

THE COVERAGE GAP

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A unique feature of the Medicare Part D drug benefit is the coverage gap, or so-called “doughnut hole” — a gap in coverage in which Part D enrollees are required to pay 100 percent of total drug costs until they reach the catastrophic coverage level. The coverage gap was included because the cost of providing continuous coverage with no gap would have exceeded the budgetary limit imposed on the legislation when the Medicare drug benefit was established. In 2009, nearly all Part D plans have a coverage gap, which totals \$3,454 for plans offering the standard Medicare Part D benefit; by 2016, it is projected to exceed \$6,000. Part D plans may offer an alternative benefit design that helps cover at least some drug costs in the gap. Part D enrollees who qualify for the low-income subsidy (LIS), including beneficiaries dually eligible for Medicare and Medicaid, are generally not responsible for costs in the coverage gap.

This Part D Data Spotlight examines gap coverage offered by Medicare stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug (MA-PD) plans, based on the authors’ analysis of data from the Centers for Medicare & Medicaid Services (CMS). This research is part of a broader effort analyzing Medicare Part D plans in 2009 and trends since 2006, with key findings summarized in a series of data spotlights.¹

GAP COVERAGE, 2006-2009

In 2009, 25 percent of PDPs (416 plans) offer some type of gap coverage, down from 29 percent (529 plans) in 2008, but higher than in 2006, the program’s first year. Of the 17 PDP sponsors with plans available in every region in 2009, 9 offer some type of gap coverage in at least one of their plan offerings (down from 12 in 2008). The share of MA-PD plans offering some gap coverage is 51 percent (1,076 plans), the same share as in 2008 and twice the share of PDPs with gap coverage.²

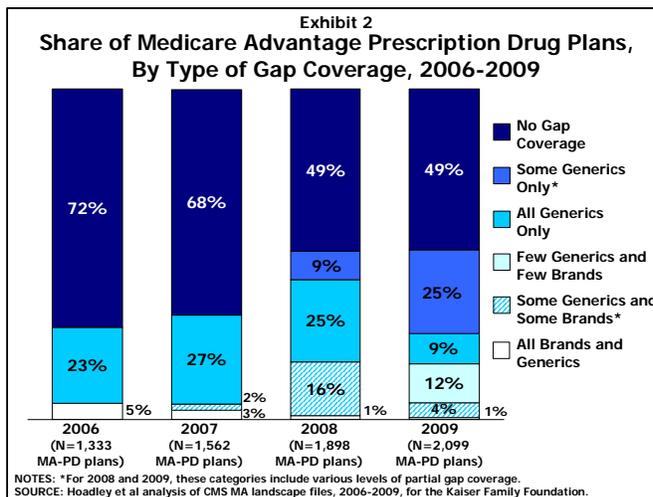
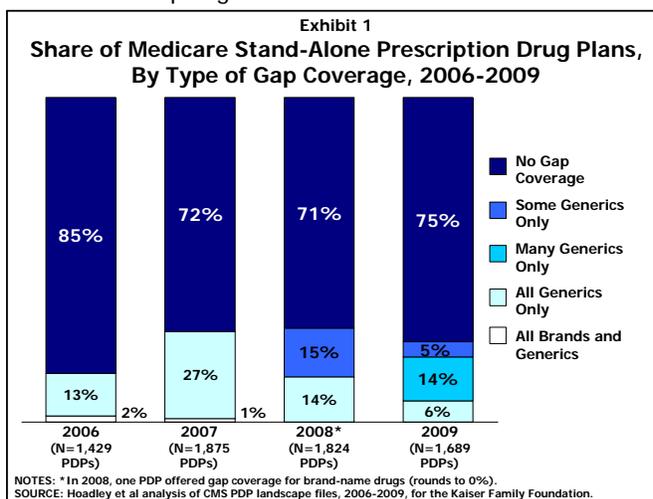
The generosity of gap coverage continues to decline. In 2009, as in previous years, the vast majority of plans offering gap coverage cover generic drugs only. At the same time, gap coverage for generics is becoming more limited. Among both PDPs and MA-PD plans offering gap coverage for generic drugs, most cover only a subset of the generics listed on their formularies.

GAP COVERAGE QUANTIFIED FOR 2009

For the first time in 2009, CMS has defined the terminology used to describe the level of gap coverage offered by Part D plans. As in 2008, plans offer several variations of gap coverage, particularly among MA-PD plans. The variations include coverage of “few”, “some”, “many”, and “all” brand-name or generic drugs. Unlike in past years, for 2009 these terms are specifically defined to quantify the percent of brand-name or generic drugs on formulary that a plan covers in the gap. For example, a plan that covers “some” brand-name drugs and “many” generic drugs in the gap would cover from 10 percent to less than 65 percent of brands and from 65 percent to less than 100 percent of generics on their formularies in the gap. This quantification of the level of gap coverage marks a step forward in helping consumers compare and better understand the differences between drug plans.

FIRMS OFFERING PART D PLANS WITH FULL GAP COVERAGE, 2006-2009

Full gap coverage for brand-name and generic drugs does not exist in the PDP market in 2009. In 2006, Humana offered a PDP with full gap coverage in most regions, and Sierra Rx offered such coverage in 2007 in 24 regions. Both companies stopped offering this coverage in subsequent years after experiencing significant adverse selection by high-



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cost enrollees. One Florida PDP offered some gap coverage for brands in 2008, but attracted only 390 enrollees and dropped brand coverage for 2009. Three PDPs (one each in Florida, Michigan, and Wisconsin) cover a “few” brands in the gap (less than 10 percent of brands on formulary) in 2009; each plan had fewer than 3,000 enrollees in 2008.

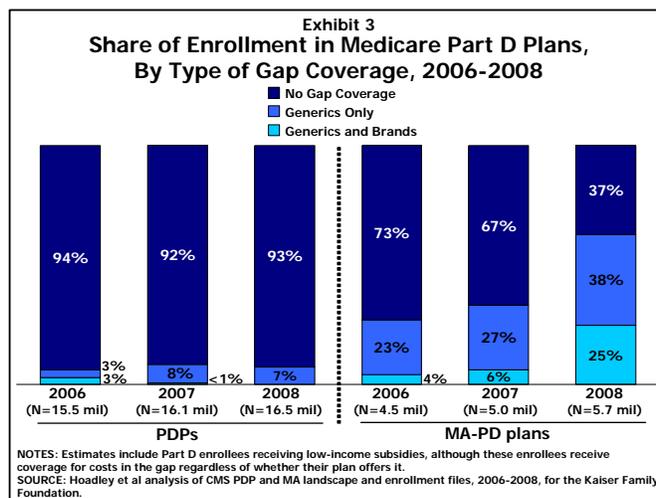
In 2009, about 355 MA-PD plans (17 percent) cover at least a few brand-name drugs in the gap. But only 35 MA-PD plans (2 percent) cover more than 10 percent of brand drugs on formulary and just 15 of these plans (1 percent) offer coverage of all brands and generics in the gap. Most of the MA-PD plans covering at least some brands in the gap in 2009 are local HMOs serving only a small area; the two largest are CareMore Health Plan in southern California and Seniors Dimensions offered by the Health Plan of Nevada.

HIGHER PREMIUMS FOR GAP COVERAGE OFFERED BY PDPs³

Monthly premiums for PDPs that provide gap coverage are about double that of PDPs with no gap coverage in 2009.⁴ Average monthly premiums are \$73.36 for PDPs that offer some gap coverage (up from \$63.29 in 2008), \$33.80 for PDPs with basic benefits and no gap coverage (up from \$30.14 in 2008), and \$40.59 for PDPs with enhanced benefits but no gap coverage (up from \$31.97 in 2008). Although many beneficiaries are interested in reducing their costs in the gap, it is unclear whether limited coverage of generics provides added value commensurate with higher premiums.

ENROLLMENT IN PLANS WITH GAP COVERAGE

A relatively small share of Part D enrollees overall are in plans that offer gap coverage (aside from LIS enrollees who receive coverage for costs in the gap regardless of whether their plan offers it) (Exhibit 3). The share of PDP enrollees with gap coverage has remained roughly the same from 2006 to 2008 (6 percent in 2006, 8 percent in 2007, and 7 percent in 2008), although the subset of PDP enrollees with gap coverage of brands and generics decreased from about 3 percent in 2006 to nearly zero in 2008, as this level of coverage was not widely available. A much larger share of MA-PD plan enrollees than PDP enrollees have gap coverage. The share of MA-PD plan enrollees with gap coverage increased from 27 percent in 2006 to 63 percent in 2008, and the share with coverage of both brands and generics increased from 4 percent in 2006 to 25 percent in 2008 (with most having coverage of some, but not all, brands).



DISCUSSION

The availability and generosity of gap coverage varies widely across Part D plans. The share of PDPs offering gap coverage remains the same in 2009 as in 2008, but the generosity of gap coverage has become more limited. A growing number of MA-PD plans offer some gap coverage, but most do not cover the cost of brand-name drugs in the gap. As health plans covering the full set of Medicare services, MA-PD plans have somewhat stronger incentives than PDPs to offer at least some gap coverage in order to avoid the negative health and cost consequences that could arise if enrollees do not take their medications when they reach the gap. In addition, the Medicare Payment Advisory Commission estimates that federal payments to MA-PD plans exceed the average cost of health services, providing a margin for Medicare Advantage plans to subsidize drug coverage and premiums.⁵

CMS has quantified the terminology used to describe the extent of gap coverage for 2009, but the large number of variations in gap coverage may still be a source of confusion. In 2009, as in previous years, a relatively small share of Part D enrollees are expected to be in plans that cover brand-name drugs in the gap. Only 6 percent of Part D enrollees not receiving LIS chose to switch plans between 2007 and 2008.⁶ If PDP enrollees do not switch plans for 2009, nearly all (97 percent) will see no change in gap coverage, and most will have no gap coverage in both years.

There is growing evidence that some enrollees who reach the gap forgo needed medications when faced with the full cost of their prescriptions. An estimated 3.4 million Part D enrollees (14 percent of all enrollees and 26 percent of those using prescription drugs and not eligible for the low-income subsidy) reached the coverage gap in 2007.⁷ On average, 15 percent of those using drugs in eight selected drug classes stopped taking medications in that class upon reaching the gap. With many Part D enrollees at risk of forgoing needed medications in the coverage gap, or of incurring high out-of-pocket spending, issues related to the “doughnut hole” are likely to remain on the policy agenda.

¹ Other Medicare Part D 2009 Data Spotlights, based on the authors’ analysis of CMS data, are available at <http://www.kff.org/medicare/med110608pkg.cfm>.

² Counts of Medicare Advantage plans are based on the number of distinct contract and plan ID numbers. A single plan may represent an entire state or different regions of a state, depending on whether the plan design varies across geographic areas.

³ Premiums for the drug benefit portion of MA-PD plans are not separately reported from the overall plan premium.

⁴ Hoadley J et al., “Medicare Part D 2009 Data Spotlight: Premiums,” Kaiser Family Foundation, November 2008.

⁵ Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Chapter 3, March 2008.

⁶ Centers for Medicare & Medicaid Services, “Medicare Prescription Drug Benefit’s Projected Costs Continue to Drop,” January 31, 2008.

⁷ Hoadley J et al., “The Medicare Part D Coverage Gap: Costs and Consequences in 2007,” Kaiser Family Foundation, August 2008.