MEDICARE PRESCRIPTION DRUG PLANS IN 2009 AND KEY CHANGES SINCE 2006:

SUMMARY OF FINDINGS

Prepared by Elizabeth Hargrave[i], Jack Hoadley[ii], Juliette Cubanski[iii] and Tricia Neuman[iii]

JUNE 2009

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). These Medicare drug plans (also referred to as Part D plans) receive payments from the government to provide Medicare-subsidized drug coverage to beneficiaries enrolled in a Part D plan. 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 26 million Medicare beneficiaries are enrolled in Medicare drug plans, including 17.5 million in stand-alone prescription drug plans and 9 million in Medicare Advantage drug plans.[2]

This report summarizes findings from a series of Medicare Part D 2009 Data Spotlights documenting changes in drug coverage and costs since 2006, and incorporates some additional information.[3,4] 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, based on data from the Centers for Medicare & Medicaid Services (CMS) for all plans participating in Part D. More detail about the methods used in this analysis is provided on page 8.

HIGHLIGHTS AND KEY FINDINGS

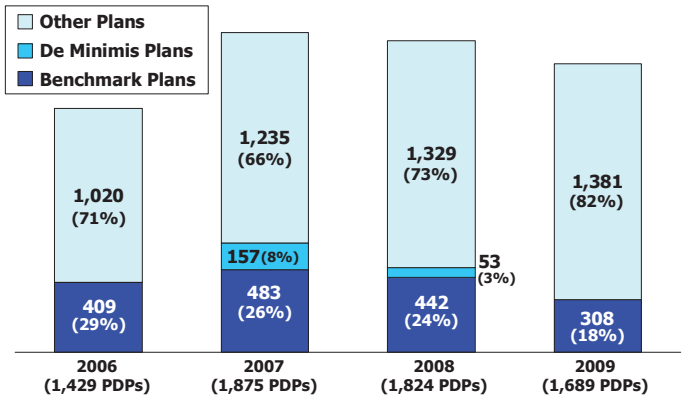
PLAN AVAILABILITY

- ***The number of PDPs is higher in 2009 than in 2006, with a total of 1,689 PDPs and at least 45 PDPs offered in every state this year.[5] After a fairly significant increase in PDPs between 2006 and 2007, the total number of PDPs has declined modestly.***

  - The number of PDPs increased sharply between 2006 and 2007, remained relatively steady between 2007 and 2008, and decreased modestly between 2008 and 2009 (Exhibit 1). This decrease is mainly due to mergers between sponsoring organizations and consolidation of plan offerings by individual sponsors.
  - The number of PDPs available in 2009 varies across regions, from a low of 45 in Alaska to a high of 57 in the region covering Pennsylvania and West Virginia.
  - The number of MA-PD plans has increased by about 50 percent since 2006, from 1,333 plans in 2006 to 1,991 plans in 2009, with a very modest increase since 2008.

Exhibit 1

Distribution of Medicare Stand-Alone Prescription Drug Plans, by Benchmark Status, 2006-2009



NOTE: Excludes PDPs in the territories.
SOURCE: Georgetown/NORC analysis of CMS PDP Landscape files, 2006-2009, for the Kaiser Family Foundation.

Author affiliations: [i] NORC at the University of Chicago [ii] Georgetown University [iii] Kaiser Family Foundation

- ***Fewer "benchmark" plans are available to beneficiaries receiving Part D low-income subsidies (LIS) than in any previous year (Exhibit 1). Benchmark plans are available to Part D LIS enrollees for no monthly premium.***

  - The number of benchmark plans for Part D low-income subsidy (LIS) recipients is lower in 2009 than in any other year of the program – despite the new method CMS implemented for calculating the LIS premium benchmark for 2009 that was intended to lessen turnover and increase the number of qualifying benchmark plans.[6] Of the 442 benchmark plans available to LIS recipients for zero premium in 2008, 175 were no longer benchmark plans in 2009. These benchmark PDPs were either withdrawn from the Part D market entirely or their 2009 premiums exceeded the regional premium benchmark amounts. There has also been annual turnover in which plans qualify. Of the 308 benchmark plans available in 2009, 41 were not benchmark plans in 2008.
  - Over 1.6 million beneficiaries were reassigned to new PDPs in 2009.[7] Another two million LIS recipients remained in non-benchmark plans and are paying premiums for Part D coverage in 2009.
  - The number of LIS benchmark plans varies considerably across regions in 2009, ranging from a low of one PDP in Nevada and two PDPs in Arizona to a high of 16 PDPs in Wisconsin.

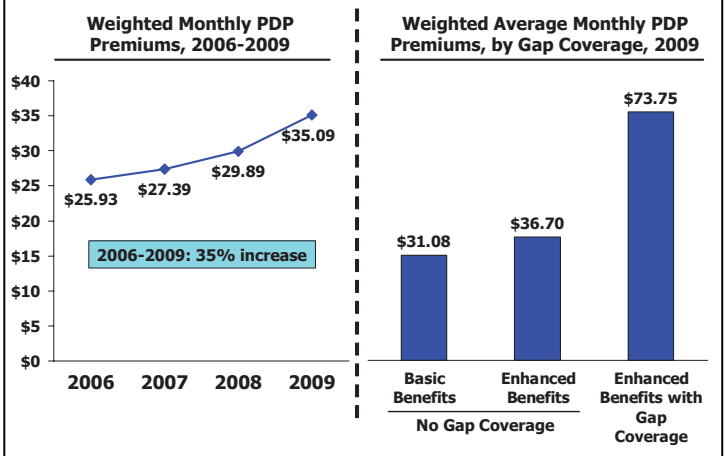
PREMIUMS

- ***Since 2006, the weighted average PDP has increased by 35 percent, increasing more between 2008 and 2009 than in previous years. Monthly PDP premiums vary widely in 2009, as in previous years.***

  - The weighted average premium paid by beneficiaries for stand-alone Part D coverage has increased by 35 percent, from $25.93 in 2006 to $35.09 in 2009 (Exhibit 2).[8,9] Between 2008 and 2009 alone, the average PDP enrollee paid 17 percent more in premiums – the largest one-year premium increase to date.[10]
  - Monthly premium increases for the drug plans with the highest enrollment have been especially large. Since 2006, the premium for the AARP MedicareRx Preferred plan (sponsored by UnitedHealthcare) has increased by 41 percent, while the average monthly premium for the Humana Standard PDP has quadrupled.

Exhibit 2

Average Monthly Premiums for Stand-Alone PDPs



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

  - If all beneficiaries had remained in the same plan between 2008 and 2009, one in four 2008 PDP enrollees would have experienced an annual premium increase of at least $120. Despite significant premium increases in some of the more popular Part D plans, the majority of enrollees have not switched plans.[11]
  - Monthly premiums for stand-alone Part D plans range widely, in part because different plans offer different benefits. Yet even among the stand-alone drug plans offering actuarially equivalent basic benefits, premiums in 2009 vary from a low of $11.50 per month to a high of $112.70 per month.[12]
  - MA-PD premiums are lower than PDP premiums, on average. MedPAC reports the average 2009 monthly premium amount attributable to drug benefits was $15.15, about $20 below the PDP average, but also up considerably over 2008.[13] Many MA-PD plans lower or eliminate their premiums by using a portion of rebates from the Medicare Advantage payment system. Still, CMS calculates that on average MA-PD premiums prior to rebates are about $11 per month lower than those for PDPs.[14]
  - Enrollees in stand-alone Part D plans tend to pay substantially higher premiums for gap coverage. On average, the weighted monthly premium for a stand-alone PDP offering some gap coverage (mainly for generic drugs) is twice that for plans offering an enhanced benefit with no gap coverage (Exhibit 2).

Although many beneficiaries are interested in reducing their costs in the gap, it is unclear whether gap coverage that is limited to generics (and not always all generics, as described below) provides added value commensurate with higher premiums.

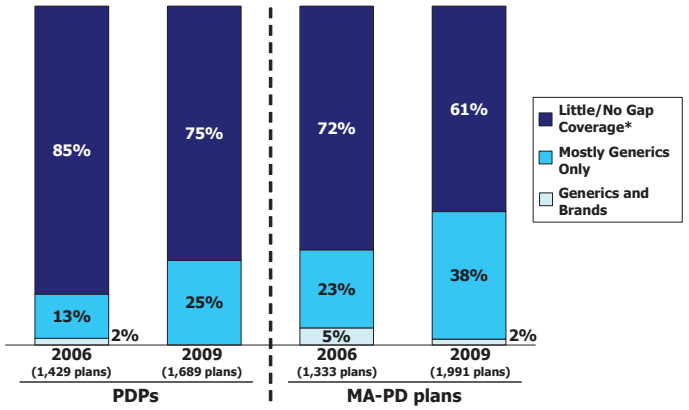
THE COVERAGE GAP

- ***In 2009, a majority of Part D plans – both PDPs and MA-PD 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. No PDPs offer full gap coverage for all of the drugs they cover in 2009.***

  - In 2009, three-quarters of stand-alone PDPs and three-fifths of MA-PD plans offer little or no gap coverage (Exhibit 3).[15] In 2009, the coverage gap begins after enrollees incur $2,700 in total drug costs. (The coverage gap does not apply to enrollees receiving LIS, who receive coverage for drug costs in the gap regardless of whether their plan offers it.) Of the 17 PDP sponsors with plans available in every region in 2009, nine offer some type of gap coverage in at least one of their plan offerings, down from 12 sponsors in 2008.

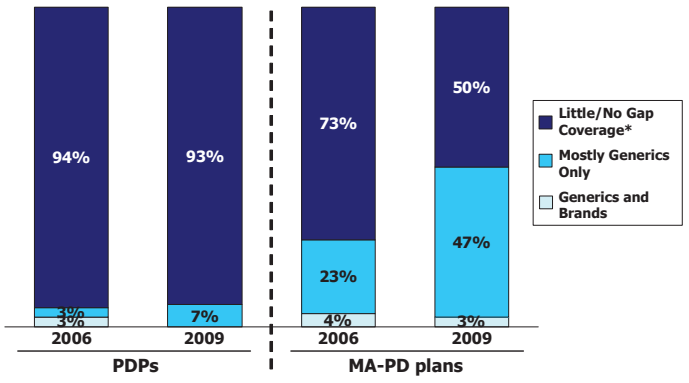
  - The vast majority of plans offering any gap coverage only cover generic drugs in the gap (Exhibit 3). While the overall share of plans offering gap coverage has increased since 2006, and is similar to the level in 2008, the generosity of gap coverage continues to decline. The share of PDPs covering all generics in the gap fell by more than half from 2008 to 2009, with more plans covering only selected generic drugs in the gap. Gap coverage for brand-name drugs is even less common in 2009; only 2 percent of all MA-PD plans offer relatively generous coverage of brands in the gap, while only three PDPs (one each in Florida, Michigan, and Wisconsin) cover a "few" brands in the gap (defined as less than 10 percent of brands on formulary); each of these PDPs with limited brand coverage has fewer than 1,800 enrollees.

Exhibit 3
Share of Medicare Part D Plans, By Type of Gap Coverage, 2006 and 2009



NOTE: *"Little/No Gap Coverage" includes plans that cover few drugs only.
SOURCE: Hoadley et al analysis of CMS PDP landscape files, 2006-2009, for the Kaiser Family Foundation.

Exhibit 4
Share of Enrollment in Medicare Part D Plans, By Type of Gap Coverage, 2006 and 2009



NOTE: Estimates include Part D enrollees receiving low-income subsidies, but who receive coverage for costs in the gap regardless of whether their plan offers it. *"Little/No Gap Coverage" includes plans that cover few drugs only.
SOURCE: Hoadley et al analysis of CMS PDP and MA landscape and enrollment files, 2006-2009, for the Kaiser Family Foundation.

  - In 2009, 93 percent of PDP enrollees are enrolled in plans with no gap coverage (Exhibit 4). However, this estimate includes LIS recipients who receive subsidized coverage of their drug costs in the gap. Thus, the share of PDP enrollees who actually face a gap is considerably smaller, about 45 percent. Among non-LIS Part D enrollees in PDPs, 89 percent are in plans with no gap coverage (as opposed to 93 percent of all PDP enrollees).

  - Half of MA-PD plan enrollees have at least some gap coverage, a substantial increase since 2006.[16] This is largely because Medicare Advantage plans are able to use payments received from the government for providing benefits covered under Parts A and B to reduce cost-sharing and premiums under Part D.[17] Furthermore, because Medicare Advantage plans cover hospital and physician services and other Medicare benefits, they have somewhat stronger incentives than PDPs to offer at least some gap

coverage to forestall the negative health and cost consequences that could arise if enrollees do not take their medications when they reach the gap.

BENEFIT DESIGN AND COST SHARING

- ***Most Part D plans do not offer the defined standard benefit, with a deductible and 25 percent coinsurance; the vast majority have a tiered cost-sharing structure with incentives for enrollees to use less expensive generic and "preferred" brand-name drugs. Within that tiered structure, cost sharing has increased since 2006, particularly for brand-name drugs.***

  - In 2009, as in previous years, only about 10 percent of PDPs (170 of 1,689 plans) and 5 percent of MA-PD plans (92 of 1,991 plans) offer the defined standard benefit. A more common Part D plan design is a plan with no deductible and tiered, flat dollar copayments. The most common model for tiered cost sharing includes four tiers: generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs). Plans with only one tier for brand-name drugs are becoming less common, while a few plan sponsors now offer formularies with two generic tiers.

  - Since 2006, the median cost sharing for a 30-day supply of "non-preferred" brand-name drugs in stand-alone PDPs has increased by 35 percent, from $55 to $74.75, while cost sharing for "preferred" brand drugs increased by 32 percent, from $28 to $37 (Exhibit 5). Cost sharing for generic drugs in PDPs remained fairly stable from 2006 through 2008, but the median increased from $5 in 2008 to $7 in 2009.

Exhibit 5

Cost Sharing for Medicare Part D Plans, 2006-2009, and Employer-Sponsored Plans, 2008

FORMULARY TIER	PART D PLAN TYPE	PART D COST SHARING				EMPLOYER PLANS
		2006	2007	2008	2009	2008
Generic	PDP	$5	$5	$5	$7	$10
	MA-PD	$5	$5	$5	$5	
Preferred brand	PDP	$28	$28	$30	$37	$26
	MA-PD	$26.70	$29	$30	$30	
Non-preferred brand	PDP	$55	$60	$71.50	$74.75	$46
	MA-PD	$55	$60	$60	$60	
Specialty	PDP	25%	30%	30%	33%	28%
	MA-PD	25%	25%	25%	33%	

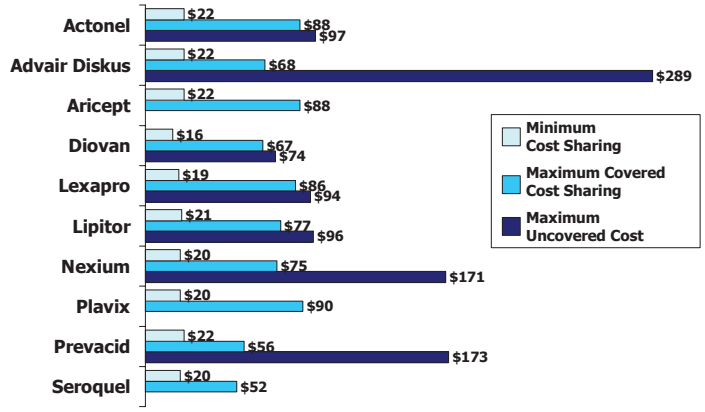
NOTE: Part D cost-sharing amounts are medians; employer plan cost-sharing amounts are means. Part D plan estimates weighted by enrollment in each year; analysis excludes generic/brand plans, plans with coinsurance for regular tiers, and plans with flat copayments for specialty tiers.
SOURCE: Georgetown/NORC analysis of data from CMS for MedPAC and the Kaiser Family Foundation; data on employer plans from Kaiser/HRET Employer Health Benefits Survey, 2008.

  - Medicare Part D plans generally charged more than employer plans did in 2008 for preferred and non-preferred brand drugs, but somewhat less for generics (Exhibit 5). For example, employer plans typically charged $26 per month for a preferred brand in 2008, less than the median $30 charged by Part D plans that year. Cost-sharing differences were even greater for non-preferred brands.

  - Cost-sharing amounts for commonly used brand-name drugs without generic equivalents vary widely across Part D plans in 2009, as they have in previous years. For example, an individual with Alzheimer's disease could pay as little as $22 for a month's supply of Aricept under one of the 44 national and near-national PDPs in 2009, but as much as $88 per month under another (Exhibit 6). Cost sharing for Advair Diskus for asthma or chronic obstructive pulmonary disease ranges from $22 and $68 in national PDPs when on formulary, while an enrollee in a national PDP that does not cover Advair Diskus would pay up to $289 per month – thirteen times the lowest cost-sharing amount.

Exhibit 6

Monthly Cost Sharing for Top Ten Brand-Name Drugs in National Plans, 2009



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

- ***Many Part D enrollees have seen double-digit increases in prices for brand-name drugs when they reach the coverage gap, based on analysis of the monthly posted prices for commonly used brands in the two PDPs with the highest enrollment.[18]***

  - Part D enrollees pay the full cost of their prescriptions when they reach the coverage gap. Between 2007 and 2009, the two PDPs with the highest enrollment, AARP MedicareRx Preferred and Humana Standard PDP, posted double-digit price increases for commonly used brand-name drugs.[19] Over the two-year period, prices for the following brand-name drugs increased, on average, by about 19 percent in both the AARP and Humana PDPs: Actonel, Advair Diskus, Aricept, Diovan, Lexapro, Lipitor, Nexium, Plavix, and Prevacid.
  - For example, between 2007 and 2009:
    - The monthly price for Actonel, an osteoperosis treatment, increased by 23.7 percent (from $73.22 to $90.57) in AARP MedicareRx Preferred and by 34.1 percent (from $71.87 to $96.39) in Humana Standard.
    - The monthly price for Aricept, an Alzheimer's disease treatment, increased by 24.9 percent (from $147.63 to $184.35) in AARP MedicareRx Preferred, and by 16.8 percent (from $145.40 to $169.78) in Humana Standard.
    - The monthly price for Lexapro, to treat depression, increased by 19 percent (from $73.13 to $87.01) in AARP MedicareRX Preferred, and by 14.5 percent (from $71.79 to $82.18) in Humana Standard.
    - The monthly price for Lipitor, used to lower cholesterol, increased by 14.7 percent (from $75.25 to $86.29) in AARP MedicareRx Preferred, and by 11.3 percent (from $73.88 to $82.26) in Humana Standard.

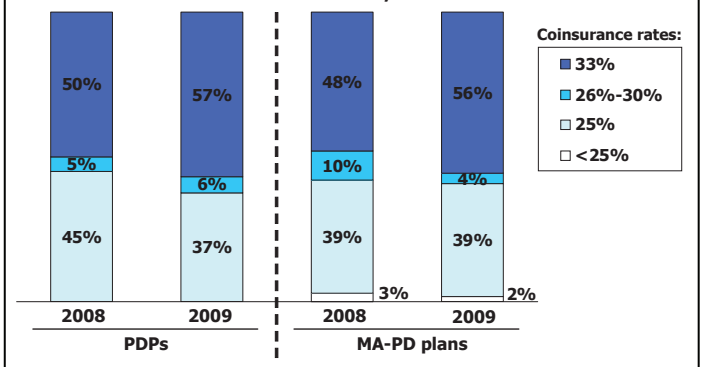
SPECIALTY TIERS

- ***Most Part D plans use a specialty tier for high-cost medications in 2009, and more than half of Part D enrollees are in plans with a 33 percent coinsurance rate for specialty tier drugs.***

  - Specialty tiers are commonly used by Medicare drug plans for relatively expensive drugs (at least $600 per month in 2009). Plans typically have higher cost sharing for specialty-tier drugs than they do for preferred or non-preferred drugs, with coinsurance rates ranging from 25 percent to 33 percent. In 2009, among Part D enrollees in plans using tiered cost sharing, 87 percent of PDP enrollees and 98 percent of MA-PD plan enrollees are in plans with a specialty tier. This contrasts with the much lower use of specialty tiers in 2006. Many of the plans without specialty tiers charge coinsurance for all covered brand-name drugs and thus the cost sharing for covered drugs in these plans would be similar to plans with designated specialty tiers.

Exhibit 7

Share of Enrollment in Medicare Prescription Drug Plans with Specialty Tiers, by Specialty Tier Coinsurance Rate, 2008-2009



NOTE: Estimates weighted by enrollment in each year. Analysis excludes small share of plans with copayments for specialty tiers (0.1% of PDPs and 2% of MA-PD plans). Analysis of MA-PD plans excludes Special Needs Plans.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

  - Just as more Part D enrollees are in plans using specialty tiers for high-cost medications in 2009, more enrollees are exposed to higher coinsurance rates for these drugs. In 2009, a majority of Part D enrollees are in plans charging 33 percent coinsurance for specialty drugs in the initial coverage period (Exhibit 7). By contrast, only four of the 35 national or near-national PDPs charged this rate in 2006 (not shown). CMS limits cost sharing for drugs placed on a specialty tier to 25 percent coinsurance, but allows plans to have higher cost sharing for drugs on the specialty tier if offset by a lower deductible.[20]

- The placement of a drug on a specialty tier has significant implications for enrollees' out-of-pocket costs during the initial coverage period. To illustrate, an enrollee taking a specialty drug with a total monthly cost of $600 would pay, at the median, $37 per month if the drug is covered on a preferred tier or $74.75 if covered on a non-preferred tier, but $200 if the drug is covered on a specialty tier with 33 percent coinsurance – a five-fold difference. Beneficiaries taking a specialty drug on a regular basis (and not protected by the low-income subsidy) will quickly reach the coverage gap and be liable for the full cost of the drug. While some enrollees are likely to stop taking their specialty medication when they are faced with the full cost in the gap, those who are able to pay and who continue taking the drug are likely to reach the catastrophic coverage level (when they have paid a total of $4,350 out of pocket for their medications) well before the end of the year, regardless of how much they paid during the initial coverage period.[21]

FORMULARIES AND UTILIZATION MANAGEMENT

- ***The scope of formulary coverage continues to vary widely across PDPs in 2009. Since 2007, PDPs have applied utilization management restrictions to an increasing share of on-formulary brand-name drugs.***

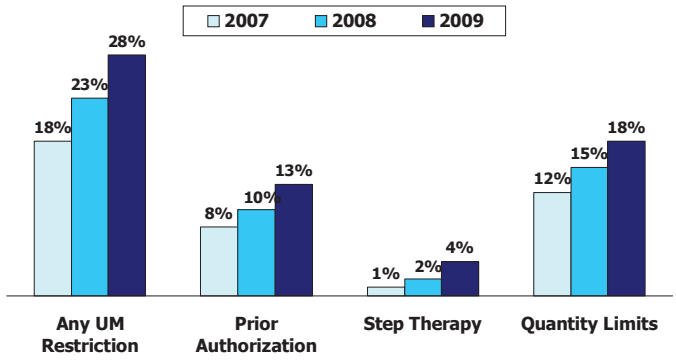
  - Part D plan formularies typically include more drugs than CMS standards require, but formulary coverage varies considerably across plans.[22] Some plans list all drugs from the CMS drug reference file on their formularies, while other plans list as few as 56 percent of these drugs.[23] In 2009, the average PDP formulary lists 89 percent of the drugs in the CMS drug reference file, similar to the share of covered drugs in the previous two years. MA-PD plans list slightly more drugs (91 percent) on formulary.

  - Even if a drug is listed on a plan's formulary, utilization management (UM) restrictions may restrict a beneficiary's access to the drug. Part D plans may require step therapy or prior authorization before covering a drug, or may limit the quantity covered. UM restrictions have increased since 2007, with 28 percent of drugs subject to some UM restriction in 2009, up from 18 percent in 2007 (Exhibit 8). The use of each type of UM restriction has also increased. On average across all PDPs (weighted for enrollment), quantity limits are applied to 18 percent of drugs in 2009, prior authorization is applied to 13 percent of drugs, and step therapy to 4 percent of drugs. The application of UM restrictions is, on average, nearly identical among MA-PD plans.

  - Examining coverage of the top ten brand-name drugs commonly used by Medicare beneficiaries provides an illustration of the variation in formulary coverage and application of UM restrictions (Exhibit 9). In 2009, only three of the top ten drugs are listed on the formularies of all 44 national and near-national PDPs. A majority of the top ten brands are on a preferred cost-sharing tier in most of these plans. Two of the top ten drugs – Plavix for cardiovascular disease and Aricept for dementia – are the most likely to be covered on a preferred tier without

Exhibit 8

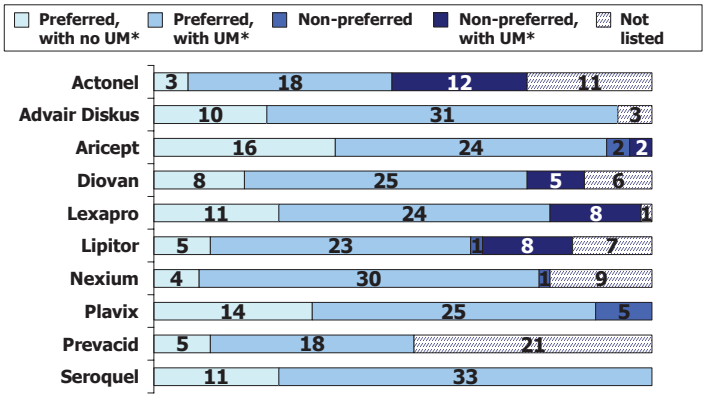
Share of Drugs with Utilization Management Restrictions Across All PDPs, 2007-2009



NOTE: Calculations are share of listed chemical entities, weighted by enrollment in each year.
SOURCE: Georgetown/NORC analysis of data from CMS for MedPAC.

Exhibit 9

National Plans Covering Top Ten Brand-Name Drugs, by Preferred Status and Restrictions, 2009



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

UM restrictions. Conversely, four drugs (Nexium and Prevacid for gastrointestinal disease, Actonel for osteoporosis, and Lipitor for high cholesterol) are covered without restrictions in only a few national and near-national plans; each of these drugs has alternatives in its drug class, including generics.

CONCLUSION

Medicare Part D plans are an important source of prescription drug coverage for nearly 60 percent of the 45 million Medicare beneficiaries in 2009. Findings from this analysis show significant increases in premiums, cost-sharing amounts, use of specialty tiers, and utilization management restrictions since 2008 that could have important implications for beneficiaries' access to needed medications and out-of-pocket expenses. Most PDPs do not offer coverage in the coverage gap, and those that do primarily cover generics; even then, they tend to cover fewer generics during the gap than in the initial coverage period. 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 increases each year (from $3,216 in 2008 to $3,454 in 2009). Among beneficiaries who reach the gap, one-fifth either stop taking one of their drugs or switch to another alternative in the drug class.[24]

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 coverage and costs for the medications they take. Ongoing research and monitoring are needed to evaluate the impact of plan changes over time that shift more costs onto enrollees in the form of higher premiums and cost sharing. Moreover, additional steps could be required to guard against the churning that has occurred for many low-income subsidy recipients when their zero-premium plan was no longer offered in their area. After three years of experience with Medicare Part D, further research will be critical in assessing the extent to which Medicare beneficiaries have access to necessary and affordable medications through Part D plans.

METHODS

This report synthesizes findings presented in a series of Medicare Part D 2009 Data Spotlights prepared by Jack Hoadley (Health Policy Institute, Georgetown University), Elizabeth Hargrave (NORC at the University of Chicago), and Tricia Neuman and Juliette Cubanski (Kaiser Family Foundation), as well as previous work by Hoadley, Hargrave and others.

Data on plan availability and premiums were collected primarily from the CMS "landscape file" released in October 2008 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.

Results on plan benefits and formularies were collected primarily from analysis funded by the Medicare Payment Advisory Commission (MedPAC) and performed by Hoadley, Hargrave, and Katie Merrell and Lan Zhao (Social and Scientific Systems). This analysis used plan benefit and formulary files released by CMS and analyzed under contract for MedPAC. An important element of this analysis is that a drug is defined as a unique chemical entity. Thus, a plan is counted as listing a drug on its formulary if it lists any brand or generic version or any form or strength of the chemical entity.

Findings on the top ten brand-name drugs are based on the analysis of data for the 44 unique, national stand-alone PDPs offered by 16 organizations in 2009, representing 89 percent of all PDPs nationwide. The remaining PDPs are mainly local or regional plans offered in 30 or fewer regions. The list of the top ten brand-name drugs is based on the number of prescriptions filled in 2006 in all Part D plans. At the time of our data collection, none of these ten drugs had direct generic equivalents, although some are in a class with a similar drug that is off-patent. 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. Unless otherwise noted, the analysis reports weighted average calculations, based on February 1, 2009 Medicare Part D plan enrollment data from CMS.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the involvement of Laura Summer as lead author on one of the spotlights in this series[25], as well as the assistance of Katie Merrell and Lan Zhao of Social and Scientific Systems on the MedPAC analysis, Rachel Schmidt and Joan Sokolovsky of MedPAC for guidance and support, and help from Kosali Simon of Cornell University in obtaining data from the Medicare Prescription Drug Plan Finder website.

[1] In 2009, the defined standard benefit has a $295 deductible, 25 percent coinsurance up to an initial benefit limit of $2,700 in total Part D drug costs, a $3,453.75 coverage gap (the "doughnut hole"), and catastrophic coverage after $6153.75 in total Part D drug costs.

[2] U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services, "Total Medicare Beneficiaries with Prescription Drug Coverage As Of February 1, 2009" (accessed at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/2009_Enrollment_Release.zip on February 24, 2009).

[3] Other Medicare Part D 2009 Data Spotlights are available at http://www.kff.org/medicare/med110608pkg.cfm. The 2008 Data Spotlight series is available at http://www.kff.org/medicare/med102507pkg.cfm. These Spotlights also build on two previous reports prepared for 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," 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," November 2006, available at http://www.kff.org/medicare/7589.cfm.

[4] This report also incorporates analysis of Part D data prepared by Jack Hoadley, Elizabeth Hargrave, and others for the Medicare Payment Advisory Commission (MedPAC). See Hoadley J, Hargrave E, Merrell K, Zhao L. Medicare Part D Benefit Designs and Formularies, 2006-2009. Presentation to the Medicare Payment Advisory Commission: Washington, D.C. December 5, 2008.

[5] This number excludes plans offered in the territories.

[6] For the 2007 and 2008 plan years, CMS used its demonstration authority to phase in enrollment weighting in calculating regional benchmarks, and to implement a "de minimis" policy. Under the "de minimis" policy, LIS beneficiaries who were enrolled in a plan losing benchmark status were allowed to stay in that plan and retain the full premium subsidy as long as the new monthly premium did not exceed the regional benchmark by more than a small (de minimis) amount ($2 in 2007 and $1 in 2008). Under the new approach used for 2009, the

de minimis rule is not in effect and CMS is using full enrollment weighting. However, benchmarks are weighted based on each plan's share of enrollees receiving the low-income subsidy, rather than their share of total Part D enrollment. This rule is intended to promote stability in benchmark plan availability from year to year by reducing the impact of lower MA-PD plan premiums on the benchmark calculation.

[7] CMS, "Year 2008 Re-Assignment Data – Premium Increase" and "Year 2008 Re-Assignment Data – Terminating Plans." November 2008; accessible at http://www.cms.hhs.gov/limitedincomeandresources/.

[8] The 2009 average reported here ($35.09) is lower than the amount reported in the November 2008 spotlight ($37.29) because the new average is weighted by actual 2009 enrollment. The average amount is lower because net switches in plan enrollment in the fall open enrollment season (including LIS beneficiaries reassigned to new plans by CMS) were to lower-premium plans.

[9] This is larger than the 21 percent increase in the monthly premium between 2006 and 2009 for a single person enrolled in FEHB BC/BS (from $125.82/month in 2006 to $152.06/month in 2009).

[10] 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.

[11] According to CMS, about 3.1 million Part D enrollees, or 12 percent, switched plans between 2007 and 2008 (data have not been released to date on switching between 2008 and 2009). 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, "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop," January 31, 2008.

[12] The plan with the $112.70 premium has only 350 enrollees. The most expensive plan with over 1,000 enrollees has a $69 premium.

[13] MedPAC, Report to the Congress: Medicare Payment Policy, March 2009.

[14] CMS, "Lower Medicare Part D Costs than Expected in 2009," press release, August 14, 2008.

[15] We classify plans labeled by CMS as covering few brands or few generics (defined as less than 10 percent of drugs in a particular category) as having "little or no coverage." We have not analyzed information on which drugs are included in the "few" drugs covered by these plans. Similarly our category "mostly generics only" includes plans that add just a "few" brand drugs to their coverage of generics.

[16] As with our reporting of plans with gap coverage, this estimate excludes enrollees in plans covering only a "few" drugs in the gap.

[17] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Chapter 3, March 2009.

[18] Based on the authors' analysis of data from the Medicare Prescription Drug Plan Finder, 2007-2009. The analysis uses prices posted on the Medicare Prescription Drug Plan Finder in 2007 and 2009 to assess prices paid by enrollees in the coverage gap; because prices vary by PDP region and pharmacy choice, the analysis examines prices in Maryland at a preferred pharmacy. Posted prices are the total cost of each drug paid in full by enrollees when they fill prescriptions in the coverage gap as well as during the deductible period.

[19] The analysis looks at trends in prices beginning in 2007, rather than 2006, because of reported problems with data presented on the Medicare Prescription Drug Plan Finder in 2006, the first year of the Part D program. In most cases, price increases over the three-year period from 2006 to 2009 appear to be significantly greater than over the two-year period from 2007 to 2009.

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

[21] In the example here, the beneficiary would spend about half of the year in the coverage gap (if she is taking no other drugs), and would reach the catastrophic cap in October or November. Once the beneficiary has paid $4,350 out of pocket, she will pay just 5 percent of the drug's costs for the rest of the year, regardless of the drug's tier placement. By the end of the year, she would have paid $4,382 in a plan that charges a $38 copayment in the initial coverage period, and $4,412 in a plan that charges 33 percent coinsurance in the initial coverage period.

[22] 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, available at http://www.cms.hhs.gov.

[23] These results are from analysis for MedPAC by Hoadley, Hargrave, and other colleagues. For that analysis, the universe of drugs includes all unique chemical entities in the CMS reference file. For example, plans are considered to cover a drug if they cover a generic version even if they do not cover the brand version or omit certain forms or strengths of the drug.

[24] Hoadley J, Hargrave E, Cubanski J, Neuman T, "The Medicare Part D Coverage Gap: Costs and Consequences in 2007," Kaiser Family Foundation, August 2008, available at http://www.kff.org/medicare/7811.cfm.

[25] Summer L, Hoadley J, Hargrave E, Cubanski J, Neuman T, "Medicare Part D 2009 Data Spotlight: Low Income Subsidy Plan Availability," Kaiser Family Foundation, available at http://www.kff.org/medicare/7836.cfm.