MEDICARE PRESCRIPTION DRUG PLANS IN 2008 AND KEY CHANGES SINCE 2006: SUMMARY OF FINDINGS

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INTRODUCTION

Since 2006, Medicare beneficiaries have had access to prescription drug coverage offered by private plans, either stand-alone prescription drug plans (PDPs) or Medicare Advantage prescription drug plans (MA-PD plans). Medicare drug plans (also referred to as Part D plans) receive payments from the government to provide Medicare-subsidized drug coverage to enrolled beneficiaries. Part D plans are required to offer either a defined standard benefit or one that is equal in value, and may also offer an enhanced benefit.[1] Medicare drug plans must meet defined requirements, but may vary in terms of premiums, benefit design, gap coverage, formularies, and utilization management rules. Today, more than 25 million Medicare beneficiaries are enrolled in Medicare drug plans, including 17.4 million in stand-alone prescription drug plans and 8.0 million in Medicare Advantage drug plans.[2]

This report synthesizes findings from a series of Medicare Part D 2008 Data Spotlights that documents the scope and generosity of drug coverage available to Medicare beneficiaries under Part D plans, and changes in drug coverage and costs since 2006. It presents key findings related to Medicare drug plan premiums, the coverage gap, benefit design and cost sharing, the specialty tier, formularies and utilization management.[3] The analysis is based on data from the Centers for Medicare and Medicaid Services (CMS) for the 47 unique, national stand-alone PDPs offered in 2008, representing 88 percent of all PDPs nationwide.

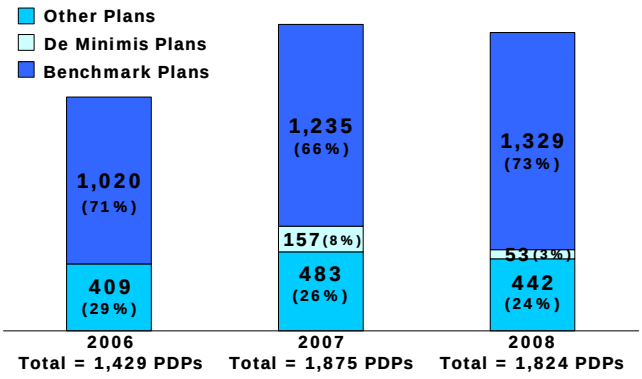
HIGHLIGHTS AND KEY FINDINGS

PLAN AVAILABILITY

- ***The number of stand-alone prescription drug plans available in 2008 (excluding the territories) is 1,824. About a quarter of all PDPs in 2008 are "benchmark" plans for the low-income subsidy (LIS); that is, they qualify to enroll beneficiaries receiving the full LIS with no monthly premium payment required.***
  - The number of PDPs remained relatively steady between 2007 and 2008, after a sharp increase between 2006 and 2007 (Exhibit 1). The number of PDPs available in 2008 varies across regions, from a low of 47 in Alaska to a high of 63 in the region covering Pennsylvania and West Virginia.
  - The number of benchmark plans available to LIS beneficiaries is higher in 2008 than it was in 2006, although there has been some turnover in the availability of these plans from year to year, creating instability for some LIS beneficiaries. Beginning in 2007, CMS

Exhibit 1

Distribution of Medicare Prescription Drug Plans, by Benchmark Plan Status, 2006-2008



NOTE: Excludes PDPs in the territories.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

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implemented a policy that limited somewhat the number of LIS recipients who would need to switch plans because their plan no longer qualified as a benchmark plan.[4] However, over 2 million beneficiaries were reassigned to new plans in 2008.

- The number of LIS benchmark plans varies considerably across regions in 2008, ranging from a low of two benchmark plans available in Nevada to a high of 19 benchmark plans available in Illinois.

PREMIUMS

- ***Monthly PDP premiums vary widely in 2008, as in previous years, and are substantially higher for plans offering some gap coverage. On average, enrollees who stayed with the same drug plan between 2007 and 2008 faced higher premiums in 2008.***

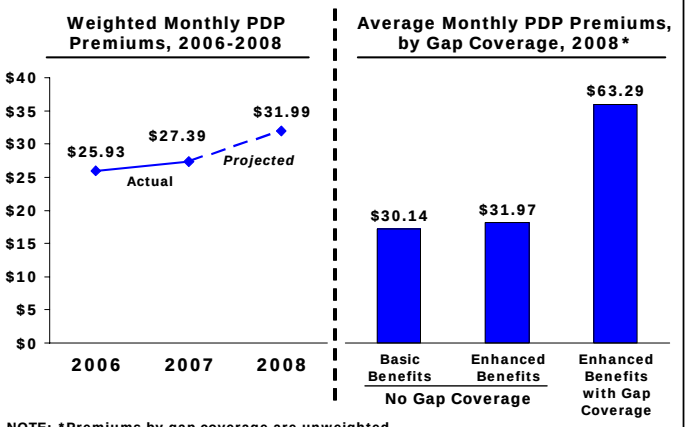
  - Monthly premiums for stand-alone Part D plans range widely, in part because different plans offer different benefits.[5] Yet even among the stand-alone drug plans offering actuarially equivalent basic benefits, premiums vary from a low of $9.80 per month to a high of $72.00 per month.

  - Enrollees in stand-alone Part D plans tend to pay substantially higher premiums for gap coverage. On average, the unweighted monthly premium for a stand-alone PDP offering some gap coverage is twice as much as the monthly premium for plans offering an enhanced benefit, but no gap coverage (Exhibit 2).

  - The weighted average premium for stand-alone Part D coverage rose from $25.93 in 2006 to $27.39 in 2007 (Exhibit 2). If all PDP enrollees remained in the same plan from 2007 to 2008, rather than switch to a different drug plan, the average monthly premium (weighted by enrollment) would increase from $27.39 to $31.99, a 17 percent increase, with nearly one in five 2007 PDP enrollees experiencing an annual increase of at least $120.[6] According to CMS data, the majority of enrollees elect to keep the coverage they have from one year to the next rather than switch plans.[7]

Exhibit 2

Average Monthly Premiums for Stand-Alone PDPs



NOTE: *Premiums by gap coverage are unweighted.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

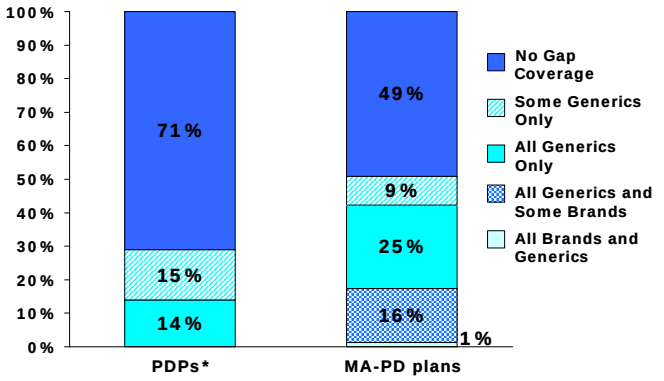
THE COVERAGE GAP

- ***In 2008, a majority of Part D plans have a gap in drug coverage (the so-called "doughnut hole") in which enrollees pay 100 percent of total drug costs before catastrophic coverage begins. Only a relatively small share of Part D enrollees are enrolled in plans that offer gap coverage.***

  - In 2008, the coverage gap begins after enrollees incur $2,510 in total drug costs. (The coverage gap does not apply to enrollees receiving low-income subsidies, who receive coverage for drug costs in the gap regardless of whether their plan offers it). In 2008, more than a quarter of stand-alone Part D plans and half of Medicare Advantage plans offer some type of gap coverage, mainly for generic drugs (Exhibit 3).

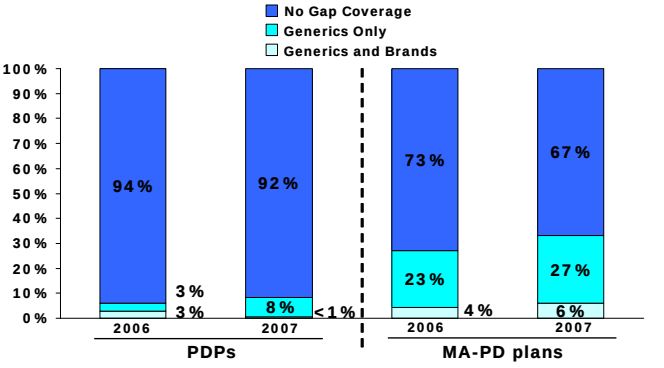
- Nationwide, only one stand-alone PDP and 17 percent of all Medicare Advantage drug plans offer coverage for at least some brand-name drugs in the gap.
- A relatively small share of Part D enrollees are in plans that offer gap coverage (Exhibit 4). From 2006 to 2007, enrollment in PDPs with any gap coverage increased modestly from 6 percent to 8 percent, while enrollment in PDPs that offered gap coverage of both brands and generics decreased from 3 percent to 0.5 percent. Among MA-PD plans, in which nearly one-third of all Part D beneficiaries are enrolled, enrollment in plans offering gap coverage increased from 27 percent to 33 percent, and the share with coverage of both brand and generics rose slightly from 4 percent to 6 percent.
- Even when Part D plans offer some gap coverage, that coverage tends to be limited to either generic drugs only or to generics plus a limited set of brand-name drugs. New among Part D plans in 2008 is the wide variation in the scope of benefits offered in the gap and the more limited scope of gap coverage even for generic drugs. About half of the PDPs with gap coverage in 2008 do not cover all generics, but rather describe their plans as covering only "preferred" or "some" generics. The increase in the share of MA-PD plans offering gap coverage is mainly among plans covering all generics and "some" brand-name drugs in the coverage gap.

Exhibit 3
Share of Medicare Prescription Drug Plans, By Type of Gap Coverage, 2008



NOTE: *In 2008, 1 PDP will offer gap coverage for brand-name drugs (rounds to 0%).
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

Exhibit 4
Share of Enrollment in Medicare Part D Plans, By Type of Gap Coverage, 2006-2007



NOTE: Estimates include Part D enrollees receiving low-income subsidies who receive coverage for costs in the gap regardless of whether their plan offers it.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

BENEFIT DESIGN AND COST SHARING

- ***Most stand-alone plans do not offer the defined standard benefit, and more PDPs have shifted to a tiered cost-sharing structure. Cost sharing for brand-name drugs has increased since 2006, particularly for non-preferred brand-name drugs.***
  - In 2008, as in previous years, only about 10 percent of national PDPs (5 of 47 plans) offer the defined standard benefit, which includes 25 percent coinsurance and a deductible. More typically, PDPs eliminate the deductible and use tiered, flat dollar copayments.

- Cost sharing for preferred and non-preferred brand-name drugs has increased since 2006, on average. Since 2006, average cost sharing for a 30-day supply of "non-preferred" brand-name drugs increased by 29 percent, from $55.36 to $71.31, while average cost sharing for "preferred" brand drugs increased by 11 percent, from $26.87 to $29.86 (Exhibit 5). Cost sharing for generic drugs has remained fairly stable since 2006. Plans use tiered cost sharing as incentives for enrollees to use less expensive generic and "preferred" brand-name drugs.

Exhibit 5
Change in Weighted Average Cost Sharing for National and Near-National PDPs, 2006-2008, and Employer-Sponsored Plans, 2007

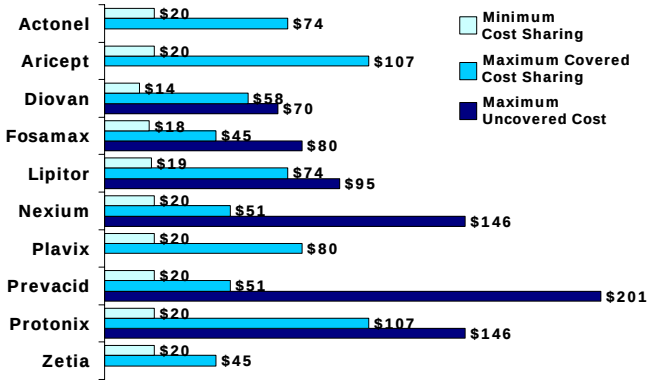
FORMULARY TIER	MEDICARE PDPs			EMPLOYER PLANS
	2006	2007	2008	2007
Generic	$5.87	$4.77	$5.32	$11
Preferred brand	$26.87	$29.36	$29.86	$25
Non-preferred brand	$55.36	$63.31	$71.31	$43
Specialty	26.4%	30.0%	30.2%	36%

NOTES: PDP estimates weighted by enrollment; analysis based on plans with three flat dollar copayment tiers and a specialty tier with coinsurance and includes only plans that will be offered in 2008.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation; data on employer plans from Kaiser/HRET Employer Health Benefits Survey, 2007.

- Medicare Part D plans charged more in 2007, on average, for preferred and non-preferred brand drugs than did employer plans, and the financial incentives for drug switching (from non-preferred to preferred drugs and from brands to generics) appear to be stronger in PDPs than in employer plans (Exhibit 5).

- Cost-sharing amounts for commonly used drugs vary widely across Part D plans in 2008, as they have in previous years. For example, an individual with Alzheimer's disease could pay $20 for a month's supply of Aricept under one plan in 2008, but $107 per month under another (Exhibit 6). Cost sharing for Nexium ranges between $20 and $51 in plans that cover the drug, but can cost as much as $146 per month in a plan that does not cover Nexium on its formulary. A beneficiary enrolled in a national PDP that does not cover Prevacid would pay $201 for a month's supply in 2008—ten times more than the lowest cost-sharing amount of $20 offered by a national PDP that covers the drug on its formulary.

Exhibit 6
Monthly Cost Sharing for the Top Ten Brand-Name Drugs in National Plans, 2008



SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

SPECIALTY TIERS

➢ ***Most national stand-alone drug plans use a specialty tier for high-cost medications in 2008, and more plans are opting to charge a higher coinsurance rate for their specialty tier drugs.***

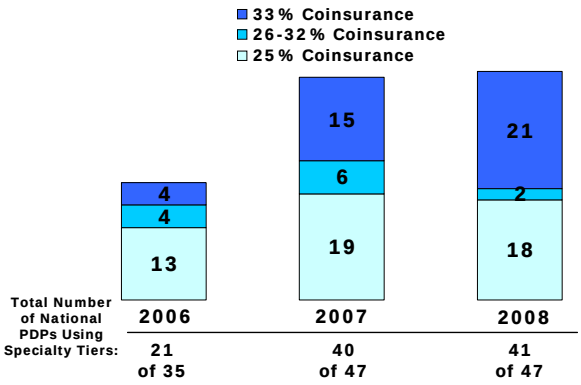
- Specialty tiers are commonly used by Medicare drug plans for relatively expensive drugs (at least $600 per month in 2008), and plans are able to charge more for specialty-tier drugs than they typically do for preferred or non-preferred drugs. In 2008, 41 of the 47 national PDPs place some drugs on a specialty tier—about twice the number of plans that had a

specialty tier in 2006 (Exhibit 7). The remaining plans charge coinsurance for brand-name drugs and do not differentiate between specialty and non-specialty drugs.

- The number of national PDPs charging 33 percent coinsurance for specialty tier drugs has increased more than five-fold since 2006, from 4 to 21 national PDPs in 2008. Cost sharing for drugs placed on a specialty tier is generally limited to 25 percent coinsurance, although CMS allows plans to have higher cost sharing for drugs on the specialty tier if offset by a lower deductible.[8]

Exhibit 7

Specialty-Tier Coinsurance Rates in Medicare Prescription Drug Plans, 2006-2008



SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

- The placement of a drug on a specialty tier has cost implications for enrollees. For example, if a plan covers a brand-name drug with a total monthly cost of $600, an enrollee might face an average flat dollar monthly copayment of $30 if the drug is covered as preferred, $72 if covered as non-preferred, or $180 per month if the drug is covered on a specialty tier with a 30 percent coinsurance rate.

FORMULARIES AND UTILIZATION MANAGEMENT

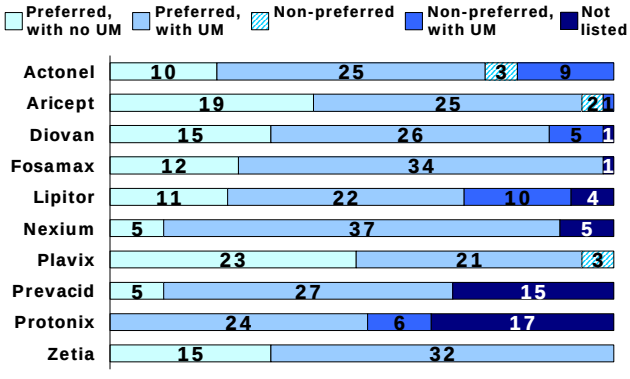
- ***The scope of formulary coverage continues to vary widely across PDPs in 2008, with the greatest differences relating to the treatment of brand-name drugs. Based on an analysis of coverage of a sample of 169 drugs, PDPs have increased the use of utilization management restrictions for on-formulary brand-name drugs.***

  - Part D plan formularies typically include more drugs than CMS standards require, but formulary coverage varies considerably across plans, particularly for brand-name drugs.[9] While some brands appear on all formularies, others are included by far fewer plans. In 2008, most national PDPs (91 percent) cover a vast majority (at least 90 percent) of the generic sample drugs, while only 28 percent of plans cover a similarly high share of brand-name sample drugs.

  - Among ten brand-name drugs commonly used by Medicare beneficiaries, formulary coverage by national PDPs in 2008 varies (Exhibit 8). The majority (8 of 10 drugs) are listed on the formularies of all or nearly all national PDPs. Yet, even if a drug is listed on a plan's formulary, utilization management restrictions may limit a beneficiary's access to the drug. Plans may require step therapy or prior authorization before covering a drug, or may limit the quantity covered. Plans may also place drugs on a non-preferred tier, associated with higher cost sharing. Most

Exhibit 8

Number of National Plans Covering Top Ten Brand-Name Drugs, by Preferred Status and Restrictions, 2008



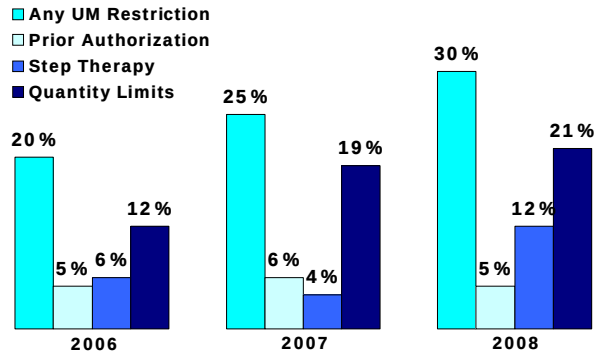
NOTE: UM is utilization management.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

national plans apply at least one of these restrictions to most of the top ten brand-name drugs; only two of the ten drugs (Aricept and Plavix, which have no clear clinical alternatives) are placed on a preferred tier with no utilization management restrictions by more than one-third of the national plans (Exhibit 8).

- Utilization management restrictions are more common among plans in 2008 than in 2006, with 30 percent of the 169 sample drugs subject to some use restriction in 2008, up from 20 percent in 2006 (Exhibit 9). Quantity limits are applied to 21 percent of sample drugs in 2008, on average across the national PDPs, up from 12 percent in 2006, while use of step therapy has doubled from 6 percent of sample drugs in 2006 to 12 percent in 2008. The average use of prior authorization among national PDPs has remained flat since 2006, at about 5 percent of sample drugs.

Exhibit 9

Share of Sample Drugs with Utilization Management Restrictions, Averaged Across All National PDPs, 2006-2008



SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

CONCLUSION

Medicare Part D plans are a relatively new and important source of prescription drug coverage for a growing number of Medicare beneficiaries. Findings from this analysis show relatively minimal change in PDP formularies since 2006, but increases in cost sharing and utilization management restrictions that could have important implications for beneficiaries' access to needed medications and out-of-pocket expenses. Most Medicare drug plans do not offer coverage in the "doughnut hole", and those that do primarily cover generics. Some Medicare Advantage drug plans continue to offer coverage for at least a limited number of brand-name drugs in the gap. The limited availability of coverage for brand-name drugs in the coverage gap puts Part D enrollees at risk of incurring substantial costs, an increasing concern as the size of the coverage gap expands each year (currently in excess of $3,000). Wide variations across Part D plans, rising premiums, and changes in plan offerings, benefit design, coverage and costs that occur from year to year underscore the importance for consumers to compare plans each year and make informed decisions based on the medications they take. Ongoing monitoring activities are critical for assessing the extent to which Medicare beneficiaries have access to needed and affordable medications through Part D plans.

METHODS

This report synthesizes findings presented in a series of Medicare Part D 2008 Data Spotlights prepared by Jack Hoadley (Health Policy Institute, Georgetown University), Elizabeth Hargrave and Katie Merrell (NORC at the University of Chicago), and Juliette Cubanski and Tricia Neuman (Kaiser Family Foundation). Additional assistance was provided by Lauren Bakios, Jennifer Thompson, and Laura Summer (Health Policy Institute, Georgetown University) and Kosali Simon (Cornell University).

Some of these findings are based on the analysis of data for the 47 unique, national stand-alone PDPs offered by 15 organizations in 2008, representing 88 percent of all PDPs nationwide. The organizations that sponsor stand-alone prescription drug plans nationally in 2008 account for 1,598 plans – 88 percent of the 1,824 PDPs offered nationwide. The analysis of benefit designs and formularies excludes the remaining 285 plans (12 percent), which are mainly local or regional plans offered in 30 or fewer regions, as well as prescription drug plans offered through Medicare Advantage plans.

Data on the characteristics of plan benefits were collected primarily from the CMS "landscape file" released in October 2007 and the CMS Medicare Prescription Drug Plan Finder website. In a few cases, these data were supplemented or verified by more detailed information collected directly from plan benefit summary materials and other documents on each sponsoring organization's website. Complete formulary, cost-sharing, and pricing data for drugs are also available on the Plan Finder, but the time demands in collecting information from the website made it impossible to collect data on all FDA-approved drugs for the analysis included in the Data Spotlight series.

The analysis is based on a sample of 169 prescription drugs selected to include the most commonly prescribed drugs and all alternative medications in some of the drug classes most commonly used by Medicare beneficiaries. The sample of drugs was selected with several goals in mind: 1) including drugs that are among the most frequently prescribed drugs used by Medicare beneficiaries; 2) including drugs that belong to certain commonly prescribed drug classes; and 3) including a sub-sample of high-cost drugs. Four types of data for each drug were collected from the Medicare Prescription Drug Plan Finder from the Medicare.gov website: whether a drug was on plan formularies, the cost-sharing tier for each covered drug, whether utilization management tools (prior authorization, quantity limits, or step therapy) were applied, and the price for purchases at retail pharmacies.

A detailed appendix describing the methodology used in the Medicare Part D 2008 Data Spotlight series is available at http://www.kff.org/medicare/med102507pkg.cfm.

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[1] In 2008, the defined standard benefit has a $275 deductible, 25 percent coinsurance up to an initial benefit limit, a $3,216 coverage gap (the "doughnut hole"), and catastrophic coverage after $5,726.25 in total Part D drug costs.

[2] U.S. Department of Health and Human Services (HHS), "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop", January 31, 2008 (data as of January 2008).

[3] The 2008 Data Spotlight series (available at http://www.kff.org/medicare/med102507pkg.cfm) builds on two previous reports commissioned by the Kaiser Family Foundation that provided an in-depth look at Medicare drug plans in 2006 and 2007. See Hoadley et al, "An In-Depth Examination of Formularies and Other Features of Medicare Drug Plans," Kaiser Family Foundation, April 2006, available at http://www.kff.org/medicare/7489.cfm; and Hoadley et al, "Benefit Design and Formularies of Medicare Drug Plans: A Comparison of 2006 and 2007 Offerings," Kaiser Family Foundation, November 2006, available at http://www.kff.org/medicare/7589.cfm.

[4] Under the "de minimis" policy, LIS beneficiaries who are enrolled in a plan losing benchmark status are allowed to stay in that plan and retain the full premium subsidy as long as the new monthly premium does not exceed the regional benchmark by more than a small (de minimis) amount ($2 in 2007 and $1 in 2008).

[5] Beneficiaries pay, on average, 25.5 percent of the cost for standard drug coverage; the federal government subsidizes the remaining 74.5 percent. In 2008, more than 9 million Part D enrollees are receiving Part D low-income subsidies and do not pay a premium as long as they are enrolled in a benchmark plan.

[6] The weighted premium is lower than the unweighted premium because enrollment is disproportionately distributed, with more enrollees in lower-premium plans than higher-premium plans.

[7] According to CMS, about 3.1 million Part D enrollees, or 12 percent, switched plans between 2007 and 2008. Of those who switched, 2.1 million were beneficiaries receiving the low-income subsidy who were reassigned so they would not have to pay a premium. According to CMS, about six percent of all non-LIS beneficiaries who are enrolled in Part D made a change between 2007 and 2008. See HHS, January 31, 2008.

[8] CMS, "Medicare Part D Manual, Chapter 6, Part D Drugs and Formulary Requirements" March 9, 2007.

[9] Plans must list at least two drugs in every drug category and class, as well as most or all drugs in six protected classes. See CMS, Chapter 6, "Part D Drugs and Formulary Requirements" in the Medicare Part D Manual (http://www.cms.hhs.gov).