


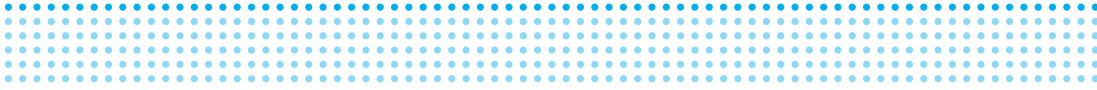
*IMS  
Special  
Report*

# Medicare Part D: The First Year





The introduction of the Medicare Part D benefit on January 1, 2006, was a watershed event in U.S. healthcare. Not since the introduction of Medicare in 1965 had such a far-reaching social program been provided to a potential population of almost 30 million people. While 2006 was very much an inaugural year for the program, looking at the first year in retrospect provides useful early indicators on the impact of this program on Medicare beneficiaries, as well as other healthcare stakeholders.



IMS  
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## Executive Summary: *A Turning Point in U.S. Healthcare*

Launched at the outset of 2006, Medicare Part D provides seniors and the disabled with the first prescription drug benefit ever offered under the Medicare program. Going into the year, uncertainty about the program prevailed. Policy makers, health plans, pharmaceutical manufacturers, providers, payers and the public pondered a variety of questions: How many beneficiaries would enroll? How would the coverage gap impact beneficiary behavior? How many employers would drop coverage for senior retirees? How would insurers compete for Part D business? And, importantly, how much would the program cost?

More broadly, there also was concern about the federal government's ability to attain "value" from its expenditure on this program—with value being measured by incremental health benefits for seniors.

Recognizing the program's impact on the overall U.S. healthcare landscape, IMS® expanded its industry-leading prescription/health plan database to incorporate Medicare Part D insights. The database—which currently covers more than 5,400 commercial and Medicare plans, and offers 80% Medicare Part D plan-level granularity—offers the most comprehensive view available of U.S. prescription activity by plan type.

*In this report, IMS presents an evidence-based perspective on the first year of the Medicare Part D program and its impact on pharmaceutical usage. Our report is based on an analysis of our prescription and anonymized patient- and plan-level information by IMS consultants who have extensive experience helping industry stakeholders understand the effect of Medicare Part D. We are pleased to share our perspectives and improve understanding of this critical topic.*



## Key Study Findings

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In developing our *Medicare Part D: The First Year* report, we examined the impact of Part D on key issues such as access to therapy, out-of-pocket spending, rates of compliance and persistency, generic drug usage and the coverage gap caused by beneficiaries reaching their initial coverage limit.

After one year, more than three-quarters of expected enrollees joined a Part D plan, or 23.9 million of the 29.3 million anticipated by The Centers for Medicare & Medicaid Services (CMS). Only a quarter of employers dropped coverage for senior retirees. Insurers vigorously pursued Part D business, and the total program cost was slightly less than expected.<sup>1</sup>

Surveys of beneficiaries showed a positive impression of the program and increasing satisfaction with Part D throughout 2006.<sup>2</sup> CMS declared the program a success and continued efforts to reach the approximately 3 million low-income beneficiaries who were still not enrolled.<sup>3</sup>


Our leading takeaways from the 2006 experience are that:

- More than half, 58%, of Part D beneficiaries previously held some private drug coverage, while 14% previously paid for therapies totally out-of-pocket. Almost a quarter, 24%, had previously received coverage under Medicaid.
- The previously uninsured benefited the most from Part D, saving 60% of their previous cost and increasing their utilization of pharmaceuticals by 26%.
- Induced demand—a measure of new patient starts and improved compliance resulting from Part D—was highest among non-dual-eligible beneficiaries (those

eligible for both Medicare and Medicaid) and highest in classes that treat chronic and asymptomatic conditions.

- Among Medicare beneficiaries over the age of 65 who did not have drug coverage in 2005, a quarter joined a Part D plan in 2006. Over half, 55%, continued with no drug coverage.

While it was surprising that only a quarter of eligible cash-paying patients enrolled and filled scripts in a Part D plan, one explanation is that this population contains relatively ‘healthy seniors,’ who simply do not need chronic medications.



- The coverage gap had limited impact on beneficiaries, with approximately 6% of beneficiaries entering the “donut hole” after reaching their initial coverage limit. Of that group, 45% did not enter until the last quarter of 2006, and many of them did not enter the gap until the last days of 2006. Most of those who entered the gap early in the year spent out-of-pocket at the same or faster rate, reaching catastrophic coverage as quickly as possible.

1 CMS press release, July 11, 2006, <http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1895>

2 Kaiser Family Foundation and Harvard School of Public Health survey, November 2006, <http://www.kff.org/kaiserpolls/upload/7604.pdf>

3 CMS press release, January 30, 2007, [http://www.cms.hhs.gov/apps/media/press\\_releases.asp](http://www.cms.hhs.gov/apps/media/press_releases.asp)

# Beneficiary Dynamics

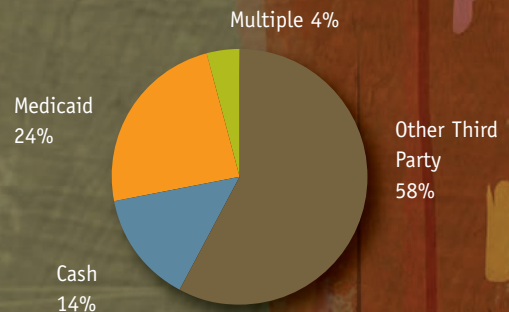
The largest group of Part D patients, 58%, moved into Part D after having some other kind of private drug coverage, or third-party coverage, in 2005. Another 24% of Part D patients had been covered by Medicaid in 2005, and 14% of Part D patients in 2006 did not have drug coverage in 2005 and paid for their medicines totally out-of-pocket.

Therefore, the Part D program provided about 3.4 million seniors with drug coverage they did not have in the prior year. The 20.5 million other Part D program beneficiaries had received some form of third-party or Medicaid coverage previously.

A quarter of seniors paying for pharmaceuticals totally out-of-pocket in 2005 moved to Part D in 2006, but another 55% continued to pay cash. This group of about 7.4 million seniors include those who may have decided that participating in this program did not make financial sense. Also in the mix were low-income seniors who were not able to be reached by the awareness-building and enrollment program conducted by CMS during late 2005 and into the first half of 2006.

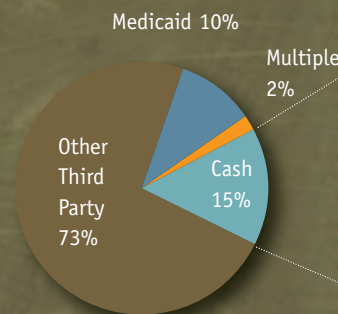
## MORE THAN HALF OF PATIENTS IN PART D SWITCHED FROM OTHER PRIVATE COVERAGE

Percent of patients with Part D activity in 2006 by former payment type

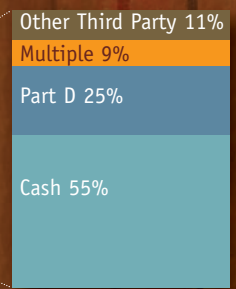


## A QUARTER OF SENIORS PAYING CASH IN 2005 MOVED TO PART D IN 2006

METHOD OF PAYMENT Patients age 65+ 2005



METHOD OF PAYMENT Patients age 65+ 2006



Source: IMS Health, Medicare Part D Analysis, 2007

# Prescription Drug Usage

Medicare Part D plan enrollees filled approximately 486 million prescriptions during the course of 2006. This represents almost 15% of the total retail prescriptions filled in the year.

Of this total, 122 million of the prescriptions were for drugs that treat hypertension—including ACE inhibitors, angiotensin II antagonists, alpha blockers, calcium blockers and diuretics. The second largest group of drugs received through Part D were lipid regulators, accounting for 7.4% of all prescriptions dispensed, or about 36 million prescriptions. The next-largest therapy class was antidepressants, with 25 million prescriptions filled under Part D plans. Other therapy areas with more than 20 million prescriptions filled were for the treatment of diabetes, pain and anti-ulcerants.

Medicare Part D drove utilization across most chronic therapeutic classes observed, with the greatest induced demand in the proton pump inhibitor (PPI) market, where making the switch from over-the-counter drugs made economic sense for beneficiaries.

LEADING THERAPY CLASSES BY PART D PRESCRIPTIONS

	Volume of Part D prescriptions, millions	Share of Part D prescriptions
1 Antihypertensives	122.0	25.0
2 Lipid Regulators	36.0	7.4
3 Antidepressants	25.0	5.1
4 Diabetes, Non-Insulin	24.1	5.0
5 Analgesic, Narcotic	24.0	4.9
6 Anti-ulcerants	20.3	4.2
7 Anti-infectives, Broad	14.8	3.0
8 Thyroid Hormones	14.5	3.0
9 Antithrombotics	14.4	2.9
10 Seizure Disorders	12.0	2.5
<b>Top ten total</b>	<b>307.1</b>	<b>63.0</b>

Source: IMS Health, Medicare Part D Analysis, 2007

Drug usage patterns were broadly in line with the rest of the population, and more particularly with the 65 years and older patient cohort. However, antihypertensives in particular took a disproportionate share of prescriptions, accounting for 25% of Part D prescriptions compared to 15.3% of non-Part D

retail prescriptions. Lipid regulators and anti-diabetics also represented more than 2% higher share of the Part D prescriptions. This skew in the types of prescription drugs dispensed likely reflects the age of the Part D patients as well as increased access by patients with asymptomatic conditions.



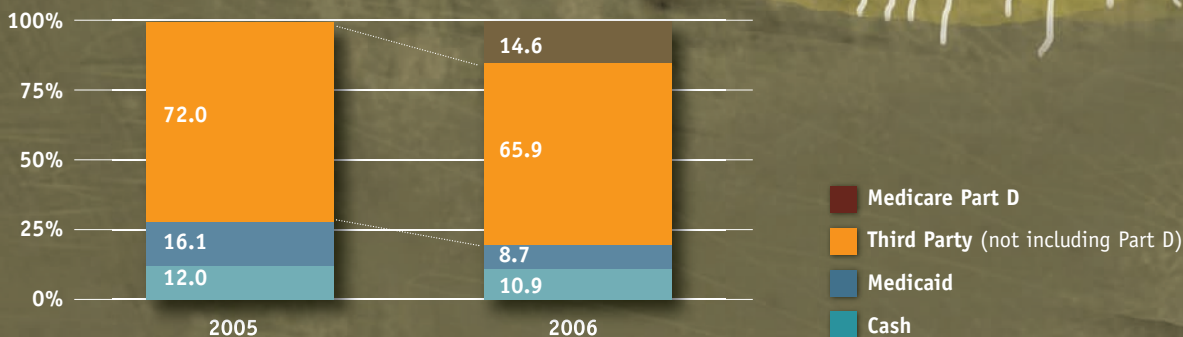
Of the 14.6% of retail scripts dispensed through Part D plans, former Medicaid-reimbursed scripts accounted for 7.4 points—or 246 million prescriptions—reflecting the movement of dual eligibles. Another 6.1 points (203 million prescriptions) shifted from private insurance reimbursement in 2005. The remaining 37 million prescriptions filled under Part D (1.1 points) would

have been paid solely out-of-pocket or without any insurance coverage.

The uptake of Part D prescription volume increased steadily through June as enrollment continued and patients grew familiar with the program. During the second half of the year, the Part D share of the retail market stabilized at 17%.

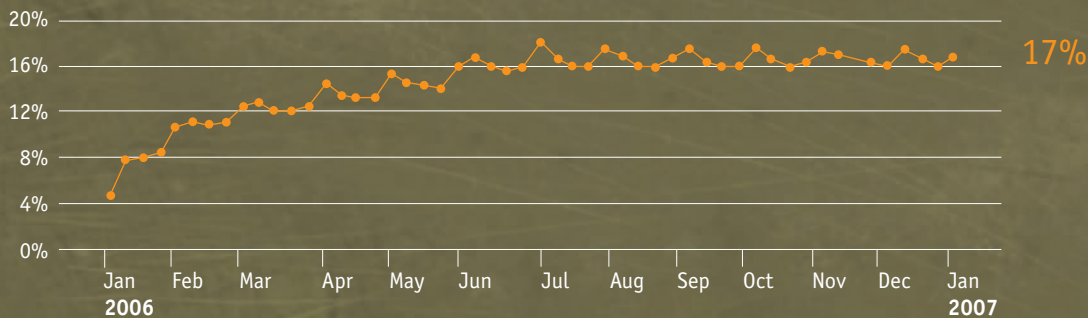
#### SHIFT TO PART D FROM THIRD PARTY, MEDICAID, AND CASH PAYMENT TYPES

% Dispensed retail TRx by payment type



#### PART D RXs STABILIZED AT 17% OF U.S. RETAIL RXs BY MID-YEAR

Part D reimbursed share of retail

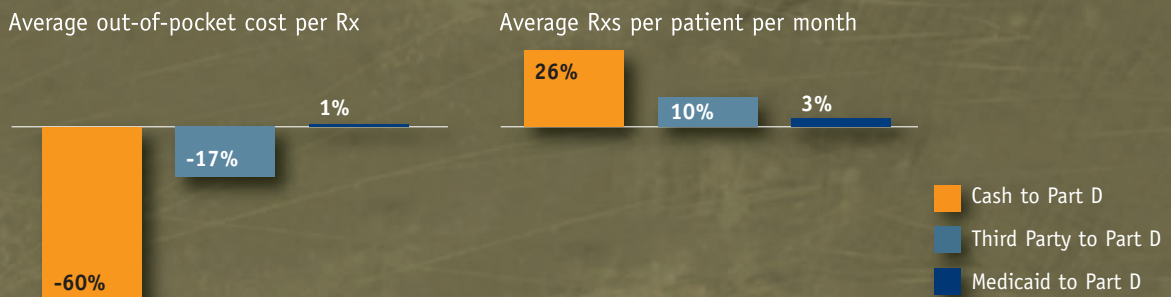


Source: IMS Health, Medicare Part D Analysis, 2007

# Program Impact on Beneficiaries

Among Part D beneficiaries, seniors previously uninsured realized the greatest benefit, paying on average 60% per Rx less than they did in the prior year for their prescriptions.

WHERE OUT-OF-POCKET COSTS WERE REDUCED, HIGHER UTILIZATION OCCURRED IN PATIENTS AGE 65+: 2006 VS. 2005



PART D INDUCED DEMAND WAS POSITIVE FOR SOME LARGE CHRONIC CONDITIONS WITH LOWER EXPOSURE TO DUAL-ELIGIBLES

	% of Part D enrollees among eligible patients	Incremental new to market	Increase in compliance	Induced demand
1 Angiotensin II Antagonists	49%	1.5%	2.4%	3.9%
2 Antipsychotics	71%	(15.3%)	5.9%	(9.4%)
3 Oral Antidiabetics	54%	(7.7%)	(0.1%)	(7.8%)
4 PPIs	50%	2.7%	2.3%	5.0%
5 Statins	50%	5.5%	1.5%	7.0%

Source: IMS Health, Medicare Part D Analysis, 2007

Seniors who previously had third-party coverage paid on average 17% less for their Rx's compared to the prior year, and filled about 10% more Rx's than in 2005. Dual-eligibles were essentially unchanged in their average cost and use of prescription drugs, consistent with the design of the Part D program.

Many Part D beneficiaries appear to have changed their usage patterns of prescriptions drugs compared to the prior year—measured by the number of new therapy starts, changes in compliance levels, and net switching activity.

This change is mostly confined to those other than former Medicaid beneficiaries, and differed by therapy class.

Patient use of PPIs increased by 2.7% as a result of incremental new patients starting therapy. Similarly, prescriptions for angiotensin II antagonists increased by 1.5% due to new therapy starts, and a further 2.4% due to improved compliance. The long-term health effects of increased patients starting and continuing therapy for these conditions has yet to be assessed, but will potentially yield the real value of the introduction of the Part D benefit.

# Effect of the Coverage Gap

The absence of coverage in the “donut hole,” or coverage gap, affected an estimated 6% of Part D patients. Low-income and dual-eligible beneficiaries—61% of enrollees—were not subject to the rule, and 33% simply did not

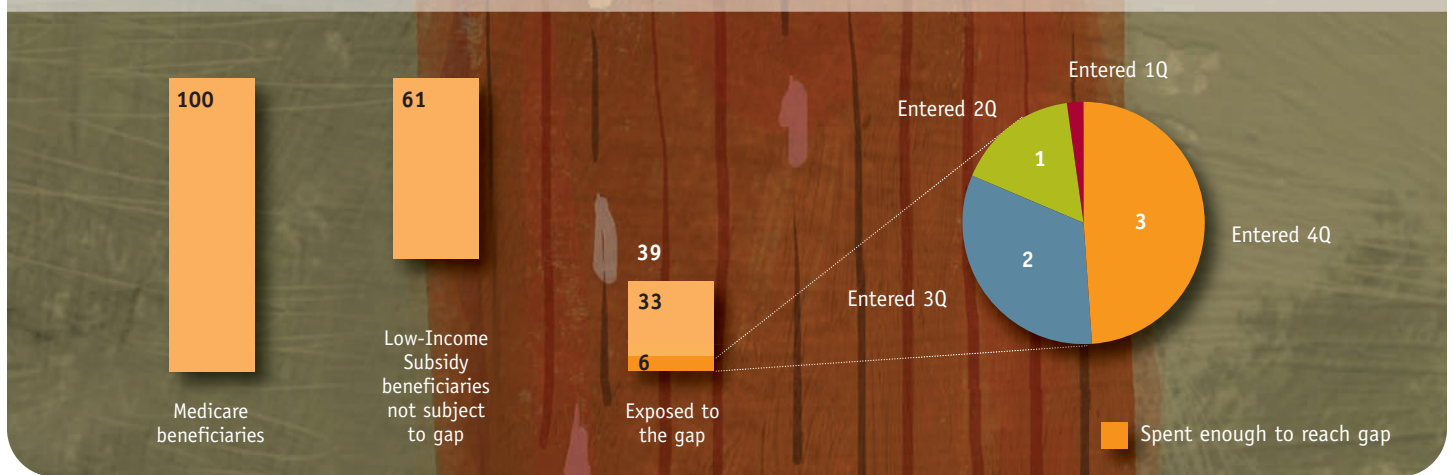
Our extensive research on 12 therapeutic classes found that the relatively few patients who reached the ‘donut hole’ largely remained on their therapies after losing coverage.

require more than \$2,250 in drug spending over the year and, therefore, never reached the coverage gap.

A sizable portion of the 3% who entered the gap in the last quarter of the year did so in the final days of the year, which could reflect careful management of out-of-pocket spending. Of those who reached the gap earlier in the year—in the first, second, or third quarters—many kept spending at the same or a quicker pace in order to move through the gap as quickly as possible.

A major concern at the beginning of 2006 was the impact the coverage gap would have on adherence. A study of 14 large brands for chronic conditions found that between 14-25% of patients dropped their medications upon reaching the gap.

SIX PERCENT OF MEDICARE BENEFICIARIES ENTERED THE COVERAGE GAP IN 2006



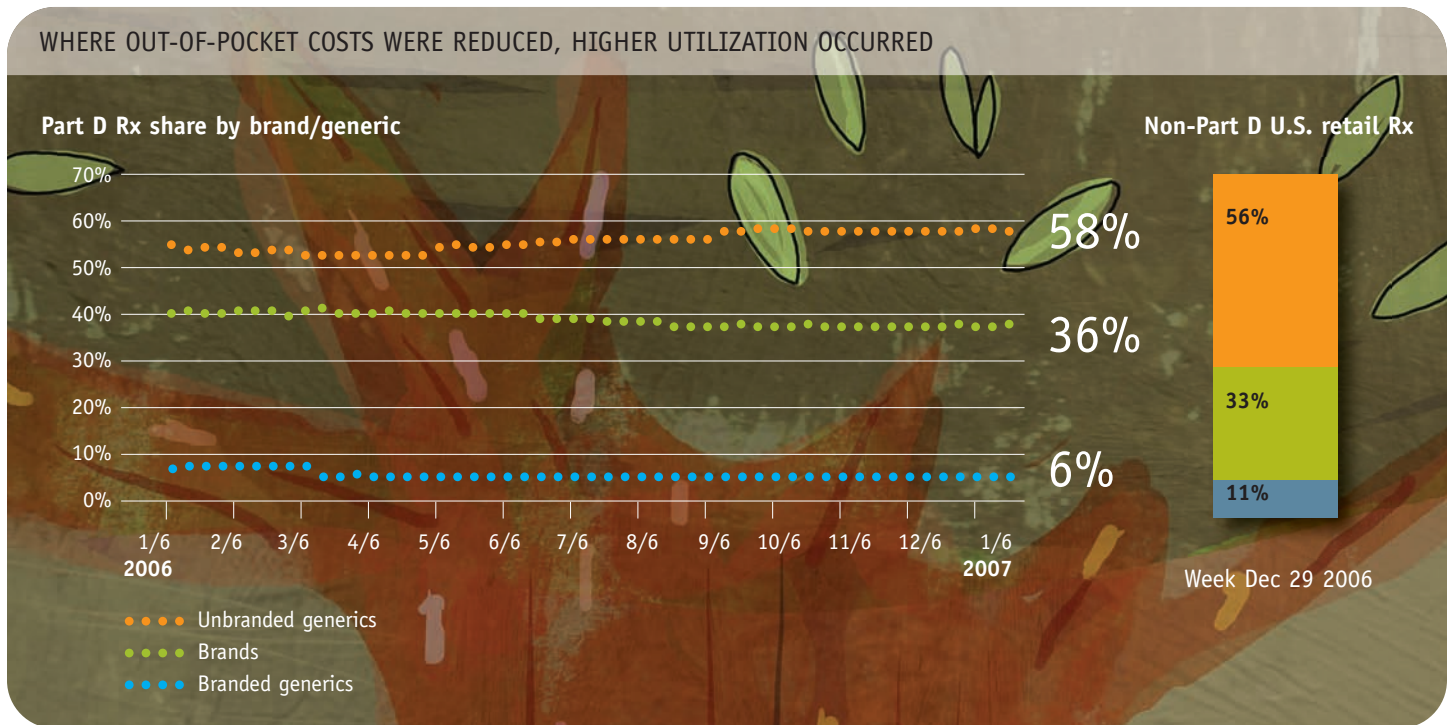
Source: IMS Health, Medicare Part D Analysis, 2007

# Use of Generic Drugs

## Generic utilization in Part D was slightly above the rest of the retail marketplace.

By the final week of 2006, unbranded generic share of Part D scripts was 58%, compared to a 57% share among total retail prescriptions. Brand share of Part D scripts was 36% by year-end, slightly higher than the 34% brand share

recorded for all retail prescriptions. Branded generics held a smaller share among Part D scripts—6% versus 10% among all retail prescriptions.



Source: IMS Health, Medicare Part D Analysis, 2007



# Looking Ahead

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The Part D experience in 2006 was largely positive. Enrollment came in at a reasonably high level, and most enrollees appear satisfied. While 2007 should produce more of the same—with CMS formulary guidance essentially unchanged from 2006—the future depends on a number of factors: demands on the treasury, potential payer actions, enrollment decisions of the 4-5 million eligibles not yet enrolled, and the more than 2 million new Medicare beneficiaries entering the system each year.

This first year of Part D is only the beginning for pharmaceutical companies and, in all likelihood, 2006-07 will be golden years for enrollees and branded pharmaceutical companies alike.

Longer term, we foresee bumps in the road that may lead plan sponsors to increase their level of control over escalating costs, or allow beneficiaries to experience pricing differentials more directly. Moreover, from 2008 onward, we anticipate that systematic methods of managing access and uptake—be it through quasi-consumerism, utilization management, or a reliance on dramatically superior clinical outcomes to prove cost-effectiveness—will challenge current thinking. Pharmaceutical companies will need to re-evaluate their orientation toward innovation, strategies for launch and brand management, and approaches to physician and consumer education.<sup>1</sup>

<sup>1</sup> IMS Report, "The Long and Winding Road Ahead: Medicare Part D," by Jon Resnick, Jan. 2006. To access a copy, please visit the IMS Press Room at [www.imshealth.com](http://www.imshealth.com).

## IMS®: Helping Healthcare Stakeholders Understand and Operate in the Medicare Marketplace

IMS has the insights and expertise to help health care stakeholders make the best-informed decisions about operating in the new Medicare Part D environment. With 80% Medicare Part D granularity, we are the most comprehensive, trusted resource for assessing influence, allocating resources and measuring performance under Medicare Part D.

We help stakeholders clarify not only *what* is happening in the Medicare and managed care markets, but also *why* it's happening. Our consultants combine their deep subject knowledge of the Medicare program with hands-on experience in areas like reimbursement strategies, market analytics and therapy utilization to help stakeholders make evidence-based decisions.

Among the many applications we support through our unique combination of information, analytics and consulting are:

- Determining the potential of products in development
- Product forecasting
- Assessing the impact of formulary status and positioning
- Negotiating and administering managed care contracts
- Choosing the right strategies to meet program goals

By incorporating our leading anonymized patient-level data assets, we help stakeholders understand patient dynamics across deductible levels and coverage tiers, as well as around and through the "donut hole." We also use these insights to help health care stakeholders develop strategies, policies and approaches based on patient compliance, persistency and consumption trends.

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**ABOUT IMS**

Operating in more than 100 countries, with \$2 billion in 2006 revenue, IMS provides clients with evidence-based, customized intelligence about the pharmaceutical and healthcare markets—delivering critical information, analytics and consulting that drive superior client business strategies, decisions and results.

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