THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE PART D 2010 DATA SPOTLIGHT

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," where Part D enrollees are required to pay 100 percent of total drug costs after their spending exceeds the initial coverage limit and before reaching the catastrophic coverage limit. The coverage gap exists because the cost of providing continuous coverage with no gap exceeded the budgetary limit imposed on the legislation that established the Medicare drug benefit. In 2010, most Part D plans have a coverage gap, which totals $3,610 in drug costs for plans offering the standard Medicare Part D benefit; by 2019, the gap is projected to be nearly $6,000. Part D sponsors are permitted to offer an alternative benefit design that covers at least some drug costs in the gap. Part D enrollees who qualify for the low-income subsidy (LIS) are generally not responsible for costs in the coverage gap.

This Part D Data Spotlight examines the coverage gap in 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 2010 and trends since 2006, with key findings summarized in a series of data spotlights.[1]

GAP COVERAGE, 2006-2010

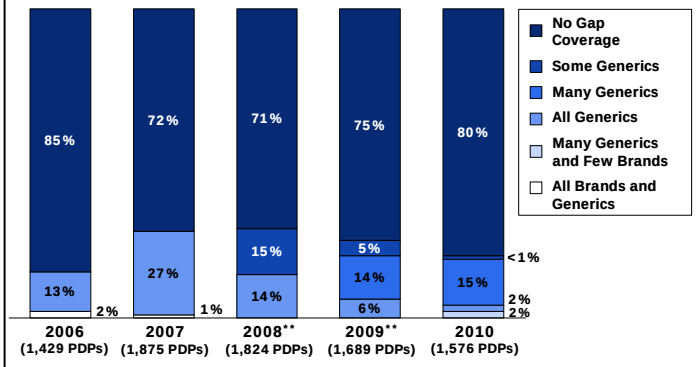
In 2010, most PDPs (80 percent) do not offer gap coverage, a larger share than in any year since 2006 (Exhibit 1). Seven of the 15 PDP sponsors with plans available in nearly every region (referred to as national PDPs) do not offer gap coverage in any of their plan offerings. A larger share of MA-PD plans than PDPs offer gap coverage in 2010, but nearly half of all MA-PD plans (48 percent) do not, as was the case in 2008 and 2009 (Exhibit 2).[2]

Gap coverage, when offered, is typically quite limited. In 2010, as in previous years, the vast majority of both PDPs and MA-PD plans that offer gap coverage cover generic drugs but not brand-name drugs. Among those PDPs offering gap coverage of generic drugs, the share covering all generics in the gap has declined from 14 percent in 2008 to 2 percent in 2010; similarly, the share of MA-PD plans covering all generics in the gap has dropped from 25 percent to 7 percent. Furthermore, plans offering gap coverage for generic drugs have covered a smaller share of generics over time.[3]

In 2010, as in 2009, no PDP offers full coverage of all brand-name and generic drugs in the gap. Prior to 2009, a small number of PDPs offered full gap coverage, but these plans were withdrawn after experiencing

Exhibit 1

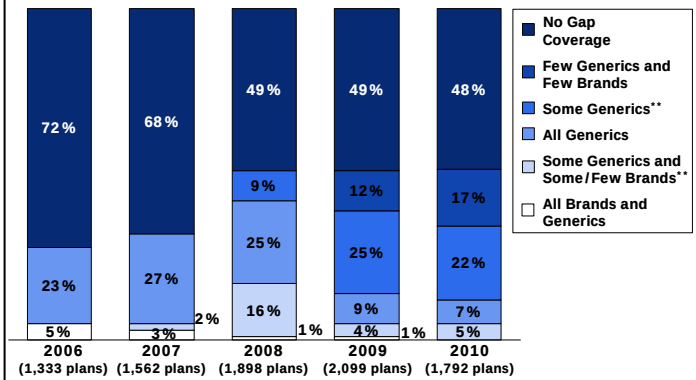
Share of Medicare Stand-Alone Prescription Drug Plans, By Type of Gap Coverage*, 2006-2010



SOURCE: Georgetown/NORC analysis of CMS PDP Landscape Source Files, 2006-2010, for the Kaiser Family Foundation.
NOTE: * Percent of formulary drugs covered in the gap: "few"=>0%-<10%; "some"==10%-<65%; "many"==65%-<100%. **In 2008, one PDP offered gap coverage for brand-name drugs (rounds to 0%). In 2009, three PDPs offered gap coverage for brand-name drugs (rounds to 0%).

Exhibit 2

Share of Medicare Advantage Prescription Drug Plans, By Type of Gap Coverage*, 2006-2010



SOURCE: Georgetown/NORC analysis of CMS MA Landscape Source Files, 2006-2010, for the Kaiser Family Foundation.
NOTES: * Percent of formulary drugs covered in the gap: "few"=>0%-<10%; "some"==10%-<65%; "many"==65%-<100%.
** For 2009 and 2010, these categories include various levels of partial gap coverage.

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significant adverse selection by high-cost enrollees. In 2010, 35 PDPs (a CIGNA plan offered in all 34 regions and one local plan in Wisconsin) cover a "few" brand-name drugs in the gap (less than 10 percent of all brands on formulary), up from three PDPs with such coverage in 2009 (with 12,000 enrollees in total). But in fact, the "few" brands covered by CIGNA are limited to 9 branded generic drugs only, according to the plan's formulary.

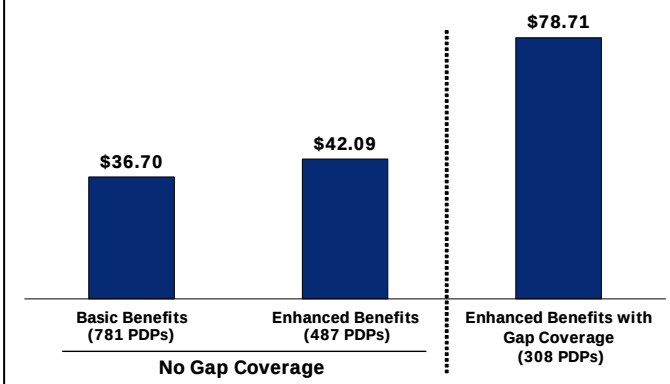
Among MA-PD plans, 23 percent cover at least a few brand-name drugs in the gap in 2010, up from 18 percent in 2009. Only 1 percent of all MA-PD plans (24 plans nationwide) cover more than 10 percent of brand-name drugs on formulary and just 4 of these plans cover all brand-name and generic drugs on their formulary in the gap – a decline since 2009. Most of the MA-PD plans covering more than 10 percent of formulary brand-name drugs in the gap in 2010 are local HMOs serving portions of California, Florida, Louisiana, Nevada, New York, and Texas.

HIGHER PREMIUMS AND COST SHARING FOR PDPS WITH GAP COVERAGE FOR GENERIC DRUGS

Beneficiaries face substantially higher premiums for PDPs that offer gap coverage than for plans without it. The average monthly premium for PDPs with gap coverage in 2010 ($78.71) is nearly double that for PDPs with no gap coverage (Exhibit 3).

Exhibit 3

Unweighted Average Monthly Premiums for PDPs, By Type of Gap Coverage, 2010



SOURCE: Georgetown/NORC analysis of CMS PDP Landscape Source Files, 2010, for the Kaiser Family Foundation.

Eight of the 15 national PDP sponsors offer gap coverage in 2010, and all but one (CIGNA Plan Three) restrict that coverage to generic drugs (Exhibit 4). Only one of the eight national PDPs (CCRx Gold) covers all generics on its formulary in the gap, while the others cover "many" generics (between 65 percent and 100 percent of generics on the formulary). Weighted average monthly premiums for these PDPs range from $63.58 to $101.34 – amounts that are $17 to $60 higher than the average monthly premiums for the most comparable PDPs without gap coverage offered by the same sponsors.

One-third of all PDPs with gap coverage, including several of the national PDPs, charge higher cost sharing for generic drugs during the gap than in the initial coverage period. For example, enrollees in AARP MedicareRx Enhanced pay twice as much for generic drugs when they reach the gap ($14) than prior to reaching the gap ($7). For enrollees in another 11 percent of PDPs that offer gap coverage (corresponding to CIGNA's national PDP), the generic drug copayment switches from a flat $6 amount during the initial coverage period to 25 percent coinsurance in the gap.[4]

Exhibit 4

Level of Gap Coverage, Cost Sharing, and Average Monthly Premium for National PDPs Offering Gap Coverage, 2010

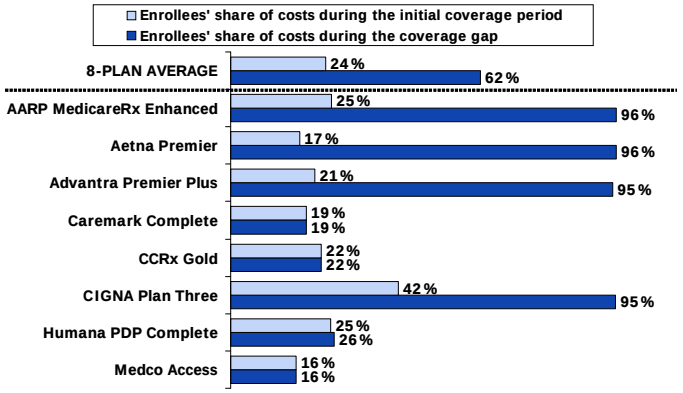
Name of PDP	Level of generic gap coverage	Generic cost-sharing amount		Weighted average monthly premium
		During initial coverage period	During the coverage gap	
AARP MedicareRx Enhanced	Many	$7	$14	$79.29
Aetna Premier	Many	$6*	$16	$86.38
Advantra Premier Plus	Many	$5*	$15	$63.58
Caremark Complete	Many	$7.50**	$7.50	$74.45
CCRx Gold	All	$6	$6	$73.22
CIGNA Plan Three	Many***	$6	25%	$63.89
Humana PDP Complete	Many	$7	$7	$101.34
Medco Access	Many	$6	$6	$77.64

SOURCE: Georgetown/NORC analysis of CMS PDP Landscape Source Files, 2006-2010, for the Kaiser Family Foundation.
NOTES: * Aetna and Advantra have non-preferred generic drug tiers with $37 and $25 copayments, respectively (no coverage in the gap). ** Caremark has a "value" generic tier with a $2.50 copayment. *** CIGNA also covers "few" brand-name drugs in the gap.

The share of total drug costs paid by beneficiaries in the coverage gap varies substantially across the eight national plans that offer gap coverage in 2010. Based on analysis of 12 generic drugs commonly prescribed to treat a range of medical conditions (not likely to be taken at the same time by the same individual), Part D enrollees in PDPs that offer generic gap coverage would pay between 16 percent and 96 percent of total costs for these drugs during the coverage gap (Exhibit 5).[5] For four of the national PDPs offering gap coverage of generics, cost sharing

for these 12 generic drugs is the same (or nearly so) in the initial coverage period and the coverage gap (between 16 percent and 26 percent). For the other four national PDPs, cost sharing increases dramatically, from between 17 percent and 42 percent in the initial coverage period to roughly 95 percent in the gap. The latter coverage is less generous because these PDPs charge higher cost sharing in the gap and do not provide coverage in the gap for some of the more expensive generic drugs. For most beneficiaries, even those plans offering a more generous level of gap coverage for generics are unlikely to offer savings of equal or greater value than the higher monthly premiums associated with gap coverage.

Exhibit 5
Share of Costs Paid Out of Pocket by Part D Enrollees in National PDPs Offering Gap Coverage, 2009



SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.
NOTES: Amounts shown are for 12 common generic drugs based prices found on the Medicare Drug Plan Finder.

DISCUSSION

Most PDPs and nearly half of all MA-PD plans offer no coverage in the so-called "doughnut hole" in 2010. The share of PDPs offering gap coverage has declined over the last few years, and the generosity of gap coverage has become more limited. Although a larger share of MA-PD plans than PDPs offer gap coverage, most do not cover the cost of brand-name drugs in the gap. Because MA-PD plans cover all Medicare-covered services, they have somewhat stronger incentives than PDPs to offer at least some gap coverage to avoid negative health and cost consequences that could arise if enrollees do not take their medications when they reach the gap. In addition, federal payments to MA-PD plans exceed the average cost of health services, providing a margin for these plans to subsidize drug coverage and premiums.

Enrolling in a plan that offers gap coverage might make financial sense for a beneficiary taking several relatively expensive generic drugs, if the plan continues to cover those particular drugs in the coverage gap and does not charge higher cost-sharing amounts for them during the gap. Even then, the value of gap coverage will depend on the mix of drugs taken by an individual and the total number of months spent in the gap. CMS could enhance the value of gap coverage for consumers by prohibiting plans from charging higher cost sharing for prescriptions filled in the gap than in the initial coverage period and by requiring plans to cover the same set of generic drugs in the coverage gap that they cover during the initial coverage period. CMS could also assess the actuarial value of gap coverage and require that premiums do not exceed the value of coverage, unless justified by other benefit enhancements.

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.[6] 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 or incurring high out-of-pocket spending in the coverage gap, options for phasing out the "doughnut hole" over a period of years and providing some relief for those who reach the gap are under active consideration in health reform legislation.

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[1] Other Medicare Part D 2010 Data Spotlights, based on the authors' analysis of CMS data, are available at http://www.kff.org/medicare/med110909pkg.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] CMS classifies plans that offer gap coverage as providing coverage in the gap for "few" (up to 10 percent), "some" (10 to 65 percent), "many" (more than 65 percent), or "all" of the brand-name or generic drugs on their formularies.
[4] The switch to 25 percent coinsurance results in higher cost sharing for generics that cost more than $24 but lower otherwise.
[5] The drugs studied include albuterol/ipratropium, alendronate, amlodipine, hydrochlorothiazide, hydrocodone/acetaminophen, levothyroxine, metformin, metoprolol, pantoprazole, sertraline, sumatriptan, and zolpidem. We tested the robustness of these findings with several modifications and found the same general pattern of results.
[6] Hoadley J et al., "The Medicare Part D Coverage Gap: Costs and Consequences in 2007," Kaiser Family Foundation, August 2008.