**HEALTH CARE POLICY AND LAW**

**Favorable Formulary Placement of Branded Drugs in Medicare Prescription Drug Plans When Generics Are Available**

In the Medicare Part D program, the potential of generic drugs to achieve savings is underused. One reason is that prescription drug plans earn some of their profits through rebates and other price concessions paid by pharmaceutical manufacturers (Medicare calls this direct and indirect remuneration). Although the goal of prescription drug plans is to provide cost-effective drug management, the Medicare program has raised concerns that the remuneration structure creates an incentive for plans to prefer higher-priced drugs instead of less expensive alternatives, because manufacturers of higher-priced drugs may offer greater price concessions.¹

**Methods** | We examined the 57 unique drug formularies offered across all 750 Medicare Part D standalone prescription drug plans in November 2016² to determine how often branded products were given more favorable formulary placement than generic products. We defined favorable placement as the placement of a branded product in a lower cost-sharing tier or when a branded product had fewer utilization controls (ie, prior authorization, step therapy, or quantity limits) than its corresponding generic product. We analyzed drugs for which both generic and branded products were available³ (hereafter called multisource drugs) and examined the lowest strength per drug when multiple strengths were available. We compared drug prices by dividing the mean cost per unit of the branded products by the mean cost per unit of the corresponding generic products in 2016 Medicare Part D claims data.⁴ Because of the confidentiality of price concessions, this approach may have overestimated the difference in price between branded and generic products. The human participants research policy of the Johns Hopkins Institutional Review Board determined that this study did not require approval because it did not involve human participants research.

**Results** | The 57 formularies covered, on average, 1657 different drugs, of which 935 were multisource. A total of 120 multisource drugs (12.8%) did not have generic products covered in any formulary. A total of 41 of the 57 formularies (72%) placed at least 1 branded product in a lower cost-sharing tier than its generic product, and all formularies had at least 1 multisource drug covered without a generic product. In addition, 17 of the 57 formularies (30%) adopted fewer utilization controls on the branded product for at least 1 drug.

We also examined 222 multisource drugs that were covered in all formularies and had branded and generic products covered in at least 1 formulary. A total of 11 of these drugs (5.0%) had branded products more frequently placed in a lower cost-sharing tier than the corresponding generic products, and 67 drugs (30.2%) had less frequent utilization controls imposed on branded products than on generic products (Figure).

Based on the Medicare claims data, we also found that, among these 222 multisource drugs, the price of the branded product was a median of 3.9 times higher than that of the generic product (interquartile range, 1.7-12.5).

**Discussion** | We found that 72% of Part D formularies had a lower cost-sharing tier and 30% of Part D formularies had fewer utilization controls on branded products for at least 1 multisource drug. Among 222 multisource drugs covered by all formularies, 5.0% had a lower cost-sharing tier and 30.2% had fewer utilization controls on branded products. For a generic product priced at $1, the median price of its branded option was $3.90. This difference is important for beneficiaries because the drug price often determines their cost sharing.

Favorable formulary placement of branded drugs encourages the use of more expensive products and can lead to higher out-of-pocket costs for Medicare beneficiaries and higher expenditures for the Part D program.⁵ One option is for Medicare to prohibit giving branded products a more favorable formulary placement than generic products. An alternative is to change the incentive structure of Part D plans, as intended by the proposal by the Department of Health and Human Services to remove the “safe-harbor” provision that allows manufacturer rebates to be paid without triggering the federal anti-kickback statute.⁶ It is important for policy makers to recognize that manufacturers could restructure payments to drug plans as nonrebate items to avoid this restriction.

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Factors Associated With Receipt of Training Among Caregivers of Older Adults

Nearly 18 million family and unpaid caregivers assist older American individuals with disabilities.1-3 Caregivers are a crucial source of care for older adults with disabilities and complex care needs but often report feeling unprepared and poorly supported in their caregiving role.1 Emerging evidence suggests that support of family caregivers, including education and training, can improve health outcomes for caregivers and care recipients.1,3 However, to our knowledge, no previous work has examined whether caregiver characteristics are associated with receipt of training.

Methods | We used data from the 2015 National Health and Aging Trends Study (NHATS), a nationally representative survey of Medicare beneficiaries 65 years and older, and the linked National Survey of Caregivers (NSOC), a companion survey administered to family and unpaid caregivers identified by NHATS participants.4 This study includes 1861 family caregivers of 1230 NHATS study participants who were living in traditional community settings and receiving help with daily activities related to self-care, mobility, and household activities for health and function reasons.

Receipt of training was measured as a binary indicator from affirmative responses to the NSOC question, “In the last year, have you received any training to help you take care of [care recipient]?” Multivariable logistic regression was used to assess the association between older adult and caregiver characteristics and receipt of training; we adjusted for a range of older adult, caregiver, and caregiving relationship characteristics that were posited to affect receipt of training. Analyses were performed using Stata, version 14 (StataCorp) and included survey weights and design variables that account for the complex survey design of the NHATS and NSOC. The P value level of significance was .05, and all P values were 2-sided.

Results | Among the 1861 caregivers included in our sample, 1241 (66.3%) are female and the mean age was 60.2 years; among 1230 older adults included in our sample, 825 (67.1%) are female and the mean age was 81.8 years. Our analysis found that 7.3% of family and unpaid caregivers reported receiving training related to their caregiving role (1.3 million of 17.9 million in a weighted estimate). In the weighted, adjusted regression model, caregivers assisting older adults who had been hospitalized in the prior year were twice as likely to receive training (adjusted odds ratio [aOR], 1.97; 95% CI, 1.27-3.06; P = .003) as those assisting older adults who had not been hospitalized. Caregivers who were paid were 4 times more likely to receive training (aOR, 4.40; 95% CI, 1.94-9.98; P = .001). Caregivers of white older adults were less likely to receive training (aOR, 0.61; 95% CI, 0.39-0.96; P = .03) (Table).

Discussion | We found that 93% of older adults’ family caregivers did not report receiving role-related training. Neither older adults’ health status, caregiver burden, nor assisting with health care tasks were significantly associated with training. This work is subject to several limitations; we cannot provide causal inferences given the use of cross-sectional data. We are unable to comment on the mode, frequency, or quality of training or the extent to which training affects caregiving capacity. Nevertheless, results indicate that few family caregivers receive role-related training and that access to training is not significantly associated with caregiver or older adult needs.

Low levels of caregiver training are a missed opportunity for the health care system. Prior work suggests that training to better prepare family caregivers may improve health and reduce service utilization for those they assist.1,3 The emerging model of a learning health system,5 together with developing consensus that clinicians and caregivers must be partners in care,6 suggests benefits may accrue to integrated health systems that incorporate family caregiver support as part of quality improvement efforts. Clinicians and systems that incorporate the family perspective into treatment discussions and consider caregiver capacity and needs may be better positioned to deliver higher-quality, more efficient person-centered and family-centered care. The results of this study highlight a gap between older adults’ family caregivers and ac...