THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE PART D 2010 DATA SPOTLIGHT

BENEFIT DESIGN AND COST SHARING

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

DECEMBER 2009

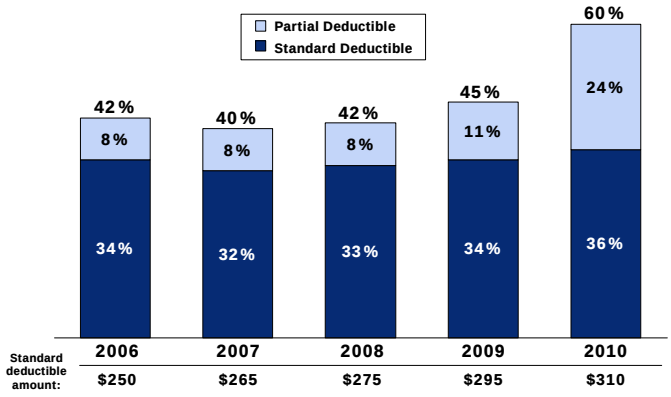
The Medicare Modernization Act (MMA) established a defined standard drug benefit for Part D stand-alone Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug (MA-PD) plans, while giving plans flexibility to offer alternative benefit designs. In 2010, the standard benefit includes a $310 deductible, followed by 25 percent cost sharing up to an initial coverage limit of $2,830. Most Part D plans offer something other than the defined standard benefit; only about one in ten PDPs offers the standard benefit in 2010. Plan sponsors can offer alternative benefit designs that are, at a minimum, actuarially equivalent to the defined standard and can also offer enhanced benefits. This Part D Data Spotlight examines the benefit designs of Medicare stand-alone PDPs in 2010. 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]

A MAJORITY OF PDPS CHARGE A DEDUCTIBLE IN 2010

2010 is the first year in which a majority of PDPs (60 percent) charge a deductible (Exhibit 1). More than one-third of all PDPs charge the standard deductible, roughly the same share as in 2006. Nearly a quarter of PDPs charge a deductible less than the standard amount, up from just one in ten PDPs in 2009. For 2010, seven national or near-national PDPs with a combined enrollment of 1.1 million (including Medco Choice, Community CCRx Choice, AdvantraRx Value, and First Health Part D-Premier) added a deductible, ranging from $100 to $150.

Exhibit 1

Share of Medicare Stand-Alone Prescription Drug Plans with a Deductible, 2006-2010



SOURCE: Georgetown/NORC analysis of CMS PDP Landscape Source Files, 2006-2010, for the Kaiser Family Foundation.
NOTE: Estimates may not sum to total due to rounding.

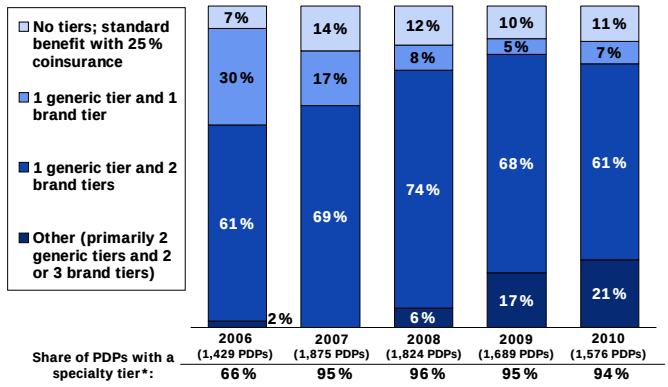
MOST PDPS HAVE GENERIC, PREFERRED, NON-PREFERRED, AND SPECIALTY TIERS

In 2010, as in previous years, most PDPs have a tiered cost-sharing structure, instead of charging enrollees 25 percent coinsurance for all drugs (Exhibit 2). Tiered copayments create incentives for enrollees to use less expensive drugs. In 2010, about three-fifths of all PDPs have one tier for generic drugs, a second tier for preferred brand-name drugs, a third tier for non-preferred brand-name drugs, and a fourth tier for specialty drugs.

Since 2006, there has been a trend toward more complicated tier structures. Between 2006 and 2010, the share of PDPs with a single tier for brand-name drugs declined from 30 percent to 7 percent, while the share of PDPs with multiple generic and brand tiers has risen from 2 percent to 21 percent. For example, AdvantraRx Premier Plus (with 161,000 enrollees in 2009), which charged $8 for generic drugs in 2008 and 2009, has added a second generic tier for 2010 and now

Exhibit 2

Share of Medicare Stand-Alone Prescription Drug Plans, By Formulary Tier Structure, 2006-2010



SOURCE: Georgetown/NORC analysis of CMS MA Landscape Source Files, 2006-2010, for the Kaiser Family Foundation.
NOTE: *Excludes plans offering the standard benefit design and unclassifiable plans.

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

charges $5 for preferred generics and $25 for non-preferred generics. CVS Caremark Plus (with about 28,000 enrollees in 2009) has six tiers: "value" generics, generics, "value" brands, preferred brands, non-preferred brands, and specialty drugs.

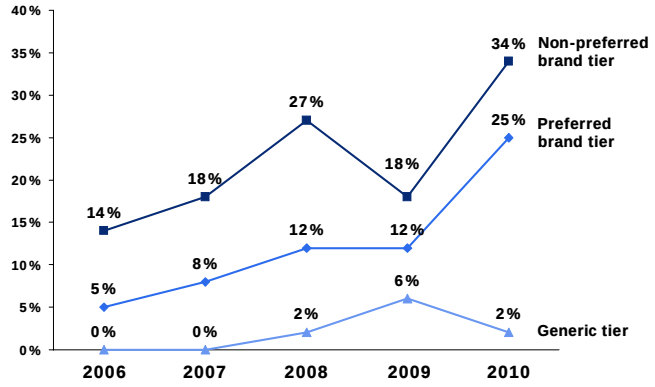
Virtually all PDPs with tiered cost sharing include a specialty tier in 2010, as has been the case since 2007. Plan sponsors use the specialty tier to help manage the cost of expensive drugs for which there are typically no cheaper alternatives, such as Enbrel for rheumatoid arthritis or the cancer drug Gleevec. According to CMS guidelines, drugs placed on the specialty tier must cost at least $600 per month.[2] Specialty tier coinsurance ranges from 25 percent to 33 percent, and enrollees are not allowed to request cost-sharing exceptions for specialty tier drugs covered by their plan. The small share of PDPs with tiered cost sharing but no separate specialty tier typically charge coinsurance of at least 25 percent for brand-name drug tiers; for example, CCRx Basic charges coinsurance rates of 25 percent or 30 percent for preferred brands and 50 percent to 75 percent for non-preferred brands (varying by region).

FLAT DOLLAR COPAYMENTS ARE MOST COMMON, BUT MORE PDPS USE COINSURANCE IN 2010

PDPs typically charge a coinsurance rate for specialty tier drugs and flat dollar copayments for drugs on their other formulary tiers. However, the share of PDPs using coinsurance rather than copayments for non-specialty brand-name drug tiers has increased overall since 2006 (Exhibit 3). In 2010, one-fourth of PDPs charge a coinsurance rate for preferred brands and one-third charge coinsurance for non-preferred brands.

Exhibit 3

Share of Medicare Stand-Alone Prescription Drug Plans Charging Coinsurance Rates, 2006-2010



SOURCE: Georgetown/NORC analysis of CMS MA Landscape Source Files, 2006-2010, for the Kaiser Family Foundation.
NOTE: Percent of plans using coinsurance for each tier is calculated as a percentage of the plans using that tier.

Coventry (with 1.2 million PDP enrollees in 2009) is the largest plan sponsor to shift from copayments to coinsurance in 2010, doing so for all five of its AdvantraRx and First Health PDPs offered nationwide. In the largest plan, First Health Part D-Premier, typical cost sharing for preferred brands has changed from a $27 copayment to 11 percent coinsurance. For non-preferred brands, cost sharing has changed from a $58 copayment to 43 percent coinsurance. In Coventry's AdvantraRx Premier Plus PDP, cost sharing for non-preferred brands has changed from a $75 copayment to coinsurance of 75 percent.

Charging coinsurance rates rather than copayments for expensive drugs can translate into higher cost sharing for enrollees. To illustrate, we examined the cost sharing that enrollees would incur for Abilify and Seroquel, two commonly-used antipsychotic medications, in the three Community CCRx PDPs sponsored by Universal American in the New York region. CCRx Basic charges coinsurance of 25 percent and 60 percent for preferred and non-preferred brands, respectively, while CCRx Choice and CCRx Gold charge copayments of $35 and $65, respectively. For Seroquel, covered by all three PDPs on the preferred tier, 25 percent coinsurance in CCRx Basic amounts to $78.62, or more than twice as much as the $35 copayment amount in the Choice and Gold PDPs – and also more than the copayment amount for the non-preferred tier in those plans. For Abilify, covered by all three PDPs on the non-preferred tier, 60 percent coinsurance in the Basic plan translates into $259.43, or four times as much as the $65 copayment in the Choice and Gold plans. Of course, the results of such comparisons will vary by drug; for preferred drugs costing less than $140 per prescription, the 25 percent coinsurance in CCRx Basic would be less than the other plans' $35 copayment.

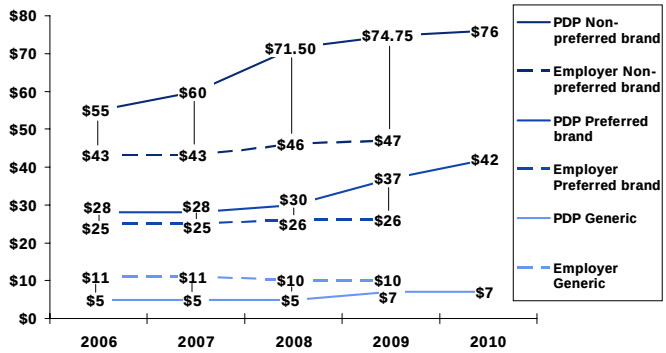
COST SHARING HAS INCREASED EACH YEAR SINCE 2006

Since 2006, median cost sharing for a 30-day supply of preferred brand-name drugs has increased by $14, or 50 percent, while median cost sharing for non-preferred brand drugs has increased by $21, or nearly 40 percent (Exhibit 4).[3] Median cost sharing for generic drugs has increased $2 since 2006, a

small dollar amount but a 40 percent increase. The rate of growth in cost sharing is smaller between 2009 and 2010 than between 2008 and 2009 for each tier.

While the median cost sharing for specialty tier drugs has increased from 25 percent in 2006 to 30 percent in 2010, the rate in 2010 is lower than the median coinsurance of 33 percent for specialty tier drugs in 2009. Under current rules, plans are permitted to increase cost sharing on the specialty tier from 25 percent to as high as 33 percent if they lower the standard deductible enough to offset the higher coinsurance. Some PDPs appear to have opted to charge a higher deductible rather than a higher specialty coinsurance rate in 2010; in fact, all of the seven national PDPs that added a partial deductible for 2010 have lowered their specialty tier coinsurance rate from 33 percent to no more than 30 percent.

Exhibit 4
Cost Sharing in Medicare Stand-Alone Prescription Drug Plans and Employer Health Benefit Plans, 2006-2010



SOURCE: Georgetown/NORC analysis of CMS MA Landscape Source Files, 2006-2010, for the Kaiser Family Foundation. Data for employer plans from Kaiser Family Foundation/HRET 2009 Employer Health Benefits Survey (not yet available for 2010).
NOTE: Amounts are weighted median values for PDPs with selected formulary tiers and means for employer plans.

Medicare Part D enrollees typically pay more for brand-name drugs but less for generics than those covered under employer plans, a pattern which has been consistent since 2006 (Exhibit 4).[4] In 2009, the median copayment was $37 for preferred brands and $74.75 for non-preferred brands in PDPs, compared to average copayments of $26 and $47, respectively, in employer plans. Only a small share of employer plans have fourth tiers (not always for specialty drugs), with average coinsurance similar to the median for Medicare PDPs (around 30 percent). These comparisons suggest that the financial incentive to switch to a lower-cost drug is generally stronger in PDPs than in employer plans. In 2009, the typical PDP enrollee faced a five-fold difference in cost sharing for preferred brands compared to generics ($37 versus $7), while the difference was only half as great ($26 versus $10) for those in employer plans. The difference between preferred and non-preferred brands was also larger in PDPs than in employer plans.

DISCUSSION

While there are many specific ways in which Medicare stand-alone PDPs have changed their benefit designs since 2006, the overall trend is toward rising costs for enrollees. As the cost of prescription drugs continues to rise, Part D plans are passing on higher costs to beneficiaries in the form of higher premiums, deductibles, and cost sharing for each prescription. This is partly a function of the design of the Part D benefit, which requires plans to charge cost sharing equivalent to 25 percent of drug costs in the initial coverage period (or to charge a higher premium if cost sharing is lower on average than the standard amount). The trend toward greater use of coinsurance and additional cost-sharing tiers could mean higher costs for Part D enrollees who need expensive drugs for which there are no alternatives.

The rising cost of medications makes it important for beneficiaries to compare plans offered in their area, yet the increasingly complex benefit design of many Part D plans can make it more difficult for beneficiaries to compare plans and choose that which is most likely to minimize their costs. For beneficiaries who try to compare plans based on more than just the current drugs they are taking, CMS may need to identify new ways to communicate the relative cost of coinsurance and copayments for common drugs. Monitoring trends in Part D benefit design and cost sharing, particularly those arrangements that appear to shift costs onto beneficiaries who rely on relatively expensive medications, will continue to be an important aspect of program oversight.

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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] Centers for Medicare & Medicaid Services, 2010 Call Letter, March 30, 2009.
[3] In PDPs with coinsurance for brand drugs, the median is 25 percent for the preferred tier and 50 percent for the non-preferred tier.
[4] Kaiser Family Foundation/HRET Employer Health Benefits 2009 Survey; http://ehbs.kff.org/.