

CHAPTER SIX

PRESCRIPTION DRUG COVERAGE IN ESRD PATIENTS medicare part D

There's battle lines being drawn
Nobody's right if everybody's wrong
Young people speaking their minds
Getting so much resistance from behind
I think it's time we stop, hey, what's that sound
Everybody look what's going down

STEPHEN STILLS, "FOR WHAT IT'S WORTH"



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As of September, 2008, 26 million Medicare-enrolled elderly and disabled people, as well as individuals with ESRD, were enrolled in a Medicare Part D prescription-drug plan (PDP).

Before 2006, these patients obtained prescription drug coverage through various insurance plans, state Medicaid programs, or pharmaceutical-assistance programs, received samples from physicians, or paid out-of-pocket. After 2006, however, the majority obtained Part D coverage. As shown on the next page, 58–59 percent of elderly CKD and general Medicare patients were enrolled in Part D in 2008, compared to 72, 61, and 53 percent of hemodialysis, peritoneal dialysis, and kidney transplant patients.

The retiree drug subsidy, designed to encourage employers to supply prescription coverage to Medicare-covered retirees that is at least as valuable as the Medicare Part D standard plan, provides employers with a tax-free rebate for 28 percent of retirees' drug costs. Other patients are enrolled in employer group health plans or government/military plans ("creditable coverage") which provide coverage that is equivalent to or better than Part D.

The proportion of patients with no known source of drug coverage is highest in the peritoneal dialysis and transplant populations. Given that many of these patients

are employed, it is likely that some have sources of prescription drug coverage not tracked by Medicare.

Prior to the start of the Medicare Part D program in 2006, patients dually-enrolled in Medicare and Medicaid received prescription benefits under state Medicaid programs. The Part D program, however, offers a substantial low-income subsidy (LIS) benefit to enrollees with limited assets and income, including those who are dually-enrolled. The LIS provides full or partial waivers for many out-of-pocket cost-sharing requirements, including premiums, deductibles, and copayments, and provides full or partial coverage during the coverage gap ("donut hole"). Compared to patients in the general Medicare population, a higher proportion of dialysis, transplant, and elderly CKD patients receive LIS benefits, and thus, in general, pay proportionally lower out-of-pocket costs for their Part D prescriptions.

Part D does not cover every medication prescribed to Medicare enrollees. Several drug categories—including over-the-counter medications, barbiturates, benzodiazepines, anorexia and weight loss or gain medications,

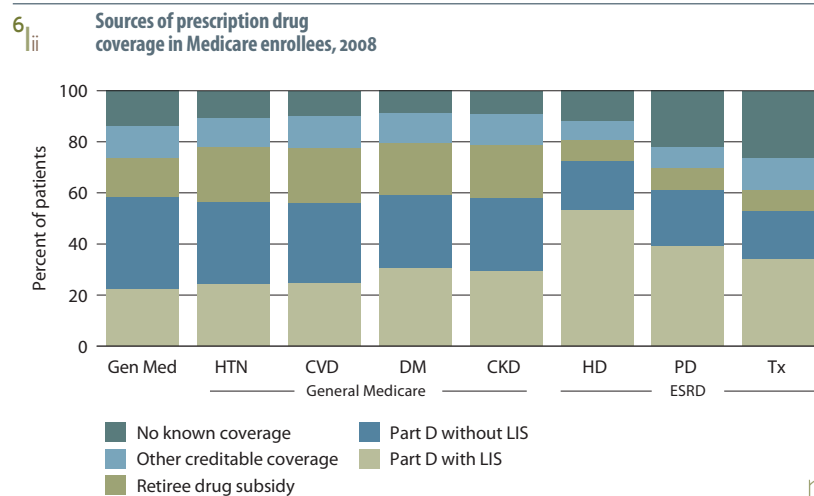
Definitions of terms used throughout this chapter are provided on page 246.

prescription vitamins (except for prenatal vitamins), and cough and cold medications — are excluded from the Part D program by law.

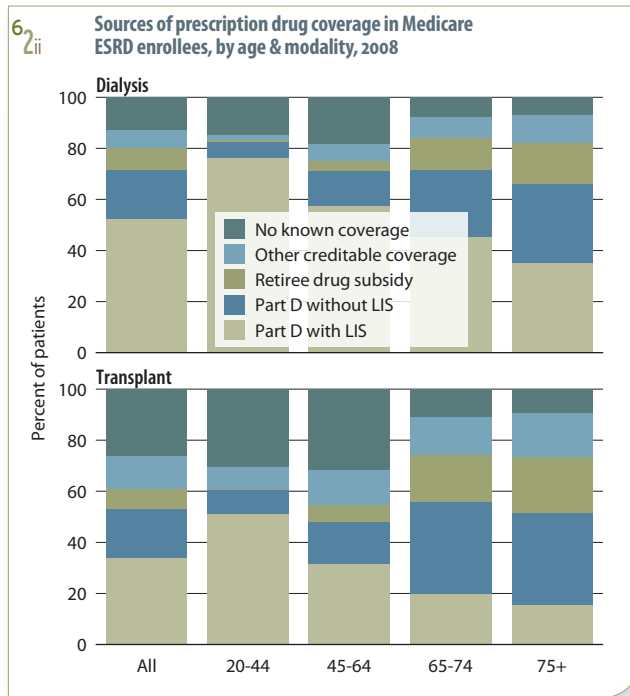
The Medicare Part D program works in concert with Medicare Part B, which covers medications administered in physician offices (e.g. erythropoiesis stimulating agents (ESAs) in CKD patients), those administered during hemodialysis (e.g. ESAs, intravenous vitamin D and iron products, IV antibiotics, and resuscitative medications), and most immunosuppressant medications required in the three-year period following a Medicare-covered kidney transplant. Medicare-covered transplant patients lose eligibility for Part B benefits after three years, but, if they become Medicare-eligible due to age or disability, they again become eligible for Part B for immunosuppressant coverage. Patients whose kidney transplant is not covered by Medicare, but who become Medicare-eligible due to age or disability, can enroll in and receive their immunosuppressant medications through Part D. Prescription drugs not covered for beneficiaries under Part B may be covered by Part D, but coverage depends on whether the drug is included on the plan formulary.

Part D benefits can be managed through a stand-alone PDP or through a Medicare Advantage (MA) plan, which provides medical as well as prescription benefits. The majority of dialysis and transplant patients are covered through PDPs (as patients may not enroll in Medicare Advantage after ESRD onset), but data in this chapter encompass both types of plans.

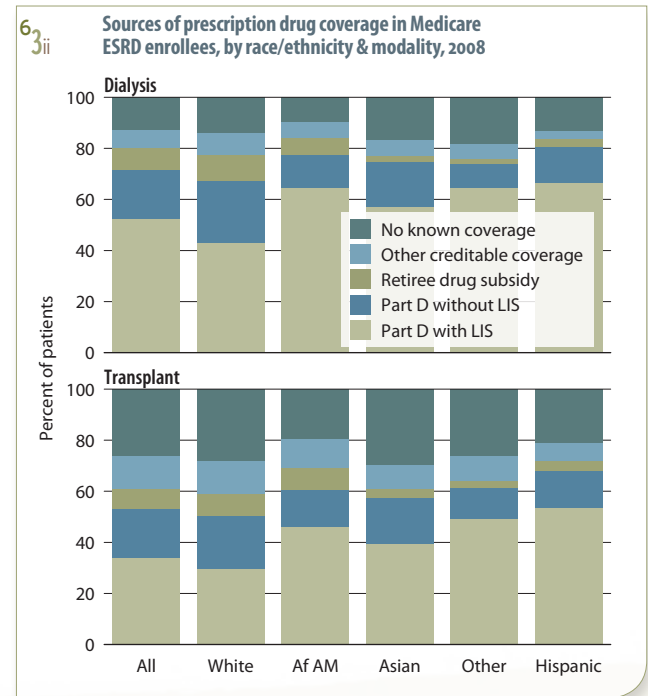
>> **Figure 6.I:** see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1, 2008.*



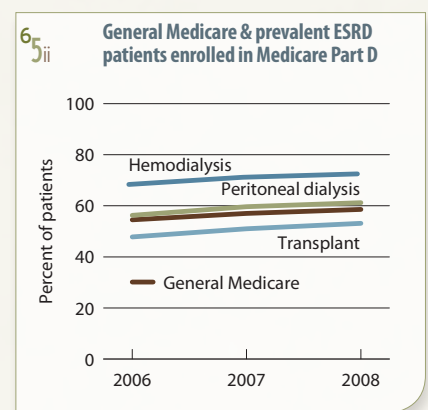
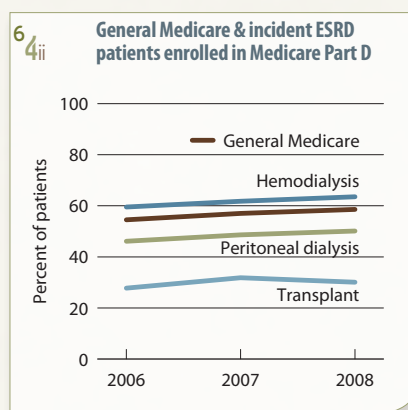
Sources of prescription drug coverage in Medicare ESRD patients vary widely by age and modality. In each age category, for example, transplant patients are markedly less likely than those on dialysis to have the low income subsidy (LIS). Younger patients on either modality have the highest Part D enrollment, and the monotonic decrease in the percentage of patients with LIS as age increases is striking — three in four dialysis patients age 20–44 with Part D receive LIS assistance, in contrast to just 35 percent of patients age 75 and older. >> **Figure 6.2**; see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1, 2008.*



The proportion of dialysis patients enrolled in Part D varies by race and ethnicity, from 67 percent among whites to 78 and 81 percent among African Americans and Hispanics, respectively. Eighty-three percent of African Americans and Hispanics with Part D coverage have LIS, compared to 64 percent of whites, and African Americans treated with dialysis are the least likely to have no known prescription drug coverage. These general trends hold true for kidney transplant patients as well, although their Part D enrollment is less than that of dialysis patients. >> **Figure 6.3**; see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1, 2008.*

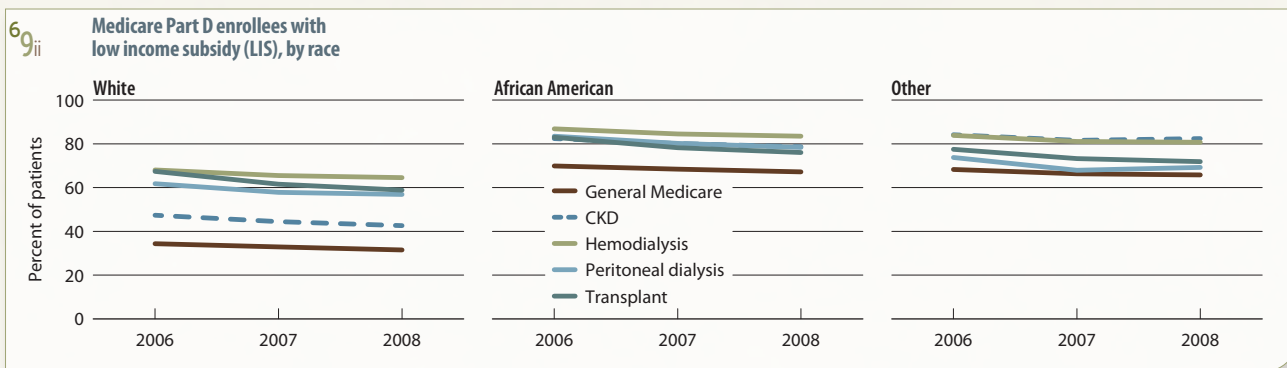
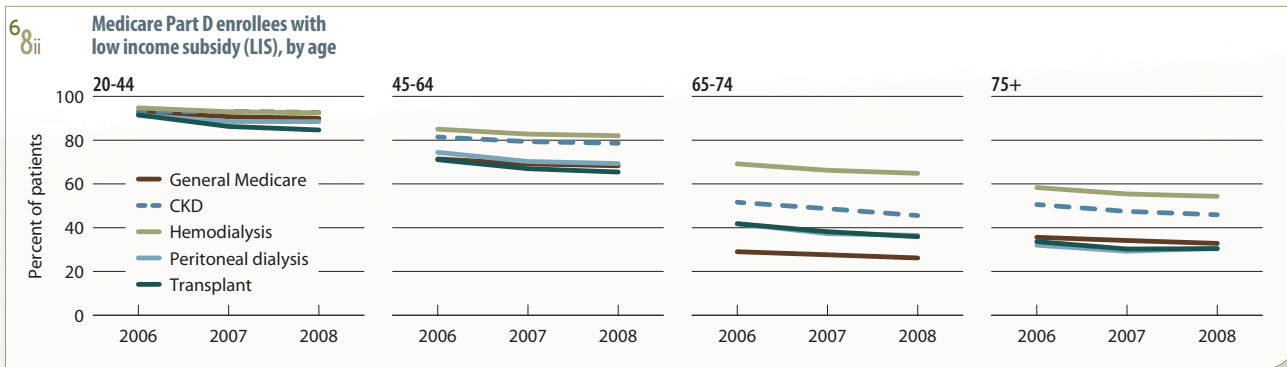
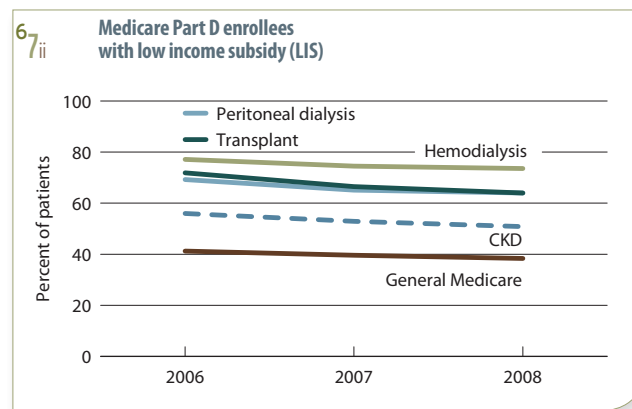
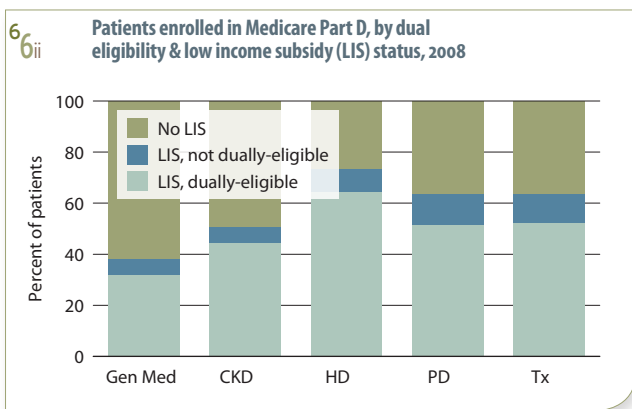


The steady increase in Part D enrollment among both incident and prevalent hemodialysis and peritoneal dialysis patients parallels that seen in general Medicare patients; the lower enrollment of peritoneal dialysis patients is most likely explained by their higher employment rate. Enrollment among the small number of patients transplanted within 90 days of ESRD initiation (about 2,300 per year) remains about 30 percent. >> **Figures 6.4–5**; see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1. Incident (day 90; 6.4) & prevalent ESRD patients (6.5).*



Patients dually-enrolled in Medicaid and Medicare qualify for LIS, and, if they do not choose a plan, are automatically enrolled in a Medicare Part D plan. Sixty-five percent of hemodialysis patients with Part D coverage are dually-eligible LIS beneficiaries, compared to 32 percent of the general Medicare population. An additional but smaller proportion of patients (6–12 percent) receive LIS after an application documenting low income and resources. Overall, 74 percent of hemodialysis patients with Part D coverage receive LIS benefits, compared to 64 percent of peritoneal dialysis and transplant patients, 51 percent of those with CKD, and 38 percent of general Medicare patients. >> Figure 6.6; see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1, 2008.*

The proportion of Part D-enrolled patients with LIS declined slightly from 2006 to 2008, probably due to increasing elective enrollment among patients without dual eligibility. The majority of younger patients (those younger than 65, primarily persons with ESRD or disabilities) enrolled in Part D have LIS. Among those age 65 and older, LIS enrollment is highest in the hemodialysis and CKD populations. By race, white Part D beneficiaries are less likely to have LIS than African Americans or those of other races. In 2008, the spread between general Medicare and hemodialysis patients with LIS was largest in white beneficiaries, at 33 percentage points. >> Figure 6.7–9; see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1, 2008.*

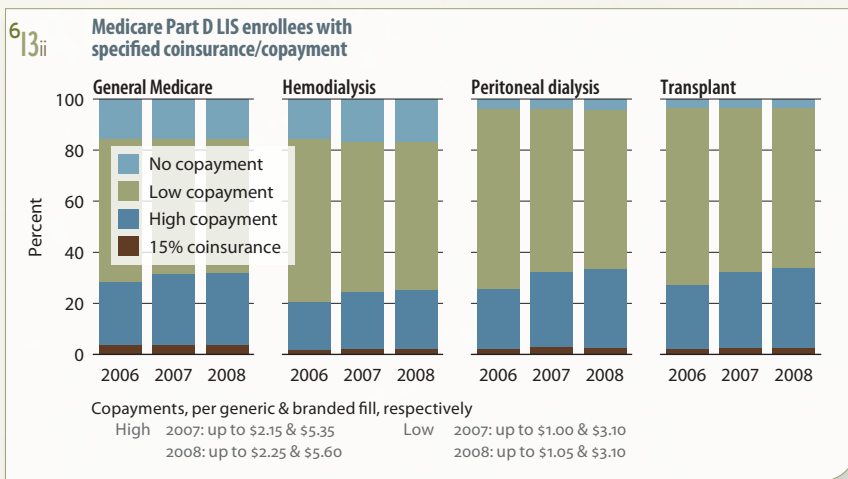
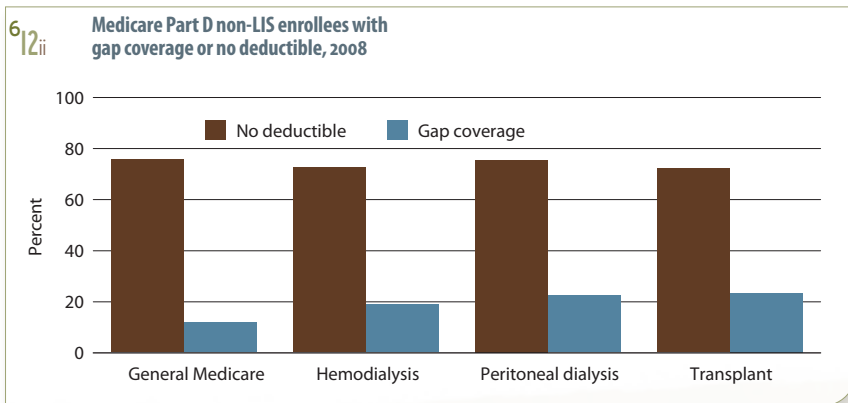
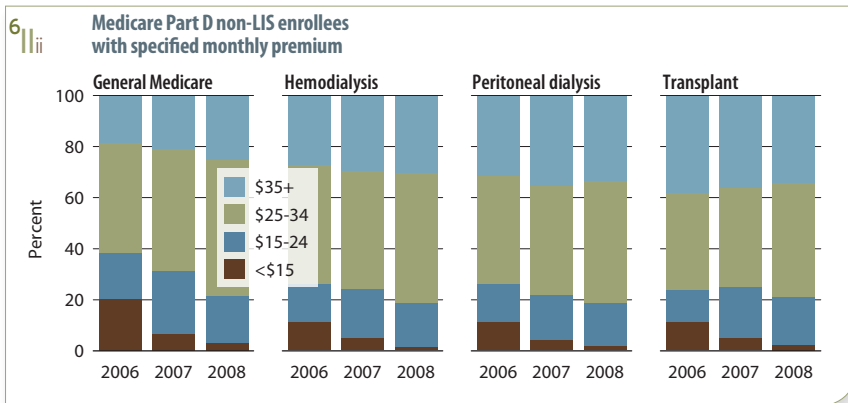


CMS provides prescription drug plans (PDPs) with guidance on structuring a “standard” Part D PDP. The upper portion of this table shows the standard benefit design for PDPs in 2006, 2007 and 2008. In 2008, for example, beneficiaries shared costs with the PDP (as coinsurance or copayments) until the combined total reached \$2,510 during the initial coverage period. After reaching this level, beneficiaries went into the coverage gap or “donut hole,” where they paid 100 percent of costs. Since 2010, the government has been providing those reaching the coverage gap with more assistance each year. In 2008, beneficiaries who obtained a yearly out-of-pocket drug cost of \$4,050 reached the catastrophic coverage phase, in which they paid only a small copayment for their drugs until the end of the year.

PDPs have the latitude to structure their plans differently from what is presented here; companies offering non-standard plans must show that their coverage is at least actuarially equivalent to the standard plan. Many have developed plans with no deductibles or with drug copayments instead of the 25 percent coinsurance, and some plans provide generic and/or brand name drug coverage during the coverage gap.

The lower portions of the table show drug copayment, coinsurance, and deductible amounts for beneficiaries with full and non-full dual eligibility and with full or partial subsidies. >> Figure 6.10 <http://www.q1medicare.com/PartD-The-2008-Medicare-Part-D-Outlook.php>.

6.10ii Medicare Part D benefit parameters, 2006–2008			
Part D Standard Benefit Design Parameters:			
Deductible - (after the Deductible is met, Beneficiary pays 25% of covered costs up to total prescription costs meeting the Initial Coverage Limit.	2006	2007	2008
	\$250	\$265	\$275
Initial Coverage Limit - Coverage Gap (Donut Hole) begins at this point. (The Beneficiary pays 100% of their prescription costs up to the Out-of-Pocket Threshold)	\$2,250	\$2,400	\$2,510
Total Covered Part D Drug Out-of-Pocket Spending including the Coverage Gap - Catastrophic Coverage start after this point.	\$5,100.00	\$5,451.25	\$5,726.25
Out-of-Pocket Threshold - This is the Total Out-of-Pocket Costs including the Donut Hole. 2008 Example: \$275 (Deductible) + ((\$2,510 - \$275) * 25%) (Initial Coverage) + ((\$5,726.25 - \$2,510) * 100%) (Donut Hole) = \$4,050 (Maximum Out-Of-Pocket Cost prior to Catastrophic Coverage - excluding plan premium)	\$3,600	\$3,850	\$4,050
	\$250.00	\$265.00	\$275.00
	\$500.00	\$533.75	\$558.75
	\$2850.00	\$3051.25	\$3216.25
	\$3600.00	\$3850.00	\$4050.00
Catastrophic Coverage Benefit:			
Generic/Preferred Multi-Source Drug	\$2.00	\$2.15	\$2.25
Other Drugs	\$5.00	\$5.35	\$5.60
Part D Full Benefit Dual Eligible Parameters:			
Copayments for Institutionalized Beneficiaries	\$0.00	\$0.00	\$0.00
Maximum Copayments for Non-Institutionalized Beneficiaries			
Up to or at 100% FPL:			
Up to Out-of-Pocket Threshold			
Generic/Preferred Multi-Source Drug	\$1.00	\$1.00	\$1.05
Other	\$3.00	\$3.10	\$3.10
Above Out-of-Pocket Threshold	\$0.00	\$0.00	\$0.00
Over 100% FPL:			
Up to Out-of-Pocket Threshold			
Generic/Preferred Multi-Source Drug	\$2.00	\$2.15	\$2.25
Other	\$5.00	\$5.35	\$5.60
Above Out-of-Pocket Threshold	\$0.00	\$0.00	\$0.00
Part D Non-Full Benefit Dual Eligible Full Subsidy Parameters:			
Resources ≤ \$6,120 (individuals) or ≤ \$9,190 (couples)			
Maximum Copayments up to Out-of-Pocket Threshold			
Generic/Preferred Multi-Source Drug	\$2.00	\$2.15	\$2.25
Other	\$5.00	\$5.35	\$5.60
Maximum Copay above Out-of-Pocket Threshold	\$0.00	\$0.00	\$0.00
Resources between \$6,120-\$20,210 (individuals) or \$9,190-\$20,410 (couples)			
Deductible	\$50.00	\$53.00	\$56.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%	15%
Maximum Copayments above Out-of-Pocket Threshold			
Generic/Preferred Multi-Source Drug	\$2.00	\$2.15	\$2.25
Other	\$5.00	\$5.35	\$5.60
Part D Non-Full Benefit Dual Eligible Partial Subsidy Parameters:			
Deductible	\$50.00	\$53.00	\$56.00
Coinsurance up to Out-of-Pocket Threshold	15%	15%	15%
Maximum Copayments above Out-of-Pocket Threshold			
Generic/Preferred Multi-Source Drug	\$2.00	\$2.15	\$2.25
Other	\$5.00	\$5.35	\$5.60

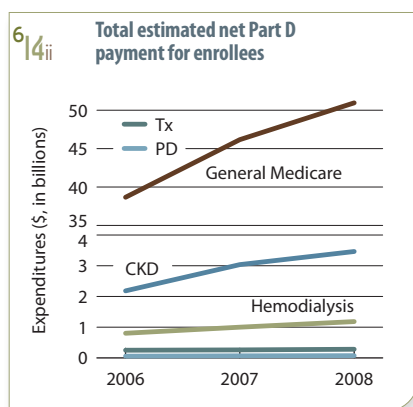


Patients without the low income subsidy (LIS) pay monthly premiums. Over the first three years of Medicare Part D, patient enrollment in plans with higher premiums increased. In 2008, 30–34 percent of ESRD patients enrolled in plans with premiums greater than \$35 per month, compared to 25 percent of general Medicare patients.

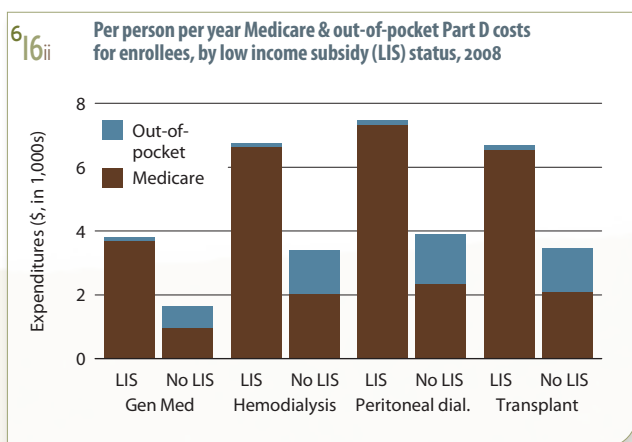
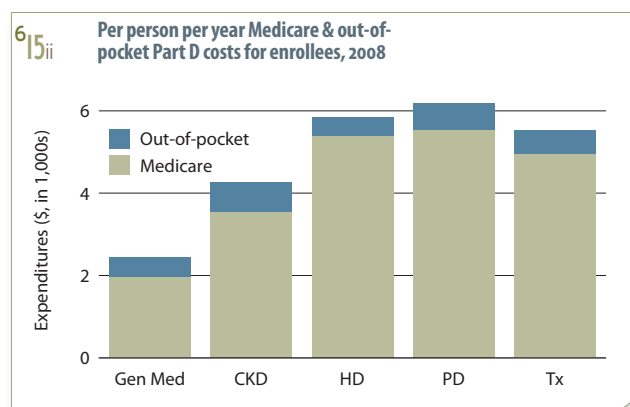
The percentage of Part D non-LIS enrollees with no deductible is similar in the general Medicare and ESRD populations, at 72–76 percent. Gap (“donut hole”) coverage, in contrast, is more common in the peritoneal dialysis and transplant populations, at 23–24 percent compared to 19 percent among hemodialysis patients, and 12 percent for those in the general Medicare population.

Most Part D enrollees with LIS (full-benefit dual-eligible patients) do not pay monthly premiums, but non-institutionalized patients with LIS do pay drug copayments or coinsurance based on income and assets. Seventy-five percent of hemodialysis patients with LIS have low or no copayments for their Part D medications, compared to 66–68 percent of peritoneal dialysis, transplant, and general Medicare patients. Only 2–4 percent pay 15 percent coinsurance for their medications. Even those patients with high copayments (23–31 percent of patients in 2008) paid a maximum of just \$2.25 per generic and \$5.60 for branded medication. >> Figures 6.11–13; see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1, excluding those in Medicare Advantage Part D plans.*

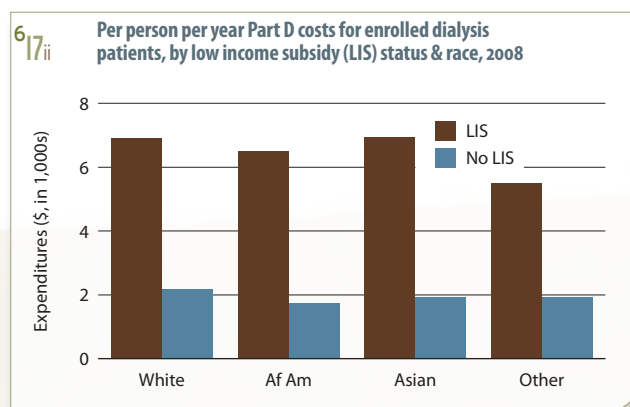
Total net Part D payment for patients with identified kidney disease (hemodialysis, peritoneal dialysis, and transplant patients, and CKD patients not on dialysis) was \$5 billion in 2008 — 10 percent of total Part D prescription drug costs. These costs do not include costs of drugs billed to Part B, including intradialytic medications (ESAs, IV vitamin D, iron) and immunosuppressants. >> Figure 6.14; see page 387 for analytical methods. *All patients enrolled in Part D.*



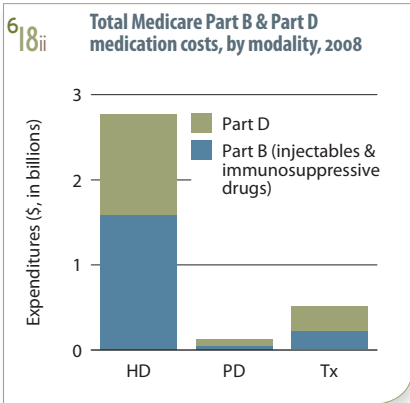
At \$5,536 and \$6,183, the per person per year (PPPY) total cost of medications covered by Medicare Part D is 2.3–2.5 times higher, respectively, in dialysis and transplant patients than in the general Medicare population. Proportional to total Part D costs, however, out-of-pocket costs are lower in ESRD patients, representing 8 percent of PPPY costs for hemodialysis patients and 10 percent for both peritoneal dialysis and transplant patients, compared to 19 percent in the general Medicare population. >> Figure 6.15; see page 387 for analytical methods. *All patients enrolled in Part D.*



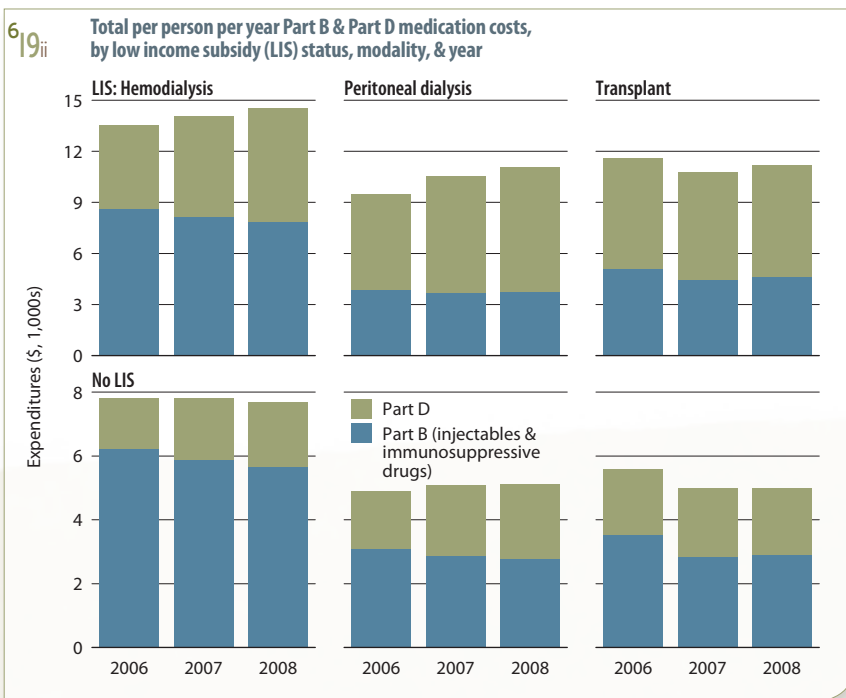
Across populations, total Part D medication costs are approximately twice as high in patients with LIS benefits than in those without. In the LIS population, however, out-of-pocket costs represent only 2–3 percent of these total expenditures, compared to 40–41 percent in each of the non-LIS populations. Regardless of LIS status, total PPPY Part D costs are 1.8–2.4 times greater for patients with ESRD than for those in the general Medicare population. >> Figure 6.16; see page 387 for analytical methods. *All patients enrolled in Part D.*



Among dialysis patients with LIS benefits, Part D costs per person per year are \$6,496–\$6,945 for whites, African Americans, and Asians, compared to \$5,481 for patients of other races. There is no wide variation in costs for non-LIS populations. >> Figure 6.17; see page 387 for analytical methods. *Period prevalent dialysis patients enrolled in Part D.*



Medicare Part D covers most medications taken by ESRD patients at home, while Medicare Part B covers those administered during dialysis (erythropoiesis stimulating agents, IV vitamin D, and so on) as well as immunosuppressive medications for patients with Medicare-covered transplants. In 2008, Medicare Part D costs for ESRD patients reached \$1.54 billion, while Medicare Part B costs were \$1.87 billion. >> **Figure 6.18**; see page 387 for analytical methods. *Period prevalent ESRD patients.*



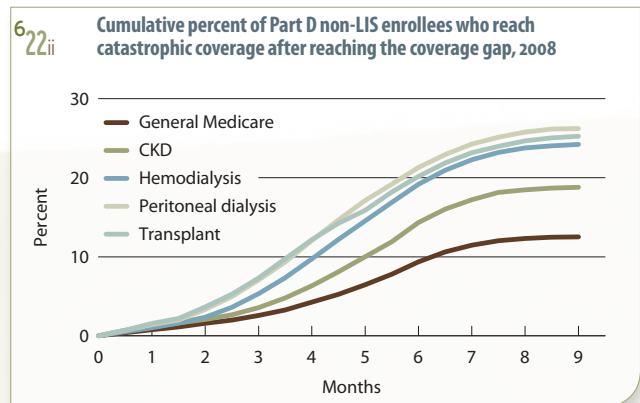
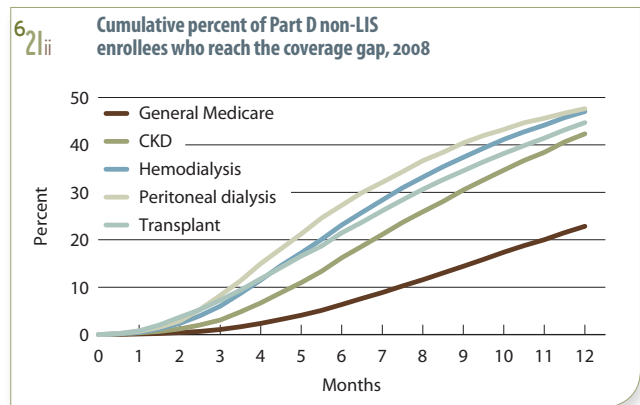
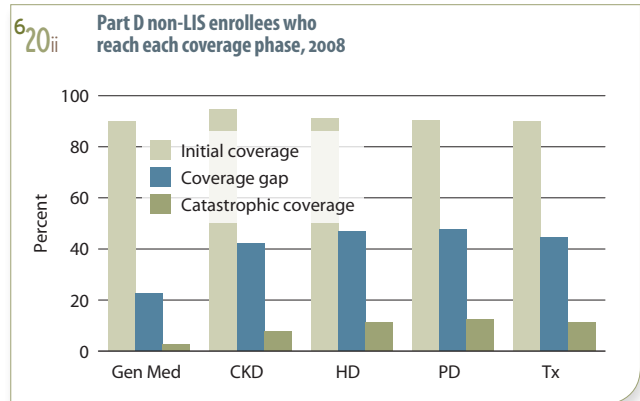
In 2008, hemodialysis patients with LIS benefits had combined Part B and Part D medication costs of \$14,536 per person per year. Regardless of LIS status, combined costs were greatest in hemodialysis patients.

Part B costs declined slightly between 2006 and 2008, most likely a result of lower ESA doses. Part D costs in dialysis patients, however, increased during this period, possibly reflecting shifting tier placement by prescription drug plans for some branded drugs. And in transplant patients, Part B and Part D costs were unstable, particularly from 2006 to 2007, which may reflect patient, pharmacy, and/or payor confusion over which program was paying for immunosuppressive medications as Medicare Part D was implemented in 2006. >> **Figure 6.19**; see page 387 for analytical methods. *Period prevalent ESRD patients.*

Part D enrollees who do not have the low income subsidy (LIS) may encounter three coverage phases, depending on total and out-of-pocket (OOP) costs per year. In 2008, patients with total Part D drug costs up to \$2,510 fell into the initial coverage phase, while those with costs over that amount entered the coverage gap (“donut hole”), in which they were responsible for 100 percent of drug costs. Patients whose total OOP costs reached \$4,050 then entered the catastrophic coverage phase, in which they paid only a fraction of overall drug costs.

In 2008, 42–48 percent of CKD, hemodialysis, peritoneal dialysis, and transplant patients reached the coverage gap, and 8–13 percent reached catastrophic coverage, compared to 23 and 3 percent, respectively, in the general Medicare population.

On average, peritoneal dialysis patients reach the coverage gap sooner than CKD or other ESRD patients, while general Medicare patients take the longest. Twenty-four to 26 percent of ESRD patients who reach the coverage gap will subsequently attain catastrophic coverage, compared to 19 percent in the CKD population, and 12.5 percent of general Medicare patients. ESRD and CKD patients thus reach catastrophic coverage much faster than do general Medicare patients. >> Figures 6.20–22; see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1, excluding those in employer-sponsored & national PACE Part D plans.*



6 D ii Twelve-month probability of reaching the coverage gap in Part D non-LIS enrollees, by modality, 2008			
	Hemodialysis	Peritoneal dialysis	Transplant
All	47.1	47.7	44.7
20-44	32.6	31.2	22.4
45-64	44.4	47.7	44.5
65-74	52.1	53.1	53.6
75+	46.6	46.5	47.3
Male	43.7	46.6	43.0
Female	52.0	49.1	47.6
White	49.4	50.3	46.5
African American	40.6	37.0	36.9
Asian	48.3	46.0	42.8
Other	42.8	38.1	39.2
Hispanic	40.6	42.2	40.1
Hypertension	47.4	48.7	46.0
CVD	47.3	49.8	53.8
Diabetes	49.6	51.4	56.2
Cancer	48.8	59.1	53.9
Fills per month in 2007			
<2 per month	24.3	28.1	21.7
2-<4	44.1	46.6	38.7
4-<6	59.6	56.2	52.4
6+	73.3	66.8	73.8

The twelve-month probability of non-LIS Part D enrollees reaching the coverage gap is 45–48 percent across ESRD modalities, but varies by demographic characteristic. Patients age 20–44, men, and African Americans are the least likely to reach the gap; by comorbidity, patients with diabetes reach it at a higher rate than do those with other diagnoses. Not surprisingly, the likelihood of reaching the gap rises with the number of prescription fills per month in the previous year. >> **Table 6.a**; see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1, excluding those in employer-sponsored & national PACE Part D plans.*

6 D ii Part D-covered prescription fills per person per month in Part D non-LIS enrollees, by modality, 2008			
	Hemodialysis	Peritoneal dialysis	Transplant
Patients who do not reach the coverage gap	2.41	2.58	2.55
Patients who reach coverage gap, but not catastrophic coverage			
During initial coverage period	4.74	4.63	5.43
During coverage gap	4.42	4.28	5.14
Patients who reach catastrophic coverage			
During initial coverage period	6.31	6.12	7.10
During coverage gap	6.70	6.39	7.48
During catastrophic coverage	7.44	7.46	8.03

Number, fill rate, and prescription cost influence whether patients stay in the initial coverage phase or progress to the coverage gap and then to catastrophic coverage. Among those who reach one of the latter two phases, transplant patients have the highest fill rate. Among those who reach the gap but do not get to catastrophic coverage, the fill rate declines once the gap is reached. This could be due either to a reduction in medication adherence or to a decision to obtain medications outside the Part D plan, and it is a pattern not seen in patients who reach catastrophic coverage. In these patients, the fill rate rises as each phase is reached. Patients with a higher number of Part D medications could be incentivized to fill prescriptions in order to reach this phase more quickly, as their out-of-pocket expenses then decrease dramatically. >> **Table 6.b**; see page 387 for analytical methods. *Point prevalent Medicare enrollees alive on January 1, excluding those in employer-sponsored & national PACE Part D plans.*

In 2008, cardiovascular and gastrointestinal medications, phosphate binders, insulin, and cinacalcet were the predominant drugs used in the dialysis population. Metoprolol, a beta blocker, continued to be the most frequently used drug, reflecting the extensive use of beta blockers for CHF and atrial fibrillation, and after myocardial infarction, PCI, and CABG. Sevelamer HCl was the predominant phosphate binder, and, at \$255 million, topped the list in terms of net Part D costs, with cinacalcet coming in at \$213 million. Costs for calcium acetate, insulin therapies, and lanthanum carbonate costs were each close to \$50 million.

Sevelamer carbonate represented 5.3 percent of sevelamer use in 2008. Together, costs for sevelamer hydrochloride and carbonate reached \$270 million — about 21 percent of the \$1.26 billion in Part D costs in the dialysis population. >> Table 6.c; see page 388 for analytical methods. *Part D claims for all dialysis patients, 2008.*

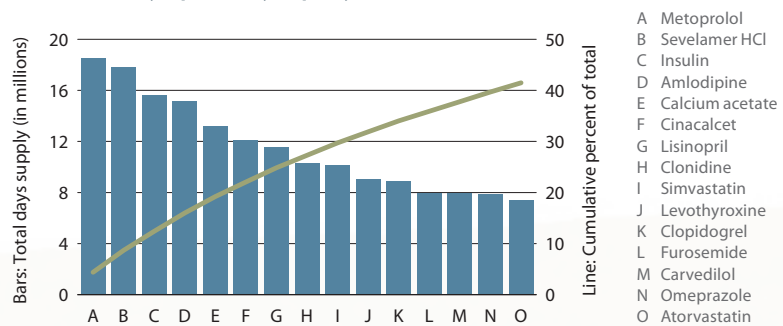
In 2008 hemodialysis patients, the top 15 medications (in terms of total days supply) accounted for nearly 42 percent of all Part D medications.

Sevelamer hydrochloride represented only 4.3 percent of total Part D drugs used in these patients, but accounted for 20.3 percent of their net Part D drug costs. Calcium acetate, in contrast, accounted for 3.1 percent of the medications and 4 percent of costs, demonstrating the stark contrast in costs to Medicare between use of a generic phosphate binding agent (calcium acetate) versus branded phosphate binding products (sevelamer hydrochloride or carbonate). Similarly, cinacalcet — available only in branded form — represented 2.9 percent of total Part D drugs used in 2008, but 16.9 percent of their costs. >> Figures 6.23–24; see page 388 for analytical methods. *Part D claims for all hemodialysis patients, 2008.*

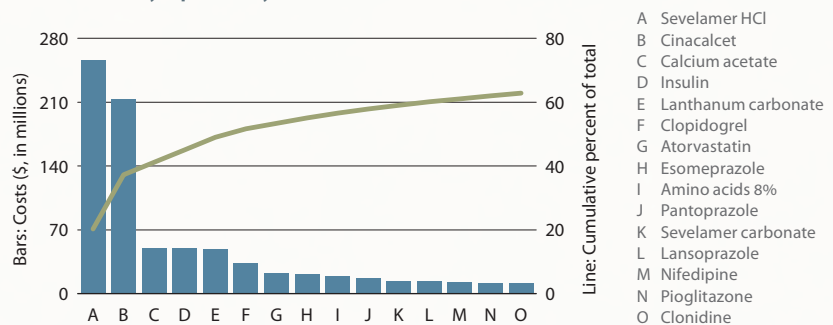
6 Cii Top 25 drugs used by Part D-enrolled dialysis patients, by frequency & net cost, 2008

By frequency Generic name	Total days supply	By net costs Generic name	Total days supply	Total cost (dollars)
Metoprolol	18,519,761	Sevelamer HCl	17,804,550	255,639,977
Sevelamer HCl	17,804,550	Cinacalcet	12,051,808	213,384,687
Insulin	15,630,838	Calcium acetate	13,198,502	49,785,847
Amlodipine	15,120,000	Insulin	15,630,838	49,270,601
Calciumacetate	13,198,502	Lanthanum carbonate	3,001,874	48,825,125
Cinacalcet	12,051,808	Clopidogrel	8,855,704	33,549,441
Lisinopril	11,575,329	Atorvastatin	7,398,132	21,884,604
Clonidine	10,286,086	Esomeprazole	4,254,689	20,854,548
Simvastatin	10,151,596	Amino acids 8%	231,171	18,831,418
Levothyroxine	9,014,532	Pantoprazole	5,442,180	17,187,145
Clopidogrel	8,855,704	Sevelamer carbonate	992,319	14,049,386
Furosemide	7,905,050	Lansoprazole	2,723,129	13,609,627
Carvedilol	7,897,755	Nifedipine	6,461,228	11,887,174
Omeprazole	7,875,290	Pioglitazone	2,332,897	11,483,495
Atorvastatin	7,398,132	Clonidine	10,286,086	10,971,889
Warfarin	7,157,863	Valsartan	4,377,843	10,503,139
Nifedipine	6,461,228	Omeprazole	7,875,290	8,586,724
Hydrocodone/acetaminophen	6,367,414	Amlodipine	15,120,000	8,129,829
Gabapentin	5,950,037	Oxycodone	1,140,867	8,008,673
Pantoprazole	5,442,180	Metoprolol	18,519,761	7,879,893
Hydralazine	4,673,601	Doxercalciferol	724,126	7,467,454
Zolpidem	4,465,733	Thalidomide	42,735	7,191,397
Valsartan	4,377,843	Fluticasone/salmeterol	1,221,841	7,182,088
Esomeprazole	4,254,689	Quetiapine	1,017,911	5,872,095
Metoclopramide	4,132,211	Simvastatin	10,151,596	5,794,211

6.23ii Top 15 drugs used by Part D-enrolled hemodialysis patients, by frequency, 2008



6.24ii Top 15 drugs used by Part D-enrolled hemodialysis patients, by cost, 2008

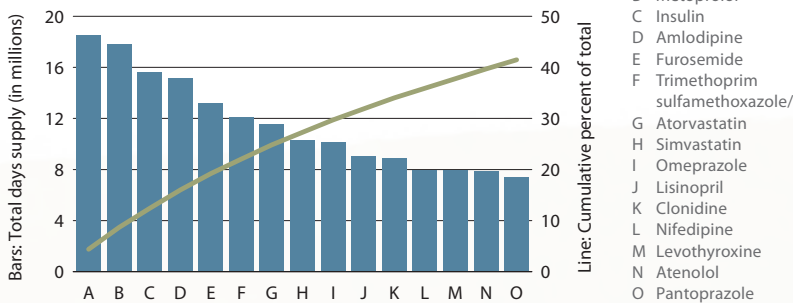


6dii

Top 25 drugs used by Part D-enrolled transplant patients, by frequency & net cost, 2008

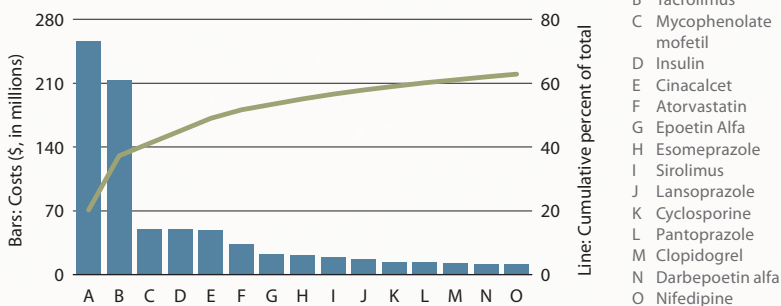
By frequency Generic name	Total days supply	By net costs Generic name	Total days supply	Total cost (dollars)
Prednisone	6,830,943	Valganciclovir	842,247	34,925,147
Metoprolol	5,972,951	Tacrolimus	1,403,900	21,935,093
Insulin	5,554,451	Mycophenolate mofetil	1,321,958	20,350,510
Amlodipine	4,119,216	Insulin	5,554,451	20,175,462
Furosemide	3,856,362	Cinacalcet	694,297	11,235,709
Trimethoprim/sulfamethoxazole	3,843,886	Atorvastatin	3,229,589	8,846,123
Atorvastatin	3,229,589	Epoetin alfa	236,674	7,172,394
Simvastatin	2,545,228	Esomeprazole	1,336,219	6,531,041
Omeprazole	2,427,009	Sirolimus	281,839	5,650,531
Lisinopril	2,392,100	Lansoprazole	966,799	4,984,923
Clonidine	2,283,255	Cyclosporine	974,249	4,839,859
Nifedipine	1,937,098	Pantoprazole	1,469,335	4,703,303
Levothyroxine	1,864,654	Clopidogrel	1,107,259	3,982,579
Atenolol	1,749,685	Darbepoetin alfa	74,900	3,451,173
Pantoprazole	1,469,335	Nifedipine	1,937,098	3,127,638
Calcitriol	1,429,963	Mycophenolate sodium	216,435	2,869,074
Allopurinol	1,423,202	Pioglitazone	578,779	2,763,435
Tacrolimus	1,403,900	Omeprazole	2,427,009	2,460,936
Warfarin	1,340,296	Tamsulosin HCl	943,147	2,347,391
Esomeprazole	1,336,219	Metoprolol	5,972,951	2,265,657
Famotidine	1,318,865	Oxycodone	314,366	2,213,325
Alendronate sodium	1,164,793	Clonidine	2,283,255	2,131,198
Potassium chloride	1,131,872	Amlodipine	4,119,216	2,104,311
Clopidogrel	1,107,259	Ezetimibe	814,814	1,955,440
Ranitidine	1,080,357	Losartan	987,860	1,736,504

6.25ii

Top 15 drugs used by Part D-enrolled transplant patients, by frequency, 2008


A Prednisone
B Metoprolol
C Insulin
D Amlodipine
E Furosemide
F Trimethoprim sulfamethoxazole/
G Atorvastatin
H Simvastatin
I Omeprazole
J Lisinopril
K Clonidine
L Nifedipine
M Levothyroxine
N Atenolol
O Pantoprazole

6.26ii

Top 15 drugs used by Part D-enrolled transplant patients, by cost, 2008


A Valganciclovir hydrochloride
B Tacrolimus
C Mycophenolate mofetil
D Insulin
E Cinacalcet
F Atorvastatin
G Epoetin Alfa
H Esomeprazole
I Sirolimus
J Lansoprazole
K Cyclosporine
L Pantoprazole
M Clopidogrel
N Darbepoetin alfa
O Nifedipine

Among transplant patients, prednisone (a generic immunosuppressant) was the most frequently used medication in 2008, followed by metoprolol and insulin. Trimethoprim-sulfamethoxazole, used for prophylaxis against *pneumocystis carinii* pneumonia, was sixth on the list. Except for tacrolimus, no trade name immunosuppressant made the top 25 list in terms of frequency, not surprising given that most are covered under Medicare Part B. Valganciclovir, which is used for prophylaxis against cytomegalovirus and does not have an available generic, topped the list by cost, though not by frequency. The immunosuppressants tacrolimus, mycophenolate mofetil, sirolimus, cyclosporine, and mycophenolate sodium do appear on the list by cost, implying that their costs are relatively higher than the frequency of their use. >> Table 6.d; see page 388 for analytical methods. *Part D claims for all transplant patients, 2008.*

Together, valganciclovir and tacrolimus represented 20 percent of all Part D drug costs for 2008 kidney transplant patients. Insulin therapies accounted for 4.7 percent of Part D medication use, but 7.1 percent of Part D costs; several new therapies continued under patent in 2008. Epoetin alfa and darbepoetin alfa, trade name products not among the most frequently used medications, were among those with the greatest cost, together accounting for 3.7 percent of Part D net costs among transplant patients. >> Figures 6.25–26; see page 388 for analytical methods. *Part D claims for all transplant patients, 2008.*

Patients enrolled in Medicare Part D, 2008

GENERAL MEDICARE

» 59% (FIG 6.4)

INCIDENT ESRD

» HEMODIALYSIS 64% » PERITONEAL DIALYSIS 50% » TRANSPLANT 30% (FIG 6.4)

PREVALENT ESRD

» HEMODIALYSIS 72% » PERITONEAL DIALYSIS 61% » TRANSPLANT 53% (FIG 6.5)

Medicare Part D enrollees with low income subsidy, 2008

» GENERAL MEDICARE 38% » HEMODIALYSIS 74% » PERITONEAL DIALYSIS 64% » TRANSPLANT 64% (FIG 6.7)

total estimated Medicare Part D net payment for enrollees, 2008

» HEMODIALYSIS \$1.18 BILLION » PERITONEAL DIALYSIS \$78 MILLION » TRANSPLANT \$284 MILLION (FIG 6.14)

per person per year Medicare Part D costs for enrollees, 2008

MEDICARE COSTS

» HEMODIALYSIS \$5,397 » PERITONEAL DIALYSIS \$5,537 » TRANSPLANT \$4,961 (FIG 6.15)

OUT-OF-POCKET COSTS

» HEMODIALYSIS \$456 » PERITONEAL DIALYSIS \$646 » TRANSPLANT \$575 (FIG 6.15)

per person per year Medicare Part D costs for enrollees, 2008

PATIENTS WITH LOW INCOME SUBSIDY

» HEMODIALYSIS \$6,645 » PERITONEAL DIALYSIS \$7,334 » TRANSPLANT \$6,553 (FIG 6.16)

PATIENTS WITH NO LOW INCOME SUBSIDY

» HEMODIALYSIS \$2,028 » PERITONEAL DIALYSIS \$2,341 » TRANSPLANT \$2,083 (FIG 6.16)

Part D non-LIS enrollees who reach the coverage gap, 2008

AT 12 MONTHS

» GENERAL MEDICARE 23% » HEMODIALYSIS 47% » PERITONEAL DIALYSIS 48% » TRANSPLANT 45% (FIG 6.21)

Part D non-LIS enrollees who reach catastrophic coverage after reaching the coverage gap, 2008

AT 9 MONTHS

» GENERAL MEDICARE 13% » HEMODIALYSIS 24% » PERITONEAL DIALYSIS 26% » TRANSPLANT 25% (FIG 6.22)

terms used in the Part D analyses

Low income subsidy (LIS) For Medicare beneficiaries with limited income and/or assets, the costs of participation in Medicare Part D may be reduced by the LIS. Beneficiaries who are dually eligible for Medicare and Medicaid are automatically granted the LIS, while beneficiaries who are not dually eligible may apply for it. While the LIS may take eight different levels, with monthly premiums and copayments either eliminated or reduced, all dually eligible beneficiaries pay no monthly premiums.

Creditable coverage Prescription drug coverage that is actuarially equivalent to the standard Part D benefit, as defined annually by CMS. Beneficiaries with creditable coverage may forgo participation in Medicare Part D without having to pay increased monthly premiums upon future enrollment. Examples of creditable coverage include the Federal Employee Health Benefits Program, TRICARE, VA Health Care Benefits, State Pharmacy Assistance Programs (SPAPs), and private insurance that is eligible for the retiree drug subsidy. Private insurance for the working aged may or may not be creditable.

Retiree drug subsidy (RDS) A program designed to encourage employers to continue to provide prescription drug coverage to retirees eligible for Medicare Part D. Under the program, employers receive a tax-free rebate equal to 28 percent of covered prescription drug costs incurred by their retirees. The program is relatively simple to administer, but may ultimately be more costly than providing employees a type of Part D plan known as an "employer group waiver plan." Following passage of the Patient Protection and Affordable Care Act, the tax-free status of the subsidy is due to expire on December 31, 2012.

Fills per person Each prescription drug purchase constitutes a fill. Fills per person are calculated from the quotient of cumulative fills in a population and the number of people in that population.

Total days supply Each prescription drug is disbursed with sufficient quantity to administer for a set number of days, so long as instructions are followed (i.e., so long as adherence is perfect). Total days supplied equals the cumulative number of days supplied through all fills of a particular medication in a population.

Deductible At the beginning of each calendar year, each non-LIS Part D enrollee is responsible for 100 percent of gross drug costs up to a set amount (i.e., the deductible), at which point cost sharing begins. In the standard benefit, the deductible was \$250, \$265, and \$275 in 2006, 2007, and 2008, respectively.

Initial coverage period The interval following the deductible phase, but preceding the coverage gap. During this time, the Part D enrollee without the LIS is normally responsible for 25 percent of gross drug costs (in the standard benefit).

Coverage gap The interval following the initial coverage period, but preceding catastrophic coverage. During this time, non-LIS Part D enrollees are normally responsible for 100 percent of gross drug costs (in the standard benefit). In 2010, the Affordable Health Care Act made several changes to Medicare Part D to reduce the effect of the coverage gap, so that it phases out by 2020. In 2010, non-LIS enrollees received a \$250 rebate from Medicare to partially cover costs during the coverage gap. In 2011, non-LIS enrollees were given a 50 percent discount on the total price of brand name drugs and a 7 percent reduction in cost of generic medications while in the gap.

Catastrophic coverage The interval following the coverage gap. During this time, the Part D enrollee without the LIS is normally responsible for 5 percent of gross drug costs (in the standard benefit).

Medicare Advantage Part D plans (MA-PDs) Medicare Part D plans that are offered only to participants in Medicare Part C.