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Trends in Generic Tiering in Medicare Part D, 2011–2021


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Summary

From 2011 to 2021, there was an increase in higher formulary tiering, patient out-of-pocket spending, and negotiated price for a cohort of generics.

In recent years, Part D plan sponsors have increasingly placed generic drugs on higher formulary tiers. Because higher tiers generally have greater cost sharing requirements, this formulary placement trend could result in higher patient out-of-pocket (OOP) spending for some generic drugs.

The Biden administration recently proposed in its Fiscal Year 2025 budget the creation of a new, permanent benefit to Part D coverage that would require all Part D plans to offer a standard list of generic drugs at a maximum copayment of $2 per 30-day supply. This policy builds on the proposed Medicare High Value Drug List Model, a voluntary model that would be administered by the Centers for Medicare and Medicaid Services Innovation Center. The administration intends for the new benefit to lower beneficiaries' OOP costs by offering fixed cost sharing for commonly used generic drugs treating chronic conditions.

To further evaluate these trends and their impacts on patient costs, Avalere analyzed longitudinal changes in generic tier placement, patient OOP spending, and negotiated pricing within Medicare

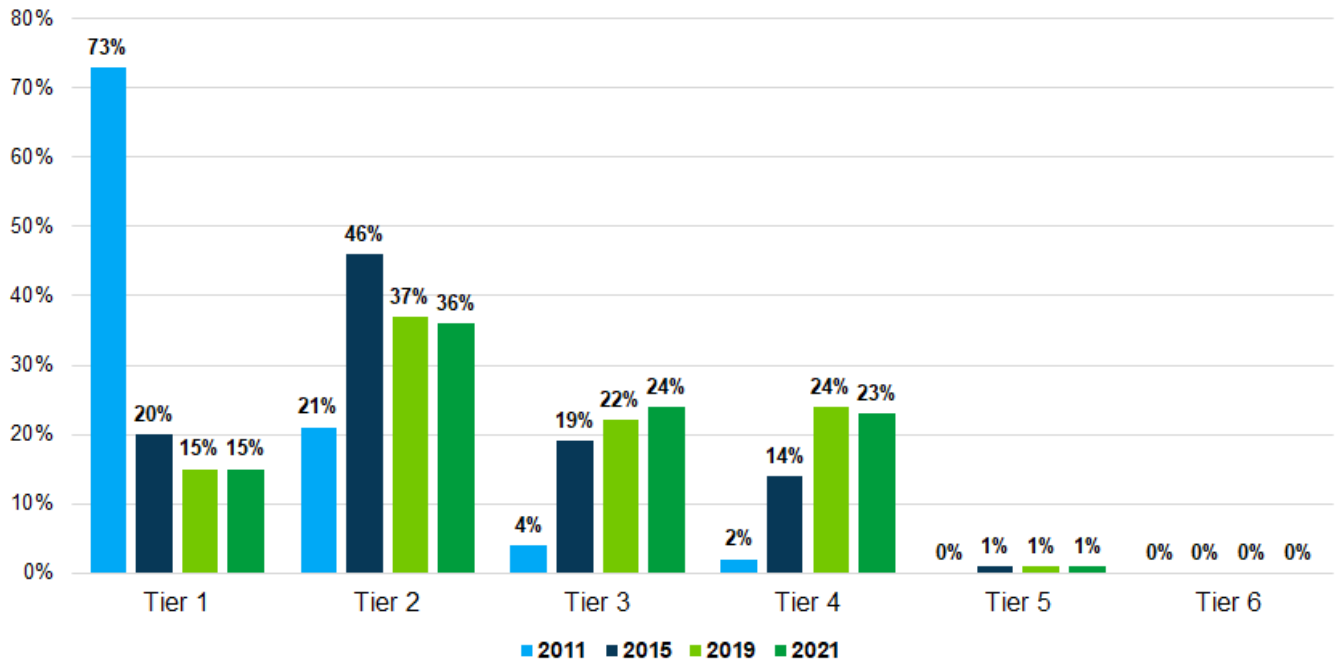
Part D. Avalere's assessment focuses on a single cohort of generic drugs that were on Part D formularies in 2011, 2015, 2019, and 2021. The analysis was limited to this cohort in order to focus on changes to tier placement for generic drugs after they have been on the market for multiple years, and it did not include generics new to market during this period.

Key Findings

Generic Tiering: From 2006 through 2011, Part D plans largely offered a benefit with up to four formulary tiers—often one generic tier, two brand tiers (preferred and non-preferred), and one specialty drug tier. Under this structure, generic drugs were usually placed on the generic tier. By 2015 and beyond, most Medicare Part D plans moved to a five-tier structure, often following this pattern: 1) preferred generic; 2) non-preferred generic; 3) preferred brand; 4) non-preferred drug; and 5) specialty. Tier 6 often refers to "other," "select care," or "unspecified" tier.

Consistent with these changes and with prior findings, the analysis found that the percentage of generic drugs in the cohort on Tier 1 decreased between 2011 and 2021, while the percentage of generic drugs on Tier 3 and Tier 4 increased (Figure 1). In 2011, 73% of analyzed generic drugs were placed on Tier 1. That percentage sharply decreased to 20% in 2015, decreased further to 15% in 2019, and then remained steady at 15% in 2021.

Figure 1. Distribution of Generic Drugs on Part D Formulary Tiers

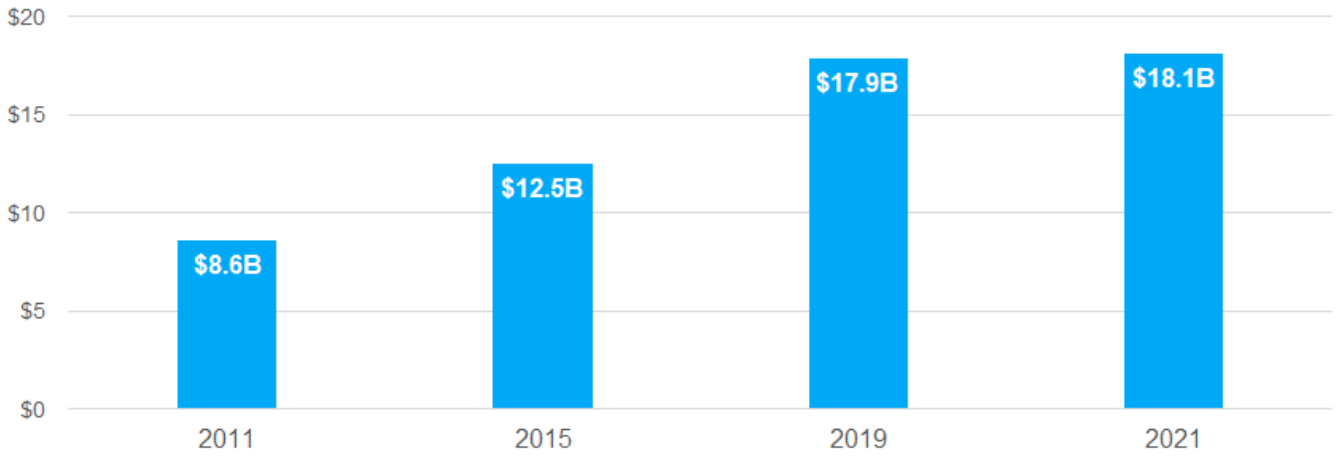


**The analysis was completed using tier number rather than tier name.*

Patient OOP Costs: To assess the effect of tier placement on patient costs, Avalere calculated total patient OOP spending on the assessed generics within Medicare Part D (Figure 2). Total Medicare Part D patient spending on the assessed generics increased 110% between 2011 and 2021, rising from $8.6 billion in 2011 to $18.1 billion in 2021.

This increase does not appear to be driven by greater volume, as the volume of submitted prescription claims for drugs in the cohort increased modestly, by 5% from 2011 to 2021. This includes a 13% growth in volume between 2011 to 2015, a 4% decrease from 2015 to 2019, and a subsequent 4% decrease from 2019 to 2021.

Figure 2. Aggregate Annual Patient OOP Spending for Cohort Generics in Part D



Product Pricing: Avalere found that average negotiated prices (i.e., the prices plans agree to pay pharmacies, not what pharmacies pay to manufacturers) for the cohort of analyzed generic drugs increased 35% between 2011 and 2021, rising from $66.11 for a 30-day supply to $89.31. Average negotiated prices grew 29% between 2011 and 2015, grew 13% between 2015 and 2019, and decreased 7% between 2019 and 2021. However, as noted, negotiated price is not a measure of generic manufacturer pricing. Although this analysis did not measure changes in generic manufacturer prices, multiple other studies suggest consistent downward pressure on generic drug prices over this period.

These trends in average negotiated price were driven primarily by changes in the negotiated prices of Tier 5 drugs. Although Tier 5 drugs accounted for 1% or less of analyzed drugs in each study year, their average negotiated price increased by 730% from 2011 to 2021, rising from $116.52 for

a 30-day supply to $966.77. The average negotiated prices of other tiers decreased or experienced modest increases across the study period. While generic prices are largely falling, Medicare beneficiaries face higher cost sharing due to generic drugs being placed on higher formulary tiers.

Key Takeaways

Between 2011 and 2021, the percent of cohort generics placed on higher formulary tiers increased the longer they were on the market. Over that same period, patient OOP spending on the cohort generics increased at a faster rate than the average negotiated price and volume of the cohort generics. This growth was driven primarily by changes that took place between 2011 and 2019; changes to generic tiering, patient OOP spending, and pricing were minimal between 2019 and 2021.

These findings offer insight into current trends in generic tiering, spending, and pricing. However, it is important to note that this analysis examines trends within a defined set of generic products, and it is not necessarily reflective of trends for generics that were not on the market in all four years studied. Additionally, this analysis did not examine if other factors could impact product tier placement and patient spending, such as changes in Part D enrollment, new drugs entering the market, shifts in prescribing patterns, or changes in clinical guidelines.

Methodology

Avalere utilized the CMS Medicare Part D Public Use Files from 2011, 2015, 2019, and 2021 to assess generic drug tier placement for all Medicare Advantage prescription drug plans and standalone Part D plans. Different Part D plans can place the same product on different tiers and the analysis reflects the percentage distribution of all plan-drug combinations.

To calculate product volume, Avalere used the Medicare Part D Drug Dashboard files to identify the number of claims. Medicare Part D utilization in the Medicare Part D Drug Dashboard files does not provide information beyond the chemical entity and brand name of a drug. As such, Avalere assumed that the volume for each chemical entity was evenly distributed among package sizes.

Negotiated price was calculated at the drug level using data from Pricing Information Files and is unweighted. Patient spending was calculated by assessing the negotiated price and assigned cost sharing for the tier of the product and multiplying it by volume. Cost sharing was weighted by enrollment in each plan. Avalere did not incorporate other components of the Part D benefit, such as plan deductibles, the coverage gap, low-income subsidies, and other components of the

Medicare Part D benefit.

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