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SENIORS PAY MORE FOR GENERICS IN MEDICARE PRESCRIPTION DRUG PLANS DESPITE STABLE PRICES

Avalere analysis finds that price of generic drugs has remained flat but the cost to seniors is increasing

New research from Avalere finds that seniors with Medicare prescription drug plans (Part D) pay more for generic drugs even as the market price of these drugs stays stable.

Avalere experts note that seniors are paying more because generic drugs are being placed on higher formulary tiers where patients pay more out of pocket for drugs. The number of generic prescription drugs placed on the lowest tier, where patients pay less for their drugs, declined 53 percentage points between 2011 and 2015. This shift resulted in a 93% increase in total patient cost sharing for these drugs, or a total of $6.2 billion.

This higher cost sharing and movement of generics to higher tiers did not correspond with an increase in the underlying price of generic drugs over that same time period, according to an analysis by Avalere experts of the average volume-weighted price of generics that were included on plan formularies in both 2011 and 2015.

“The use of generic drugs has saved the Medicare Part D program billions of dollars,” said Dan Mendelson, president at Avalere. “However, higher tier placement of generic drugs is leading to higher out-of-pocket costs for patients and may reduce savings.”

As plans face pressure to cover new, innovative medications, they have responded with increased utilization management and tier placement strategies to moderate the average cost of covered drugs on each tier. If a plan is faced with higher-priced branded drugs, one way it can reduce the overall average price of all drugs on a particular formulary tier is to increase the number of lower-cost generics on that same tier.

Since the implementation of the Medicare Part D program in 2006, plan benefit designs have evolved and, on average, include a growing number of formulary tiers. In 2018, more than 80% of Part D plans have 5 tiers, compared to 2006, when about half of all plans had only 4 tiers. Part D plans have considerable flexibility as to how they design formularies and tier structure, as long as they meet CMS’ nondiscrimination requirements.

In 2011, 71% of generic drugs were placed on tier 1, the lowest tier in the formulary. By 2015, 19% of covered generics were placed on tier 1, while 46% were placed on tier 2 and 35% were placed on tier 3 or higher (Figure 1). This shift represents a 53 percentage point decrease in the number of generics being placed on the lowest tier between 2011 and 2015.

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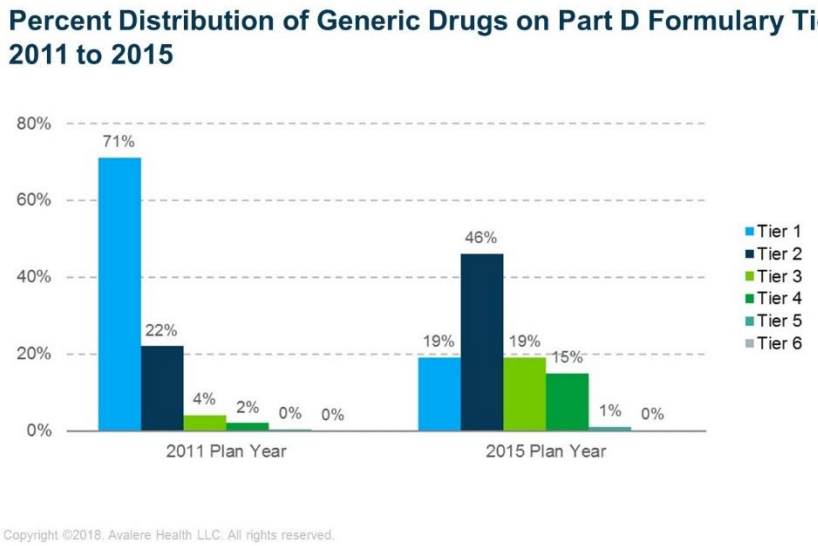
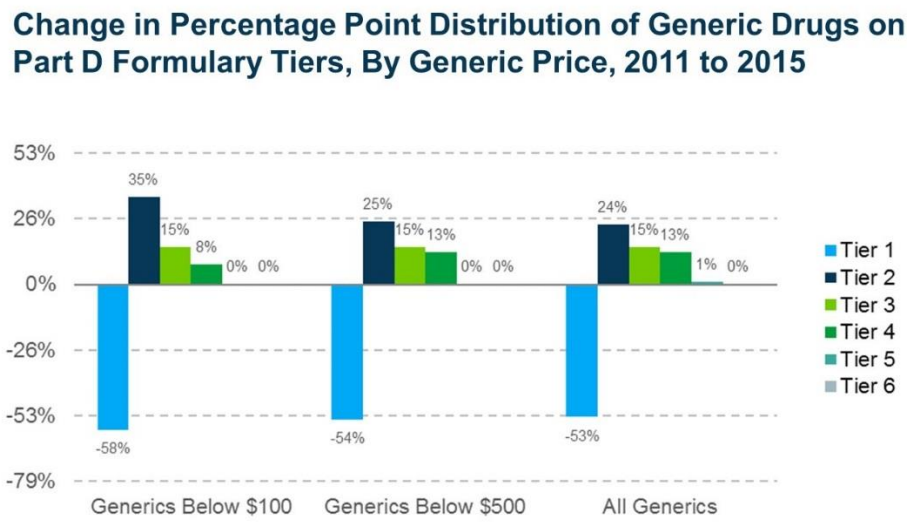
Figure 1: Tier Placement of Generics, 2011-2015



Additionally, this movement from tier 1 to higher tiers was observed across all generics irrespective of price (Figure 2). In fact, there was a greater percentage point change in the number of generics costing less than $100 that moved from tier 1 to higher tiers compared to generics overall (53 percentage point change).

Figure 2: Change in Tier Distribution of Generic Drugs, 2011-2015



"Generic drugs are being shifted to higher tiers regardless of price," said Clara Soh, director at Avalere. "Continuing to realize the cost savings from high generic utilization requires further examination of the factors driving the shift of generic drugs to higher tiers and its impact on patient access."

Funding for this analysis was provided by the Association for Accessible Medicines. Avalere retained full editorial control.

METHODOLOGY

Avalere analyzed historical tier placement and cost sharing of generic drugs in the Medicare Part D program from 2011–2015 to see how plans covered generics in the years before the creation of the "non-preferred drug" tier. The analysis encompassed all generic products that were included on formularies in both 2011 and 2015. To conduct this analysis, Avalere cross-walked Medicare Part D public use files with the CMS Prescription Plan Formulary, Pharmacy Network, and Pricing Information Files and the CMS Medicare Part D Dashboard Files for 2011 and 2015. Because CMS is prohibited from disclosing data on rebates, the prices used here are exclusive of manufacturer rebates and other price concessions.

For the cost-sharing analysis, Avalere relied solely on the cost sharing associated with each tier in the formulary benefit design and did not incorporate plan deductibles or OOP costs associated with the coverage gap; this methodology results in a conservative estimate and likely underestimates the true OOP costs that patients face. Additionally, because the publicly available data from CMS do not include product- or plan-specific claims, Avalere weighted the plans and cost sharing according to the enrollment for each plan. Finally, because the Medicare Drug Dashboard reports claims aggregate to the chemical entity level, Avalere assumed that claims for a chemical entity were distributed evenly across all dosages.

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