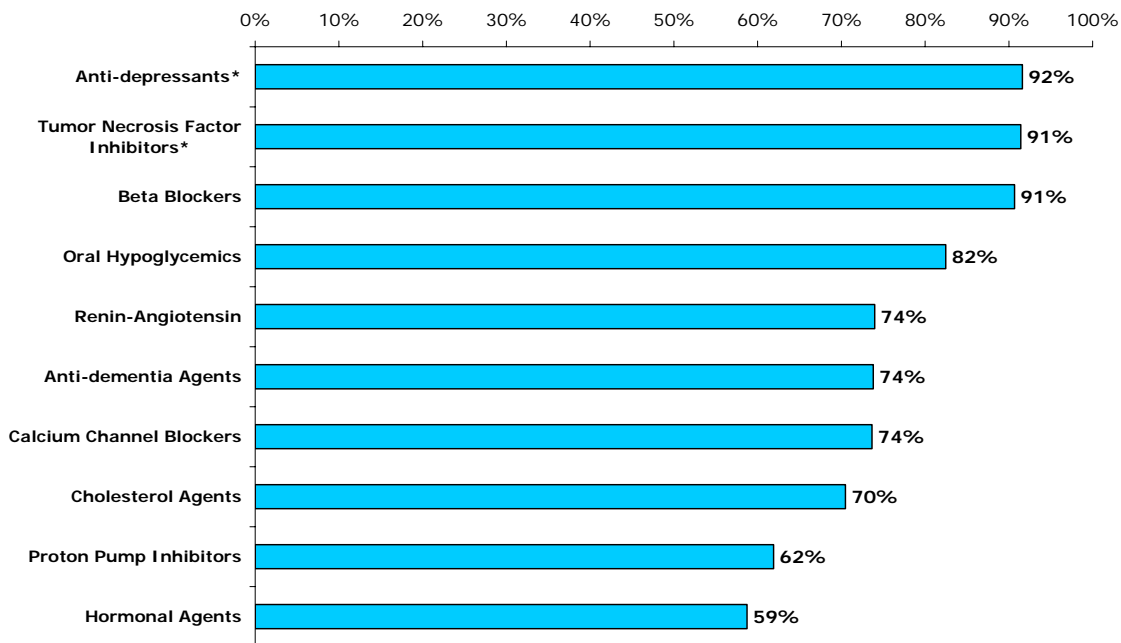
<sup>13</sup> Levothyroxine products existed prior to 1938, and are thus not subject to official FDA criteria for bioequivalence. As a result, use of brand-name and generic products has been controversial. "Bioequivalence of generic and brand-name levothyroxine," B. Dong et al., JAMA . 277:1205-13. April 16, 1997.

<sup>14</sup> Of the other seven organizations, three offer only one plan, and four use the same formulary for all of their plans.

## The comprehensiveness of formulary coverage varies considerably by drug group.

- Approximately 90 percent of antidepressants, beta blockers, and tumor necrosis factor (TNF) inhibitors (used to treat rheumatoid arthritis) are covered on plan formularies (averaged across all plans in this analysis); by contrast, roughly 60 percent of hormonal (parathyroid and metabolic bone disease) agents and proton pump inhibitors (PPIs) are covered by the PDPs that we analyzed. (See Exhibit 2)

**EXHIBIT 2: Percent of 152 Sample Drugs Covered, by Drug Group**



SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

- Although CMS guidelines require Medicare drug plans to cover at least two drugs in every USP class, one drug in every key type, and “all or substantially all” drugs in certain classes, we found that some plans do not cover the drugs that would be expected if they were following these guidelines without any exceptions.<sup>15</sup> (See Appendix B)
  - Only 12 of the 35 Medicare drug plans in our analysis cover the expected minimum number of required drugs in every class and key drug type in our sample of drugs. For example, one plan covers only a single proton pump inhibitor, rather than the required two in the class, and three plans do not cover Zetia (for cholesterol), the only drug in its key drug type. Although not all plans meet the standard of coverage for expected minimum number of required drugs, no plan covers less than the minimum expected number in more than four classes or key drug types.<sup>16</sup>

<sup>15</sup> There are two ways that a plan could be granted exceptions from these rules: 1) plans could design a drug classification system different from that developed by USP, which may group drugs differently and lead to a different minimum distribution of covered drugs when two are covered in every class; or 2) plans could specifically request from CMS an exception from the minimum coverage requirements for specific drugs. We are unable to ascertain whether our finding of noncompliance with formulary guidelines is due to either of these circumstances.

<sup>16</sup> The total would have been significantly different (with fewer plans covering the expected minimum) had CMS not recently issued a determination that prescription Niacin (the only product in one of the key drug types for treating cholesterol) should be excluded from Part D coverage since it is a vitamin. Certain drugs, including vitamins, are

- Fifteen plans did not cover all antidepressants, while nine plans did not cover all TNF inhibitors, although plans are expected to cover all drugs in these classes.<sup>17</sup> A few of the antidepressants omitted by some plans do not have major clinical uses, but others are important therapeutic agents.

**Most Medicare drug plans use some form of tiering structure for drugs on their formularies, and there is variation across plans in the number of tiers and the number and types of drugs assigned to each tier.<sup>18</sup> (See Exhibit 3)**

- Three-quarters of the national and near-national plans (24 of 35) use at least a three-tier cost-sharing structure – typically, Tier 1 for generic drugs, Tier 2 for preferred brand-name drugs, and Tier 3 for non-preferred brands. Fifteen of these plans add a specialty tier for certain high-cost drugs.<sup>19</sup>
- Nine plans use two tiers for the majority of their drugs (Tier 1 for generic drugs and Tier 2 for brand-name drugs); six of these plans add a specialty tier.
- Two plans replicate the “standard” benefit design with regard to cost sharing, using 25 percent coinsurance for all covered drugs. Although these standard plans designate tiers for their drugs on both plan and Medicare websites, in practice these tiers have no effect on beneficiary cost sharing.
- The majority of the Medicare drug plans that we studied (21 of 35) use a specialty tier, primarily for biotechnology or injectable drugs.<sup>20</sup>
  - Both the Formulary Finder and the Plan Finder websites designate all formulary tiers in numeric order. Neither the Formulary Finder nor the Plan Finder on Medicare.gov explicitly identifies which tier is the plan’s specialty tier, nor the drugs assigned by the plan to this tier, despite the distinctive nature of specialty drugs and the importance of conveying this information to beneficiaries. The Final Rule implementing the drug law gives plans permission to deny enrollees the right to request a tiering exception for drugs on the specialty tier, as they can for drugs placed on other tiers. Because the website displays are ambiguous about which tier plans may have designated as their specialty tier, beneficiaries may not know how this provision could affect them when they are comparing plans.
- The specialty tier was used for three of the 10 drug groups in our study: hormonal agents, calcium channel blockers (one specific drug in that class), and TNF inhibitors. However, some plans place even these expensive drugs on tiers for either preferred or non-preferred brand drugs. **(See Exhibit 3)**

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excluded by law from Part D coverage. We excluded Niacin from our counts of whether plans cover one drug in every key drug type. See CMS Memorandum from Abby Block, Director, Center for Beneficiary Choices to Medicare Part D plans on Prescription Niacin products, February 3, 2006.

<sup>17</sup> Among the antidepressants, CMS guidelines allow plans to cover either Lexapro or citalopram; we count a plan as covering “all” drugs if they cover at least one of these drugs. Similarly, our list includes both standard and extended-release versions of some antidepressants, but the CMS guidelines do not require plans to cover all versions of a drug. If a plan covered either version of a drug on our list, we count it as covering that drug.

<sup>18</sup> On the Medicare website, tiers are generally only described by number. To organize our analysis of tier placement, we recoded tier information into a standard set of categories. As a result, we categorize some plans with fewer tiers than the actual number of tiers displayed on websites and in other reports that describe these plans.

<sup>19</sup> Because the website does not specifically designate which formulary tier might correspond to a plan’s “specialty” tier, in our analysis we designated tiers as specialty tiers when they were designated as such by plans on their websites or when they shared the characteristics of a specialty tier.

<sup>20</sup> See note 19.

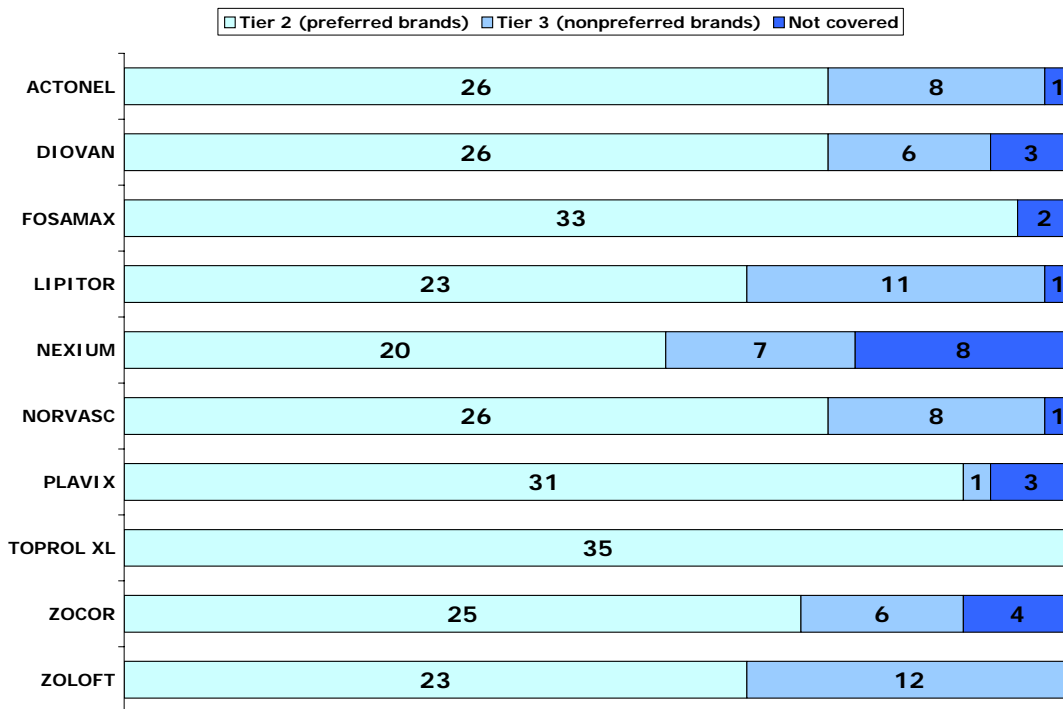
**Exhibit 3: Formulary Tier Placement of 152 Sample Drugs, by Drug Group  
Percent of Drugs in Each Group in Each Formulary Tier, Averaged Across All Plans**

<b>Name of Drug Group</b>	<b>Tier 1 (Generics)</b>	<b>Tier 2 (Preferred Brands)</b>	<b>Tier 3 (Nonpreferred Brands)</b>	<b>Specialty Tier</b>	<b>Not Covered</b>
Anti-dementia Agents	10%	48%	16%	0%	26%
Antidepressants	54%	23%	14%	0%	8%
Beta Blockers	75%	13%	3%	0%	9%
Calcium Channel Blockers	46%	17%	9%	2%	26%
Cholesterol Agents	19%	28%	23%	0%	30%
Hormonal Agents	1%	35%	19%	4%	41%
Oral Hypoglycemics	43%	30%	9%	0%	18%
Proton Pump Inhibitors	12%	28%	22%	0%	38%
Renin-Angiotensin	38%	17%	19%	0%	26%
Tumor Necrosis Factor Inhibitors	0%	25%	12%	54%	9%
<b>TOTAL</b>	<b>44%</b>	<b>23%</b>	<b>13%</b>	<b>1%</b>	<b>19%</b>

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

- Plans with a third formulary tier for non-preferred covered drugs vary widely in how they use that tier, placing anywhere from 7 percent to 38 percent of the sample drugs they cover on the non-preferred tier. Plans are most likely to place expensive drugs on Tier 3 or on the specialty tier.
- Each of the top 10 brand-name drugs is placed on the preferred tier by a majority of plans. However, for every drug but one (Toprol XL), each of the top 10 brands is placed on the non-preferred tier by at least one plan. Nexium, Lipitor, and Zoloft – each of which has significant competitors in their class – are less likely than the other top 10 brands to appear on the preferred tier. **(See Exhibit 4)**
- The likelihood that a brand-name drug will be on Tier 2 versus Tier 3 or the specialty tier varies by drug group. **(See Appendix B)**
  - In the anti-dementia, beta blocker, and oral hypoglycemic groups, there are on average at least three times as many drugs on Tier 2 as on Tier 3.
  - Cholesterol-fighting bile acid sequestrants and fibrates, sulfonyleureas for controlling diabetes, and aldosterone receptor antagonists and ACE inhibitors for high blood pressure are drug types and classes in which at least half of the on-formulary brand-name drugs are on Tier 3.
  - TNF inhibitors are three times more likely to be on Tier 3 or the specialty tier than on Tier 2.

**EXHIBIT 4: Tier Placement of Top 10 Brand-Name Drugs  
Number of Drug Plans with Drug on Each Tier**



SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

**COST SHARING IN THE INITIAL COVERAGE PERIOD<sup>21</sup>**

**The amount enrollees pay for covered drugs varies substantially across plans, due to variation in tier placement (whether the drug is covered on Tier 1, 2 or 3, or the specialty tier) and the amount plans charge for covered drugs based on their benefit design for each tier. (See Exhibit 5)**

- As noted earlier, the most common cost-sharing arrangement is a three-tier system of flat dollar copayments.<sup>22</sup> Among the 21 plans with three tiers and flat copayments<sup>23</sup>, the copayment for a 30-day supply varies as follows:
  - Median cost sharing for Tier 1 drugs is \$5, but ranges from \$0 to \$10.

<sup>21</sup> Cost-sharing amounts presented in this section incorporate both flat copayment amounts and estimated coinsurance amounts. For the two plans that charge coinsurance for all covered drugs and the 22 plans that charge coinsurance for at least some drugs, estimated coinsurance amounts for specific drugs were calculated from the plan's coinsurance rate and the negotiated price reported in the Plan Finder. In addition, for plans that charge a flat copayment, we assumed that enrollees would pay the plan's negotiated price for a drug if that price was lower than the plan's copayment amount.

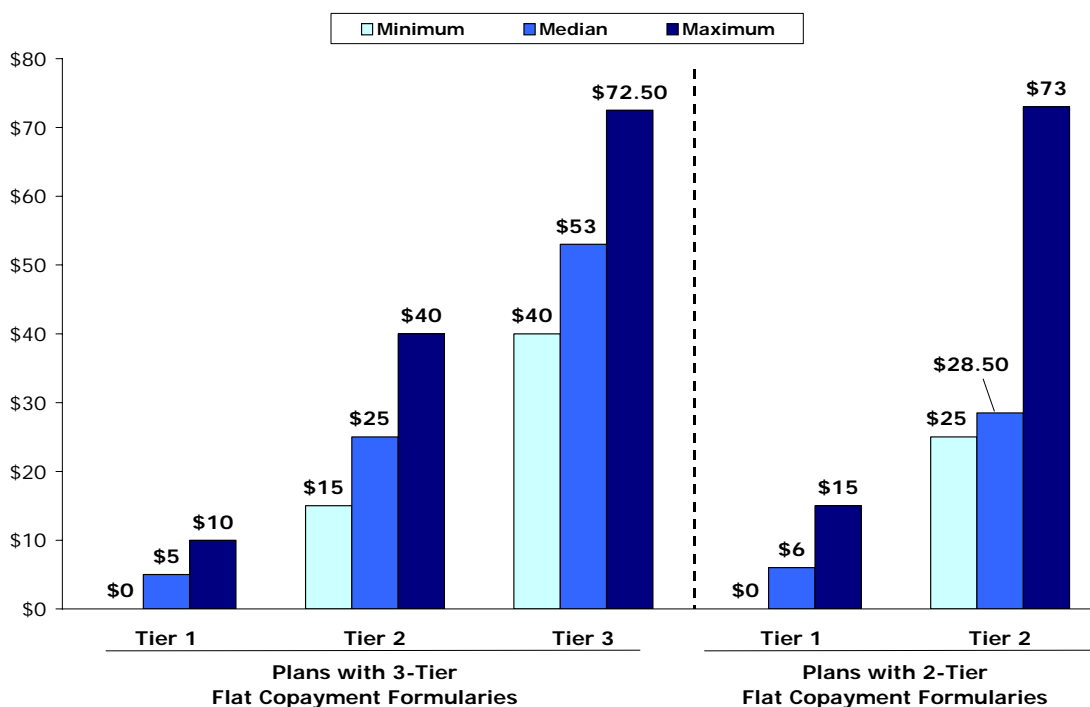
<sup>22</sup> In the Plan Finder, some plans display more tiers than the effective number of tiers. For example, Wellcare displays two generic tiers – one for preferred generic drugs and one for non-preferred generic drugs. In each case, however, the same copayment applies. Similarly, some plans that follow the standard benefit design organize drugs into multiple tiers even though the standard 25 percent coinsurance applies to each tier. In our analysis, we collapse these tiers into one if the same cost-sharing amount applies to drugs that the plan itself designates in separate tiers.

<sup>23</sup> Fifteen of the three-tier plans with flat copayments also include a specialty tier.



- Median cost sharing for Tier 2 drugs is \$25, but ranges from \$15 to \$40.
- Median cost sharing for Tier 3 drugs is \$53, but ranges from \$40 to \$72.50.
- Median cost sharing for preferred and non-preferred brand-name drugs is higher under the stand-alone Medicare drug plans than in plans offered to retirees by large private sector employers.<sup>24</sup>
- For the eight plans with two tiers and flat copayments<sup>25</sup>, cost sharing for a 30-day supply varies as follows:
  - Median cost sharing for Tier 1 drugs is \$6, but ranges between \$0 and \$15.
  - Median cost sharing for Tier 2 drugs is \$28.50, but ranges between \$25 and \$73.

**EXHIBIT 5: Cost Sharing for Covered Drugs by Formulary Tier**  
**Medicare Drug Plans with 2-Tier and 3-Tier Flat Copayment Formularies**



NOTE: Exhibit excludes six plans that use some form of coinsurance for at least one of their formulary tiers (other than the specialty tier).

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

- Six plans charge a percentage of the total price of the drug instead of a flat dollar amount for at least some covered drugs (other than specialty drugs). Two of these plans follow the standard benefit design with 25 percent coinsurance for all covered drugs. The other four plans base cost sharing for at least some brand-name drugs on coinsurance rates that range from 25 percent to 75 percent. Three of those four plans also include a specialty tier.

<sup>24</sup> According to the 2005 Kaiser/Hewitt Survey on Retiree Health Coverage, median cost sharing for a 30-day supply is \$10 for generic drugs, \$20 for preferred brands, and \$40 for non-preferred brands.

<sup>25</sup> Six of the two-tier plans with flat copayments also include a specialty tier.

- For the six plans charging coinsurance, the median cost sharing for the 152 drugs in our sample (translated from coinsurance rates into dollar amounts) is \$19.73. Amounts range widely from a minimum of \$0.64 to a maximum of \$957.56, due to the large variation in drug prices.
- When drugs are divided by tier, underlying drug prices lead to a far wider range of coinsurance amounts within each tier than in plans that charge flat copayments. The median calculated coinsurance amounts among plans that use a coinsurance structure are \$5.21 for drugs on Tier 1 (ranging from \$0.64 to \$100.39), \$20.99 for drug on Tier 2 (ranging from \$2.21 to \$455.54), and \$30.50 for drugs on Tier 3 (ranging from \$2.24 to \$957.56).
- All of the studied Medicare drug plans that use a specialty tier apply a coinsurance rate for drugs placed on this tier. Of the 21 plans with a specialty tier:
  - Thirteen plans apply a 25 percent coinsurance rate to these drugs.
  - Eight plans charge between 30 percent and 33 percent of the cost of drugs on this tier, despite CMS guidance that “encourages” plans to set beneficiary coinsurance for these tiers no higher than 25 percent.
  - Because these coinsurance rates are applied to relatively high negotiated prices, the cost sharing for drugs placed on a specialty tier is also quite high. For the drugs covered on a specialty tier in our sample, cost sharing ranges from \$149 to \$450.

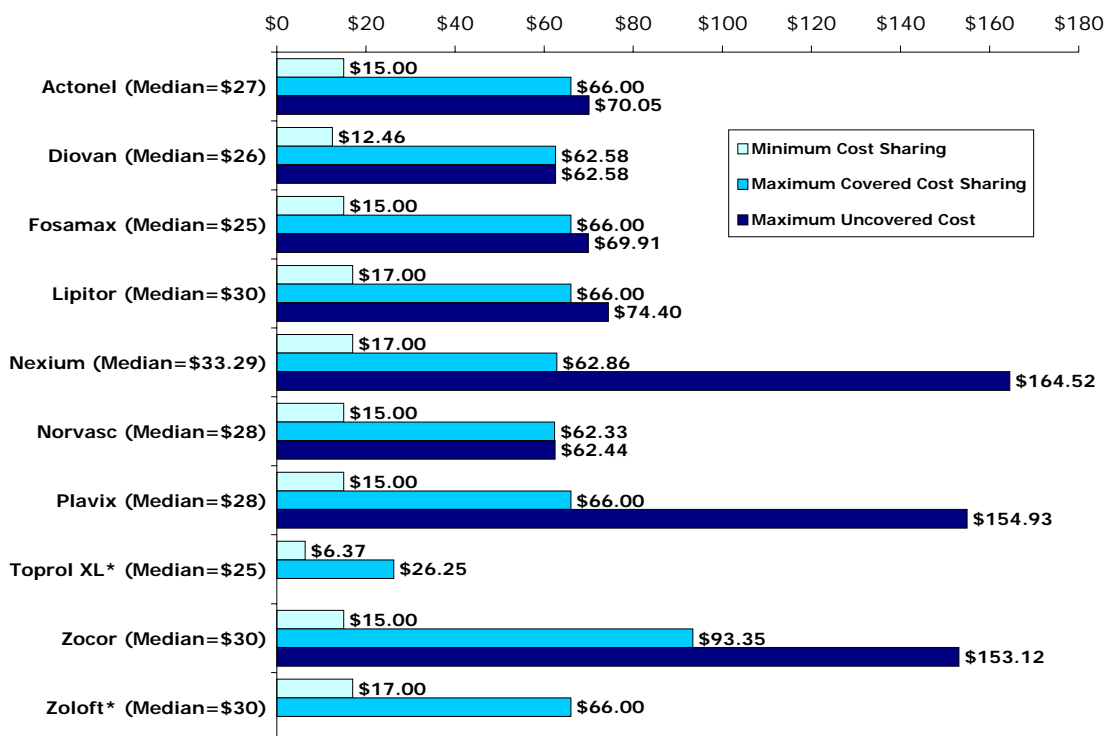
**Tiered cost-sharing arrangements provide strong financial incentives for enrollees to switch from a non-preferred to a preferred brand drug, and from a brand-name drug to a generic drug, when available.**

- The median cost-sharing for a drug on Tier 3 is more than twice the amount for a Tier 2 drug, and the median cost-sharing for drugs on Tier 2 is four times greater than the median for a Tier 1 drug. However, the sharpness of the incentives varies. For example, one plan in our analysis charges \$30 for a Tier 2 drug versus no copayment for a generic, while another has a \$23 copayment for Tier 2 and \$10 for Tier 1.
- For two plans that use coinsurance for their Tier 3 drugs, the coinsurance rate for the specialty tier is actually lower than that for the third tier (25 percent for the specialty tier compared to a range of 40 to 75 percent for Tier 3).

**The amount enrollees could pay for a given drug when it is covered on the plan’s formulary varies considerably across Medicare drug plans.** Some of this variation results from placement of brand-name drugs on non-preferred versus preferred tiers, or on specialty tiers, which typically results in higher cost-sharing for enrollees when the underlying price of the drug is high.

- Among the top 10 brand-name drugs, an enrollee could pay as little as \$15 for a 30-day supply of Actonel under one plan, but more than four times as much (\$66) in another. Similar differences can be seen for other drugs, such as Diovan, Fosomax, and Zocor. **(See Exhibit 6)**
- A more dramatic example of this variation across plans is for Enbrel (a TNF inhibitor to treat rheumatoid arthritis, among other conditions), with cost sharing that varies from a low of \$20 in one Medicare drug plan to \$1,276 in a plan that covers it but places it on a 75-percent coinsurance tier.

**EXHIBIT 6: Cost Sharing for Top 10 Brand-Name Drugs Across Sample Medicare Drug Plans Including Covered and Non-Covered Drugs**



NOTE: \* indicates drug covered by all plans.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

**The spread between the lowest and highest amounts that enrollees could pay out of pocket for a given drug is even greater when some plans leave the drug off their formularies. (See Exhibit 6 and Appendix Table A4)**

- Other than for some relatively inexpensive drugs, the differential across plans between low and high costs for a particular drug grows even larger when comparing costs between plans that do and do not place the drug on their formulary.
  - For example, in the case of Zocor, the maximum amount paid out of pocket rises from \$93.35 (when placed on formulary) to \$153.12 (when off formulary).
  - In a more extreme example, an enrollee could pay a flat copayment of \$20 for a month's supply of Zometa (a hormonal agent used for cancer patients) in one plan that covers the drug or a \$275 coinsurance amount in another plan that also covers the drug, but \$1,003 for a month's supply in a plan that does not include the drug on its formulary.

**Within drug classes, plans have made coverage and tiering decisions that result in substantial differences in cost sharing for individual drugs across plans. (See Appendix B)**

Drugs are categorized in the same class when they are therapeutically similar. With some exceptions, plans could elect not to cover all competing products in a class. For beneficiaries already stabilized on certain medications, patients and their doctors could be willing to switch among competing products. The potential for switching and the costs associated with this could be influenced greatly by plans' decisions with regard to the placement of therapeutically similar drugs on their formularies.

- Among the statins used to treat high cholesterol, six of 14 plans include all six therapeutic alternatives<sup>26</sup>, but six plans cover no more than three of these medications.<sup>27</sup> (**See Exhibit 7**) Enrollees in the plans that cover all six drugs can achieve savings by choosing the one generic option (lovastatin) or a preferred brand product, while enrollees in plans that offer more limited coverage of statins could save over \$100 by choosing an on-formulary drug over off-formulary alternatives.

**Exhibit 7: Coverage and Cost of Statins for Treating High Cholesterol, by Plan**

Name of Plan	Alto- prev <sup>1</sup>	Crestor	Lescol	Lipitor	Lova- statin <sup>1</sup>	Mevacor <sup>1</sup>	Prava- chol	Zocor
Aetna Essentials	\$93	\$81	\$58	\$25	\$5	\$69	\$132	\$25
Caremark Silverscript	\$100	\$20	\$14	\$18	\$9	\$88	\$140	\$153
Cigna Value	\$40	\$40	\$20	\$40	\$4	\$24	\$40	\$20
Coventry AdvantraRx Value	\$10	\$81	\$58	\$74	\$123	\$89	\$132	\$42
Humana Standard	\$23	\$20	\$14	\$18	\$8	\$17	\$33	\$33
Medco	\$17	\$17	\$43	\$17	\$4	\$89	\$99	\$17
MemberHealth CCRX Basic	\$102	\$101	\$72	\$19	\$0	\$91	\$142	\$34
Pacificare Saver	\$100	\$99	\$70	\$53	\$8	\$89	\$140	\$22
Prescription Pathway Bronze	\$94	\$20	\$58	\$18	\$12	\$89	\$34	\$135
Sterling	\$47	\$25	\$25	\$25	\$10	\$89	\$66	\$67
Uicare Medicare Rx Rewards	\$93	\$81	\$58	\$25	\$5	\$17	\$132	\$25
United AARP	\$55	\$55	\$55	\$28	\$5	\$89	\$55	\$28
United American	\$30	\$30	\$58	\$30	\$9	\$89	\$60	\$30
Wellcare Signature	\$99	\$97	\$69	\$66	\$0	\$88	\$139	\$66

NOTE: Shaded cell indicates off-formulary drug for specific plan.

1: Altoprev and Mevacor are branded generic versions of the generic lovastatin.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study.

- Formularies are generally more restrictive with regard to coverage of proton pump inhibitors (PPIs) used to treat certain gastrointestinal ailments, perhaps based on clinical evidence suggesting the relative comparability of these products. (**See Exhibit 8**) Only one plan places all five alternatives on its formulary<sup>28</sup> and two plans cover four out of five. Beneficiaries could achieve savings of \$100 or more by choosing a plan with their drug in a preferred tier or by asking their doctors to switch their prescription to an alternative product.

<sup>26</sup> Crestor, Lescol, Lipitor, Pravachol, and Zocor are the brand-name competitors; Altoprev and Mevacor are branded generic versions of the multi-source generic drug lovastatin.

<sup>27</sup> In order to simplify the display of information, we have focused for this analysis on one plan (specifically the lowest-premium plan or only plan) for each of the national or near-national organizations. Some of the higher-premium plans have more extensive formularies.

<sup>28</sup> Aciphex, Nexium, Prevacid, Prilosec, and Protonix are the brand-name competitors; omeprazole is the generic equivalent of Prilosec.

**Exhibit 8: Coverage and Cost of Proton Pump Inhibitors for Treating Gastrointestinal Conditions, by Plan**

Name of Plan	Aciphex	Nexium	Omepra-zole <sup>1</sup>	Prevacid	Prilosec CR	Protonix
Aetna Essentials	\$130	\$132	\$66	\$25	\$176	\$25
Caremark Silverscript	\$144	\$33	\$9	\$33	\$44	\$129
Cigna Value	\$40	\$40	\$135	\$40	\$206	\$20
Coventry AdvantraRx Value	\$130	\$132	\$136	\$163	\$206	\$42
Humana Standard	\$32	\$33	\$10	\$33	\$44	\$26
Medco	\$145	\$17	\$4	\$17	\$71	\$129
MemberHealth CCRX Basic	\$147	\$33	\$0	\$165	\$209	\$27
Pacificare Saver	\$129	\$22	\$8	\$132	\$207	\$22
Prescription Pathway Bronze	\$132	\$33	\$8	\$34	\$178	\$107
Sterling	\$145	\$25	\$10	\$25	\$25	\$130
Unicare Medicare Rx Rewards	\$130	\$132	\$5	\$25	\$176	\$25
United AARP	\$55	\$28	\$5	\$55	\$207	\$28
United American	\$145	\$30	\$9	\$30	\$60	\$130
Wellcare Signature	\$143	\$165	\$0	\$162	\$205	\$66

NOTE: Shaded cell indicates off-formulary drug for specific plan.

1: Prilosec is the brand-name version of the generic omeprazole.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study.

- The most commonly prescribed brand-name products, as well as competing generic alternatives, appear most likely to be included on plan formularies.
  - Among the statins, Lipitor, Zocor, and generic lovastatin are on nearly all plan formularies, although some plans place only one of the two competing brands on a preferred tier. The less commonly prescribed competitors (Crestor, Lescol, and Pravachol) are omitted from about half of the plan formularies.
  - Nexium, Prevacid, and the generic omeprazole are the PPIs most likely to be on formulary, while Aciphex is off formulary for 11 of 14 plans.
- The brand-name versions of drugs with generic equivalents are more often than not excluded from plan formularies.
  - Thirteen of 14 plans offer generic lovastatin as the least expensive alternative among the statins, but about half the plans make at least one of the brand-name versions of lovastatin (Altoprev or Mevacor) available at relatively low prices as well. Only one plan offers a branded generic version for a cheaper price than the generic.
  - Only five of 14 plans included the brand-name version of omeprazole (Prilosec) on formulary. The smallest price difference between the brand and generic alternatives for a one-month supply is \$15 (\$25 for the brand versus \$10 for the generic).

**Typical cost sharing in Medicare drug plans is often more than 25 percent of the total cost of covered drugs in the initial coverage period, across the set of drugs we studied.<sup>29</sup>** While individuals may expect to pay 25 percent of drug costs based on their understanding of the standard drug benefit (\$250 deductible and 25 percent coinsurance),

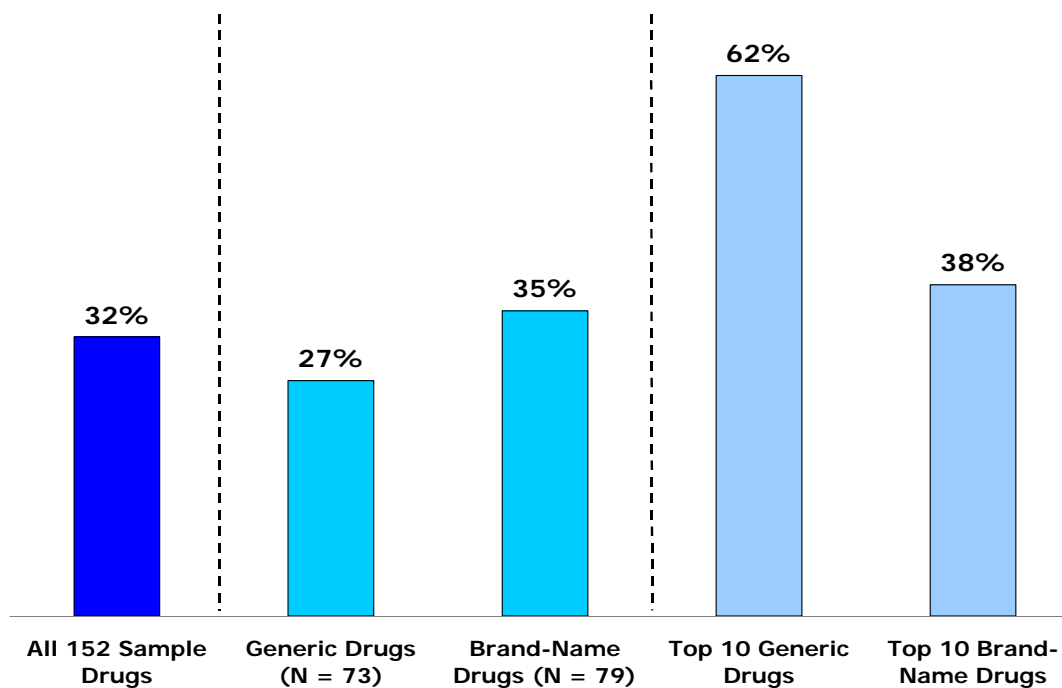
<sup>29</sup> This cost sharing rate is measured as the amount enrollees are expected to pay in the initial coverage period (before the doughnut hole) as a share of the plan's negotiated price reported on the Medicare Drug Plan Finder.

our analysis indicates that cost sharing for specific drugs can deviate considerably from the standard 25 percent amount. It appears that many plans have made a tradeoff in benefit design for 2006 by reducing or eliminating the deductible; in this case, for a benefit design to be actuarially equivalent to the standard benefit, average cost sharing in the initial coverage period must be higher than 25 percent.

Across all on-formulary drugs in our sample, our analysis shows:

- Median cost sharing is 32 percent of the negotiated price for all covered drugs. (*See Exhibit 9*)
  - Medicare drug plans charge, on average, more than half of the drug’s negotiated price for about one-third of the 152 sample drugs (24 of the 73 generic drugs and 28 of the 79 brand-name drugs).

**EXHIBIT 9: Cost Sharing as a Percent of Negotiated Price for Covered Sample Drugs**



SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

- For the 73 generic drugs in our sample, median cost sharing is 27 percent of the negotiated price.
  - For the top 10 generic drugs, median cost sharing is 62 percent of the negotiated price.
  - For four of the top 10 generic drugs, the median cost sharing faced by plan enrollees is the full cost of the drug.
- For the 79 brand-name drugs, median cost sharing is 35 percent of the negotiated price.

- For the top 10 brand-name drugs, median cost sharing is 38 percent of the negotiated price.

**An analysis of prices for our sample drugs posted on the Medicare Prescription Drug Plan Finder shows there is relatively modest variation across plans in the amount enrollees pay for covered drugs when they are required to pay 100 percent of the cost (in the deductible and doughnut hole) – much less variation across plans than other parameters in this analysis.**<sup>30</sup> Looking forward, a key question is whether plans with relatively higher enrollment than other plans will be able to use this volume as leverage to offer enrollees prices that are lower than what their competitors offer.

- The median negotiated price for the 152 sample drugs ranges from \$45.74 for the organization with the lowest overall prices to an average of \$56.22 for the organization with the highest prices – a swing of about 10 percent from the middle of the distribution (*See Exhibit 10*).
  - For brand-name drugs in particular, variation across plans is minimal. When total negotiated prices of the brand-name drugs in our sample are examined by organization, the organization with the lowest median prices (\$85.80) and the organization with the highest prices (\$96.68) are each about six percent from the middle.
  - For the 10 most commonly prescribed brand-name drugs, the range of prices across the 14 organizations for a one-month prescription is often quite modest. (*See Exhibit 11*) Some of the drugs with relatively small differences include Actonel (\$64.51 to \$71.90), Lipitor (\$69.12 to \$76.22), and Zoloft (\$73.91 to \$80.48).

**EXHIBIT 10: Range of Median Negotiated Prices for Sample Drugs**

	Median Organization	Organization with LOWEST Median Price		Organization with HIGHEST Median Price	
	Median of organization's negotiated prices	Median of organization's negotiated prices	% difference from median organization	Median of organization's negotiated prices	% difference from median organization
All drugs	\$49.82	\$45.74	-8%	\$56.22	13%
Generic drugs	\$18.11	\$13.21	-27%	\$23.27	28%
Brand-name drugs	\$92.16	\$85.80	-7%	\$96.68	5%

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

- For generic drugs, variation in negotiated prices is much greater in percentage terms, with the 14 organizations in our study ranging from median prices of \$13.21 (27 percent below the middle) to \$23.27 (28 percent above). (*See Exhibit 11*) Although the percentage difference is greater for generics than for brands, the difference in dollar terms is similar because the absolute prices for generics are lower. Examples of these ranges can be found among some of the 10 most commonly prescribed generic drugs: Atenolol (\$3.26 to \$9.66), Lisinopril (\$6.68 to \$24.38), and Warfarin (\$9.86 to \$27.02).

<sup>30</sup> As described above, these prices are indicated on the Medicare Prescription Drug Plan Finder website as prices charged by plans in the deductible and the coverage gap, where applicable. In most cases, they represented negotiated prices reported by the plans (likely without regard to rebates negotiated between plans and drug manufacturers). It appears that CMS has imputed some prices for off-formulary drugs in cases where they were not supplied by plans.

**EXHIBIT 11: Range of Median Negotiated Prices for Top 10 Brand-Name and Generic Drugs**

<b>Top 10 Brands</b>	<b>Lowest Price</b>	<b>Median</b>	<b>Highest Price</b>	<b>High-Low \$ Difference</b>	<b>High-Low % Difference</b>
Actonel	\$64.51	\$69.98	\$71.90	\$7.39	11%
Diovan	\$46.98	\$50.12	\$65.83	\$18.85	40%
Fosamax	\$65.15	\$69.99	\$71.91	\$6.76	10%
Lipitor	\$69.12	\$71.18	\$76.22	\$7.10	10%
Nexium	\$78.11	\$131.67	\$164.52	\$86.41	111%
Norvasc	\$58.62	\$62.44	\$64.34	\$5.72	10%
Plavix	\$118.72	\$121.30	\$154.93	\$36.21	31%
Toprol XL	\$21.68	\$25.77	\$28.11	\$6.43	30%
Zocor	\$110.31	\$133.70	\$153.12	\$42.81	39%
Zoloft	\$73.91	\$78.69	\$80.48	\$6.57	9%
<b>Top 10 Generics</b>	<b>Lowest Price</b>	<b>Median</b>	<b>Highest Price</b>	<b>High-Low \$ Difference</b>	<b>High-Low % Difference</b>
Atenolol	\$3.26	\$4.19	\$9.66	\$6.40	196%
Furosemide	\$4.03	\$4.60	\$13.10	\$9.07	225%
Hydrochlorothiazide	\$2.66	\$3.14	\$5.21	\$2.55	96%
Hydrocodone/Acetaminophen	\$3.68	\$4.58	\$5.51	\$1.83	50%
Levothyroxine	\$5.84	\$9.08	\$12.14	\$6.30	108%
Lisinopril	\$6.68	\$10.35	\$24.38	\$17.70	265%
Metformin	\$10.17	\$14.06	\$23.34	\$13.17	129%
Metoprolol Tartrate	\$3.83	\$5.13	\$15.94	\$12.11	316%
Potassium Chloride CR	\$12.55	\$19.95	\$36.74	\$24.19	193%
Warfarin	\$9.86	\$12.92	\$27.02	\$17.16	174%

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

- No differences in negotiated prices were found based on the placement of brand-name drugs on preferred vs. non-preferred tiers.
- Among our sample drugs, the average negotiated price for on-formulary drugs is 15 percent lower than the average negotiated price for off-formulary drugs. It is possible that this price difference is a result of CMS imputing prices for some drugs, because plans were not required to report prices for off-formulary drugs. However, the Medicare.gov website does not denote when prices have been imputed. The price differential between formulary and non-formulary drugs is greater, in percentage terms, for generic drugs (29 percent less expensive) than brand-name drugs (9 percent less expensive). However, the magnitude of the price differential for generic drugs translates into relatively small dollar values, because generics are generally less expensive than brand-name drugs.

**UTILIZATION MANAGEMENT TOOLS**

**There is significant variation across plans in the application of utilization management tools that affect access to drugs, including which tools plans use and whether they ever use more than one strategy at once on a single drug.** At this point, little is known about how these utilization management tools will be applied, and the extent to which they may deter beneficiaries from getting needed prescriptions.



- Four of the 35 plans offered on a national or near-national basis use these tools on 10 percent or less of their covered drugs, while 13 plans apply utilization management practices to at least 25 percent of their covered drugs.
  - Seven plans never apply more than one utilization management strategy to a single drug, while three plans do use all three tools on at least one of the drugs in our sample.

**Plans are more likely to establish quantity limits for covered drugs than to require step therapy, which is required slightly more often than prior authorization.**

- On average across the Medicare drug plans and sample drugs that we studied, 14 percent of covered drugs are subject to quantity limits, seven percent are subject to step therapy, and six percent to prior authorization. *(See Exhibit 12)*
- Utilization management tools are more commonly applied to brand-name drugs than generic drugs. At least half of the plans use these tools on five of the top 10 brand-name drugs – most often, quantity limits. Specifically, two hormonal agents used to treat osteoporosis (Actonel and Fosamax), two statins for treating cholesterol (Lipitor and Zocor), and one drug for gastrointestinal ailments (Nexium) are most likely to have quantity limits applied; Diovan (for hypertension) and Nexium are most likely to have step therapy requirements; and Nexium is most likely to require prior authorization.
- Restrictions are far less common for the top 10 generic drugs. Only two of the top 10 generic drugs are subject to utilization management practices, and only 12 plans restrict the use of either or both of these drugs. Lisinopril, like other ACE inhibitors, is subject to either step therapy or quantity limits. Several plans place quantity limits on hydrocodone, an addictive and commonly abused painkiller.

**The use of restrictions varies across groups of drugs.**

- Among the ten drug groups analyzed in this paper, utilization restrictions are most commonly imposed on TNF inhibitors (most often, prior authorization), PPIs (quantity limits), hormonal agents (quantity limits), and renin-angiotensin drugs (step therapy), and are least common for beta blockers, calcium channel blockers, and oral hypoglycemics (used to treat diabetes). *(See Exhibit 12)*

**Exhibit 12: Application of Utilization Management Tools, by Drug Group**  
*Percent of Covered Sample Drugs in Each Group Subject to Utilization Management, Averaged Across All Plans*

Name of Drug Group	Prior authorization	Quantity limits	Step therapy	Any UM tool applied
Anti-dementia Agents	20%	13%	0%	27%
Antidepressants	2%	12%	9%	19%
Beta Blockers	0%	2%	1%	3%
Calcium Channel Blockers	0%	8%	0%	8%
Cholesterol Agents	2%	32%	3%	36%
Hormonal Agents	20%	28%	0%	43%
Oral Hypoglycemics	2%	8%	4%	13%
Proton Pump Inhibitors	33%	51%	24%	69%
Renin-Angiotensin	1%	16%	31%	48%
Tumor Necrosis Factor Inhibitors	86%	15%	0%	86%
<b>TOTAL</b>	<b>6%</b>	<b>14%</b>	<b>7%</b>	<b>24%</b>

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

## CONCLUSIONS AND POLICY IMPLICATIONS

Our analysis of the formularies and other benefit design features of PDPs offered by 14 national and near-national organizations that sponsor a vast majority of the Medicare stand-alone drugs plans available to people on Medicare finds considerable variation across plans with respect to virtually every key indicator, including: the comprehensiveness of formularies, the treatment of covered drugs as preferred or non-preferred, cost-sharing arrangements, the amounts enrollees pay for covered drugs in the initial coverage period, and the application of utilization management tools. Variation in each of these areas could have a significant impact on beneficiaries' access to medications and their out-of-pocket expenditures over the course of the year.

From a consumer perspective, our findings confirm the complexity of the Medicare marketplace and underscore the importance of making careful decisions when choosing among the many Medicare drug plans. Comparing plans along a number of dimensions is especially important for beneficiaries with high-cost illnesses for which they use one or more drugs that are more likely to be placed on a higher cost-sharing tier or specialty tier – if the drugs are covered at all. The complexity of these comparisons across a large number of plans poses a challenge to beneficiaries. Without careful consideration of the ways in which plans differ with respect to these benefit design details, beneficiaries may find themselves paying hundreds, if not thousands, of dollars more to fill their prescriptions, depending upon which plan they select. For several commonly used brand-name drugs, enrollees could face a four-fold difference in cost sharing for a 30-day supply from one plan to another, even when the drug is covered by both plans, and filled at a network pharmacy. In the case of certain high-cost drugs, such as TNF inhibitors (used by people with rheumatoid arthritis, among other conditions), the cost-sharing differences across plans are even more extreme.

In addition to examining plan formularies and cost-sharing requirements, the results of this study suggest that beneficiaries should also carefully inspect whether and how plans apply utilization management tools to the drugs they take. Prior authorization, step therapy, and quantity limits can be used effectively by plans to manage utilization of drugs that are subject to overuse or abuse, or where use should be restricted to certain types of beneficiaries with specific health conditions. However, the application of these utilization management tools might have the practical effect of making plan formularies less generous than they appear. Further monitoring is needed to assess how these tools are being used and whether they impose undue hardship on enrollees.

Even if beneficiaries are able to sort through the variation in formularies, cost sharing, and other benefit features and find a Medicare drug plan that meets their needs, their choice is based only on their prescription drug needs at the time they enroll. A Part D plan enrollee can not be certain that their chosen plan will meet their needs if their health status changes mid-year or the need arises for new medications that they did not take when they enrolled in a particular plan. Moreover, plans are able to change their formularies throughout the year, while enrollees are generally locked into their plan for the remainder of the year. So although the choice of plan is made at a single point in time, the potential exists at any time during the year for changes to an enrollee's drug needs as well as their plan's formulary. The static nature of the enrollment decision, combined with the dynamic nature of both an enrollee's health status and the drugs covered by their plan, could lead to some beneficiaries lacking access to drugs they need after they have enrolled in a particular plan.

The feature that varied the least across plans in our analysis was the negotiated price that individuals pay for our sample of drugs when they are responsible for all of their drug costs – generally in the deductible period and in the doughnut hole. The hypothesis is that larger or more established organizations will be able to negotiate larger price discounts or rebates from drug manufacturers, based on expected volume. Yet we found minimal variation in negotiated prices, especially for brand-name drugs. These results call into question the degree to which competition among the organizations offering drug plans has produced lower negotiated drug prices for enrollees thus far. Future research should monitor whether plans with a higher concentration of enrollees offer lower negotiated prices than their competitors.

Our results also raise a question about whether plan sponsor organizations (or the companies purchasing drugs on their behalf) might favor rebates over drug price discounts at the point of sale in their negotiations with pharmaceutical manufacturers. For 2006 it appears that plans may be using negotiated rebates as a way to offset deductibles (and likely also premiums) – features that are more apparent to consumers upfront – rather than offering lower prices that beneficiaries would pay in the doughnut hole. This would indicate that competition among plans for enrollment – at least for 2006 – is based more on premiums than drug prices. These questions cannot be tested empirically at this time, due to a lack of transparency and publicly available data related to price negotiations between plan sponsoring organizations and manufacturers.

From a policy perspective, the findings of our study confirm the importance of careful oversight in monitoring plan compliance with the law, the final regulations implementing the MMA, and other official guidelines related to the design of formularies, cost sharing, and actuarial equivalence. Our analysis suggests that some plans do not meet all of the formulary coverage standards established by CMS (e.g., covering the minimum number of drugs in a class or category or covering most or all drugs in the six key classes designated by CMS in the formulary guidelines). Although in some cases CMS may have granted approval for exceptions to the guidelines, it is possible that such exceptions could create an uneven playing field for plans. Our finding that median cost sharing across the plans in our analysis is greater than 25 percent for our sample drugs suggests that the federal government will need to be diligent on the issue of determining actuarial equivalence to ensure that beneficiaries and the Medicare program are getting the best possible value from plans, as well as what the law requires.

Our results also confirm the need for special attention to the placement of drugs on higher cost-sharing tiers and specialty tiers to verify that plans are not systematically discriminating against beneficiaries with certain conditions. High-priced drugs, such as those in the TNF inhibitors class, are routinely placed by plans on their highest formulary tiers, which in general translates into high cost sharing for the beneficiary. Accurate risk adjustment will be essential to ensure that plans offering relatively generous coverage are not penalized for attracting a disproportionate share of beneficiaries who take high-cost drugs, and that beneficiaries who enroll in these plans are not penalized with unjustifiably higher premiums because they chose a plan that attracted higher-cost beneficiaries. Specialty tiers are another feature of plans that should be monitored. Although relatively few drugs in our analysis were assigned to the specialty tier, the use of coinsurance – even in plans that use only flat copayments for other tiers – guarantees high cost sharing for these drugs. In addition, the specialty tier is not consistently labeled on the Medicare website or elsewhere. Beneficiaries who are newly prescribed drugs on this tier mid-year could face unexpectedly higher cost sharing compared to what they pay out of pocket for their other prescriptions. Yet if they want to request an exception from their plan to get the

drug covered on a lower cost-sharing tier, they may be unable to do so, according to a provision of the final regulations governing the drug benefit program.

With the large number of Medicare drug plans available in 2006, our analysis illustrates the numerous ways in which these plans differ, underscoring the importance for beneficiaries – particularly those who rely heavily on medications – of making *good* plan decisions. Those who try to compare the various features of plans will no doubt face tradeoffs among the list of covered drugs, premiums, levels of coverage, cost-sharing amounts, and rules governing utilization. The absence of any standardization for many features of plan benefit design, and even some of the basic terminology used to describe the plans, adds to challenges for beneficiaries. Faced with similar problems in the Medigap market years ago, Congress responded by creating standard benefit packages to facilitate “apples-to-apples” comparisons, and by limiting the range of choices available to beneficiaries. Given the significant needs and vulnerabilities of the Medicare population, our findings confirm the importance of federal safeguards and ongoing oversight to minimize unnecessary complexity in the drug plan marketplace, and to ensure that all Medicare-subsidized drug plans meet minimum standards to provide beneficiaries with good coverage at an affordable price.

## APPENDIX A: METHODOLOGY

This study provides an in-depth examination of the coverage provided by Medicare's new stand-alone Prescription Drug Plans (PDPs). Due to data limitations, the analysis focuses on a subset of plans, which represent 86 percent of all PDPs nationwide, and a subset of drugs, which represent about 60 percent of the total prescription volume for Medicare beneficiaries, as reported in the 2001 Medicare Current Beneficiary Survey. This appendix provides a detailed description of the Medicare drug plans selected for this analysis, the methodology for selecting the specific drugs that we analyzed, and the procedures used for data collection and analysis.

### Prescription Drug Plans in This Analysis

As described in the report, our analysis focuses on the 35 unique stand-alone prescription drug plans (PDPs) offered by the 14 national and near-national organizations that sponsor such plans in at least 31 of the 34 regions established by CMS (excluding the territories). The list of organizations and plans included in this analysis appears in **Table A1** below. One of the near-national organizations is more complex than the others. Plans marketing under the name of Prescription Pathway are available in 32 regions, operating under the names of three different subsidiaries (American Progressive Life, Pennsylvania Life, Marquette National Life). In some regions, the organization is represented by a single subsidiary; in others, multiple subsidiaries offering nearly identical plans.

As noted in the report, the 14 organizations that sponsor stand-alone prescription drug plans account for 1,222 plans – 86 percent of the 1,429 PDPs offered nationwide.<sup>31</sup> Our analysis excludes the remaining 207 plans (14 percent), which are mainly local plans offered in a single region or a smaller number of regions. We also excluded from this analysis prescription drug benefits offered by Medicare Advantage prescription drug (MA-PD) plans.

These 14 organizations each offer between one and four different plan design for a total of 35 unique plan options. CMS announced during the review of plan bids that it would only permit three plan options per organization, despite the fact that some organizations had submitted as many as five or six options. Prescription Pathway had more than three options approved in some regions because of the way it operates under different subsidiaries. For this analysis, we count Prescription Pathway as offering four plan options (Bronze, Silver, Gold, Platinum) since the organization's other options are nearly exact duplicates of these four. In addition, one national organization (Unicare, sponsored by Wellpoint), offers three different plans in most regions but only a single plan option in Region 7. Finally, we exclude from our analysis additional plan options offered on a more limited basis by two of the organizations in our study. Specifically, we exclude additional plans offered by United HealthCare in four regions, and plans offered by Coventry under its First Health subsidiary in 13 regions.

Although the cost sharing features change from one plan option to another, formularies do not always change. Across the 35 unique plan options, there are 21 unique formularies. Four of the organizations with multiple plan options use the same formulary in each plan option (Cigna, MemberHealth, United HealthCare, and Humana. The other seven organizations with multiple plan options have two different formularies. Among the latter

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<sup>31</sup> The 10 national organizations offer 882 (62 percent) of the 1,429 plans offered nationwide, and the four near-national firms offer another 340 plans (24 percent) nationwide.

cases, some use the alternate formulary just for their highest-premium plan, some use it for their two higher-premium plans, and one organization uses it only for its mid-premium plan.

Data on the characteristics of plan benefits were collected from the CMS Medicare Prescription Drug Plan Finder website<sup>32</sup>, when available. These data were supplemented by information (for example, cost sharing amounts for formulary tiers) collected directly from plan benefit summary materials and other documents on each sponsoring organization's website.

## **Sample of Drugs in This Analysis**

### **Selecting the Drug Sample**

Given the limited way in which formulary, cost-sharing, and pricing data for drugs were publicly available on Medicare.gov at the time of this analysis, the time demands in collecting information made it impossible to include the universe of FDA-approved drugs. CMS has since released public use files which may make it easier to download and analyze data for all covered drugs, across all PDP and MA-PD plans, in the future. Those files, however, are compiled at the level of National Drug Code (NDC) (where each form and strength of a drug and each manufacturer are assigned a separate code number), which makes analysis challenging. Also, those files do not contain the pricing information needed for this analysis.

We generated the sample of drugs for our analysis with several goals in mind: 1) including drugs that are among the most frequently prescribed drugs used by Medicare beneficiaries; 2) including drugs that belong to certain commonly prescribed drug classes; and 3) including a sub-sample of high-cost drugs. In total, our sample consisted of 152 drugs, including 73 generic drugs and 79 brand-name drugs. Together, these drugs include nearly 60 percent of the total prescription volume for Medicare beneficiaries, as reported in the 2001 Medicare Current Beneficiary Survey.<sup>33</sup> As a result, this analysis encompasses a substantial amount of all drug utilization by beneficiaries. The full list of drugs in our sample appears in **Table A2** below.

### **Most Prescribed Drugs by Medicare Beneficiaries**

Our sample of drugs includes the 10 most commonly prescribed brand-name drugs and the 10 most commonly prescribed generic drugs used by beneficiaries as determined by volume of prescriptions from the Medicare-endorsed prescription drug discount card program.<sup>34</sup> We compared this list of commonly used drugs to another list of most prescribed drugs for the total U.S. population (compiled by Verispan) to confirm no unusual characteristics associated with purchases through the discount card program.

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<sup>32</sup> <http://www.medicare.gov/MPDPF/Public/Include/DataSection/Questions/MPDPFIntro.asp>

<sup>33</sup> There is a key methodological issue involved in using the 2001 Medicare Current Beneficiary Survey as a proxy for estimating current prescription volume, and that is the real potential for changes in the availability of prescription drugs in the intervening years. At the drug class level, this may be a relatively minor issue, but it could be a larger concern at the individual drug level, as brand-name drugs lose patent protection and generics are introduced, drugs may be withdrawn from the market for safety reasons, and new drugs are given FDA approval and brought to market.

<sup>34</sup> The list of most commonly prescribed drugs in the discount card program was provided by CMS to congressional staff, but is not posted on the CMS website.

We included in our sample another 15 drugs that appear on one of several lists of the most commonly prescribed drugs, but were not in one of the common drug classes described below. These include drugs that are among the 25 most prescribed drugs in the Medicare-endorsed discount card program, but not included among the top 10 brands or top 10 generics. Other added drugs were those ranked among the top 10 brands and generics for the general population on the Verispan list (measured by either volume of prescriptions or dollars) but not in the discount card program. These additional 15 drugs include several commonly prescribed drugs from the following drug categories: anti-bacterials, respiratory tract agents prescribed for asthma, sedatives, analgesics, and certain cardiovascular medications. Because these are commonly prescribed drugs, they represent a significant share of total prescription volume.

### Common Drug Groups

We included drugs in our sample that comprised several complete drug groups because sponsoring organizations often make coverage decisions in the context of entire therapeutic categories and classes of drugs. In selecting drug groups, we relied on the drug classification system developed by the United States Pharmacopoeia (USP) and adopted by CMS as the model drug classification system. According to CMS, a majority of drug plans chose to use this system. The structure of the USP system involves 41 therapeutic categories, most of which are further divided into pharmacologic classes. There are a total of 146 unique categories and classes in the USP system. In addition, many of the categories are classes are further divided by USP into key drug types. Although these are not part of the official classification system, they were used by CMS in its formulary guidelines.

Our sample includes all drugs from four of the 10 classes of the largest category in the USP system, cardiovascular drugs:

- Beta-adrenergic Blocking Agents (treatments for hypertension, known as beta blockers)
- Calcium Channel Blocking Agents (treatments for hypertension)
- Dyslipidemics (treatments for high cholesterol)
- Renin-angiotensin-aldosterone System Inhibitors (treatments for hypertension, including ACE inhibitors and angiotensin receptor blockers or ARBs).

Our sample includes all of the drugs in several therapeutic categories, as defined by USP:

- Antidepressants (including all three classes in this category)
- Anti-dementia Agents (including all three classes in this category, several of which are used to treat Alzheimer's Disease)

Finally, our sample includes drugs in particular classes or key drug types in the following areas:

- Oral hypoglycemics class of Blood Glucose Regulators (drugs used to treat diabetes)
- Proton Pump Inhibitors class of Gastrointestinal Agents (drugs used to treat ulcers and gastroesophageal reflux disease or GERD)
- Parathyroid/Metabolic Bone Disease Agents class of the Hormonal Agents (Replacement, Stimulating, Modifying) category (two key drug types, bisphosphonates and calcium regulating hormones, in this class that include those used to treat osteoporosis)
- Tumor Necrosis Factor (TNF) Inhibitors, a key drug type in the Immune Suppressants class of Immunological Agents category (drugs used to treat rheumatoid arthritis)

Most of these drug classes were selected based on the volume of drugs prescribed from them. Others (e.g., drugs to treat osteoporosis or rheumatoid arthritis) were selected to ensure that the sample included some of very high-cost drugs and some specialty drugs (e.g., biotechnology drugs and self-injected drugs).

Drugs omitted from this analysis generally fall into two categories. There are many drugs in clinically important but less commonly prescribed classes of drugs (e.g., HIV/AIDS drugs and cancer agents) that we did not select for study. In addition, there are many alternative drugs in classes where we selected a commonly-prescribed drug but have not studied the entire class (e.g., antibacterials, analgesics, hormonal agents, and respiratory tract agents).

The placement of the different drug groups in our sample within the USP classification system is further outlined in **Table A3**. The full listing of drugs in Table A2 shows which drugs are in which category, class, and key drug type (where applicable).

### **Defining and Classifying Drugs**

The drug sample selection process as described above identified the chemical entities that we studied. We then determined which version of a drug to include. Generally, we chose to study only the generic version where both a generic and brand-name alternative are available. In order to study how plans make decisions when both versions are available, we did include both the brand-name and generic version of a few drugs. In addition, we chose to include a few drugs that are variants of another drug, such as the weekly version of Prozac or the continuous-release version of Paxil.

The formulary data available from the Medicare Prescription Drug Formulary Finder<sup>35</sup> related to coverage, pricing, and utilization management are specified at a more detailed level than drug name to include both the form and strength of a medication. For example, the Formulary Finder lists multiple dosages and forms of potassium chloride, including a liquid as well as tablets. Likewise, there are four different strengths of hydrocodone with acetaminophen, each having a different combination of dosages for the two drugs.

At least in theory, plans could apply different tier placement or utilization restrictions depending on the form or strength of a drug. Therefore, we established a standard form, strength, and monthly dose for each drug. Because we did not have the resources to collect data on every form and strength of all 152 sample drugs, we started from the default form and strength offered to consumers on the Medicare.gov website. Thus, our findings reflect only plan coverage information for this specific version of each drug on our list. Yet plans could cover some, all, or none of the different forms and strengths of certain drugs and their variants. Therefore it is possible that some plans that fail to cover the specific version of a drug we studied may actually cover another version. It is also possible that some plans cover only the form and strength we studied, but fail to cover other forms or strengths that are also widely used by Medicare beneficiaries.

With respect to a 30-day supply, the Formulary Finder includes a default monthly amount of 30 units for drugs in tablet or capsule form, without regard to whether this is a common dosage (defaults are also provided for drugs not in pill form). In fact, there are several cases where the default quantity was inaccurate or inappropriate. These include drugs that are taken less frequently than on a daily basis (e.g., Fosamax, Actonel, Prozac Weekly, Enbrel and Remicade) or drugs that are taken several times a day. In these cases, we determined a standard dosage from sources such as rxlist.com and relied on this

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<sup>35</sup> [formularyfinder.medicare.gov/formularyfinder/selectstate.asp](http://formularyfinder.medicare.gov/formularyfinder/selectstate.asp)



information to modify the number of pills obtained per month for over one-third of all the drugs on our list. This information is essential for determining in the Plan Finder the drug's negotiated price for a monthly supply.

Most of the medications on our list are maintenance drugs that would be taken for conditions such as hypertension, high cholesterol, or diabetes for the full 12 months of a year. However, our list of commonly prescribed drugs does include a few antibiotics and pain medications where patient use does not necessarily follow this pattern. Since dosing for these types of drugs varies considerably according to the type of infection being treated or the degree of pain experienced by the patient, we generally settled on a 30-pill supply for a month's prescription. In some cases, this would represent a two-week course of an antibiotic taken two times a day or pain medication taken four times a day for one week.

### **Methodology for Collecting Data on Tier, Price, and Usage Restrictions**

Data for this study were collected from the CMS website using the Formulary Finder and Medicare Prescription Drug Plan Finder following the November 15, 2005 start of open enrollment season. Once plan enrollment began, plans were not allowed to change their formularies, including information about cost-sharing tiers and utilization management practices until three months into 2006 (except where data errors exist). In a few cases where we became aware of systematic errors on the website prior to the completion of our analysis, the erroneous data we had already collected were replaced with new, accurate information. This was not a frequent occurrence.

### **Collecting Information from the Medicare Prescription Drug Formulary Finder**

We collected three types of data for each drug from the Formulary Finder for Prescription Drug Plans on the Medicare.gov website: whether a drug was on plan formularies, the cost-sharing tier for each covered drug, and whether utilization management tools (prior authorization, quantity limits, or step therapy) were applied. For each drug, we used the form, strength, and dosage, as described above. We chose the state of Maryland as the point of entry for the website, and we cross-checked tier information for plans in California to see if there were any differences. Since the formularies were the same in both regions, we assumed that plans did not vary their formularies from region to region – an assumption that was later verified with the CMS public use files.

Tier information on the website is based on the nominal tiers that are listed by the plans. As noted in the main report, we preferred to establish a standardized tier designation across plans. Some plans display more tiers than the effective number of tiers with different cost-sharing characteristics. For example, Wellcare displays two generic tiers: one for preferred generic drugs and one for non-preferred generic drugs. In each case, however, the same copayment applies. Similarly, some plans that follow the standard benefit design organize drugs into multiple tiers even though the standard 25 percent coinsurance applies to each tier. In our analysis, we collapsed these tiers into one if the same cost-sharing amount applies to drugs that the plan itself designates in separate tiers.

Similarly, neither plans nor the Medicare website have a systematic means of designating specialty tiers, despite the distinctive nature of specialty drugs and certain rules regarding appeals and exceptions that apply only to these tiers. We chose to label tiers as specialty tiers if they had coinsurance amounts of between 25 percent and 33 percent, were listed separately from other tiers, and contained drugs that were generally characterized as specialty drugs.

## Collecting Information from the Medicare Prescription Drug Plan Finder

We collected price information for purchases at retail pharmacies from the Medicare Prescription Drug Plan Finder between November 15, 2005 and January 2006. Drugs were entered in large enough groups to ensure that a hypothetical enrollee would incur expenses in the coverage gap so that we could retrieve the plan's negotiated prices that enrollees would pay in the coverage gap or before a plan deductible is met. We used a zip code in Maryland as the point of entry for the website, but did not enter a specific pharmacy. We verified through spot-checking that negotiated prices do not appear to differ across plan options when a single organization offers plans with different formularies. Instead, it appears that sponsoring organizations use a single negotiated price list for each of their plan options. As noted in the full report, we did some checking for price changes at a later date.

We then combined data on cost-sharing tiers, utilization management practices, and negotiated prices into one data file for analysis. Cost sharing for each drug was calculated based on plan benefit designs and negotiated prices. Flat dollar copayments for specific drugs reflect either the cost sharing amount for the drug's tier or the actual negotiated price of the drug, whichever was lower.<sup>36</sup> Cost sharing for specific drugs where a coinsurance rate was charged was calculated by multiplying the applicable percentage times the plan's negotiated price for the drug. Again, the lower of the calculated coinsurance amount or the actual negotiated price was used in the analysis.

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<sup>36</sup> Medicare Part D rules do not require that beneficiaries pay the lesser of the copayment or the negotiated price of the drug. But website displays seem to apply this rule in all cases. Although we have not found this payment rule stated explicitly in plan benefit summaries, we assumed for the purposes of our analysis that it applies in all cases.

**Table A1: Overview of Medicare Drug Plans in This Analysis**

Sponsor Organization	Plan Name	Number of Regions Where Offered	Standard (S), Alternative (A), or Enhanced (E) Benefit	Average Premium <sup>1</sup>	Deductible	Cost Sharing			Specialty Tier	Gap Coverage <sup>2</sup>	Coverage of 152 Sample Drugs - Number (%)	Coverage of Top 10 Drugs - Number of Brands/Generics
						Tier 1	Tier 2	Tier 3				
Aetna	Aetna Medicare Rx Essentials	34	A	\$34.25	\$250	\$5	\$25	--	--	NONE	106 (70%)	9/10
	Aetna Medicare Rx Plus	34	E	\$45.06	\$0	\$7	\$35	--	--	G	106 (70%)	9/10
Caremark	Aetna Medicare Rx Premier	34	E	\$60.87	\$0	\$2	\$20	\$40	--	G	147 (97%)	10/10
	SilverScript	34	A	\$28.67	\$250	\$9 <sup>^</sup>	25%	--	25%	NONE	109 (72%)	9/10
	SilverScript Plus	34	A	\$56.68	\$100	\$8 <sup>^</sup>	\$25 <sup>^</sup>	\$60 <sup>^</sup>	25%	NONE	120 (79%)	10/10
	CIGNATURE Rx Value	34	A	\$34.61	\$250	\$4	\$20	\$40	--	NONE	139 (91%)	9/9
Cigna	CIGNATURE Rx Plus	34	E	\$39.89	\$0	\$5	\$30	\$50	--	NONE	139 (91%)	9/9
	CIGNATURE Rx Complete	34	E	\$47.82	\$0	\$5	\$30	\$50	--	G	139 (91%)	9/9
	AdvantiraRx Value	34	E	\$20.82	\$0	\$12 <sup>^</sup>	\$42 <sup>^</sup>	--	--	NONE	103 (68%)	5/10
	AdvantiraRx Premier	34	E	\$32.17	\$0	\$5 <sup>^</sup>	\$25 <sup>^</sup>	\$57 <sup>^</sup>	--	NONE	141 (93%)	10/10
Coventry	AdvantiraRx Premier Plus	34	A	\$44.13	\$0	\$0 <sup>^</sup>	\$20 <sup>^</sup>	\$63 <sup>^</sup>	--	NONE	141 (93%)	10/10
	Humana PDP Standard	31	S	\$10.00	\$250	25%	--	--	--	NONE	146 (96%)	10/10
	Humana PDP Enhanced	31	E	\$16.21	\$0	\$7	\$30	\$60	25%	NONE	146 (96%)	10/10
	Humana PDP Complete	31	E	\$58.08	\$0	\$7	\$30	\$60	25%	B/G	146 (96%)	10/10
Medco	YOURx PLAN	34	A	\$31.87	\$250	\$4	\$17	75%	25%	NONE	129 (85%)	10/10
	Community Care Rx BASIC	34	A	\$30.40	\$250	\$0	25%	45%	--	NONE	116 (76%)	10/10
	Community Care Rx CHOICE	34	A	\$38.48	\$250	\$4	\$20	\$40	--	NONE	116 (76%)	10/10
	Community Care Rx GOLD	34	E	\$42.43	\$100	\$4	\$25	\$50	--	NONE	116 (76%)	10/10
PacifiCare	PacifiCare Saver	34	A	\$26.85	\$0	\$7.50 <sup>^</sup>	\$22 <sup>^</sup>	\$51.82 <sup>^</sup>	33%	NONE	97 (64%)	9/10
	PacifiCare Select	34	A	\$40.17	\$0	\$7.50	\$22	\$64.14 <sup>^</sup>	33%	NONE	107 (70%)	10/10
	PacifiCare Comprehensive	34	E	\$44.62	\$0	\$7.50	\$22	\$52.22 <sup>^</sup>	33%	G	97 (64%)	9/10
	Prescription Pathway Bronze	32	S	\$29.88	\$250	25%	--	--	--	NONE	117 (77%)	9/10
Amer. Progressive/ Marquette/ Pennsylvania Life *	Prescription Pathway Silver	32~	A	\$39.37	\$250	\$4 <sup>^</sup>	\$29 <sup>^</sup>	--	25%	NONE	117 (77%)	9/10
	Prescription Pathway Gold	32~	E	\$50.74	\$0	\$5 <sup>^</sup>	\$28 <sup>^</sup>	--	25%	NONE	117 (77%)	9/10
	Prescription Pathway Platinum	27~	E	\$67.46	\$0	\$4 <sup>^</sup>	\$26 <sup>^</sup>	\$42 <sup>^</sup>	25%	NONE	146 (96%)	10/10
	Sterling*	32	A	\$54.75	\$100	\$10	\$25 <sup>^</sup>	45% <sup>^</sup>	25%	NONE	120 (79%)	10/10
Unicare-Wellpoint	MedicareRx Rewards	34	A	\$23.56	\$250	\$5	\$25	--	25%	NONE	109 (72%)	9/10
	MedicareRx Rewards Plus	33	E	\$31.24	\$0	\$10	\$30	--	25%	NONE	109 (72%)	9/10
	MedicareRx Rewards Premier	33	E	\$41.64	\$0	\$10	\$30	\$60	30%	G	141 (93%)	10/10
United American *	United American	32	A	\$34.82	\$0	\$9	\$30	\$60	33%	NONE	129 (85%)	10/10
	AARP MedicareRx	34	A	\$26.41	\$0	\$5	\$28	\$55 <sup>^</sup>	25%	NONE	145 (95%)	10/10
United HealthCare	United Medicare MedAdvance	34	A	\$29.71	\$0	\$10	\$23	\$53 <sup>^</sup>	25%	NONE	145 (95%)	10/10
	WellCare Signature	34	A	\$0	\$0	\$0	\$68 <sup>^</sup>	--	32% <sup>^</sup>	NONE	106 (70%)	9/10
WellCare	WellCare Complete	34	E	\$42.62	\$0	\$0	\$15	\$50	30%	NONE	104 (68%)	8/10
	WellCare Premier	34	E	\$45.72	\$0	\$0	\$30	\$60	30%	NONE	104 (68%)	8/10

NOTE: \* indicates near-national organization

1: Average across regions where plan offered.

2: G = generics. PG = preferred generics. B/G = brands and generics. NONE = no coverage.

^ indicates median cost sharing amount for plans that use different tiered cost sharing arrangements across regions.

-- plan formulary does not have this tier.

~ Prescription Pathway plans are offered by multiple sponsors and some plans are offered more than once in a region. There are 61 separate Silver plans, 61 Gold plans, and 29 Platinum plans across the regions.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

**Table A2: List of 152 Drugs in the Study Sample**

Drug Group/Drug Name	Dosage	Drug Group/Drug Name	Dosage
<b>Anti-dementia Agents (Alzheimer's disease)</b>		<b>Cardiovascular: Beta Blockers (Hypertension)</b>	
<i>Cholinesterase Inhibitors</i>		<i>Alpha-beta-adrenergic Blocking Agents</i>	
Aricept	10mg TAB	Coreg	25mg TAB
Cognex	10mg CAP	LABETALOL HCL	200mg TAB
Exelon	3mg CAP	<i>Cardioselective Beta-adrenergic Blocking Agents</i>	
Razadyne	8mg TAB	ACEBUTOLOL HCL	200mg CAP
<i>Glutamate Pathway Modifiers</i>		ATENOLOL*	50 mg TAB
Namenda	10mg TAB	BETAXOLOL HCL	10mg TAB
<i>Other Anti-dementia Agents</i>		BISOPROLOL FUMARATE	5mg TAB
ERGOLOID MESYLATES	1mg TAB ORAL	METOPROLOL TARTRATE*	50mg TAB
<b>Anti-depressants</b>		Toprol XL*	50mg TAB
<i>Monoamine Oxidase (Type A) Inhibitors</i>		<i>Nonselective Beta-adrenergic Blocking Agents</i>	
Nardil	15mg TAB	CARTEOLOL	SOL Ophth 1%
Parnate	10mg TAB	Levator	20mg TAB
<i>Reuptake Inhibitor: SSRIs</i>		NADOLOL	40mg TAB
CITALOPRAM HYDROBROMIDE	20mg TAB	PINDOLOL	5mg TAB
FLUOXETINE	20mg CAP	PROPRANOLOL HCL	20mg TAB
FLUVOXAMINE	100mg TAB	SOTALOL HCL	80mg TAB
Lexapro	10mg TAB	TIMOLOL MALEATE	0.5% OP SOL
PAROXETINE	20mg TAB	<b>Cardiovascular: Calcium Channel Blockers (Hypertension)</b>	
Paxil CR	25mg TAB	<i>Dihydropyridines</i>	
Prozac Weekly	90mg CAP	Dynacirc	5mg CAP
Zoloft*	100mg TAB	FELODIPINE ER	5mg TAB
<i>Reuptake Inhibitor: SNRIs</i>		NICARDIPINE	20mg CAP
Cymbalta	60mg CAP	NIFEDIPINE	10mg CAP
Effexor	75mg TAB	Nimotop	30mg CAP
Effexor XR	75mg TAB	Norvasc*	10mg TAB
NEFAZODONE	200mg TAB	Sular CR	20mg TAB
<i>Reuptake Inhibitor: Tricyclics</i>		<i>Non-dihydropyridines</i>	
AMITRIPTYLINE	25mg TAB	DILTIAZEM HCL	360mg CAP
AMOXAPINE	50mg TAB	VERAPAMIL	80mg TAB
CLOMIPRAMINE	50mg CAP		
DESIPRAMINE	50mg TAB		
DOXEPIN	50mg CAP		
IMIPRAMINE	25mg TAB		
NORTRIPTYLINE	25mg CAP		
Surmontil	50mg CAP		
Vivactil	10mg TAB		
<i>Other Anti-depressants</i>			
BUPROPION ER	100mg TAB		
BUPROPION SR	150mg TAB		
MAPROTILINE	50mg TAB		
MIRTAZAPINE	15mg TAB		
TRAZODONE	100mg TAB		
Wellbutrin XL	300mg TAB		

NOTE: \* indicates top 10 brand-name/generic drug. Brand-name drugs in lowercase, generic drugs in capital letters.

**(CONTINUED ON NEXT PAGE)**

**Table A2: List of 152 Drugs in the Study Sample (continued)**

Drug Group/Drug Name	Dosage
<b>Cardiovascular: Dyslipidemics (Cholesterol)</b>	
<i>Bile Acid Sequestrants</i>	
CHOLESTYRAMINE	4gm POW
Colestid	1gm TAB
Welchol	625mg TAB
<i>Fibrates</i>	
GEMFIBROZIL	600mg TAB
Tricor	145mg TAB
<i>HMG CoA Reductase Inhibitors (Statins)</i>	
Altoprev ER	60mg TAB
Crestor	10mg TAB
Lescol	40mg CAP
Lipitor*	10mg TAB
LOVASTATIN	40mg TAB
Mevacor	20mg TAB
Pravachol	40mg TAB
Zocor*	20mg TAB
<i>Lipid Absorption Inhibitors</i>	
Zetia	10mg TAB
<i>Nicotinic Acid</i>	
Niaspan ER	500mg TAB

Drug Group/Drug Name	Dosage
<b>Gastrointestinal Agents: Proton Pump Inhibitors (Ulcers, GERD)</b>	
Aciphex	20mg TAB
Nexium*	40mg CAP
OMEPRAZOLE	20mg CAP
Prevacid DR	30mg CAP
Prilosec CR	40mg CAP
Protonix	40mg TAB

<b>Hormonal (Parathyroid/Metabolic Bone Disease) Agents (Osteoporosis)</b>	
<i>Biphosphonates</i>	
Actonel*	35mg TAB
Aredia	90mg INJ
Didronel	400mg TAB
Fosamax*	70mg TAB
PAMIDRONATE	90mg INJ
Skelid	200mg TAB
Zometa	4mg/5mL INJ
<i>Calcium Regulating Hormones</i>	
Miacalcin	200iu/mL SPR
Forteo	750mcg/3mL SOL

<b>Cardiovascular: Renin-angiotensin-aldosterone System Inhibitors (Hypertension)</b>	
<i>Aldosterone Receptor Antagonists</i>	
Inspra	25mg TAB
SPIRONOLACTONE	25mg TAB
<i>Angiotensin-converting Enzyme (ACE) Inhibitors</i>	
Aceon	4mg TAB
Altace	10mg CAP
BENAZEPRIL	20mg TAB
CAPTOPRIL	25mg TAB
ENALAPRIL	10mg TAB
FOSINOPRIL	20mg TAB
LISINOPRIL*	10mg TAB
Mavik	4mg TAB
QUINAPRIL	40mg TAB
<i>Angiotensin II Receptor Antagonists (ARBs)</i>	
Atacand	32mg TAB
Avapro	150mg TAB
Benicar	20mg TAB
Cozaar	50mg TAB
Diovan*	80mg TAB
Micardis	80mg TAB
Teveten	600mg TAB

<b>Oral Hypoglycemics (Diabetes)</b>	
<i>Alpha Glucosidase Inhibitors</i>	
Glyset	25mg TAB
Precose	50mg TAB
<i>Biguanides</i>	
METFORMIN*	500mg TAB
<i>Meglitinides</i>	
Prandin	2mg TAB
Starlix	120mg TAB
<i>Sulfonylureas</i>	
Amaryl	4mg TAB
CHLORPROPAMIDE	250mg TAB
GLIPIZIDE	5mg TAB
GLIPIZIDE ER	10mg TAB
GLYBURIDE	5mg TAB
GLYBURIDE MICRONIZED	6mg TAB
TOLAZAMIDE	250mg TAB
TOLBUTAMIDE	500mg TAB
<i>Thiazolidinediones</i>	
Actos	30mg TAB
Avandia	4mg TAB

<b>Tumor Necrosis Factor Inhibitors (Rheumatoid Arthritis)</b>	
Enbrel	25mg INJ
Humira	40mg/0.8 KIT
Remicade	100mg INJ

NOTE: \* indicates top 10 brand-name/generic drug. Brand-name drugs in lowercase, generic drugs in capital letters.

**(CONTINUED ON NEXT PAGE)**

**Table A2: List of 152 Drugs in the Study Sample (continued)**

<b>Drug Group/Drug Name</b>	<b>Dosage</b>
<b>Top 10 Brands/Generics and Other Commonly Prescribed Drugs Not in Other Drug Groups</b>	
Advair Diskus	250/50 MIS
ALBUTEROL	90mcg AER
Ambien	10mg TAB
AMOXICILLIN	500mg CAP
AMOXICILLIN/CLAVULANATE POT	875mg TAB
AMOXICILLIN/POT CLAVULANATE	875mg TAB
Celebrex	200mg CAP
CEPHALEXIN	500mg CAP
CIPROFLOXACIN HCL	500mg TAB
DIGOXIN	.125mg TAB
FUROSEMIDE*	40mg TAB
GABAPENTIN	300mg TAB
HYDROCHLOROTHIAZIDE*	25mg TAB
HYDROCODONE/ACETAMINOPHEN*	5-500mg TAB
ISOSORBIDE MONONITRATE	20mg TAB
POTASSIUM CHLORIDE CR*	20meq TAB
LEVOTHYROXINE*	100mcg TAB
Levoxyl	100mcg TAB
Neurontin	300mg CAP
Plavix*	75mg TAB
PREDNISONE	5mg TAB
PROPOXYPHENE-N/ACETAMINOPHEN	100-650 TAB
Synthroid	100mcg TAB
TRIAMTERENE/HCTZ	37.5-25 CAP
WARFARIN*	5mg TAB
Zithromax	200/5mL SUS
Zithromax Z-Pak	Z-PAK TAB

NOTE: \* indicates top 10 brand-name/generic drug. Brand-name drugs in lowercase, generic drugs in capital letters.

**Table A3: Classification of Drugs in This Analysis**

<b>Drug Group</b>	<b>USP Category</b>	<b>USP Class/Key Drug Type</b>	<b>Position in USP Classification System</b>	<b>Number of Unique Chemicals</b>	<b>Number of Drugs</b>	<b>Percentage of Total Prescriptions</b>
Anti-dementia drugs	Anti-dementia		Category	6	6	0.33%
Anti-depressants	Anti-depressants		Category	24	29	4.16%
Beta blockers	Cardiovascular agents	Beta-adrenergic blocking agents	Class	14	15	5.50%
Calcium channel blockers	Cardiovascular agents	Calcium channel blocking agents	Class	9	9	5.05%
Dyslipidemics	Cardiovascular agents	Dyslipidemics	Class	13	15	6.02%
Renin-angiotensin-aldosterone System Inhibitors	Cardiovascular agents	Renin-angiotensin-aldosterone System Inhibitors	Class	18	18	7.43%
Oral hypoglycemics	Blood glucose regulators	Oral hypoglycemics	Class	13	15	4.29%
Proton pump inhibitors	Gastrointestinal agents	Proton pump inhibitors	Class	5	6	2.57%
Hormonal agents (Osteoporosis)	Hormonal agents, stimulating/replacement/modifying	Parathyroid & Metabolic bone disease agents/Biphosphonates, Calcium regulating hormones	2 Key Drug Types	8	9	1.50%
Tumor necrosis factor inhibitors	Immunological agents	Immune suppressants/Tumor necrosis factor inhibitors	Key Drug Type	3	3	0.20%
"Top 10" drugs not in another group	NA	NA	Various	7	9	11.92%
Other commonly prescribed drugs not in another group	NA	NA	Various	15	18	10.69%
<b>TOTAL</b>				<b>135</b>	<b>152</b>	<b>59.66%</b>

**Table A4: Minimum and Maximum Costs for 152 Sample Drugs  
(both Covered and Uncovered)**

<b>Drug Name (Drug Group)</b>	<b>Brand/ Generic</b>	<b>Minimum Cost Sharing for Drug if Covered</b>	<b>Maximum Cost Sharing for Drug if Covered</b>	<b>Maximum Cost for Drug if Not Covered</b>
Acebutolol HCL (Beta Blockers)	G	\$0.00	\$18.77	\$62.42
Aceon (Renin-Angiotensin)	B	\$10.72	\$50.16	\$52.66
Aciphex (Proton Pump Inhibitors)	B	\$32.38	\$92.38	\$146.65
Actonel (Hormonal Agents)	B*	\$15.00	\$66.00	\$70.05
Actos (Oral Hypoglycemics)	B	\$17.00	\$70.33	\$251.25
Advair Diskus (Other Commonly Used Drugs)	B	\$15.00	\$67.84	\$213.05
Albuterol (Other Commonly Used Drugs)	G	\$0.00	\$10.00	NA
Altace (Renin-Angiotensin)	B	\$13.70	\$55.04	\$60.17
Altoprev (ER) (Cholesterol Agents)	B	\$0.00	\$83.22	\$102.01
Amaryl (Oral Hypoglycemics)	B	\$9.09	\$45.63	\$46.13
Ambien (Other Commonly Used Drugs)	B	\$17.00	\$66.00	NA
Amitriptyline (Anti-depressants)	G	\$0.00	\$7.50	NA
Amoxapine (Anti-depressants)	G	\$0.00	\$27.62	NA
Amoxicillin (Other Commonly Used Drugs)	G	\$0.00	\$10.00	NA
Amoxicillin/Clavulanate Potassium (Other Commonly Used Drugs)	G	\$0.00	\$29.00	\$345.57
Amoxicillin/Potassium Clav (Other Commonly Used Drugs)	G	\$0.00	\$100.39	NA
Aredia (Hormonal Agents)	B	\$20.00	\$238.79	\$843.60
Aricept (Anti-dementia Agents)	B	\$15.00	\$66.00	NA
Atacand (Renin-Angiotensin)	B	\$15.48	\$62.00	\$76.45
Atenolol (Beta Blockers)	G*	\$0.00	\$6.04	NA
Avandia (Oral Hypoglycemics)	B	\$15.00	\$66.00	NA
Avapro (Renin-Angiotensin)	B	\$11.61	\$46.70	\$64.78
Benazepril (Renin-Angiotensin)	G	\$0.00	\$10.00	NA
Benicar (Renin-Angiotensin)	B	\$11.53	\$53.88	\$56.38
Betaxolol HCL (Beta Blockers)	G	\$0.00	\$13.61	\$68.16
Bisoprolol Fumarate (Beta Blockers)	G	\$0.00	\$14.30	NA
Bupropion ER (Anti-depressants)	G	\$0.00	\$26.44	\$94.59
Bupropion SR (Anti-depressants)	G	\$0.00	\$29.21	NA
Captopril (Renin-Angiotensin)	G	\$0.00	\$4.00	NA
Carteolol (Beta Blockers)	G	\$0.00	\$11.20	\$21.48
Celebrex (Other Commonly Used Drugs)	B	\$17.00	\$66.00	\$122.66
Cephalexin (Other Commonly Used Drugs)	G	\$0.00	\$10.83	NA
Chlorpropamide (Oral Hypoglycemics)	G	\$0.00	\$11.22	\$23.07
Cholestyramine (Cholesterol Agents)	G	\$0.00	\$12.43	\$70.42
Ciprofloxacin HCL (Other Commonly Used Drugs)	G	\$0.00	\$14.04	NA
Citalopram Hydrobromide (Anti-depressants)	G	\$0.00	\$10.00	\$11.72
Clomipramine (Anti-depressants)	G	\$0.00	\$13.78	NA
Cognex (Anti-dementia Agents)	B	\$40.00	\$134.76	\$354.04
Colestid (Cholesterol Agents)	B	\$8.78	\$41.04	\$41.04
Coreg (Beta Blockers)	B	\$12.55	\$50.44	\$50.44
Cozaar (Renin-Angiotensin)	B	\$12.10	\$66.00	\$69.23
Crestor (Cholesterol Agents)	B	\$17.00	\$62.00	\$100.54
Cymbalta (Anti-depressants)	B	\$17.00	\$84.57	\$138.59
Desipramine (Anti-depressants)	G	\$0.00	\$17.56	NA
Didronel (Hormonal Agents)	B	\$17.00	\$106.68	\$193.87
Digoxin (Other Commonly Used Drugs)	G	\$0.00	\$12.29	\$11.79
Diltiazem (HCL) (Calcium Channel Blockers)	G	\$0.00	\$20.63	NA
Diovan (Renin-Angiotensin)	B*	\$12.46	\$62.58	\$62.58
Doxepin (Anti-depressants)	G	\$0.00	\$13.65	NA
Dynacirc (Calcium Channel Blockers)	B	\$17.00	\$30.00	\$143.86
Effexor (Anti-depressants)	B	\$20.00	\$83.50	\$131.43
Effexor XR (Anti-depressants)	B	\$20.00	\$69.40	\$92.53
Enalapril (Renin-Angiotensin)	G	\$0.00	\$10.00	NA
Enbrel (TNF Inhibitors)	B	\$20.00	\$1,276.24	NA
Ergoloid Mesylates (Anti-dementia Agents)	G	\$0.00	\$22.96	\$103.68
Exelon (Anti-dementia Agents)	B	\$17.00	\$71.42	\$158.32
Felodipine (ER) (Calcium Channel Blockers)	G	\$0.00	\$29.08	\$84.72
Fluoxetine (Anti-depressants)	G	\$0.00	\$10.00	NA
Fluvoxamine (Anti-depressants)	G	\$0.00	\$65.30	NA

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**Table A4: Minimum and Maximum Costs for 152 Sample Drugs  
(both Covered and Uncovered) (continued)**

<b>Drug Name (Drug Group)</b>	<b>Brand/ Generic</b>	<b>Minimum Cost Sharing for Drug if Covered</b>	<b>Maximum Cost Sharing for Drug if Covered</b>	<b>Maximum Cost for Drug if Not Covered</b>
Forteo (Hormonal Agents)	B	\$17.00	\$269.32	\$657.39
Fosamax (Hormonal Agents)	B*	\$15.00	\$66.00	\$69.91
Fosinopril (Renin-Angiotensin)	G	\$0.00	\$13.40	\$32.11
Furosemide (Other Commonly Used Drugs)	G*	\$0.00	\$5.49	NA
Gabapentin (Other Commonly Used Drugs)	G	\$0.00	\$29.78	\$120.80
Gemfibrozil (Cholesterol Agents)	G	\$0.00	\$12.82	NA
Glipizide (Oral Hypoglycemics)	G	\$0.00	\$4.87	\$11.46
Glipizide ER (Oral Hypoglycemics)	G	\$0.00	\$11.97	NA
Glyburide (Oral Hypoglycemics)	G	\$0.00	\$7.97	NA
Glyburide Micronized (Oral Hypoglycemics)	G	\$0.00	\$13.18	\$28.64
Glyset (Oral Hypoglycemics)	B	\$15.33	\$60.00	\$72.38
Humira (TNF Inhibitors)	B	\$17.00	\$1,276.25	\$1,337.50
Hydrochlorothiazide (Other Commonly Used Drugs)	G*	\$0.00	\$5.00	NA
Hydrocodone / APAP (Other Commonly Used Drugs)	G*	\$0.00	\$5.51	NA
Imipramine (Anti-depressants)	G	\$0.00	\$19.55	NA
Inspra (Renin-Angiotensin)	B	\$25.00	\$85.48	\$122.14
Isosorbide Mononitrate (Other Commonly Used Drugs)	G	\$0.00	\$16.58	NA
Labetalol HCL (Beta Blockers)	G	\$0.00	\$15.46	NA
Lescol (Cholesterol Agents)	B	\$14.32	\$57.79	\$72.07
Levatol (Beta Blockers)	B	\$12.79	\$51.39	\$60.16
Levothyroxine (Other Commonly Used Drugs)	G*	\$0.00	\$10.00	\$12.04
Levoxyl (Other Commonly Used Drugs)	B	\$0.00	\$16.47	\$17.72
Lexapro (Anti-depressants)	B	\$16.94	\$67.75	\$86.80
Lipitor (Cholesterol Agents)	B*	\$17.00	\$66.00	\$74.40
Lisinopril (Renin-Angiotensin)	G*	\$0.00	\$10.00	NA
Lovastatin (Cholesterol Agents)	G	\$0.00	\$15.42	\$122.54
Maprotiline (Anti-depressants)	G	\$0.00	\$20.90	\$19.98
Mavik (Renin-Angiotensin)	B	\$8.31	\$48.87	\$51.37
Metformin (Oral Hypoglycemics)	G*	\$0.00	\$10.16	NA
Metoprolol Tartrate (Beta Blockers)	G*	\$0.00	\$10.00	NA
Mevacor (Cholesterol Agents)	B	\$17.18	\$68.73	\$90.94
Miacalcin (Hormonal Agents)	B	\$17.00	\$66.00	\$86.23
Micardis (Renin-Angiotensin)	B	\$13.49	\$60.00	\$62.65
Mirtazapine (Anti-depressants)	G	\$0.00	\$22.71	NA
Nadolol (Beta Blockers)	G	\$0.00	\$13.35	\$16.48
Namenda (Anti-dementia Agents)	B	\$15.00	\$100.30	NA
Nardil (Anti-depressants)	B	\$12.27	\$49.30	NA
Nefazodone (Anti-depressants)	G	\$0.00	\$25.41	\$39.66
Neurontin (Other Commonly Used Drugs)	B	\$30.08	\$90.08	\$151.42
Nexium (Proton Pump Inhibitors)	B*	\$17.00	\$62.86	\$164.52
Niaspan (ER) (Cholesterol Agents)	B	\$12.19	\$50.00	\$52.78
Nicardipine (Calcium Channel Blockers)	G	\$0.00	\$15.17	\$39.89
Nifedipine (Calcium Channel Blockers)	G	\$4.00	\$20.24	\$64.35
Nimotop (Calcium Channel Blockers)	B	\$17.00	\$1,800.47	\$2,169.76
Nortriptyline (Anti-depressants)	G	\$0.00	\$20.99	NA
Norvasc (Calcium Channel Blockers)	B*	\$15.00	\$62.33	\$62.44
Omeprazole (Proton Pump Inhibitors)	G	\$0.00	\$40.00	\$135.83
Pamidronate (Hormonal Agents)	G	\$4.00	\$224.42	\$876.84
Parnate (Anti-depressants)	B	\$15.00	\$76.86	NA
Paroxetine (Anti-depressants)	G	\$0.00	\$20.58	NA
Paxil CR (Anti-depressants)	B	\$17.00	\$80.34	\$100.99
Pindolol (Beta Blockers)	G	\$0.00	\$15.63	NA
Plavix (Other Commonly Used Drugs)	B*	\$15.00	\$66.00	\$154.93
Potassium Chloride (Other Commonly Used Drugs)	G*	\$0.00	\$11.39	NA
Prandin (Oral Hypoglycemics)	B	\$15.00	\$66.00	\$100.38
Pravachol (Cholesterol Agents)	B	\$27.00	\$99.46	\$142.09
Precose (Oral Hypoglycemics)	B	\$15.00	\$66.00	\$68.09
Prednisone (Other Commonly Used Drugs)	G	\$0.00	\$6.80	NA
Prevacid DR (Proton Pump Inhibitors)	B	\$17.00	\$93.11	\$165.13

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**Table A4: Minimum and Maximum Costs for 152 Sample Drugs  
(both Covered and Uncovered) (continued)**

<b>Drug Name (Drug Group)</b>	<b>Brand/ Generic</b>	<b>Minimum Cost Sharing for Drug if Covered</b>	<b>Maximum Cost Sharing for Drug if Covered</b>	<b>Maximum Cost for Drug if Not Covered</b>
Prilosec CR (Proton Pump Inhibitors)	B	\$25.00	\$103.86	\$208.69
Propoxyphene-N/Acetaminophen (Other Commonly Used Drugs)	G	\$0.00	\$6.95	\$19.52
Propranolol HCL (Beta Blockers)	G	\$0.00	\$10.00	NA
Protonix (Proton Pump Inhibitors)	B	\$20.00	\$86.44	\$129.86
Prozac Weekly (Anti-depressants)	B	\$22.77	\$82.77	\$101.51
Quinapril (Renin-Angiotensin)	G	\$0.00	\$14.32	\$61.74
Razadyne (Anti-dementia Agents)	B	\$17.00	\$66.81	\$156.31
Remicade (TNF Inhibitors)	B	\$20.00	\$1,177.24	\$1,385.22
Skelid (Hormonal Agents)	B	\$40.00	\$402.55	\$608.92
Sotalol HCL (Beta Blockers)	G	\$0.00	\$21.85	\$58.75
Spironolactone (Renin-Angiotensin)	G	\$0.00	\$10.74	NA
Starlix (Oral Hypoglycemics)	B	\$15.00	\$66.00	\$122.51
Sular CR (Calcium Channel Blockers)	B	\$12.10	\$51.15	\$51.40
Surmontil (Anti-depressants)	B	\$20.00	\$86.35	NA
Synthroid (Other Commonly Used Drugs)	B	\$3.74	\$18.81	\$18.81
Teveten (Renin-Angiotensin)	B	\$12.97	\$52.14	\$53.89
Timolol Maleate (Beta Blockers)	G	\$0.00	\$9.63	\$9.63
Tolazamide (Oral Hypoglycemics)	G	\$0.00	\$11.77	\$18.09
Tolbutamide (Oral Hypoglycemics)	G	\$0.00	\$9.68	\$10.26
Toprol XL (Beta Blockers)	B*	\$6.37	\$26.25	NA
Trazodone (Anti-depressants)	G	\$0.00	\$10.00	NA
Triamterene/HCTZ (Other Commonly Used Drugs)	G	\$0.00	\$9.00	NA
Tricor (Cholesterol Agents)	B	\$17.00	\$65.30	\$111.60
Verapamil (Calcium Channel Blockers)	G	\$0.00	\$12.63	NA
Vivactil (Anti-depressants)	B	\$20.00	\$91.88	\$142.50
Warfarin (Other Commonly Used Drugs)	G*	\$0.00	\$10.00	NA
Welchol (Cholesterol Agents)	B	\$20.00	\$100.54	\$178.40
Wellbutrin XL (Anti-depressants)	B	\$17.00	\$65.30	\$132.90
Zetia (Cholesterol Agents)	B	\$17.00	\$66.00	\$74.64
Zithromax (Other Commonly Used Drugs)	B	\$4.92	\$33.14	\$33.14
Zithromax Z-Pak (Other Commonly Used Drugs)	B	\$2.21	\$11.31	\$11.12
Zocor (Cholesterol Agents)	B*	\$15.00	\$93.35	\$153.12
Zoloft (Anti-depressants)	B*	\$17.00	\$66.00	NA
Zometa (Hormonal Agents)	B	\$20.00	\$274.87	\$1,003.39

NOTE: \* indicates top 10 brand-name/generic drug.

NA (not applicable) - maximum cost for drug if not covered is not applicable when drug is covered by all plans.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations; data from Medicare.gov.

## APPENDIX B: COVERAGE AND COST OF SAMPLE DRUGS IN SELECTED DRUG GROUPS

The ultimate cost paid by a beneficiary for a drug brings together the drug’s status on or off the formulary as well as the cost sharing assigned to the drug if it is on formulary. From the perspective of enrollees, the tier to which a drug is assigned is not as important as how tier assignment affects cost sharing, since for many beneficiaries, whether a drug is on the formulary is considerably less important than their out-of-pocket cost. To illustrate, an off-formulary drug with a total monthly cost of \$12 will cost an enrollee less than a similar on-formulary drug with a total monthly cost of \$80, but where the enrollee copayment for that drug is \$20. Cost calculations for enrollees get more complicated, however, when factoring in the coverage gap and the rules for what counts as “true out-of-pocket costs” (or TrOOP). In the case of the example above, when the beneficiary reaches the coverage gap, the relative savings is even greater for the off-formulary drug. But an important consideration for off-formulary drug purchases is that, whether before or during the doughnut hole, the \$12 monthly cost of the off-formulary drug would not be considered “true out-of-pocket costs” that would count toward the \$3,600 threshold for catastrophic coverage.

In the analysis presented in this appendix, we look at total costs to beneficiaries in the initial coverage period based on their taking one drug. Users of multiple drugs or those whose costs place them beyond the initial coverage period may have different costs because of the effect of the coverage gap or the catastrophic benefit. The cost identified for a drug is either the cost sharing in the initial coverage period if a drug is on the plan’s formulary or the total cost charged by that plan for an off-formulary drug based on the cost displayed on the Medicare Plan Finder website.

For simplicity, we focus in this section on the costs for one plan for each of the 14 national or near-national organizations in this study. Each is either the lowest-premium plan or the only plan offered by that particular organization. As described elsewhere, some of the higher-premium plans offered by these organizations have more extensive formularies; this analysis does not address those variations. Instead, it focuses on the less expensive plans that are likely to be more attractive to many enrollees.

**Table B1** shows the copayment or coinsurance rules that are applied by each of the 14 plans that are the focus of the analysis in this appendix. We focus on several drug groups that include some of the most commonly prescribed drugs. These are generally at the smaller class (second) level or the key drug (third) level of the USP classification system. We also report, in less detail, on some of the related drug groups that complete the drug categories and classes used throughout the main report.

**Table B1: Cost Sharing by Formulary Tier, by Plan**

	Tier 1	Tier 2	Tier 3	Specialty
Aetna Essentials	\$5	\$25	None	None
Caremark Silverscript	\$9	25%	None	25%
Cigna Value	\$4	\$20	\$40	None
Coventry AdvantraRx Value	\$10	\$42	None	None
Humana Standard	25%	None	None	None
Medco	\$4	\$17	75%	25%
MemberHealth CCRX Basic	\$0	25%	45%	None
Pacificare Saver	\$7.50	\$22	\$52.70	33%
Prescription Pathway Bronze	25%	None	None	None
Sterling	\$10	\$25	50%	25%
Unicare Medicare Rx Rewards	\$5	\$25	None	25%
United American	\$9	\$30	\$60	33%
United Healthcare AARP	\$5	\$28	\$55	25%
Wellcare Signature	\$0	\$66	None	31%

NOTE: For plans with small variations in cost sharing by region, this table indicates the value for Region 5, which is the region used as our data collection point in this study. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study.

## Drugs Used to Treat Ulcers

### Proton Pump Inhibitors

Proton pump inhibitors (PPIs), used to treat ulcers or GERD, includes five relatively expensive drugs (generally priced at over \$100 for one month's supply), one of which (omeprazole) is available in generic form and in fact is available over the counter at lower doses. Our drug sample includes these five products as well as the brand version of omeprazole. In the USP classification scheme, PPIs constitute one drug class in the larger category of gastrointestinal agents; as such, the statutory requirement requires that plans cover at least two PPIs. For the set of drugs in this class, there seems to be little evidence for the clinical superiority of one product over another. Thus, it is a class where plans have a fairly high incentive to select a preferred product and where beneficiaries should be able to switch products with relatively little difficulty.

Beneficiaries with a preference (or a current prescription) for one particular product will see large differences across these 14 plans. A Nexium user will save \$148 by picking Medco over Wellcare Signature, while a Protonix user will save \$104 by picking Aetna Essentials over Medco and another \$5 by picking Cigna Value. Or these beneficiaries can ask their doctors to change their prescriptions and achieve similar savings within a given plan.

All but one of these 14 plans meet the two-drug requirement, and it could be that Coventry AdvantraRx Value (which covers only Protonix) uses a different classification system or received an exception from CMS. But otherwise, plans range from covering just two to all six products on formulary (all five of the unique chemicals). Plans seem to have adopted different strategies around the use of omeprazole – with 11 plans giving the generic version a low Tier 1 copayment but three plans denying it formulary status perhaps because of its availability over the counter. Mostly, the plans discouraged use of the brand version of omeprazole (Prilosec), with only 5 of 14 plans putting it on formulary. Overall, Nexium, Prevacid, and the generic omeprazole were mostly likely, among the drugs in this class, to be on formulary. By contrast, Aciphex was only on formulary for three of 14 plans.

**Table B2: Coverage and Cost of Proton Pump Inhibitors, by Plan**

	Aciphex	Nexium	Omeprazole*	Prevacid	Prilosec CR	Protonix
Aetna Essentials	\$130	\$132	\$66	\$25	\$176	\$25
Caremark Silverscript	\$144	\$33	\$9	\$33	\$44	\$129
Cigna Value	\$40	\$40	\$135	\$40	\$206	\$20
Coventry AdvantraRx Value	\$130	\$132	\$136	\$163	\$206	\$42
Humana Standard	\$32	\$33	\$10	\$33	\$44	\$26
Medco	\$145	\$17	\$4	\$17	\$71	\$129
MemberHealth CCRX Basic	\$147	\$33	\$0	\$165	\$209	\$27
Pacificare Saver	\$129	\$22	\$8	\$132	\$207	\$22
Prescription Pathway Bronze	\$132	\$33	\$8	\$34	\$178	\$107
Sterling	\$145	\$25	\$10	\$25	\$25	\$130
Unicare Medicare Rx Rewards	\$130	\$132	\$5	\$25	\$176	\$25
United AARP	\$55	\$28	\$5	\$55	\$207	\$28
United American	\$145	\$30	\$9	\$30	\$60	\$130
Wellcare Signature	\$143	\$165	\$0	\$162	\$205	\$66

NOTE: Shaded cell indicates off-formulary drug for specific plan. \* indicates generic drug.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.

## Drugs Used to Treat High Cholesterol

### Statins

The statins are considered a key drug type in the USP classification system and grouped with other treatments for high cholesterol to form a drug class. There are separate chemical entities in this group, and we included three forms of lovastatin (the generic version and two brand alternatives – Mevacor, the original brand version, and Altoprev). Other than lovastatin, the drugs in this class are currently available only as brand products. As a result, they are typically priced between \$60 and \$140.

Two of the 14 plans have included all of the statins on their formularies, and four others include all except the brand version of lovastatin (Mevacor). As a result of tier differences, beneficiaries can still achieve savings by choosing the generic lovastatin over the various brand products or by choosing a preferred brand drug over a non-preferred drug. By contrast, six plans have only three or fewer products on formulary, typically Lipitor, Zocor, and the generic lovastatin. In most of these cases, the beneficiary can save over \$100 by switching to a preferred brand product – or even more by switching to generic lovastatin.

The two most popular drugs in this group, Lipitor and Zocor, receive similar treatment. Zocor is left off two formularies, compared to one for Lipitor, and Lipitor is available at a lower price than Zocor slightly more often, but nearly half the plans provide preferred status to both. Both of these popular drugs generally do better on the formularies than less commonly prescribed competitors such as Crestor, Lescol, or Pravachol – which are omitted from about half of the formularies. All but one of the plans offer the lowest cost sharing to beneficiaries that select generic lovastatin. But about half the plans make at least one of the branded versions of lovastatin (Altoprev or Mevacor) available at relatively low prices as well. Coventry's AdvantraRx Value is the exception here, leaving generic lovastatin off its formulary but covering the branded version, Altoprev, at the generic tier rate.

**Table B3: Coverage and Cost of Dyslipidemics (Statins), by Plan**

	Altoprev	Crestor	Lescol	Lipitor	Lova- statin*	Mevacor	Prava- chol	Zocor
Aetna Essentials	\$93	\$81	\$58	\$25	\$5	\$69	\$132	\$25
Caremark Silverscript	\$100	\$20	\$14	\$18	\$9	\$88	\$140	\$153
Cigna Value	\$40	\$40	\$20	\$40	\$4	\$24	\$40	\$20
Coventry AdvantraRx Value	\$10	\$81	\$58	\$74	\$123	\$89	\$132	\$42
Humana Standard	\$23	\$20	\$14	\$18	\$8	\$17	\$33	\$33
Medco	\$17	\$17	\$43	\$17	\$4	\$89	\$99	\$17
MemberHealth CCRX Basic	\$102	\$101	\$72	\$19	\$0	\$91	\$142	\$34
Pacificare Saver	\$100	\$99	\$70	\$53	\$8	\$89	\$140	\$22
Prescription Pathway Bronze	\$94	\$20	\$58	\$18	\$12	\$89	\$34	\$135
Sterling	\$47	\$25	\$25	\$25	\$10	\$89	\$66	\$67
Unicare Medicare Rx Rewards	\$93	\$81	\$58	\$25	\$5	\$17	\$132	\$25
United AARP	\$55	\$55	\$55	\$28	\$5	\$89	\$55	\$28
United American	\$30	\$30	\$58	\$30	\$9	\$89	\$60	\$30
Wellcare Signature	\$99	\$97	\$69	\$66	\$0	\$88	\$139	\$66

NOTE: Shaded cell indicates off-formulary drug for specific plan. \* indicates generic drug.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.

## **Other Cholesterol Medications**

Although we are not presenting a complete analysis of the other four key drug types in the USP classification system for treating high cholesterol, there are some notable results. Among the three bile acid sequestrants, plans cover between one and three of the products. The most commonly covered product is the generic cholestyramine, which is on 11 of 14 formularies. The two competing products are covered on only about half the formularies, resulting in considerable price variation. There are two products in the fibrates key drug type. All plans have chosen to cover the generic gemfibrozil, while 11 plans also cover Tricor. Because Tricor is covered as a brand drug, it is also at least twice as expensive and sometimes far higher. Zetia is the only product in the key drug type known as lipid absorption inhibitors and thus should always be covered according to CMS guidelines. Two plans do not cover this drug, perhaps having gotten permission to exclude it. The last key drug has only the drug Niaspan, which will cease to be covered, based on a recent CMS ruling, because it is a vitamin.

## Drugs Used to Treat Depression

### Antidepressants: SSRIs

SSRIs are the most commonly prescribed antidepressants, but they also tend to be the newest and most expensive drugs in the overall category of drugs. According to CMS guidelines, plans must cover most or all drugs in this entire category. But the guidelines make it clear that plans are not required to cover the extended-release drug variants (Paxil CR or Prozac Weekly), and the guidelines explicitly allowed plans to choose between citalopram and Lexapro. Four drugs are available in generic form; only Lexapro and Zoloft lack a generic alternative.

Nearly all of these plans chose to take advantage of the exceptions to the CMS “all or substantially all” guideline. Eleven plans require beneficiaries to pay full price for Prozac Weekly, and seven do the same for Paxil CR. Five plans chose not to cover Lexapro in favor of covering citalopram.<sup>37</sup> With one exception, all these plans provide coverage in the lowest tier for the generic antidepressants, but the cost sharing is generally higher for Humana Standard and Prescription Pathway Bronze, since they employ a standard benefit with 25 percent coinsurance in all tiers. These two plans generally have a smaller cost-sharing differential between the brand and generic alternatives. In addition, two plans place Zoloft (the most prescribed drug in this group) in the non-preferred tier thus creating a significant financial incentive against its use. Beneficiaries who prefer to stay with Zoloft can cut their costs at least in half by choosing most of the plans that cover it on the preferred tier.

**Table B4: Coverage and Cost of Antidepressants (SSRIs), by Plan**

	Citalopram*	Fluoxetine*	Fluvoxamine*	Lexapro	Paroxetine*	Paxil CR	Prozac Weekly	Zoloft
Aetna Essentials	\$5	\$5	\$5	\$68	\$5	\$86	\$92	\$25
Caremark Silverscript	\$9	\$9	\$9	\$17	\$9	\$98	\$99	\$20
Cigna Value	\$4	\$4	\$4	\$40	\$4	\$40	\$40	\$40
Coventry AdvantraRx Value	\$9	\$5	\$10	\$42	\$10	\$82	\$91	\$42
Humana Standard	\$12	\$2	\$15	\$17	\$14	\$20	\$23	\$20
Medco	\$4	\$4	\$4	\$85	\$4	\$17	\$100	\$17
MemberHealth CCRX Basic	\$0	\$0	\$0	\$87	\$0	\$101	\$102	\$20
Pacificare Saver	\$8	\$8	\$53	\$53	\$8	\$81	\$100	\$53
Prescription Pathway Bronze	\$6	\$1	\$9	\$17	\$13	\$99	\$100	\$20
Sterling	\$10	\$10	\$10	\$25	\$10	\$43	\$99	\$25
Unicare Medicare Rx Rewards	\$5	\$5	\$5	\$85	\$5	\$86	\$91	\$25
United AARP	\$5	\$5	\$5	\$28	\$5	\$55	\$55	\$28
United American	\$9	\$9	\$9	\$85	\$9	\$30	\$100	\$30
Wellcare Signature	\$0	\$0	\$0	\$66	\$0	\$66	\$98	\$66

NOTE: Shaded cell indicates off-formulary drug for specific plan. \* indicates generic drug.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.

<sup>37</sup> On this chart, Humana Standard is shown not covering citalopram. Since the time of our data collection, they have indicated that this drug is on formulary. The resulting price, however, is about the same.

## Other Antidepressants

In addition to the SSRIs, the antidepressant category includes two other classes and two other key drug types in the reuptake inhibitors class that includes SSRIs. According to CMS guidelines, plans should cover all of these products. In the additional two key drug types of the reuptake inhibitors class, the tricyclics are nearly universally covered – other than one drug that is omitted by one plan. Most of these drugs are generics, and are covered with modest cost sharing, although the different plan designs and drug prices mean that cost sharing ranges from \$0 to \$28. The two brand products amount this group are covered at cost sharing levels from \$20 to \$92. For the SNRIs, two products are skipped on at least two plan formularies each. All plans cover the third (Effexor) in at least one of its two formulations, and most cover both formulations in our study sample. In part because of the formulary omissions, the cost of these drugs varies substantially depending on which plan a beneficiary selects.

There are two other drug classes among the antidepressants. The MAO inhibitors include just two brand-name products. While all plans cover these two drugs and price them similarly to each other, their cost in some plans is about four times as high as in other plans. By contrast, not all plans cover the four unique chemical products in the other antidepressants class. One of the drugs is omitted by two formularies. Our study sample contains three versions of the drug bupropion. All plans cover at least one of the generic versions, and all but two plans cover the brand version (Wellbutrin XL), albeit at higher cost-sharing levels. This is consistent with the guidelines that do not require that plans cover special versions of a drug, such as extended-release versions taken just one time a day.



## Drugs Used to Treat Hypertension

### Angiotensin Receptor Blockers

There are seven angiotensin receptor blockers (ARBs) in this key drug type that is part of the rennin-angiotensin aldosterone system inhibitors class. As a result, CMS guidelines require that at least one be covered. All are available only as brand products, and there are no variations among the products we analyzed. The actual cost of a monthly supply of drugs in this group are more modest than some of the other brand products discussed above, ranging from about \$45 to \$75.

Plans handled this set of drugs quite differently. Six plans placed only two of the seven drugs on formulary, meaning that beneficiaries using the off-formulary products will pay double to triple the price to obtain these drugs. Three plans cover all seven drugs, but two divide the drugs between preferred and non-preferred tiers, resulting in a doubling of the cost-sharing amount. In contrast, under Humana Standard, with its standard benefit, all seven drugs have roughly the same cost sharing. Other plans fall somewhere in between these extremes.

Certain drugs were more likely to be given preferred placement on plan formularies. Diovan, the most commonly prescribed product in this group, has preferred status on 13 of 14 formularies, and Cozaar is covered on 11 of 14 formularies (but not always with preferred status). By contrast, Teveten is off formulary in 11 plans and covered only on a non-preferred tier by two other plans. Most of the other products in this group are covered by about half the plans, but are generally more likely to be on the non-preferred tier when covered.

**Table B5: Coverage and Cost of Renin-angiotensin-aldosterone System Inhibitors (ARBs)**

	Atacand	Avapro	Benicar	Cozaar	Diovan	Micardis	Teveten
Aetna Essentials	\$62	\$47	\$47	\$25	\$25	\$54	\$52
Caremark Silverscript	\$74	\$12	\$13	\$12	\$12	\$60	\$51
Cigna Value	\$40	\$40	\$40	\$40	\$20	\$20	\$40
Coventry AdvantraRx Value	\$62	\$42	\$46	\$49	\$50	\$42	\$52
Humana Standard	\$15	\$12	\$12	\$12	\$12	\$13	\$13
Medco	\$17	\$17	\$54	\$17	\$17	\$17	\$52
MemberHealth CCRX Basic	\$76	\$65	\$56	\$13	\$16	\$63	\$54
Pacificare Saver	\$74	\$63	\$22	\$69	\$22	\$61	\$52
Prescription Pathway Bronze	\$16	\$47	\$47	\$49	\$13	\$55	\$53
Sterling	\$31	\$25	\$23	\$25	\$25	\$27	\$52
Unicare Medicare Rx Rewards	\$62	\$47	\$46	\$25	\$25	\$54	\$52
United AARP	\$55	\$28	\$28	\$48	\$28	\$55	\$52
United American	\$30	\$30	\$54	\$30	\$30	\$30	\$52
Wellcare Signature	\$73	\$62	\$45	\$66	\$63	\$53	\$51

NOTE: Shaded cell indicates off-formulary drug for specific plan.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.

## ACE Inhibitors

Of the nine drugs in this key drug type in the renin-angiotensin aldosterone system inhibitors class, the six generics are covered by at least 13 of the 14 plans and at cost-sharing amounts of \$10 or less. The brand options in this group are much less likely to be covered and are more expensive when they are covered.

## Cardioselective Beta Blockers

Most of the drugs in the cardioselective beta blockers key drug type in the larger class of beta blockers are available in generic form, and most are inexpensive drugs. The one exception is Toprol XL, a commonly prescribed extended-release version of Metoprolol. As a key drug type, the CMS guidelines require that at least one drug be covered. Several of the drugs in this group are among the most commonly prescribed drugs used by Medicare beneficiaries.

Because most of these drugs are generics, it is not surprising that four of the six drugs in this group are covered by all plans – and at similar cost to the beneficiary. Toprol XL, the only brand in this group and one of the top 10 most commonly prescribed brand drugs, is typically several dollars more expensive than the others. But given its relatively low list price, users often pay close to full price for this drug. Four plans chose to leave one or two of the products in this group off their formularies. Enrollees in these plans who chose to remain with these products would pay considerably more as a result. The standard benefit offered by Humana Standard and Prescription Pathway Bronze means that the cost of these beta blockers rises and falls with the underlying costs of the drug. Thus, users of Toprol XL, Metoprolol, or Atenolol would save by joining these plans, but users of Acebutolol would face somewhat higher costs.

**Table B6: Coverage and Cost of Cardioselective Beta Blockers, by Plan**

	Acebutolol*	Atenolol*	Betaxolol*	Bisoprolol*	Metoprolol*	Toprol XL
Aetna Essentials	\$5	\$4	\$5	\$5	\$4	\$25
Caremark SilverScript	\$62	\$3	\$68	\$9	\$5	\$6
Cigna Value	\$4	\$4	\$4	\$4	\$4	\$20
Coventry AdvantraRx Value	\$10	\$4	\$10	\$10	\$5	\$26
Humana Standard	\$12	\$1	\$7	\$7	\$1	\$6
Medco	\$4	\$4	\$4	\$4	\$4	\$17
MemberHealth CCRX Basic	\$0	\$0	\$68	\$0	\$0	\$7
Pacificare Saver	\$25	\$6	\$30	\$8	\$5	\$22
Prescription Pathway Bronze	\$6	\$1	\$8	\$8	\$1	\$7
Sterling	\$62	\$3	\$68	\$10	\$5	\$25
Unicare Medicare Rx Rewards	\$5	\$4	\$5	\$5	\$5	\$25
United AARP	\$5	\$4	\$5	\$5	\$5	\$25
United American	\$9	\$5	\$9	\$9	\$6	\$26
Wellcare Signature	\$0	\$0	\$0	\$0	\$0	\$24

NOTE: Shaded cell indicates off-formulary drug for specific plan. \* indicates generic drug.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.

### **Nonselective Beta Blockers**

The pattern for nonselective beta blockers, the other large key drug type of beta blockers, is similar to the cardioselective beta blockers, but with slightly more variation. The six generics in this group are covered on between 11 and 14 formularies. The one brand drug in the group is covered by only three plans. Only one plan omits as many as three of the seven drugs in this group.

### **Calcium Channel Blockers**

The calcium channel blockers drug class of hypertension medications has two key drug types: dihydropyridines (with seven drugs) and non-dihydropyridines (with two drugs). Coverage in this class is quite mixed. Plans cover between two and seven of the seven dihydropyridines, while all plans cover the two non-dihydropyridines. One drug (Dynacirc) in the first key drug type is rarely covered (just two plans), while two of the seven, including the commonly prescribed Norvasc, are covered by 13 of 14 plans. Typically coverage is broadest among the generics in the group. Among the rest, Nimotop is the most expensive drug in our study sample (list price of over \$2,000). It is uncovered by seven plans and covered on a specialty tier by three other plans, but on a tier with a modest copayment by four others. The result is that enrollees' out-of-pocket costs vary widely for this drug, which is used in only rare circumstances.

## Drugs Used to Treat Diabetes

### Oral Hypoglycemics

This drug class of oral hypoglycemics contains five separate key drug types. Four of these subgroups (shown below in **Table B7**) contain only one or two drugs, while the sulfonylureas group (shown in **Table B8**) has six drugs (two alternate forms in the latter group are excluded from this analysis). Most of the drugs in this class are relatively inexpensive, but drugs in two of the key drug types are brand-name drugs that come at a higher price tag.

All 14 plans meet the CMS guidelines of covering at least one drug in each key drug type. The sole drug among the biguanides (metformin) is a commonly prescribed drug available as a generic and is always priced at \$10 or below. The alpha glucosidase inhibitors, the meglitinides, and the thiazolidinediones each have two brand-name drugs. In the first two groups, many plans chose to cover one of the two alternatives, but seemed to always put one in the preferred tier (for plans making such distinctions). Both drugs in the thiazolidinediones are covered by most of the plans, and many plans have placed both in the preferred tier. There are clear favorites in each class: Precose over Glyset, Prandin over Starlix, and Avandia over Actos.

**Table B7: Coverage and Cost of Oral Hypoglycemics , by Plan**

	Alpha Glucosidase Inhibitors		Biguanides	Meglitinides		Thiazolidinediones	
	Glyset	Precose	Metformin*	Prandin	Starlix	Actos	Avandia
Aetna Essentials	\$25	\$68	\$5	\$25	\$25	\$25	\$25
Caremark Silverscript	\$72	\$17	\$9	\$25	\$122	\$40	\$22
Cigna Value	\$40	\$20	\$4	\$20	\$40	\$20	\$20
Coventry AdvantraRx Value	\$72	\$42	\$10	\$42	\$104	\$42	\$42
Humana Standard	\$15	\$17	\$3	\$25	\$26	\$40	\$20
Medco	\$46	\$17	\$4	\$17	\$17	\$17	\$17
MemberHealth CCRX Basic	\$28	\$17	\$0	\$26	\$26	\$41	\$23
Pacificare Saver	\$72	\$53	\$8	\$53	\$123	\$161	\$53
Prescription Pathway Bronze	\$16	\$17	\$3	\$25	\$26	\$41	\$21
Sterling	\$72	\$25	\$10	\$25	\$122	\$25	\$25
Unicare Medicare Rx Rewards	\$62	\$25	\$5	\$100	\$25	\$25	\$25
United AARP	\$55	\$28	\$5	\$55	\$28	\$28	\$28
United American	\$60	\$30	\$9	\$30	\$30	\$30	\$30
Wellcare Signature	\$71	\$66	\$0	\$66	\$66	\$251	\$66

NOTE: Shaded cell indicates off-formulary drug for specific plan. \* indicates generic drug.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.

In the larger sulfonylureas group, two commonly prescribed products (glipizide and glyburide) are covered by all plans.<sup>38</sup> Fewer plans (from seven to nine) cover the other four products in this group. Only one is a brand-name drug and thus is placed on a higher cost-sharing tier. Those enrollees who are prescribed a product in this group other than the two most common ones may have to shop more carefully among plans. Three plans cover just the two common products, while three plans cover all six.

**Table B8: Coverage and Cost of Oral Hypoglycemics (Sulfonylureas), by Plan**

	Amaryl	Chlorpropamide*	Glipizide*	Glyburide*	Tolazamide*	Tolbutamide*
Aetna Essentials	\$37	\$11	\$3	\$5	\$5	\$5
Caremark Silverscript	\$46	\$23	\$4	\$8	\$18	\$10
Cigna Value	\$20	\$4	\$3	\$4	\$4	\$4
Coventry AdvantraRx Value	\$37	\$10	\$4	\$8	\$10	\$6
Humana Standard	\$9	\$4	\$1	\$2	\$5	\$2
Medco	\$17	\$23	\$4	\$4	\$4	\$4
MemberHealth CCRX Basic	\$12	\$0	\$0	\$0	\$0	\$10
Pacificare Saver	\$37	\$23	\$5	\$8	\$18	\$10
Prescription Pathway Bronze	\$46	\$4	\$1	\$3	\$4	\$2
Sterling	\$18	\$23	\$4	\$8	\$18	\$10
Unicare Medicare Rx Rewards	\$46	\$23	\$4	\$5	\$18	\$10
United AARP	\$28	\$5	\$4	\$5	\$5	\$5
United American	\$30	\$23	\$4	\$8	\$9	\$9
Wellcare Signature	\$35	\$0	\$11	\$0	\$17	\$10

NOTE: Shaded cell indicates off-formulary drug for specific plan. \* indicates generic drug.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.

<sup>38</sup> Omitted from the table are the extended-release version of glipizide and the micronized version of glyburide. The one plan shown not to cover glipizide covers the extended-release version at a zero copay. All but two plans cover the micronized version of glyburide at the same or similar copayment.

**Drugs Used to Treat Dementia, Including Alzheimer's Disease**

Drugs in this category are used to treat dementia, including Alzheimer's disease. All drugs in this category are brand products, except for Ergoloid Mesylates. There are three classes within this category, with Namenda and Ergoloid Mesylates each forming their own group. Thus, the formulary guidelines require that plans cover each of those drugs, plus two of the other four drugs. Several of the drugs in this group are high-priced drugs.

In this drug category, beneficiaries face a wide range in cost sharing depending on the drug they take and the plan they select. All plans chose to cover Aricept and Namenda (and all but one covers Exelon) – but even here tier placement results in swings in cost sharing that range from 2:1 to 5:1. The cheapest drugs overall are Aricept (the most commonly prescribed in this group) and, where available, Ergoloid Mesylates (the only generic in the group). The omission from some formularies of drugs such as Cognex or Razadyne means that the range of costs for those can be nine times higher in some plans compared to others. Ergoloid Mesylates should be covered by all plans as a distinct key drug type, but is off formulary for seven of 14 plans. Because it is an expensive generic drug it would cost the beneficiary only \$4 or \$5 when covered, but cost over \$100 in most of the plans where it is off formulary. Only one plan (United AARP) covers all six of these drugs, while three plans limit coverage to just three products.

**Table B9: Coverage and Cost of Anti-Dementia Drugs, by Plan**

	Cholinesterase Inhibitors				Other Agents	Glutamate Pathway Modifiers
	Aricept	Cognex	Exelon	Razadyne	Ergoloid Mesylates*	Namenda
Aetna Essentials	\$25	\$300	\$25	\$148	\$5	\$25
Caremark Silverscript	\$35	\$352	\$40	\$147	\$103	\$33
Cigna Value	\$20	\$40	\$40	\$156	\$4	\$20
Coventry AdvantraRx Value	\$42	\$299	\$158	\$42	\$10	\$42
Humana Standard	\$35	\$75	\$40	\$37	\$80	\$33
Medco	\$17	\$352	\$17	\$17	\$103	\$100
MemberHealth CCRX Basic	\$36	\$354	\$71	\$37	\$104	\$34
Pacificare Saver	\$53	\$352	\$53	\$156	\$103	\$22
Prescription Pathway Bronze	\$35	\$352	\$40	\$156	\$23	\$34
Sterling	\$25	\$352	\$25	\$148	\$103	\$25
Unicare Medicare Rx Rewards	\$25	\$299	\$25	\$25	\$5	\$25
United AARP	\$28	\$55	\$55	\$28	\$5	\$28
United American	\$30	\$352	\$30	\$30	\$103	\$60
Wellcare Signature	\$66	\$351	\$66	\$155	\$0	\$66

NOTE: Shaded cell indicates off-formulary drug for specific plan. \* indicates generic drug.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.

### **Hormonal Agents (Parathyroid/Metabolic Bone Disease)**

The class of hormonal agents for parathyroid and metabolic bone disease is something of a mixed bag clinically. There are two key drug types in our study sample: biphosphonates and calcium regulating hormones. While two drugs in the biphosphonates group (Actonel and Fosamax) are commonly prescribed drugs for osteoporosis, the others (Aredia/pamidronate, Didronel, Skelid, and Zometa) are treatments for cancer or Paget's Disease.<sup>39</sup> The two calcium regulating hormones can be used for osteoporosis but may have other clinical uses. Most of these drugs are expensive; in fact, several have prices in the range of \$600 to \$1,000.

All plans meet the CMS guidelines of covering at least one drug in each of the key drug types, but the coverage is especially uneven among the products in this class. Most plans cover the two most common treatments for osteoporosis (Actonel and Fosamax) and generally do so in the preferred brand tier. The treatments in the calcium regulating hormones key drug type are also covered by most plans. But Forteo is often on the specialty tier and comes at a considerably higher price tag than the others.

The remaining five drugs in this class are covered by fewer than half the plans. These expensive drugs treat less common conditions, and enrollees who take them have only a few plan options available if they want choice among these medications. Because the base price for the cheapest drug in this set is nearly \$200, and the others are at least \$600, beneficiaries face high out-of-pocket costs. But if they pick one of the two plans that cover all the drugs in this class, they will have both lower costs and more options.

**Table B10: Coverage and Cost of Hormonal agents (Biphosphonates) by Plan**

	Actonel	Aredia	Didronel	Fosamax	Pami-dronate*	Skelid	Zometa
Aetna Essentials	\$25	\$842	\$187	\$25	\$702	\$537	\$25
Caremark Silverscript	\$17	\$841	\$191	\$17	\$877	\$606	\$1,001
Cigna Value	\$40	\$20	\$20	\$20	\$4	\$40	\$20
Coventry AdvantraRx Value	\$70	\$841	\$187	\$42	\$877	\$536	\$860
Humana Standard	\$17	\$179	\$47	\$17	\$164	\$134	\$215
Medco	\$17	\$842	\$17	\$17	\$877	\$403	\$1,001
MemberHealth CCRX Basic	\$18	\$844	\$194	\$18	\$877	\$609	\$1,003
Pacificare Saver	\$22	\$842	\$192	\$70	\$877	\$607	\$1,001
Prescription Pathway Bronze	\$18	\$842	\$47	\$18	\$877	\$607	\$1,001
Sterling	\$25	\$841	\$192	\$25	\$876	\$607	\$1,001
Unicare Medicare Rx Rewards	\$25	\$841	\$187	\$25	\$877	\$536	\$1,001
United AARP	\$55	\$841	\$55	\$28	\$877	\$607	\$212
United American	\$30	\$842	\$30	\$30	\$877	\$60	\$1,001
Wellcare Signature	\$66	\$840	\$191	\$66	\$876	\$606	\$1,000

NOTE: Shaded cell indicates off-formulary drug for specific plan. \* indicates generic drug.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.

<sup>39</sup> Another treatment for osteoporosis, Boniva, was not included in the USP list of drugs and is thus not in the sample of drugs for this study.

**Table B11: Coverage and Cost of Hormonal Agents (Calcium Regulating Hormones), by Plan**

	<b>Forteo</b>	<b>Miacalcin</b>
Aetna Essentials	\$25	\$86
Caremark Silverscript	\$151	\$21
Cigna Value	\$20	\$20
Coventry AdvantraRx Value	\$42	\$42
Humana Standard	\$151	\$21
Medco	\$17	\$17
MemberHealth CCRX Basic	\$269	\$22
Pacificare Saver	\$657	\$53
Prescription Pathway Bronze	\$153	\$22
Sterling	\$151	\$25
Unicare Medicare Rx Rewards	\$151	\$25
United AARP	\$149	\$55
United American	\$30	\$30
Wellcare Signature	\$656	\$66

NOTE: Shaded cell indicates off-formulary drug for specific plan.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.



## Drugs Used to Treat Rheumatoid Arthritis

### Tumor Necrosis Factor Inhibitors

The three drugs in this group form a key drug type. Beneficiaries with rheumatoid arthritis commonly use one of these drugs; all are injectable drugs that have high price tags. Remicade must be administered by a physician, and so is often covered under Medicare Part B, whereas Enbrel and Humira are self injectable, and so should normally be covered under Part D. The full retail price of each of these drugs is in the range of \$1,100 to \$1,400 per month.

Beneficiaries who use these drugs face the most dramatic cost differences of any of the drugs in this analysis. Four plans place at least one of these drugs on a preferred tier (or sole brand tier) with flat copayments; in these cases, the cost to the beneficiary is between \$17 and \$42. Two of these plans treat all three products similarly, while the others create large price differentials by placing these drugs on separate cost-sharing tiers. For example, in the case of Medco's PDP, the lower cost-sharing amount (\$17 in this plan) applies to only one of the three drugs (Humira). Medco placed Enbrel on Tier 3, with 75 percent coinsurance (\$958), and left Remicade off its formulary (\$1,385). Of the eight plans with specialty tiers, six place these drugs on their specialty tier, meaning that enrollees would pay coinsurance in the range of \$300 to \$400. Eight of the 14 plans give equal treatment to Enbrel and Humira, the two products that compete most directly because they can be injected by the patient, whereas the other plans give a more preferred status and substantially lower costs to one or the other, with savings that could range from a modest \$30 to more than \$1,000. Remicade, which is often covered under Part B, is generally treated in comparable ways, and it is omitted from two formularies.

**Table B12: Coverage and Cost of Tumor Necrosis Factor Inhibitors, by Plan**

	Enbrel	Humira	Remicade
Aetna Essentials	\$25	\$25	\$25
Caremark Silverscript	\$319	\$319	\$294
Cigna Value	\$20	\$20	\$20
Coventry AdvantraRx Value	\$42	\$1,277	\$42
Humana Standard	\$319	\$319	\$294
Medco	\$958	\$17	\$1,385
MemberHealth CCRX Basic	\$569	\$322	\$525
Pacificare Saver	\$419	\$1,338	\$386
Prescription Pathway Bronze	\$323	\$1,292	\$298
Sterling	\$319	\$319	\$294
Unicare Medicare Rx Rewards	\$319	\$319	\$294
United AARP	\$315	\$315	\$290
United American	\$60	\$30	\$1,385
Wellcare Signature	\$391	\$391	\$360

NOTE: Shaded cell indicates off-formulary drug for specific plan.

SOURCE: Authors' analysis of drug coverage in stand-alone PDPs offered by 14 national and near-national organizations. Plans included represent the lowest-premium (or only) plan for each of the 14 organizations in the study. Data from Medicare.gov.



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