THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE PART D 2010 DATA SPOTLIGHT

A COMPARISON OF PDPs OFFERING BASIC AND ENHANCED BENEFITS

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Companies that sponsor Medicare Part D prescription drug plans are required to offer a basic benefit, either the standard Part D benefit defined by law or an actuarially equivalent benefit design. In 2010, the standard benefit has a $310 deductible, 25 percent coinsurance up to an initial coverage limit of $2,830 in total drug spending, a coverage gap (also known as the "doughnut hole"), and catastrophic coverage after an enrollee's out-of-pocket drug spending exceeds $4,550. Plan sponsors can also offer plans with enhanced drug benefits. Enhanced plans are required to have a greater actuarial value than basic plans, but plans vary in the ways in which they improve coverage.[1] Enhanced plans may reduce or eliminate the deductible, charge less (on average) than the standard 25 percent coinsurance, and cover drugs in the coverage gap.

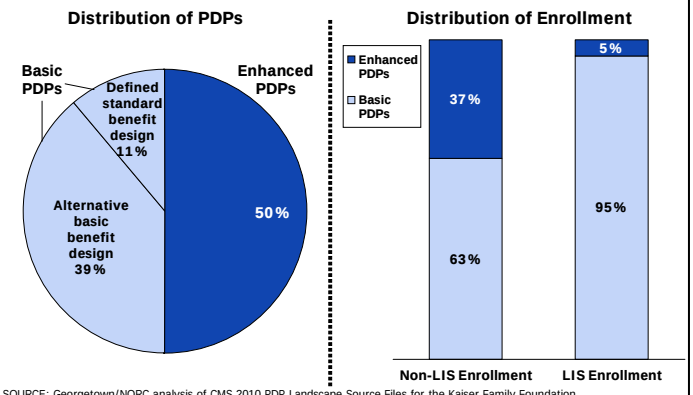
This Part D Data Spotlight examines key differences between basic and enhanced Medicare stand-alone prescription drug plans (PDPs), including monthly premiums, cost sharing, and gap coverage. It also examines plan names to assess whether they convey meaningful differences between basic and enhanced PDPs. 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.[2]

HALF OF ALL PDPS ARE ENHANCED, BUT MOST ENROLLEES ARE IN BASIC PDPS

In 2010, 11 percent of the 1,576 stand-alone PDPs (excluding the territories) offer the standard benefit, 39 percent offer actuarially equivalent basic benefits, and the remaining 50 percent offer enhanced benefits (similar to previous years) (Exhibit 1). Nearly two-thirds (63 percent) of all PDP enrollees who are not receiving low-income subsidies (LIS) are in plans that offer basic coverage. Nearly all LIS recipients (95 percent) are enrolled in basic plans – mainly because enhanced plans do not qualify for the LIS auto-enrollment process and full premium subsidies are not typically provided for LIS enrollees in enhanced plans.

Exhibit 1

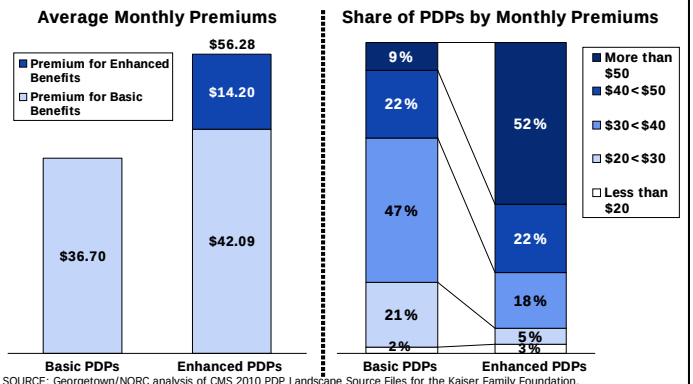
Distribution of Medicare Stand-Alone Prescription Drug Plans and Enrollment, By Benefit Design, 2010



SOURCE: Georgetown/NORC analysis of CMS 2010 PDP Landscape Source Files for the Kaiser Family Foundation.
NOTE: PDP is prescription drug plan. LIS is low-income subsidy.

Exhibit 2

Average Monthly Premiums and Distribution of Medicare Stand-Alone Prescription Drug Plans, By Benefit Design and Monthly Premium, 2010



SOURCE: Georgetown/NORC analysis of CMS 2010 PDP Landscape Source Files for the Kaiser Family Foundation.
NOTE: PDP is prescription drug plan.

PREMIUMS AND BENEFIT DESIGNS OF BASIC AND ENHANCED PDPS

Enhanced plans typically charge higher premiums, but not always. In 2010, average unweighted monthly premiums are 50 percent higher for enhanced PDPs than basic PDPs ($56.28 versus $36.70, respectively) (Exhibit 2). More than half (52 percent) of all enhanced plans have monthly premiums in excess of $50, compared to only nine percent of basic plans.

The monthly premium for an enhanced PDP can be divided into two components: one for

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the cost of the basic benefit portion of the total drug benefit package and one for the enhanced portion.[3] Enhanced PDPs charge 15 percent more on average for the basic benefit portion than basic PDPs, while also charging an additional $14.20 per month, on average, for enhanced benefits. The vast majority of enhanced PDPs have an enhanced premium amount no higher than $20 (ranging from less than $1 to $55 per month).

For 136 basic plans offered in 2010 (about one-fourth of the matched basic-enhanced PDP combinations), their monthly premiums are actually higher than premiums for enhanced plans offered by the same sponsor in the same region, despite the fact that basic plans have a lower actuarial value; in a few cases, premiums are as much as $25 higher. Three plan sponsors (Aetna, Coventry, and Humana) set their PDP premiums in this pattern more often than other sponsors.

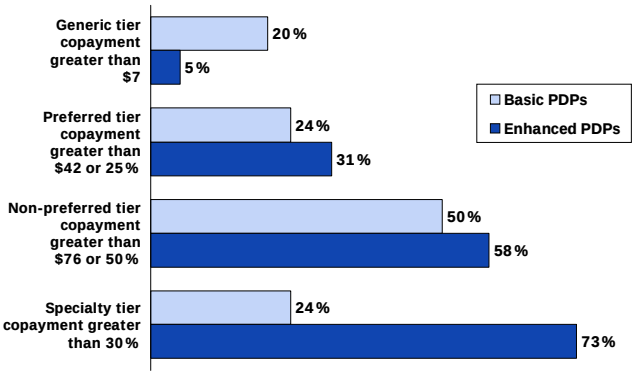
Fewer enhanced plans have deductibles. More than two-thirds (68 percent) of all enhanced PDPs charge no deductible in 2010, compared to only 12 percent of basic PDPs. Basic plans can reduce the standard deductible only if the plan's actuarial value is the same as the standard benefit. To accomplish this, they must raise cost-sharing levels. By contrast, enhanced plans do not have to reduce the value of another component of the benefit package to offer a lower deductible.

Many enhanced plans offer some gap coverage; basic plans cannot. Nearly four in ten enhanced PDPs (39 percent) offer some coverage in the gap in 2010, while basic plans cannot do so because gap coverage is, by definition, an enhanced benefit. Gap coverage, when offered, tends to be limited to a subset of generic drugs, and plans tend to charge relatively high premiums for minimal gap coverage.[4]

Enhanced plans often charge higher cost sharing than basic plans. Enhanced PDPs often charge enrollees higher cost-sharing amounts for their prescriptions than basic plans.[5] Some enhanced plans appear to offer a lower deductible in conjunction with higher cost sharing. In 2010, a larger share of enhanced than basic PDPs with different cost-sharing tiers charge more than the median amount for three of four standard cost-sharing tiers (Exhibit 3). Nearly one-third of enhanced PDPs charge a copayment above the median for preferred brand-name drugs (greater than $42 or 25 percent), compared to 24 percent of basic PDPs. More than half (58 percent) of enhanced PDPs charge more than the median cost-sharing amount for non-preferred brands (greater than $76 or 50 percent), compared to 50 percent of basic PDPs. Among PDPs with specialty tiers, nearly three-quarters of enhanced PDPs (73 percent) charge coinsurance greater than 30 percent, while only one-quarter of all basic PDPs do so.

Exhibit 3

Share of Basic and Enhanced PDPs With Tiered Cost Sharing Above Median Amounts, 2010



SOURCE: Georgetown/NORC analysis of CMS 2010 PDP Landscape Source Files for the Kaiser Family Foundation.
NOTE: PDP is prescription drug plan.

Formularies generally do not differ between basic and enhanced plans. Though Part D plans are required to meet minimum standards with respect to formularies, formularies are not taken into account by CMS in measuring a plan's actuarial value, and many sponsors use the same formulary for both basic and enhanced plans. Analysis indicates that the size of plan formularies, whether measured by the share of drugs that are on formulary or by the share of drugs with no formulary restrictions, does not differentiate basic and enhanced PDPs.[6]

DO PDP PLAN NAMES DISTINGUISH BETWEEN BASIC AND ENHANCED BENEFIT DESIGNS?

Under current rules, Medicare Part D plan sponsors are not required to use uniform terminology in naming plans to distinguish basic from enhanced plans or indicate which benefit features are associated with enhanced coverage. In 2010, plan sponsors use a variety of names for their various plan options (Exhibit 4). Plan names such as Essentials, Saver, and Value may be intended to convey to beneficiaries that coverage is basic, while Complete, Gold, or Premier may sound like enhanced coverage. But in

several instances, sponsors offering both types of plans use names that do not readily convey relative generosity with respect to basic or enhanced coverage. For example, Coventry's AdvantraRx Premier PDP is a basic plan despite having "premier" in the name, while its Value PDP is enhanced. In contrast, CVS Caremark and Medco use "Value" as the name of their basic plans and Aetna uses "Premier" as the name of one of its enhanced plans. The Humana Enhanced PDP, offered in many regions prior to 2010 as an enhanced plan, is an enhanced plan in 18 regions and a basic plan in 15 regions in 2010, but without any apparent changes in plan design.

Exhibit 4
Examples of Basic and Enhanced Medicare Stand-Alone Prescription Drug Plan Names, 2010

Plan Sponsor	Basic PDP Name				Enhanced PDP Name	
Aetna	Essentials				Plus	Premier
CIGNA	One				Two	Three
Coventry – AdvantraRx	Premier				Value	Premier Plus
CVS Caremark	Value				Plus	Complete
Envision	Silver				Gold	
First Health	Premier				Secure	
HealthNet	Orange Option 1				Orange Option 2	
Humana	Basic	Standard	Value	Enhanced*	Enhanced*	Complete
Medco	Value				Choice	Access
Rx America – Advantage	Star				Freedom	
United American	UA Medicare Silver				UA Medicare	
United HealthCare	Saver	Preferred			Enhanced	
Universal American – CCRx	Basic				Choice	
Universal Amer.–PrescribaRx	Bronze				Gold	
WellCare	Classic				Signature	

SOURCE: Georgetown/NORC analysis of CMS 2010 PDP Landscape Source Files for the Kaiser Family Foundation.
NOTE: PDP is prescription drug plan.

DISCUSSION

This analysis of basic and enhanced Medicare PDPs presents a somewhat unclear picture for consumers choosing between basic and enhanced Part D coverage. Enhanced plans generally charge higher monthly premiums than basic plans, although not consistently so. A greater share of enhanced plans than basic plans charge no deductibles, and by definition, a greater share offer some gap coverage. Yet a larger share of enhanced plans charge cost-sharing amounts higher than the median for all PDPs.

A successful competitive Medicare Part D marketplace, with consumers well-equipped to compare and choose plans based on their individual needs and circumstances, requires that comparative information about plan options be made available to beneficiaries and that differences between plans be both meaningful and transparent to consumers. In recently proposed regulations, CMS indicates that it does not expect that plan sponsors can demonstrate substantial differences between plans offering basic benefits without substantial differences in approved formularies, and that substantial coverage in the coverage gap typically must be offered to demonstrate that one enhanced plan is substantially different from another.[7] Our analysis suggests that beneficiaries may find it difficult to identify the added value of an enhanced plan, and when that added value justifies the higher premiums associated with enhanced coverage.

CMS's recent statements, together with our findings, raise several questions: Should a Part D plan sponsor's basic PDPs have lower premiums than its enhanced PDPs? Should enhanced PDPs have clearly more generous benefit design, with lower cost sharing in most (if not all) situations? Should the additional value be shown in the Medicare Prescription Drug Plan Finder and other enrollment materials to ensure greater transparency? Should plan names follow a consistent pattern so that enhanced plans can be clearly identified? How should plan sponsors be monitored to ensure they are not using the enhanced PDP designation to deter enrollment of low-income subsidy beneficiaries? Addressing these questions could help to ensure that beneficiaries understand the differences between Part D plans prior to enrolling, since the differences could have a significant impact on their out-of-pocket spending and access to needed medications.

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[1] CMS requires that plan sponsors certify the actuarial value of the benefit design, taking into account how a plan's design features influence average drug spending and thus the actuarial value.
[2] 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.
[3] Enhanced plans are required to estimate the premium for the basic benefit, which is subsidized by Medicare, and an additional premium for their extra benefits, which is paid entirely by the beneficiary.
[4] For a discussion of gap coverage, see "Medicare Part D 2010 Data Spotlight: The Coverage Gap," http://www.kff.org/medicare/med110909pkg.cfm.
[5] For a discussion of cost sharing, see "Medicare Part D 2010 Data Spotlight: Benefit Design and Cost Sharing," http://www.kff.org/medicare/med110909pkg.cfm.
[6] An unrestricted drug appears on a generic or preferred tier and has no flags for prior authorization, step therapy, or quantity limits. Formulary analysis based on plans available in 2009 was conducted by MedPAC; plans not offered in 2009 are omitted from this analysis.
[7] Centers for Medicare & Medicaid Services, "Medicare Program; Policy and Technical Changes to the Medicare Advantage and the Medicare Prescription Drug Benefit Programs," October 22, 2009.