Effect of Potential Policy Change to Part D Generic Tiering on Patient Cost Sharing and Part D Plan Costs

Summary

In a new analysis, Avalere examines the implications of CMS’ potential new requirement that Part D plans place generics only on generic tiers.

Since its inception in 2006, the Medicare Part D program has offered prescription drug coverage through private plans that actively manage prescription drug benefits through the creation of formulary tiers and cost sharing; in 2018, 44 million beneficiaries had Part D prescription drug coverage. While the formulary guidelines have changed over time, they have historically allowed Part D plans to keep premiums low and drive utilization to less expensive generic drugs, keeping down costs for both beneficiaries and the federal government. In 2016, 86% of retail prescriptions paid for by Medicare Part D plans were generics, which accounted for just 16% of total Part D program spending.

However, a previous Avalere analysis of plan years 2011 through 2015 found that plans were increasingly placing generic drugs on non-generic, higher drug tiers. Subsequent to the years included in that analysis, in 2017, the Centers for Medicare & Medicaid Services (CMS) Part D formulary guidelines started to allow Part D plans to replace their “non-preferred brand”
tier—typically tier 4—with a new “non-preferred drug” tier without any requirements on the proportion of brand and generic drugs that could be included in that tier. This policy has led to plans increasingly moving generic drugs from a generic tier (i.e., Tier 1 or 2) onto a higher tier (i.e., Tier 3 or 4), raising average out-of-pocket (OOP) costs of generic drugs for beneficiaries, despite declining generic drug prices in the program.

On January 30, 2019, in response to concerns about this trend in generic drug tiering in Part D, in Part II of the 2020 Advanced Notice and Call Letter (ANCL), CMS announced the agency was considering changing the Medicare Part D tier formulary guidelines to prohibit or restrict plans’ ability to place generic drugs on non-generic tiers. CMS expects that restricting or prohibiting generic drugs from being placed on brand formulary tiers would encourage utilization of more generics, reduce OOP costs for seniors, and limit beneficiary confusion.

In this analysis, Avalere estimates the implications of CMS’ potential new requirement on beneficiary cost sharing, plan liabilities, and the implications for plans’ share of total costs for beneficiaries. Avalere additionally quantifies the increase in generic drug placement on non-generic tiers from 2016—the year before the non-preferred drug tier was implemented—through 2019.

Generic drugs in Medicare Part D have experienced a shift from nearly exclusive placement on generic tiers prior to 2012 to nearly evenly divided placement between generic and non-generic tiers in 2019. That trend, encouraged by the creation of the non-preferred drug tier in 2017, has resulted in higher beneficiary cost sharing for generic medications over time, reducing the incentive for beneficiaries to take lower priced generic medications. As CMS considers options to incent lower-priced medications to reduce OOP costs in the Part D program, a requirement for generic drugs to be covered only on generic tiers could achieve this objective, saving patients who take generic drugs an estimated $4.1 billion in 2019. At the same time, formulary tier policies that would generally keep generic and brand drugs on separate tiers as considered in the CY2020 ANCL would shift the cost of higher priced brand drugs back to Part D plans and could result in higher plan premiums and other potential changes to plan design in reaction to those higher costs.

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

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