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DATA SPOTLIGHT

MEDICARE PART D 2011: 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." Between 2006, when the drug benefit was implemented, and 2010, Part D enrollees were required to pay 100 percent of total drug costs after their spending exceeded the initial coverage limit and before reaching the catastrophic coverage limit.[1,2] Beginning in 2011, price discounts and government subsidies included in the Patient Protection and Affordable Care Act (ACA) are reducing the amounts enrollees must pay when they reach the gap, and the gap will be phased out entirely by 2020. Since 2006, most Part D plans have had a coverage gap, and the majority of Part D enrollees, other than those receiving low-income subsidies (LIS), were in plans with a coverage gap. In 2009, about one in five Part D non-LIS enrollees who filled at least one prescription had spending high enough to reach the gap.[3]

In 2011, due to changes enacted in the health reform law, Part D plans must cover 7 percent of the total cost of generic drugs in the gap, and prices for brand-name drugs in the gap are discounted by 50 percent through an agreement with pharmaceutical manufacturers **(Exhibit 1)**. The discount on brand-name drugs alone reduces out-of-pocket costs in the gap substantially, from about $3,600 to about $1,800 in 2011 for an enrollee using only brand-name drugs. Over the next decade, Medicare will phase in additional coverage for brand-name and generic drugs, so that by 2020 beneficiaries will be responsible for 25 percent of the cost of their drugs on average (after meeting a deductible) until they qualify for catastrophic coverage. Prior to 2020, Part D sponsors can offer an alternative benefit design that covers at least some drug costs in the gap.

This Part D Data Spotlight examines coverage in the gap and the costs that beneficiaries face 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 an ongoing analytic effort that analyzes key features of Medicare Part D plans in 2011 and trends since 2006.[4]

GAP COVERAGE: AVAILABILITY AND ENROLLMENT, 2006-2011

In 2011, most PDPs (73 percent) offer little or no coverage in the gap beyond that required by the ACA, but more plans are offering at least some additional coverage, compared to past years (Exhibits 2 and 3).[5] Seven of the 15 sponsors with PDPs available in nearly every region (referred to as national PDPs) offer gap coverage for more than a few drugs in at least one of their PDP offerings.[6] A similar share of MA-PD plans as PDPs offer some gap coverage in 2011 beyond what is required by the ACA, but about two-thirds of all MA-PD plans (67 percent) have little or no gap coverage other than what is required **(Exhibits 4 and 5)**.[7]

The majority of Part D enrollees are in plans that offer no gap coverage in 2011, as in previous years, but regardless of the level of gap coverage offered by their plan, all enrollees receive the ACA-required brand discount and limited generic coverage if they reach the coverage gap. Among PDP enrollees, 94 percent are in plans with little or no additional gap coverage, 4 percent are in plans covering mostly generics in the gap, and 2 percent are in plans with gap coverage of generics and brands. Among MA-PD plan enrollees, 57 percent are in plans with little or no gap coverage beyond what the ACA requires, 42 percent are in plans covering mostly generics in the gap, and 2 percent are in plans with gap coverage of generics and brands.

In 2011, as in the two previous years, 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 coverage of brand and generic drugs in the gap, but these PDPs reduced coverage or left the program after experiencing significant adverse selection by high-cost enrollees. Just two MA-PD plans cover all brand-name and generic drugs on their formulary in the gap in 2011.[8]

Gap coverage, when offered, is typically quite limited; just 1 percent of PDPs and 5 percent of MA-PD plans cover all generics in the gap. In 2011, as in previous years, the vast majority of both PDPs and MA-PD plans that offer gap coverage cover some generic drugs but not brand-name drugs. Among those PDPs offering some gap coverage of generic drugs, the share covering all generics in the gap has declined from 14 percent in 2008 to less than 1 percent (7 PDPs) in 2011; over the same period, the share of MA-PD plans covering all generics in the gap has dropped from 25 percent to 5 percent. Furthermore, plans offering gap coverage for generic drugs have covered a smaller share of generics over time – although in 2011, unlike previous years, all plans are required to cover 7 percent of generic drug costs in the coverage gap.[9]

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Among the small share of Part D plans in 2011 offering additional coverage of brand-name drugs in the gap beyond the required discount, that coverage is limited and generally excludes many commonly-used drugs.[10] In 2011, 9 percent of PDPs offer additional gap coverage for some brands. Brand drugs covered by these PDPs generally include some antibiotics and vaccines, but exclude most popular drugs used on a regular basis to treat chronic conditions. All 106 PDPs that cover some brands in the gap include in this coverage between 10 and 65 percent of the brands on their formulary. Among MA-PD plans, only 2 percent (24 plans nationwide) cover at least "some" brand-name drugs in the gap in 2011 (defined as 10 percent of formulary brand drugs). Another one-fifth (19 percent) of MA-PD plans have coverage in the gap for a "few" brand drugs (up to 10 percent).

Premiums and Cost Sharing for Part D Plans with Gap Coverage

Beneficiaries face substantially higher premiums for PDPs that offer gap coverage beyond that required by the ACA, especially for PDPs that cover at least some brands in the gap (Exhibit 6). The average monthly premium for PDPs with coverage in the gap for some brand drugs in 2011 is more than double that for PDPs with no or little gap coverage beyond what the ACA requires ($102.27 vs. $44.32).[11] PDPs offering only generic coverage in the gap have premiums that are about 72 percent higher ($76.25) than those without significant gap coverage in addition to what the ACA requires. Part D premiums for MA-PD plans with additional gap coverage for brands are about double those with no or little additional gap coverage, while premiums for MA-PD plans with gap coverage for generics only are about 20 percent higher than for MA-PD plans without significant coverage in the gap beyond the required discounts.

Three of the national PDPs offering gap coverage beyond what is required by the ACA charge higher cost sharing for generic drugs used in the gap than in the initial coverage period. For example, enrollees in First Health Premier Plus pay no copayment for generics in the initial coverage period but then $10 for the same covered generic drugs when they reach the gap. The generic copayment in the Humana Enhanced PDP doubles from $8 before the gap to $16 for its "few" covered drugs in the gap. The full cost of many of the generic drugs covered by Humana Enhanced PDP in the gap is actually less than the required $16 generic drug copayment; because enrollees pay the lesser of the actual drug cost or the copayment, they are no better off having gap coverage for these drugs in this plan.

Discussion

In 2011, as in previous years, the majority of Part D plans available nationwide offer no coverage in the gap – but new for 2011 is the 50 percent discount for brands and coverage of 7 percent of generic drug costs that all Part D enrollees receive if they reach the coverage gap. As a result of these changes to the coverage gap made by the 2010 heath reform law, out-of-pocket expenses for beneficiaries who reach the coverage gap are significantly lower in 2011 than in previous years – and will continue to shrink between now and 2020. Nevertheless, some beneficiaries with high drug expenses will still face significant out-of-pocket costs after they reach the gap until it is completely phased out, and there is evidence from previous years that beneficiaries reduce their medication use when they reach the gap.[12] Enrolling in a plan that offers additional gap coverage beyond what is required by the 2010 health reform law 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 additional gap coverage relative to the premium will depend on the mix of drugs taken by an individual and the total number of months spent in the gap.

Beneficiaries who were considering PDPs that offer additional gap coverage for generic drugs in 2011 faced more choices and a greater variety of options than in previous years. Yet Part D plans with gap coverage beyond the brand-name drug discount and additional generic drug coverage required by the health reform law have much higher premiums than plans without it; these plans typically offer this additional coverage only for a limited list of drugs, and sometimes charge higher cost sharing in the gap than during the initial benefit period. As a result, these plans appear to offer little savings for beneficiaries beyond what is available to all enrollees under the ACA-required gap coverage benefits, unless a beneficiary's drug regimen closely matches the drugs covered in the gap by these plans. These PDPs may offer valuable enhancements other than the additional gap coverage, but their higher premiums do not appear to be commensurate with the value of their enhanced gap coverage alone for most beneficiaries, even those who expect to reach the coverage gap.

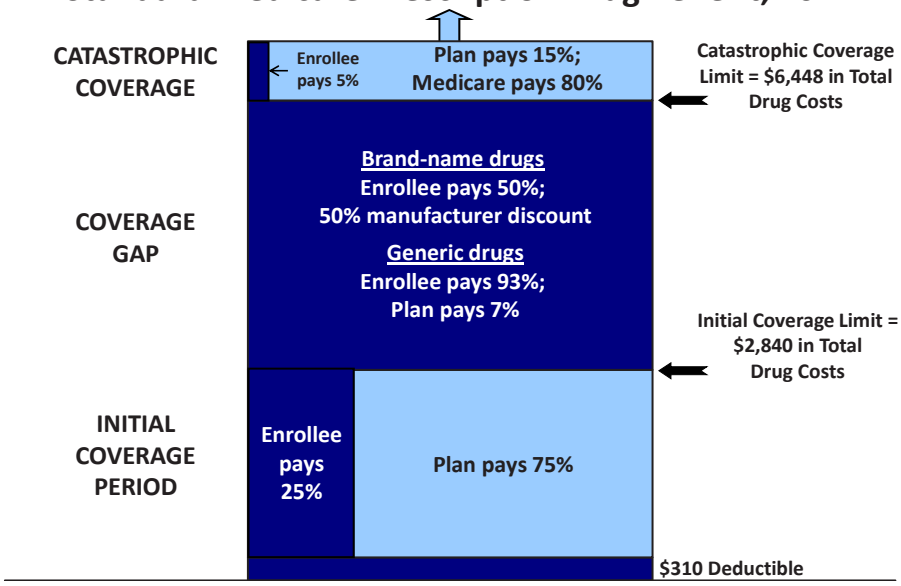
CMS has taken steps to ensure that multiple plans offered by a plan sponsor have meaningful differences, and this requirement led to a modest increase in gap coverage offerings for 2011. Moving forward, CMS could enhance the value of gap coverage and make it easier for consumers to understand by prohibiting 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 additional gap coverage beyond what is required by the 2010 health reform law and require that premiums do not exceed the value of coverage, unless justified by other benefit enhancements.

[1] Part D enrollees who qualify for the low-income subsidy (LIS) are responsible only for modest cost-sharing amounts in the coverage gap.
[2] In 2010, Part D enrollees who reached the coverage gap received a $250 rebate.
[3] Jack Hoadley et al, "Understanding the Effects of the Medicare Part D Coverage Gap in 2008 and 2009: Costs and Consequences Prior to Improvements in Coverage Established by the 2010 Health Reform Law," Kaiser Family Foundation, August 2011.
[4] Other Medicare Part D Data Spotlights, based on the authors' analysis of CMS data, are available at http://www.kff.org/medicare/rxdrugbenefits/partddataspotlights.cfm.
[5] Included in the count with "little or no" coverage are PDPs covering just a "few" generics in the gap. For example, Humana's Enhanced PDP offers gap coverage for fewer than 10 percent of the generics on its formulary – generally low-price drugs where the cost may exceed the plan's $16 copayment amount.
[6] Wellpoint is not counted here as a national PDP sponsor; although it offers gap coverage in all regions, the nature of that coverage varies by region. Wellpoint offers PDPs under the MedicareRx Rewards name in some regions, and under the Blue Medicare Rx name in other regions.
[7] About 20 percent of MA-PD plans have coverage for a "few" drugs in the gap, a level below the threshold used for this analysis. 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.
[8] CareMore Value Plus plan in Orange and Los Angeles Counties of California; Medica HealthCare Plan's MedicareMax in Dade County, Florida.
[9] 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.
[10] For plans offering additional gap coverage for brand-name drugs, the 50 percent discount applies only to the portion of the payment paid by the enrollee.
[11] Premium averages are not weighted by enrollment.
[12] Jack Hoadley et al, "Understanding the Effects of the Medicare Part D Coverage Gap in 2008 and 2009: Costs and Consequences Prior to Improvements in Coverage Established by the 2010 Health Reform Law," Kaiser Family Foundation, August 2011.

Exhibit 1

Standard Medicare Prescription Drug Benefit, 2011

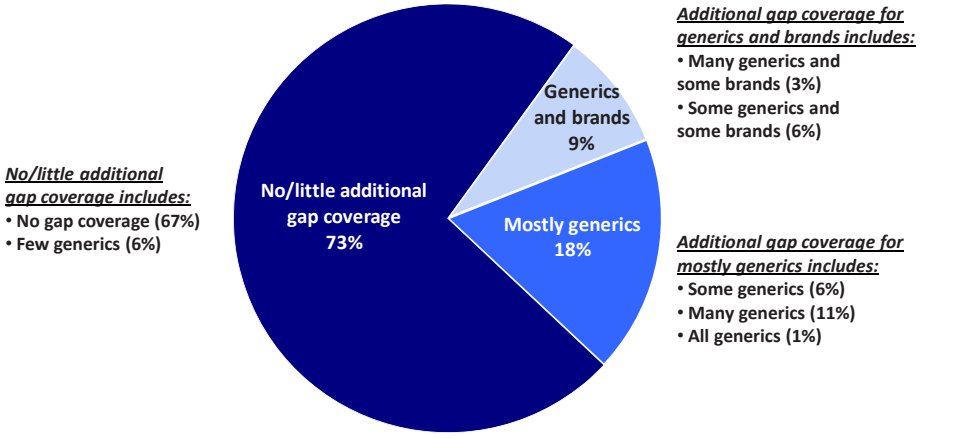


SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit parameters for 2011 (standard benefit parameter update from Centers for Medicare & Medicaid Services, April 2010). Amounts rounded to nearest dollar.

Exhibit 2

Share of Medicare Stand-Alone Prescription Drug Plans (PDPs), By Type of Gap Coverage,* 2011

In 2011, the coverage gap is partially filled by a 50% price discount for brand-name drugs and 7% coverage of generic drug costs, as required by the ACA

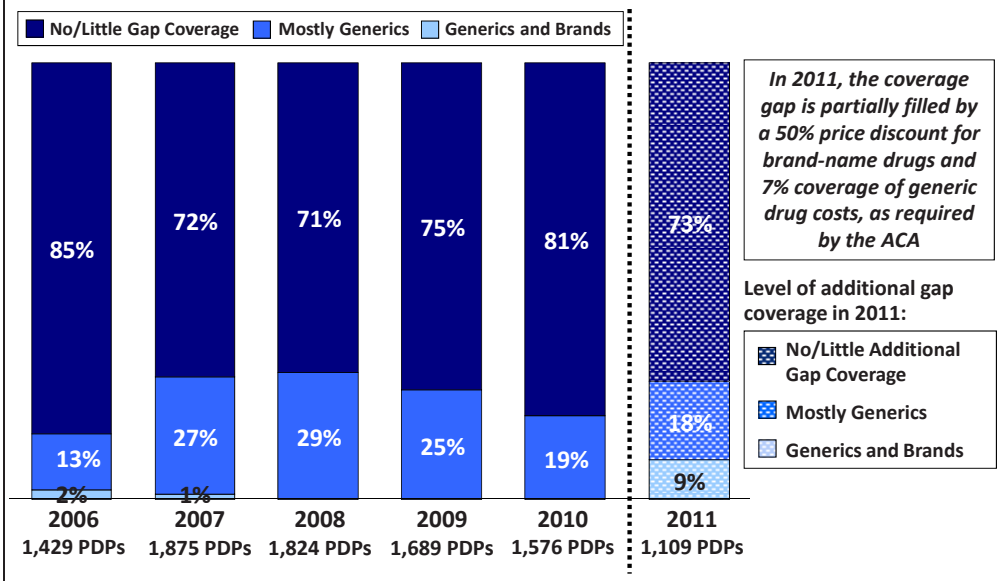


Total Number of PDPs in 2011 = 1,109

SOURCE: Georgetown/NORC analysis of CMS PDP landscape source file, 2011, for the Kaiser Family Foundation.
NOTE: ACA is the Patient Protection and Affordable Care Act. * Percent of formulary drugs covered in the gap: "few"=>0%-<10%; "some"=≥10%-<65%; "many"=≥65%-<100%.

Exhibit 3

Share of Medicare Stand-Alone Prescription Drug Plans (PDPs), By Type of Gap Coverage, 2006-2011

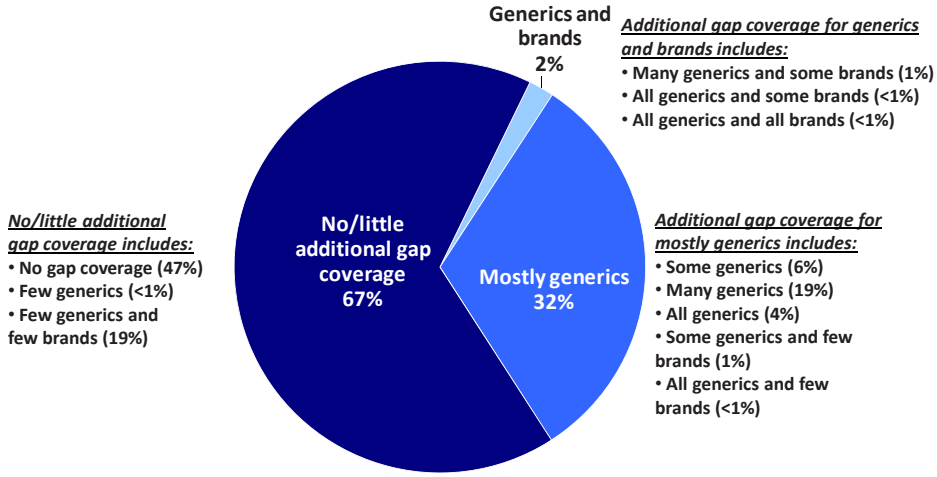


SOURCE: Georgetown/NORC analysis of CMS PDP landscape source files, 2006-2011, for the Kaiser Family Foundation.
NOTE: ACA is the Patient Protection and Affordable Care Act. Analysis excludes plans in the territories. The category "No/little" gap coverage includes PDPs offering coverage of few generics. In 2008 and 2009, the number of plans offering gap coverage for brands rounds to 0%.

Exhibit 4

Share of Medicare Advantage Prescription Drug (MA-PD) Plans, By Type of Gap Coverage,* 2011

In 2011, the coverage gap is partially filled by a 50% price discount for brand-name drugs and 7% coverage of generic drug costs, as required by the ACA

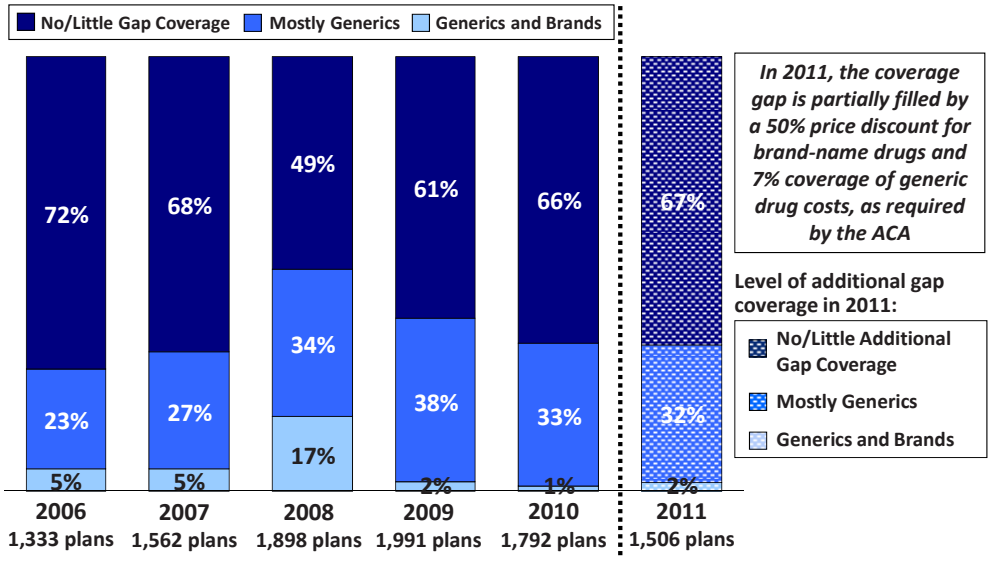


Total Number of MA-PD plans in 2011 = 1,506

SOURCE: Georgetown/NORC analysis of CMS PDP landscape source file, 2011, for the Kaiser Family Foundation.
NOTE: ACA is the Patient Protection and Affordable Care Act. * Percent of formulary drugs covered in the gap: "few"=>0%-<10%; "some"=≥10%-<65%; "many"=≥65%-<100%.

Exhibit 5

Share of Medicare Advantage Prescription Drug (MA-PD) Plans, By Type of Gap Coverage, 2006-2011

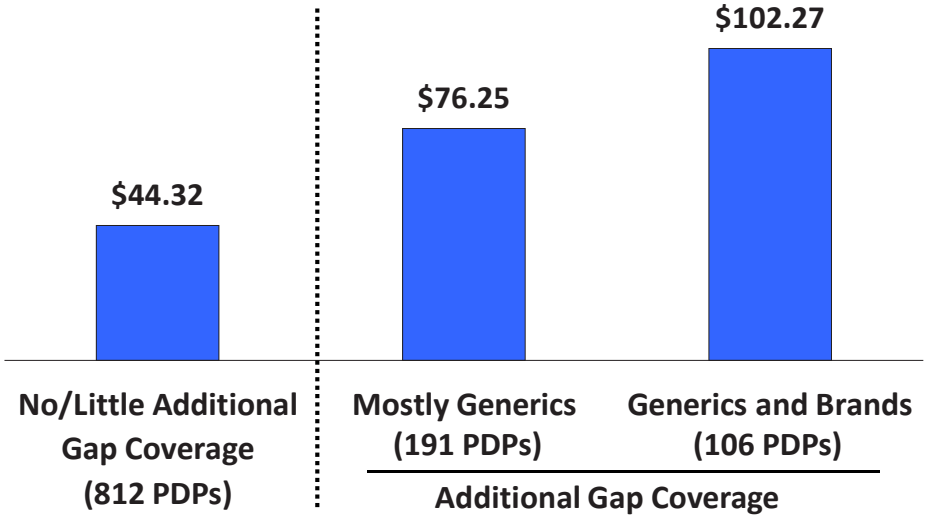


SOURCE: Georgetown/NORC analysis of CMS MA landscape source files, 2006-2011, for the Kaiser Family Foundation.
NOTE: ACA is the Patient Protection and Affordable Care Act. Analysis excludes plans in the territories.

Exhibit 6

Unweighted Average Monthly Premiums for PDPs, By Type of Gap Coverage, 2011

In 2011, the coverage gap is partially filled by a 50% price discount for brand-name drugs and 7% coverage of generic drug costs, as required by the ACA



SOURCE: Georgetown/NORC analysis of CMS PDP Landscape Source Files, 2011, for the Kaiser Family Foundation.
NOTE: ACA is the Patient Protection and Affordable Care Act.

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