MEDICARE PART D 2010 DATA SPOTLIGHT

MEDICARE PRESCRIPTION DRUG PLANS IN 2010 AND KEY CHANGES OVER FIVE YEARS: SUMMARY OF FINDINGS

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SEPTEMBER 2010

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; they 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 27 million Medicare beneficiaries are enrolled in Medicare drug plans, including 17.7 million in PDPs and 9.7 million in MA-PD plans.[2]

Part D has been in a work in progress since its inception in 2006 due to the evolution of the private plan marketplace and the regulations that govern the program. Moreover, the Affordable Care Act of 2010 will bring other significant changes to the program over the next decade, starting in 2010 with a $250 rebate for Part D enrollees who reach the coverage gap, or "doughnut hole," in the drug benefit.[3] Starting in 2011, pharmaceutical manufacturers will offer a 50 percent discount on the price of brand-name drugs in the gap. The law gradually reduces cost sharing for both brands and generics in the gap until it reaches the standard 25 percent level in 2020, thus eliminating the coverage gap. In addition, the Centers for Medicare & Medicaid Services (CMS) is implementing other statutory and regulatory changes that will affect how the program works and could result in further consolidation of Part D plan offerings for 2011 and future years.

This report summarizes findings from a series of Medicare Part D 2010 Data Spotlights documenting changes in drug coverage and costs since 2006, and incorporates some additional information and analysis.[4,5] It presents key findings related to Medicare drug plan premiums, the subsidy for low-income beneficiaries, the coverage gap, benefit design and cost sharing, formularies, and utilization management, based on data from 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 10 percent higher in 2010 than in 2006, with a total of 1,576 PDPs and at least 41 PDPs offered in every state this year.[6] After peaking in 2007, however, the total number of PDPs has declined by 15 percent since then.***
  - The number of PDPs increased sharply between 2006 and 2007, as additional sponsors entered the program and some sponsors added more plans **(Exhibit 1)**. Since 2007, the number of plans has decreased gradually, mainly due to mergers between sponsoring organizations and consolidation of plan offerings by individual sponsors.[7]
  - The number of PDPs available in 2010 varies across regions, from a low of 41 in Alaska and Hawaii to a high of 55 in the region covering Pennsylvania and West Virginia.

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- The number of MA-PD plans, excluding Special Needs Plans (SNPs), increased by about 50 percent between 2006 and 2009, from 1,333 plans to 1,991 plans. However, the availability of MA-PD plans fell about 10 percent to 1,792 plans in 2010.[8] In 2010, 538 SNPs were offered.
- CMS has announced in recent regulation its expectation that Part D plan sponsors will drop plans with low enrollment and demonstrate that their multiple plan offerings have substantially different benefits and formularies.

PREMIUMS

- ***Since 2006, the average PDP premium, weighted by enrollment, has increased by 44 percent. Monthly PDP premiums vary widely in 2010, as in previous years.***
  - The weighted average premium paid by beneficiaries for stand-alone Part D coverage has increased by 44 percent, from $25.93 in 2006 to $37.25 in 2010 **(Exhibit 2)**.[9,10] Between 2009 and 2010, the average PDP enrollee paid 6 percent more in premiums – a significantly smaller one-year premium increase than the previous year-to-year increase of 17 percent.
  - Monthly premium increases for some drug plans with the highest enrollment have been larger than the increase in the national average. Since 2006, the premium for UnitedHealth's AARP MedicareRx Preferred plan has increased by 50 percent from $26.31 to $39.41, while the average monthly premium for Humana's Enhanced PDP has nearly tripled from $14.73 to $41.40.
  - Premiums for the drug benefit offered by MA-PD plans (excluding SNPs) are lower than PDP premiums, on average. The average 2010 monthly premium amount attributable to drug benefits is $13.32, more than $20 below the PDP average.[11] Many MA-PD plans reduce or eliminate their premiums by using a portion of rebates from the Medicare Advantage payment system.[12]
  - Enrollees in stand-alone Part D plans tend to pay substantially higher premiums for plans with gap coverage compared to those without such coverage. On average, the weighted monthly premium for a stand-alone PDP offering some gap coverage (mainly for generic drugs) is more than twice that for plans offering an enhanced benefit with no gap coverage **(Exhibit 2)**.
  - Plans with an enhanced benefit design without gap coverage are priced only modestly higher than plans offering a basic benefit. Although enhanced plans are less likely to have deductibles, they often charge higher cost sharing than basic plans.

THE COVERAGE GAP

- ***In 2010, most enrollees are in Part D plans that 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 (but receive a $250 rebate this year to help with those costs). Beneficiaries can pay extra for a plan that offers some coverage in the gap, but nearly all gap protection offered by plans in 2010 covers only generic drugs. The Part D coverage gap, which in 2010 begins after enrollees (other than those with the low-income subsidy) incur $2,830 in total drug costs, will be phased out over the next decade.***
  - In 2010, most plans (81 percent of stand-alone PDPs and 66 percent of MA-PD plans) offer little or no gap coverage.[13] Thus, in 2010, 94 percent of PDP enrollees are enrolled in plans with little or no gap coverage – the same as in 2006 **(Exhibit 3)**.
  - The share of all PDP enrollees who actually face a gap is 47 percent, considerably smaller than the 94 percent enrolled in plans without gap protection, because enrollees receiving low-income subsidies do not face a gap in drug coverage. In 2010, the majority of non-LIS Part D enrollees (89 percent) are in PDPs without gap coverage, similar to previous years.

- More than 4 in 10 (44 percent) MA-PD plan enrollees have at least some gap coverage, a substantial increase since 2006 **(Exhibit 3)**.[14] 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.[15] 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.
- However, the vast majority of beneficiaries with gap coverage are in plans that only cover generic drugs in the gap. Only about 3 percent of MA-PD plans enrollees and no PDP enrollees have any significant brand coverage in the gap. Furthermore, gap coverage that includes all generic drugs has declined over time. In 2010, only 11 percent of MA-PD plan enrollees and less than 1 percent of PDP enrollees are in plans that cover all generics in 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 this tiered structure, cost sharing has increased since 2006, particularly for brand-name drugs.***
  - The number of plans that offer the defined standard benefit has declined over time; in 2010, only 11 percent of PDPs and 5 percent of MA-PD plans make no use of formulary tiers. The most common model for tiered cost sharing includes four tiers: generic drugs, preferred brand drugs, non-preferred brand drugs, and specialty drugs. An increasing number of plan sponsors now offer formularies with two generic tiers.
  - Use of a deductible by stand-alone PDPs is considerably higher in 2010 than in previous years. About 60 percent of PDPs charge a deductible this year, compared to between 40 percent and 45 percent in prior years.
  - Although flat dollar copayments remain the most common type of cost sharing, the share of PDPs using coinsurance for non-specialty brand-name drug tiers has increased since 2006. In 2010, one-fourth of PDPs charge a coinsurance rate for non-preferred brand drugs. Of these plans, most have a mixed pricing design with flat copayment in their generic drug tiers for generic drugs and sometimes for preferred brand drugs as well.
  - Since 2006, the median cost sharing for a 30-day supply of "non-preferred" brand-name drugs in stand-alone PDPs has increased by 39 percent, from $55 to $76.50, while cost sharing for "preferred" brand drugs increased by 50 percent, from $28 to $42 **(Exhibit 4)**. 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 and 2010.
  - Medicare Part D plans generally charged more than employer plans did in 2009 (the most recent year available) for preferred and non-preferred brand drugs, but somewhat less for generics **(Exhibit 4)**. For example, employer plans typically charged $26 per month for a preferred brand in 2009, well below the median $37 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 2010, as they have in previous years. For example, an individual with Alzheimer's disease could pay as little as $25 for a month's supply of Aricept under one of the 43 national and near-national PDPs in 2010, but as much as $101 per month under another **(Exhibit 5)**.

- ***Between 2009 and 2010, Part D enrollees who pay the full cost of their drugs in the coverage gap or deductible faced price increases higher than inflation for top brand-name drugs.***
  - Monthly prices in the coverage gap increased by 5 percent or more between 2009 and 2010 for half of the top ten brand-name drugs. For example, the price for Actonel, a treatment for osteoporosis, increased by 8 percent, from $91 per month in 2009 to $98 per month in 2010. By comparison the overall inflation rate was 2.7 percent in that same period, and the medical care inflation rate was 3.5 percent.
  - Between 2006 and 2010, monthly prices in the coverage gap increased by 20 percent to 25 percent for Lipitor, Plavix, Nexium, and Lexapro and by about 40 percent for Actonel and Aricept. By comparison overall inflation and medical inflation rates were 9.2 percent and 16.1 percent across the same years.

<u>SPECIALTY TIERS</u>

- ***Most Part D plans use a specialty tier for high-cost medications in 2010, and many 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 2010). 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 2010, among Part D enrollees in plans using tiered cost sharing, 89 percent of PDP enrollees and 97 percent of MA-PD plan enrollees are in plans with a specialty tier. Many of the plans without specialty tiers charge coinsurance for all covered brand-name drugs, including drugs that tend to be placed by other plans on specialty tiers.
  - In 2010, about half of PDP enrollees and three-fourths of MA-PD plan enrollees are in plans charging 33 percent coinsurance for specialty drugs in the initial coverage period **(Exhibit 6)**. Compared to 2009, this share is down modestly for PDPs, but up substantially for MA-PD plans. By contrast, only four of the 35 national or near-national PDPs charged a 33 percent coinsurance rate for specialty tier drugs in 2006. While CMS limits the coinsurance rate for drugs placed on a specialty tier to 25 percent, plans are allowed to impose higher cost sharing for specialty tier drugs if offset by a lower deductible.[16]

<u>FORMULARIES AND UTILIZATION MANAGEMENT</u>

- ***The scope of formulary coverage continues to vary widely across PDPs in 2010. Since 2007, PDPs have applied utilization management (UM) 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.[17] Some plans list all drugs from the CMS drug reference file on their formularies, while other plans list as few as 62 percent of these drugs.[18] In 2010, the average PDP formulary lists 87 percent of the drugs in the CMS drug reference file, similar to the share of covered drugs in the previous three years. MA-PD plans list slightly more drugs (90 percent) on formulary than PDPs. Beneficiaries retain the option of requesting an exception to have the plan cover an off-formulary drug or can purchase the drug by paying out of pocket.
  - Even if a drug is listed on a plan's formulary, utilization management restrictions, including step therapy, prior authorization and quality limits, may restrict a beneficiary's access to the drug.[19] UM restrictions have increased since 2007, with 28 percent of drugs subject to some UM restriction in 2010, up from 18 percent in 2007 **(Exhibit 7)**.

- Quantity limits are applied to 16 percent of drugs in 2010, prior authorization is applied to 15 percent of drugs, and step therapy to 3 percent of drugs, on average across all PDPs (weighted for enrollment). MA-PD plans tend to apply UM restrictions in a similar fashion.
- 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 8)**. In 2010, only three of the top ten drugs are listed on the formularies of all 43 national and near-national PDPs. Eight of the top ten brands are on a preferred cost-sharing tier in a majority of these plans. But only one of the top ten drugs – Plavix for cardiovascular disease – is covered on a preferred tier without UM restrictions by close to half of the large PDPs. Conversely, two drugs (Nexium for gastrointestinal conditions and Actonel for osteoporosis) are never covered without restrictions; each has alternatives in its drug class, including generics.

LIS PLAN AVAILABILITY AND ENROLLMENT DYNAMICS

- ***The number of "benchmark" plans – those available to beneficiaries receiving Part D low-income subsidies for no monthly premium – is essentially unchanged between 2009 and 2010. The benchmark market is volatile, however.***
  - The total number of benchmark plans for Part D low-income subsidy (LIS) recipients decreased by just one between 2009 and 2010, but the small change in the total number of plans masks the turnover among plans **(Exhibit 1)**. Of the 308 benchmark plans available to LIS recipients for zero premium in 2009, 97 were no longer benchmark plans in 2010. During the same period, 96 other new or existing plans gained benchmark status.
  - The benchmark plan market has changed considerably over the program's five years. Of the 409 benchmark plans offered in 2006, only 65 plans have qualified as benchmark plans each year since then. The number of LIS benchmark plans varies across regions in 2010, ranging from four in the Maine/New Hampshire region to 15 in Arkansas.
  - At the time of the open enrollment period for the 2010 plan year (November 15 to December 31, 2009), more than 3 million people – almost 4 of every 10 LIS beneficiaries – were enrolled in benchmark PDPs in 2009 that no longer qualified as benchmark plans in 2010. CMS reassigned almost 1.2 million beneficiaries to new PDPs in 2010.[20] But another 2.2 million beneficiaries were not eligible for reassignment because at some point they had switched plans on their own.
  - More than 1.7 million LIS beneficiaries remain in non-benchmark plans and are paying premiums for Part D coverage in 2010 **(Exhibit 9)**. One-third of them are paying monthly premiums of $10 or more. The proportion of LIS beneficiaries paying premiums has increased from 6 percent in 2006 to 22 percent in 2010.
  - More than 2 million beneficiaries are eligible for low-income subsidies but not receiving them. Of the 12.5 beneficiaries who were eligible for the LIS in 2009, the majority (8.1 million) were automatically enrolled because of their participation in other low-income programs, but fewer than half (40 percent) of the 4 million who must apply on their own received the LIS in 2009.[21] The low participation rate for this group has not changed significantly over the past five years.

THE PART D MARKETPLACE

- ***Over the program's first five years, the Part D marketplace has been moderately concentrated, with the ten largest firms that sponsor Part D plans accounting for over two-thirds of all enrollees in 2010.***
  - The ten largest Part D plan sponsors in 2010 have enrolled 19.1 million beneficiaries in either a stand-alone PDP or an MA-PD plan **(Exhibit 10)**. The share of enrollment (69 percent) is nearly the same as in 2006, the program's first year (72 percent).

- Eight of these ten firms sponsor both stand-alone PDPs and MA-PD plans. The exceptions are Kaiser Permanente with only MA-PD plans and CVS Caremark with only PDPs. Other than Kaiser Permanente, at least half of each of the top firms' enrollment is in PDPs.
- Enrollment growth for UnitedHealth, Universal American, and CVS Caremark is due in part to acquisitions of other plan sponsors. Beyond these changes, initial projections that considerable consolidation would occur in the program's early years did not materialize.
- UnitedHealth and Humana have been the two largest plan sponsors for each of the program's first five years, but their combined share of enrollment has dropped from 44 percent in 2006 to 35 percent in 2010.
  - UnitedHealth, in part due to its successful marketing relationship with AARP, has maintained its top position for five years and has seen its enrollment grow by about 12 percent since 2006.
  - Humana has maintained a strong Part D presence, in part due to offering the lowest PDP premiums in 2006 and retaining many of those enrollees over time. Yet, higher-than-average premium increases and a loss of LIS benchmark status in most regions have contributed to a 26 percent drop in Humana's Part D enrollment since 2006.

➢ ***Only four of the top ten PDPs or MA-PD plans by enrollment in 2010 were also in the top ten in 2006.***

- Within many plan sponsors' offerings, there have been significant changes in enrollment **(Exhibit 11)**. Since 2006, the sponsoring organizations for two of the top ten plans (UnitedHealth's AARP MedicareRx Saver PDP and Wellcare's Classic PDP), have introduced a new plan priced below their previous low-premium plan, resulting in enrollment shifts to the new lower-premium plan.
- Enrollment shifts have been accelerated by automatic re-assignment of LIS beneficiaries. If a plan loses its designation as a benchmark plan, CMS reassigns beneficiaries to a benchmark plan offered by the same sponsor if one is available; otherwise they are switched to a plan offered by another sponsor.
- Other movements in the Part D market have also caused significant shifts in enrollment from plan to plan. For example, one top plan in 2006 was terminated after a corporate acquisition.

➢ ***Concentration of enrollment in PDPs at the regional level is somewhat greater than at the national level.***

- The AARP MedicareRx Preferred PDP offered by UnitedHealth is the leading plan in 25 of 34 PDP regions, with an average of about 19 percent of overall enrollment in those regions **(Exhibit 12).** Concentration of enrollment among plans, as measured by a statistical measure of market competition, is greater within regions than at the national level.[22]

➢ ***The most popular plans for non-LIS beneficiaries are considerably different from those with the most LIS enrollment.***

- No single PDP dominates the LIS market across most regions the way that the AARP MedicareRx Preferred plan dominates the PDP market overall **(Exhibit 12)**. Community CCRx Basic has the most LIS enrollment in 13 regions, and AARP MedicareRx Saver is the leader in 10 regions. In one region (Maine/New Hampshire) the top LIS plan has nearly half of all LIS enrollees. The LIS market share of the leading plan tops 40 percent in three other regions. The system of assigning LIS beneficiaries to a limited set of benchmark plans is a key factor driving this greater market concentration within regions, compared to Part D as a whole.

Conclusion

Medicare Part D plans are an important source of prescription drug coverage for about 60 percent of the 47 million Medicare beneficiaries in 2010. Findings from this analysis show significant increases in premiums, cost-sharing amounts, use of specialty tiers, and utilization management restrictions since 2006 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. Among beneficiaries who reach the gap, one-fifth either stop taking one of their drugs or switch to an alternative in the drug class.[23] The new health reform law gradually phases out the gap over the next decade, eventually eliminating this feature of the Medicare that has put Part D enrollees at risk of incurring substantial costs.

Recently, steps have been taken to decrease the volatility of the PDP offerings available to LIS beneficiaries. The number of LIS benchmark plans is lower in 2010 than in any previous year, but a new waiver policy will allow some additional plans to retain their LIS enrollees without requiring them to pay a premium. Further, CMS has been doing more to make sure that beneficiaries who are not automatically assigned to new plans are aware that they have options for finding a plan that does not require them to pay a premium.

Depending on how plan sponsors respond to new CMS policies intended to reduce the number of plans and to ensure that available plans offer real differences, there could be more marketplace change and consolidation in the 2011 Part D marketplace than in previous years. In light of the rising premiums and changes in benefit design seen in each year of the Part D program since 2006, it remains important for consumers to compare plans each year and make informed decisions based on coverage and costs for the medications they take. At the same time, ongoing research and monitoring are needed to evaluate the impact of both the existing trends and any changes that results from recent statutory and regulatory changes in order to help ensure that the Medicare Part D program serves beneficiaries well.

METHODS

This report synthesizes findings presented in a series of Medicare Part D 2010 Data Spotlights[4] prepared by Jack Hoadley and Laura Summer (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 2009 (as well as a supplemental landscape file, which included additional premium information, released for the first time this year by CMS) 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, Summer, and Katie Merrell (Social & Scientific Systems, Inc.). 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 43 unique, national stand-alone PDPs offered by 16 organizations in 2010, representing 91 percent of all PDPs nationwide. The remaining PDPs are mainly local or regional plans offered in a small number of 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, 2010 Medicare Part D plan enrollment data from CMS.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the assistance of Katie Merrell of Social & Scientific Systems, Inc., on the MedPAC analysis, Rachel Schmidt and Joan Sokolovsky of MedPAC for guidance and support on that project, and help from Kosali Simon of Cornell University in obtaining data from the Medicare Prescription Drug Plan Finder website.

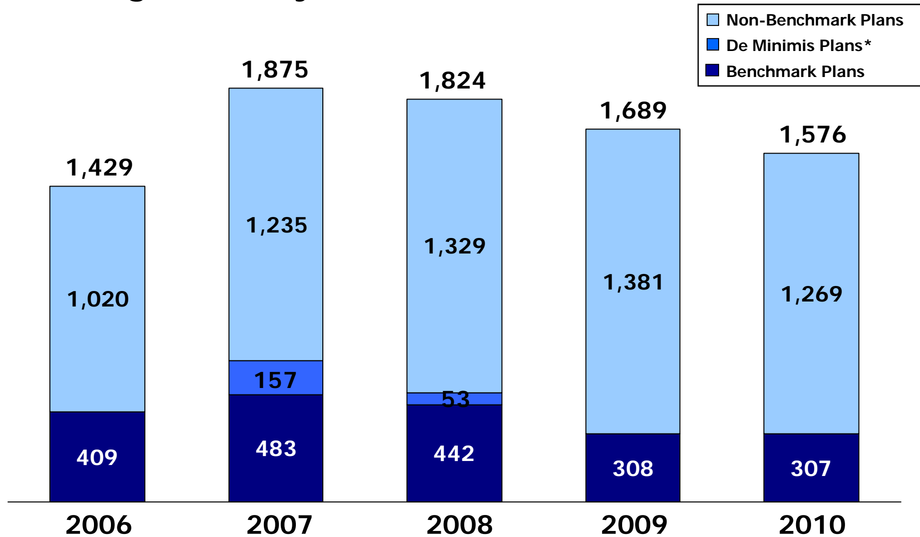


Exhibit 1
Distribution of Medicare Stand-Alone Prescription Drug Plans, by Benchmark Status, 2006-2010
Non-Benchmark Plans
De Minimis Plans*
Benchmark Plans
1,429
1,875
1,824
1,689
1,576
1,020
1,235
1,329
1,381
1,269
157
53
409
483
442
308
307
2006
2007
2008
2009
2010
NOTES: Excludes PDPs in the territories. *Under a Medicare demonstration, de minimis plans were eligible to retain LIS beneficiaries despite exceeding the benchmark premium by $2 in 2007 and $1 in 2008.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS PDP Landscape Source Files, 2006-2010.

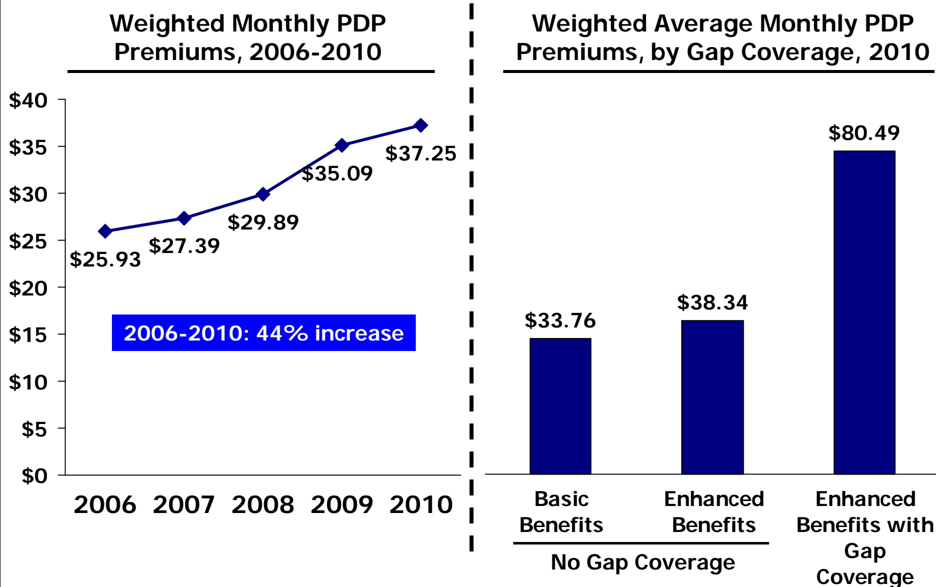
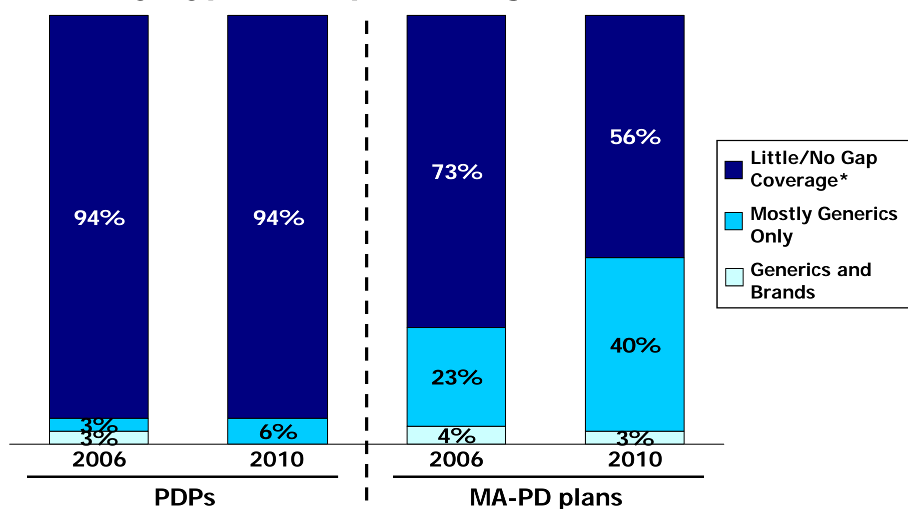


Exhibit 2
Average Monthly Premiums for Stand-Alone PDPs
Weighted Monthly PDP Premiums, 2006-2010
Weighted Average Monthly PDP Premiums, by Gap Coverage, 2010
$40
$35
$30
$25
$20
$15
$10
$5
$0
$25.93
$27.39
$29.89
$35.09
$37.25
2006-2010: 44% increase
2006
2007
2008
2009
2010
$33.76
$38.34
$80.49
Basic Benefits
Enhanced Benefits
No Gap Coverage
Enhanced Benefits with Gap Coverage
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

Exhibit 3

Share of Enrollment in Medicare Part D Plans, By Type of Gap Coverage, 2006 and 2010



NOTES: 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: Georgetown/NORC analysis of CMS Part D landscape and enrollment files, 2006-10, for the Kaiser Family Foundation.

Exhibit 4

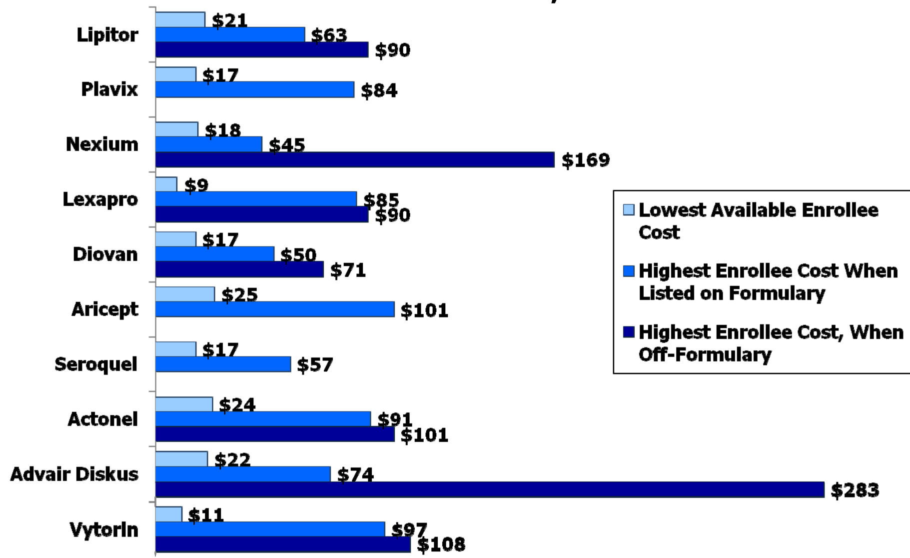
Cost Sharing for Medicare Part D Plans, 2006-2010, and Employer-Sponsored Plans, 2009

FORMULARY TIER	PART D PLAN TYPE	PART D COST SHARING					EMPLOYER PLANS
		2006	2007	2008	2009	2010	2009
Generic	PDP	$5	$5	$5	$7	$7	$10
	MA-PD	$5	$5	$5	$5	$6	
Preferred brand	PDP	$28	$28	$30	$37	$42	$26
	MA-PD	$26.70	$29	$30	$30	$39	
Non-preferred brand	PDP	$55	$60	$71.50	$74.75	$76.50	$47
	MA-PD	$55	$60	$60	$60	$79	
Specialty	PDP	25%	30%	30%	33%	30%	28%
	MA-PD	25%	25%	25%	33%	33%	

NOTES: 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, 2009.

Exhibit 5

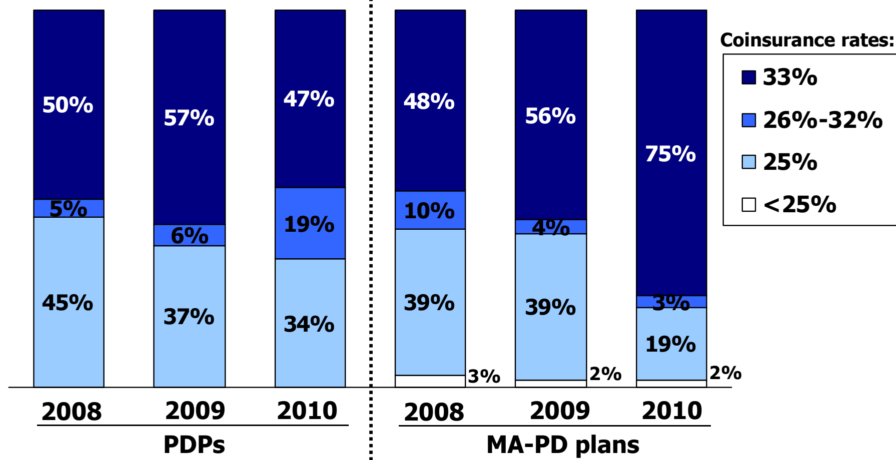
Monthly Cost Sharing for Top Brand-Name Drugs in National PDPs, 2010



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

Exhibit 6

Share of Enrollment in Medicare Prescription Drug Plans with Specialty Tiers, by Specialty Tier Coinsurance Rate, 2008-2010



NOTES: Estimates weighted by enrollment in each year. Analysis of MA-PD plans excludes Special Needs Plans.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

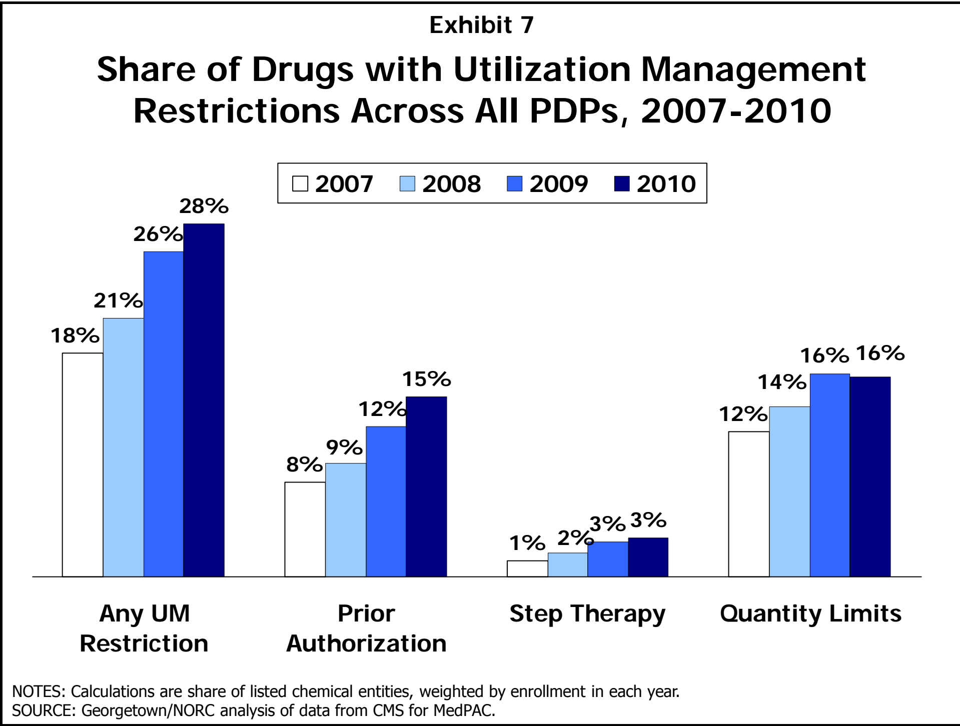


Exhibit 7
Share of Drugs with Utilization Management Restrictions Across All PDPs, 2007-2010
2007
2008
2009
2010
18%
21%
26%
28%
8%
9%
12%
15%
1%
2%
3%
3%
12%
14%
16%
16%
Any UM Restriction
Prior Authorization
Step Therapy
Quantity Limits
NOTES: Calculations are share of listed chemical entities, weighted by enrollment in each year.
SOURCE: Georgetown/NORC analysis of data from CMS for MedPAC.

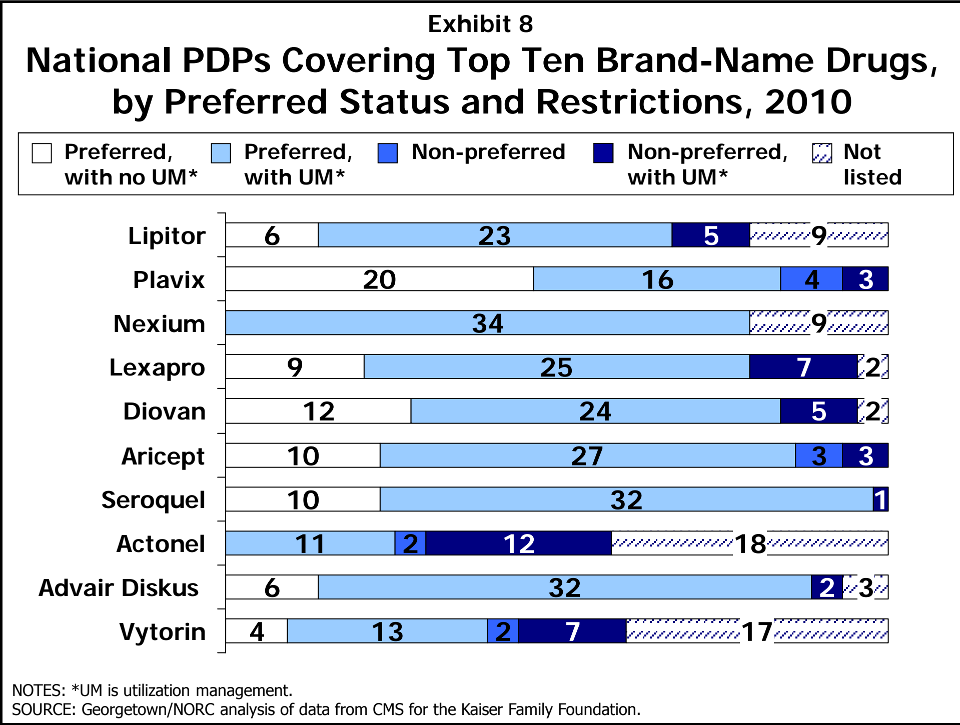
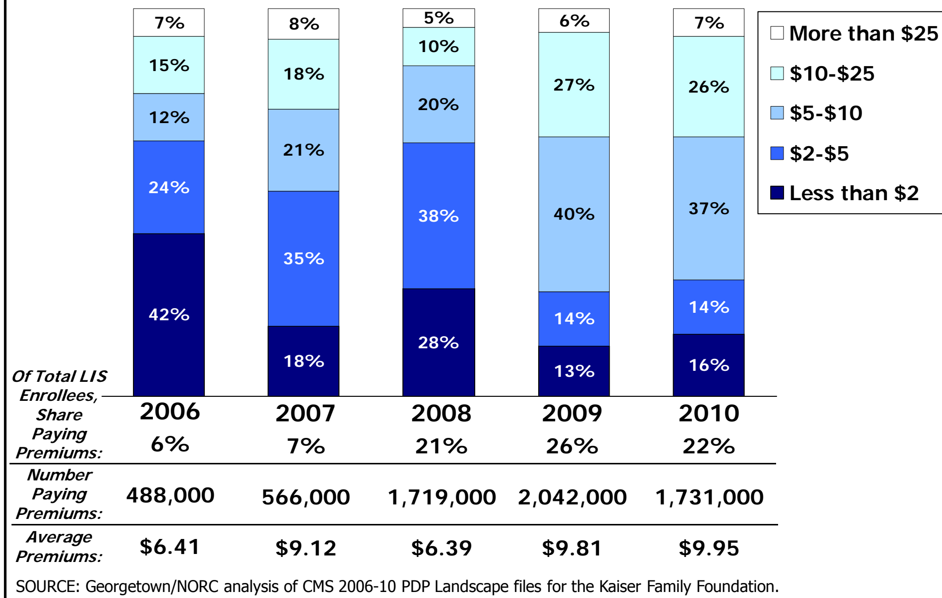


Exhibit 8
National PDPs Covering Top Ten Brand-Name Drugs, by Preferred Status and Restrictions, 2010
Preferred, with no UM*
Preferred, with UM*
Non-preferred
Non-preferred, with UM*
Not listed
Lipitor 6 23 5 9
Plavix 20 16 4 3
Nexium 34 9
Lexapro 9 25 7 2
Diovan 12 24 5 2
Aricept 10 27 3 3
Seroquel 10 32 1
Actonel 11 2 12 18
Advair Diskus 6 32 2 3
Vytorin 4 13 2 7 17
NOTES: *UM is utilization management.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

Exhibit 9

Distribution of Monthly Part D Premiums for Low-Income Subsidy PDP Enrollees Paying Premiums, 2006-2010



	2006	2007	2008	2009	2010
Of Total LIS Enrollees, Share Paying Premiums:	6%	7%	21%	26%	22%
Number Paying Premiums:	488,000	566,000	1,719,000	2,042,000	1,731,000
Average Premiums:	$6.41	$9.12	$6.39	$9.81	$9.95

SOURCE: Georgetown/NORC analysis of CMS 2006-10 PDP Landscape files for the Kaiser Family Foundation.

Exhibit 10

Top 10 Firms Offering Medicare Part D Plans Ranked by 2010 Enrollment

Name of firm	2010			2006	Change 2006-2010
	Rank	Enrollment (in millions)	% of Total Part D in 2010	Rank	
UnitedHealth Group	1	6.39	23.2%	1	+12%
Humana	2	3.21	11.6%	2	-26%
Universal American	3	2.04	7.4%	8	+330%
Coventry Health Care	4	1.78	6.5%	7	+140%
CVS Caremark	5	1.19	4.3%	11	+189%
Wellpoint	6	1.17	4.2%	3	-11%
Kaiser Permanente	7	0.93	3.4%	6	+19%
WellCare Health Plans	8	0.86	3.1%	4	-12%
Aetna	9	0.81	2.9%	12	+98%
Health Net	10	0.71	2.6%	9	+55%
TOTAL TOP 10 FIRMS		19.1 mil	69.2%		
TOTAL PART D		27.6 mil	100.0%		

NOTES: Excludes plans in the territories.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS PDP Landscape Source and Enrollment Files, 2006-2010.

Exhibit 11

Top 10 Medicare Part D Plans Ranked by 2010 Enrollment

Name of plan	2010			2006	Change 2006-2010
	Rank	Enrollment (in millions)	% of Total Part D in 2010	Rank	
AARP MedicareRx Preferred PDP	1	3.19	10.2%	1	-12%
AARP MedicareRx Saver PDP	2	1.53	5.5%	NA	NA
Humana Enhanced PDP	3	1.32	4.8%	3	+37%
Community CCRx Basic PDP	4	1.23	4.5%	5	+55%
SilverScript Value PDP	5	0.61	2.2%	13	+53%
Kaiser Permanente Senior Advantage HMO	6	0.60	2.2%	7	-9%
First Health Part D-Premier PDP	7	0.55	2.0%	18	+107%
WellCare Classic PDP	8	0.49	1.8%	NA	NA
Humana Gold Plus HMO	9	0.49	1.8%	14	+29%
AdvantraRx Value PDP	10	0.45	1.6%	55	+675%

NOTES: Excludes plans in the territories.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS PDP Landscape Source and Enrollment Files, 2006-2010.

Exhibit 12

Top Medicare Stand-Alone Prescription Drug Plans In Each Region, Different Enrollment Bases, 2010

#1 Enrollment PDP (All Enrollees)		#1 Enrollment PDP (Non-LIS Enrollees Only)		#1 Enrollment PDP (LIS Enrollees Only)	
Name of PDP	# of regions	Name of PDP	# of regions	Name of PDP	# of regions
AARP MedicareRx Preferred	25	AARP MedicareRx Preferred	28	Community CCRx Basic	13
Community CCRx Basic	4	Humana Enhanced	5	AARP MedicareRx Saver	10
AARP MedicareRx Saver	3	Blue MedicareRx Value (Illinois)	1	SilverScript Value	5
Humana Enhanced	2	TOTAL (3 PDPs)	34	PrescribaRx Bronze	3
TOTAL (4 PDPs)	34			Health Net Orange Option 1	3
				TOTAL (5 PDPs)	34

NOTES: Excludes plans in the territories.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS PDP Landscape Source and Enrollment Files, 2006-2010.

ENDNOTES

[1] In 2010, the defined standard benefit has a $310 deductible, 25 percent coinsurance up to an initial benefit limit of $2,830 in total Part D drug costs, a $3,610.75 coverage gap ("doughnut hole"), and catastrophic coverage after $6,440 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 16, 2010" (accessed at http://www.cms.gov/PrescriptionDrugCovGenIn/Downloads/2010_Enrollment_Release.zip, March 22, 2010).
[3] Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA)
[4] The Medicare Part D 2010 Data Spotlight series is available at http://www.kff.org/medicare/med110909pkg.cfm. The 2009 Data Spotlight series is available at http://www.kff.org/medicare/med110608pkg.cfm, and 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.
[5] This report also incorporates analysis of Part D data prepared by Jack Hoadley, Elizabeth Hargrave, Laura Summer, and Katie Merrell for the Medicare Payment Advisory Commission (MedPAC). See Hoadley J, Hargrave E, Merrell K. Medicare Part D Benefit Designs and Formularies, 2006-2010. Presentation to the Medicare Payment Advisory Commission: Washington, D.C. January 15, 2010, http://www.medpac.gov/transcripts/2010%20Formulary%20Analysis%20for%20MedPAC%20-%20Hoadley.pdf; see also MedPAC, "June 2010 Data Book: Healthcare Spending and the Medicare Program," http://www.medpac.gov/documents/Jun10DataBookEntireReport.pdf.
[6] This number excludes plans offered in the territories.
[7] In March 2010, CMS announced it was terminating its contract with Fox Insurance Company, which sponsored 26 PDPs, including 12 benchmark PDPs. These plans are included in the analysis presented in this report.
[8] The total number of Medicare Advantage plans included in this analysis is slightly lower than the count published by Gold et al, 2010, *Medicare Advantage Data Spotlight Premiums and Plan Availability* (http://www.kff.org/medicare/upload/8007.pdf), which counts 1,832 Medicare Advantage plans in 2010, including plans in the territories but excluding Special Needs Plans (SNPs), demonstrations, Health Care Prepayment Plans (HCPPs), Program of All Inclusive Care for the Elderly (PACE) plans, employer-sponsored (i.e., group) plans, and other plans for selected populations (e.g. Mennonites). The discrepancy is due in part to somewhat different inclusion and exclusion criteria, as well as use of the October 2009 landscape file for the present analysis.
[9] The 2010 average reported here ($37.25) is lower than the amount reported in the December 2009 spotlight ($38.24) because the new average is weighted by actual 2010 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.
[10] This is larger than the 39 percent increase in the monthly premium between 2006 and 2010 for a single person enrolled in FEHB BC/BS (from $125.82/month in 2006 to $175.08/month in 2010).
[11] The overall premium in 2010 for MA plans that include drug coverage is $44 per month, up 22 percent from 2009; see Gold M et al, "Medicare Advantage 2010 Data Spotlight: Plan Enrollment Patterns and Trends," June 2010, http://www.kff.org/medicare/8080.cfm.
[12] In 2009, CMS reported that on average MA-PD premiums prior to rebates were still about $11 per month lower than those for PDPs. CMS, "Lower Medicare Part D Costs than Expected in 2009," press release, August 14, 2008.
[13] 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.
[14] As with our reporting of plans with gap coverage, this estimate excludes enrollees in plans covering only a "few" drugs in the gap.
[15] Medicare Payment Advisory Commission, *Report to the Congress: Medicare Payment Policy*, Chapter 3, March 2009.
[16] CMS, "Medicare Part D Manual, Chapter 6, Part D Drugs and Formulary Requirements" March 9, 2007.
[17] 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.
[18] These results are from our analysis for MedPAC (see note 5). 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 any version of drug, for example if they cover a generic version but not the brand version or if they omit certain forms or strengths of the drug.
[19] These results are also from the analysis for MedPAC (see note 5). We classify a drug as having a particular type of utilization management if that characteristic applies to any form or strength of the drug that is on the lowest possible tier used by that plan for that drug.
[20] CMS, "Year 2009 Re-Assignment Data – Premium Increase" and "Year 2009 Re-Assignment Data – Terminating Plans." November 2009; accessible at http://www.cms.hhs.gov/limitedincomeandresources/.
[21] 2009 is the latest year for which LIS eligibility data are available. In addition to the 8.1 million beneficiaries deemed eligible for the LIS and the 4 million who must apply on their own, approximately half a million beneficiaries who were eligible had other coverage and therefore did not enroll in the Part D program.
[22] Market competition among PDPs, as measured by the Herfindahl index, averages 909 across the 34 regions for overall enrollment. The comparable index value computed nationally is 586. Markets in which the index is between 1000 and 1800 points are considered to be moderately concentrated, and those in which the index is in excess of 1800 points are considered to be concentrated. Highly competitive markets typically have index values below 100.
[23] 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.

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