KAISER FAMILY FOUNDATION
Medicare Policy

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE BRIEF

ANALYSIS OF MEDICARE PRESCRIPTION DRUG PLANS IN 2011 AND KEY TRENDS SINCE 2006

SEPTEMBER 2011

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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 a defined standard benefit or one that is equal in value **(Exhibit 1)**. They may also offer an enhanced benefit. Medicare drug plans must meet defined requirements, but may vary in terms of premiums, benefit design, gap coverage, formularies, and utilization management rules. Currently, more than 29 million Medicare beneficiaries are enrolled in Medicare drug plans, including 18.6 million in PDPs and 10.7 million in MA-PD plans.[1] More than 10 million enrollees are receiving extra help through the Part D Low-Income Subsidy (LIS) program to pay their drug plan premiums and cost sharing.

Part D has evolved since its inception in 2006 due to changes in the private plan marketplace and the regulations that govern the program. The Patient Protection and Affordable Care Act of 2010 (ACA) is bringing significant improvements to the program over the next decade, primarily phasing out the coverage gap, or "doughnut hole," in the drug benefit.[2] In 2012, the law provided a $250 rebate to 3.8 million Part D enrollees who reached the coverage gap.[3] Starting in 2011, pharmaceutical manufacturers are giving a 50 percent discount on the price of brand-name drugs in the gap. The law also further reduces cost sharing for drugs in the gap, beginning in 2011 for generics and 2013 for brands, 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 have resulted in some consolidation of Part D plan offerings in 2011.

This report presents findings from an analysis of the Medicare Part D marketplace in 2011 and changes in drug coverage and costs since 2006.[4] 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 9.

KEY FINDINGS

PLAN AVAILABILITY

- ***The number of PDPs in 2011 is nearly one-third lower than in 2010, with a total of 1,109 PDPs, yet even with this decline, at least 28 PDPs are offered in every region this year (excluding plans in the territories). Fewer PDPs are offered in 2011 than in any previous year.***
  - While the number of PDPs increased sharply between 2006 and 2007, the number of PDPs has decreased each year since then **(Exhibit 2)**. Both marketplace and policy factors have

contributed to the decline. The plan market has witnessed several mergers between sponsoring organizations and consolidation of plan offerings by individual sponsors. CMS, through regulations issued in 2010, indicated its intention to eliminate duplicative plan offerings and plans with low enrollment. These new policies have accelerated consolidation in the market.

- Most of the decline in the number of plans between 2010 and 2011 represented decisions by some plan sponsors to offer two plan options (one basic and one enhanced) instead of the three options offered in past years. This resulted in as many as 4 million enrollees switching from one plan to another, primarily to another plan offered by the same sponsor.[5]
- Current CMS policies suggest there may be further declines in the number of PDPs offered in future years:
  - Corporate acquisitions that occurred in 2011 are expected to lead to consolidation of the PDPs currently offered (although not necessarily in 2012) in order for sponsors to remain compliant with CMS limits on plan offerings by the same sponsor.[6]
  - The 2012 Call Letter issued by CMS reiterates the agency's authority not to renew plans with low enrollment. Currently, 51 PDPs have fewer than 100 enrollees, and 307 have fewer than 1,000 enrollees – the level at which CMS urges sponsors to consider withdrawal or consolidation.[7]

➢ ***In 2011, 1,501 Medicare Advantage drug plans are offered.***

- 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.[8] However, the availability of MA-PD plans fell in 2010 and 2011; currently, 1,501 MA-PD plans are offered, about 25 percent fewer than at the peak.

PREMIUMS

➢ ***Since 2006, the average PDP premium, weighted by enrollment, has increased by 48 percent, but the increase was smaller in 2011 than in previous years. Monthly PDP premiums vary widely.***

- The weighted average premium paid by beneficiaries for stand-alone Part D coverage has increased by 48 percent since the start of the program, from $25.93 in 2006 to $38.29 in 2011 **(Exhibit 3)**.[9,10] Between 2010 and 2011, the average PDP enrollee paid 3 percent more in premiums – the smallest year-to-year increase since the program began.
- One factor in this modest increase in average premium was the enrollment of nearly 600,000 non-LIS enrollees in the new Humana Walmart-Preferred Rx Plan – the PDP with the lowest premium in every region ($14.80). Another possible factor is the modest decrease between 2010 and 2011 in the average monthly premium for the most popular plan by enrollment, AARP MedicareRx Preferred.
- Since 2006, monthly premium increases for some drug plans with the highest enrollment have been larger than the increase in the national average, in percentage terms **(Exhibit 4)**. Between 2006 and 2011, the premium for UnitedHealth's AARP MedicareRx Preferred plan increased by 32 percent, from $26.31 to $34.73, while the average monthly premium for Humana's Enhanced PDP nearly tripled, from $14.73 to $43.76.

➢ ***Premiums for the drug benefit offered by MA-PD plans (excluding SNPs) are lower than PDP premiums, on average.***

- The average 2011 monthly premium amount attributable to drug benefits in MA-PD plans is $12.26, more than $25 below the PDP average and down 8 percent from 2010.[11] The average monthly MA-PD premium is only 1.5 percent higher than the average in 2006. Many MA-PD plans reduce or eliminate their premiums by using a portion of rebates from the Medicare Advantage payment system.[12]

- Despite considerably lower premiums for MA-PD plans across this time period, the overall share of enrollees in MA-PD plans has grown only modestly since the start of the Part D program – from about 28 percent to 37 percent of all Part D enrollees.

➢ ***The average Part D premium, combined across PDPs and MA-PD plans, has risen 37 percent from 2006 to 2011, mostly attributable to the increase in stand-alone PDP premiums.***

THE COVERAGE GAP

➢ ***In 2011, beneficiaries reaching the gap pay 50 percent of the full price for brand-name drugs in the gap, due to a manufacturer price discount of 50 percent, and 93 percent of the cost for generics (plans pay the remaining 7 percent). Most PDPs offer little or no coverage in the gap in 2011 beyond that which is required by the ACA, but compared to past years, more plans are offering at least some additional coverage.***

- A substantial majority of Part D enrollees are in plans that offer no additional gap coverage in 2011 beyond the required discount, but regardless of the level of gap coverage offered by their plans, all enrollees who reach the gap receive a 50 percent brand discount and limited generic coverage **(Exhibit 5)**. In 2011, most PDPs (73 percent) offer little or no gap coverage beyond the required discount, but those with coverage have attracted fewer enrollees.[13]

- While 94 percent of all PDP enrollees are enrolled in plans without additional gap protection beyond the price discounts required by law, only 46 percent actually face a gap in drug coverage, because enrollees receiving Low-Income Subsidies do not pay the full costs for their drugs when they reach the gap. In 2011, the majority of non-LIS Part D enrollees (89 percent) are in PDPs without additional gap coverage beyond what is required by the ACA.

- A somewhat greater share of MA-PD plans than PDPs offer some additional gap coverage in 2011 (67 percent), but a much larger share of MA-PD plan enrollees are enrolled in such plans. More than four in ten (43 percent) MA-PD plan enrollees have at least some additional gap coverage beyond what the ACA requires, a substantial increase since 2006 in the share with gap coverage **(Exhibit 5)**.[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 MA plans cover hospital and physician services and other Medicare benefits, they have 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.

➢ ***The vast majority of Part D enrollees with gap coverage beyond that which is required by law are in plans that cover only generic drugs in the gap.***

- In 2011, only about 2 percent of MA-PD plan enrollees and 3 percent of PDP enrollees have any significant gap coverage for brand-name drugs beyond the 50 percent discount that all plans must provide. Furthermore, gap coverage that includes all generic drugs has declined over time. In 2011, only 8 percent of MA-PD plan enrollees and less than 1 percent of PDP enrollees are in plans that cover all generics in the gap.

➢ ***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 about $50 per month above that for plans offering an enhanced benefit with no gap coverage. Plans with gap coverage for at least some brand-name drugs are the most expensive, with average premiums about $20 per month higher than those covering only generics in the gap. **(Exhibit 6)**

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, but there was virtually no change between 2010 and 2011.***
  - The number of plans that offer the defined standard benefit is small; in 2011, only 11 percent of PDPs and 5 percent of MA-PD plans make no use of formulary tiers (with 8 percent and 1 percent of enrollment, respectively). 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 – most of them also have two brand tiers, but a few have only one brand tier.
  - Use of a deductible by stand-alone PDPs is considerably higher in 2011 than in the first few years of the program, but down slightly from 2010 **(Exhibit 7)**. About 58 percent of PDPs charge a deductible this year, compared to between 40 percent and 45 percent from 2006 and 2009.
  - 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 2011, one-fourth of PDPs with a tier for non-preferred brand drugs charge a coinsurance rate for drugs on that tier. Of these plans, nearly all have a mixed pricing design. Typically they use a flat copayment for their generic drug tiers but a coinsurance for preferred brand drugs.
- ***Since 2006, the median cost sharing for a 30-day supply of "non-preferred" brand-name drugs in stand-alone PDPs has increased by 42 percent, from $55 to $78, while cost sharing for "preferred" brand drugs increased by 50 percent, from $28 to $42. Cost-sharing amounts were stable between 2010 and 2011.***
  - Cost sharing for generic drugs in PDPs has remained fairly stable since the median increased from $5 to $7 in 2009 **(Exhibit 8)**.
  - Cost-sharing amounts for commonly used brand-name drugs without generic equivalents vary widely across Part D plans in 2011, as they have in previous years. For preferred brand tiers, plans set copayment levels as low as about $23 and as high as $45; for non-preferred tiers, the copayments range from $60 to $95. These ranges are less than in some previous years because of new CMS guidance on allowable copayment levels, but the median for both has increased over time. For plans that use percentage coinsurance instead of dollar copayments, cost sharing may be higher or lower based on the actual retail price of the drug.
- ***Medicare Part D plans generally charged more than employer plans did in 2010 (the most recent year available) for preferred and non-preferred brand drugs, but somewhat less for generics.***
  - PDPs typically charged $42 per month for a preferred brand in 2010, well above the median $28 charged by employer plans that year **(Exhibit 8)**. Cost-sharing differences were even greater for non-preferred brands ($76.50 for PDPs vs. $48 for employer plans).

SPECIALTY TIERS

- ***Most Part D plans use a specialty tier for high-cost medications in 2011, and many Part D enrollees are in plans with a 33 percent coinsurance rate for specialty tier drugs.***
  - In 2011, among Part D enrollees in plans using tiered cost sharing, 94 percent of PDP enrollees and 100 percent of MA-PD plan enrollees are in plans with a specialty tier. Specialty tiers are commonly used by Medicare drug plans for relatively expensive drugs (at least $600 per month in 2011). 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.

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 2011, about half of PDP enrollees and over three-fourths of MA-PD plan enrollees are in plans charging 33 percent coinsurance for specialty drugs in the initial coverage period **(Exhibit 9)**. 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]

FORMULARIES AND UTILIZATION MANAGEMENT

- ***The scope of formulary coverage continues to vary widely across PDPs in 2011.***
  - 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 66 percent of these drugs.[18] In 2011, the average PDP enrollee is in a plan where the formulary lists 84 percent of the drugs in the CMS drug reference file, slightly below the average in the previous four years. The average enrollee in MA-PD plans is in a plan with slightly more drugs (87 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.
  - Examining coverage of the top ten brand-name drugs commonly used by Medicare beneficiaries provides an illustration of the variation in formulary coverage **(Exhibit 10)**.
    - In 2011, five of the top ten brand drugs are off formulary for at least 5 percent of all PDP enrollees. Nine of the top ten brands are on a preferred cost-sharing tier for a majority of PDP enrollees. The exception is Actonel, a drug for osteoporosis with a popular generic competitor. When Actonel is on a preferred tier, the typical monthly cost is about $42, whereas the cost rises to about $80 on a non-preferred tier and about $120 when purchased at full cost off formulary.
- ***Since 2007, PDPs have applied utilization management (UM) restrictions to an increasing share of on-formulary brand-name drugs.***
  - Even if a drug is listed on a plan's formulary, utilization management rules, including step therapy, prior authorization and quality limits, may restrict a beneficiary's access to the drug.[19] The presence of such rules has increased since 2007, with 32 percent of drugs subject to some utilization management in 2011, up from 18 percent in 2007 **(Exhibit 11)**.
  - Quantity limits are applied to 19 percent of drugs in 2011, prior authorization is applied to 17 percent of drugs, and step therapy to 2 percent of drugs, on average across all PDPs (weighted for enrollment). MA-PD plans tend to apply UM rules to a similar share of drugs.
  - The top ten brand-name drugs also illustrate the variations in utilization management **(Exhibit 12)**.
    - At least two-thirds of PDP enrollees face UM restrictions for nine of the top ten brand-name drugs. Most restrictions, however, are quantity limits. Only one of the top drugs (Nexium) has prior authorization required for at least 10 percent of PDP enrollees. Three drugs (Actos, Actonel, and Diovan) have step therapy requirements for at least 10 percent of PDP enrollees.

LOW-INCOME SUBSIDY PLAN AVAILABILITY AND ENROLLMENT DYNAMICS

- ***The number of "benchmark" plans – those available to beneficiaries receiving Part D Low-Income Subsidies for no monthly premium – increased between 2010 and 2011. The benchmark market is volatile, however.***
  - The total number of benchmark plans for Part D Low-Income Subsidy (LIS) enrollees nationwide increased by 25 plans between 2010 and 2011, despite the overall decrease in the number of PDPs **(Exhibit 2)**. Several new policies adopted by CMS, including the "de minimis" policy that allows plans to waive a premium amount of up to $2 in order to retain their LIS enrollees, contributed to this increase. The number of LIS benchmark plans varies across regions in 2011, ranging from 4 in the Florida and Nevada regions to 17 in Arkansas.
  - Of the 307 benchmark plans available to LIS recipients for zero premium at the start of 2010, 63 lost benchmark status in 2011, compared to 97 plans losing that status between 2009 and 2010.[20,21]
  - The benchmark plan market has changed considerably over the program's five years, which has generated some instability for low-income enrollees. Of the 409 benchmark plans offered in 2006, only 39 plans have qualified as benchmark plans each year since then. For a number of other plans, mergers interrupted continuous benchmark status, but the acquiring plan sponsor had a benchmark plan into which enrollees were transferred.[22]
  - At the time of the open enrollment period for the 2011 plan year (November 15 to December 31, 2010), about 2.1 million people – one of every four LIS beneficiaries – were enrolled in benchmark PDPs in 2010 that no longer qualified as benchmark plans in 2011. CMS reassigned about 600,000 beneficiaries to new PDPs for the 2011 benefit year. But another 1.5 million beneficiaries were not eligible for reassignment because at some point they had switched plans on their own.
- ***About 1 million LIS beneficiaries remain in non-benchmark plans and are paying premiums for Part D coverage in 2011, a number that is half that of just two years earlier.***
  - The proportion of LIS beneficiaries paying premiums rose from 6 percent in 2006 to 26 percent in 2009, but declined over the past two years to 13 percent in 2011 **(Exhibit 13)**.[23] A big factor in that decline is the de minimis waiver allowing LIS enrollees in certain plans to remain in their plans without paying a premium; about 1 million LIS beneficiaries are enrolled in these plans.
  - One-half of LIS beneficiaries who are paying premiums pay monthly premiums of $10 or more **(Exhibit 14)**. Although the share paying this level premium has increased, the absolute number has dropped from 821,000 in 2009 to 518,000 in 2011. It is possible that the low-income enrollees who pay a premium to enroll in these plans do so because of formulary or other individual considerations; another possibility, however, is that these enrollees do not understand the process they could use to switch plans and avoid paying a premium.
  - CMS estimates that more than 2 million beneficiaries are eligible for Low-Income Subsidies but not receiving them. This total represents about half of those who must apply for the LIS on their own.[24]

THE PART D MARKETPLACE, 2006-2011

- ***Over the program's first six years, the Part D marketplace has been moderately concentrated, with the ten largest firms that sponsor Part D plans accounting for nearly three-fourths of all enrollees in 2011.***
  - The ten largest Part D plan sponsors in 2011 have enrolled 21.5 million beneficiaries in either a stand-alone PDP or an MA-PD plan **(Exhibit 15)**. Their share of enrollment (73 percent) is nearly the same as in 2006 (72 percent), but up slightly from 2010 (69 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 Medco with only PDPs. Other than Kaiser Permanente, at least half of each of the top firms' enrollment is in PDPs.
- Enrollment growth since 2006 for UnitedHealth, CVS Caremark, and HealthSpring is due in part to acquisitions of other plan sponsors. Beyond these acquisitions, initial projections that considerable consolidation would occur in the program's early years have not materialized.
- UnitedHealth and Humana have been the two largest plan sponsors in each of the program's first five years, but their combined share of enrollment has dropped from 44 percent in 2006 to 37 percent in 2011.
  - UnitedHealth, likely due in part to its successful marketing relationship with AARP, has maintained its top position for five years and has seen its enrollment grow by about 21 percent since 2006.
  - Humana has maintained a strong Part D presence, likely due in part to offering the lowest PDP premiums in 2006 and retaining many of those enrollees over time. Higher-than-average premium increases and a loss of LIS benchmark status in most regions contributed to a 26 percent drop in Humana's Part D enrollment between 2006 and 2010. But Humana's introduction of the Walmart-Preferred PDP in 2011 reversed this decline with a 23 percent enrollment increase from 2010 to 2011. About one-third of enrollees in the new plan are LIS enrollees (some auto-assigned).

➢ ***There has been more change at the level of specific plan offerings than plan sponsors. Only four of the top ten PDPs or MA-PD plans by enrollment in 2011 were also in the top ten in 2006.***

- Within many plan sponsors' offerings, there have been significant changes in enrollment, with changes partly due to sponsors adding, dropping, or consolidating plans. Only 4 of the top 10 plans in 2006 have retained their high ranks as of 2011 **(Exhibit 16)**. Two of the top plans in 2011 (Wellcare Classic PDP and Humana Walmart-Preferred PDP) are new entrants since 2006 by plan sponsors with other top plans in 2006.
- 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 at random to a plan offered by another sponsor.

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

- The AARP MedicareRx Preferred PDP offered by UnitedHealth is the leading plan in 30 of 34 PDP regions and has over a third of all non-LIS enrollees. While it is still the top plan among all LIS enrollees, it is less dominant in terms of LIS enrollment. AARP MedicareRx Preferred has the most LIS enrollment in 16 regions (after consolidating the enrollment of its Saver and Preferred PDPs) and has just under a fifth of all LIS enrollees nationally **(Exhibit 17)**.
- Community CCRx Basic, which has enrolled just 3.4 percent of non-LIS beneficiaries, is the leader among LIS enrollees in 13 regions, and has nearly as many LIS enrollees nationwide as AARP MedicareRx Preferred does. Other plans with high LIS enrollment are not among the top five plans for non-LIS beneficiaries.
- Concentration of enrollment among PDPs, as measured by a statistical measure of market competition, is considerably greater within regions than at the national level.[25] The system of assigning LIS beneficiaries to a limited set of benchmark plans in each region is a key factor in this pattern.

PART D PERFORMANCE RATINGS

- ***CMS has reported performance ratings for Part D plans since the fall of 2006 and has used a five-star scale since the fall of 2008. In 2011, 84 percent of PDP enrollees are in plans with a rating of 3 or 3.5 stars, while 15 percent of enrollees are in plans with 4 or more stars.***
  - As of 2011, the Part D ratings are based on 19 measures in 4 categories. Most are process or enrollee satisfaction measures; only two are measures of patient safety. CMS has stated an intention to move toward more use of outcome and patient experience measures. In contrast to the ratings for Medicare Advantage plans, however, CMS does not use quality ratings for Part D plans to determine bonus payments to these plans.
  - Based on analysis of enrollment by plan ratings, there is little evidence to suggest that beneficiaries use ratings to guide their enrollment decisions. In 2011, the share of PDP enrollees (15 percent) in plans with high ratings (4 stars or more) is no greater than the share of PDPs (15 percent) with those ratings **(Exhibit 18)**. The share of enrollees (1 percent) in low-rated PDPs (fewer than 3 stars) is smaller than the share of PDPs (4 percent) with low ratings.[26]
  - For MA-PD plans, the distribution is skewed slightly more toward the more highly rated plans. About 23 percent of enrollees are in MA-PD plans with high ratings, compared to 19 percent of MA-PD plans with those ratings. But more enrollees are in low-rated plans (fewer than 3 stars): 15 percent of both MA-PD plans and enrollees.
  - Under current CMS policy, plans with ratings of less than three stars for three years in a row are subject to a special flag on the Plan Finder website and may have their contracts terminated. Among PDPs, the MedicareRx Rewards Standard and Plus PDPs, operated by Wellpoint have a rating of 2.5 stars in 2011. Starting this year, plans with a five-star rating are eligible to enroll new members at any time during the year. In 2011, Medco sponsors the only national PDPs with a five-star rating, but several regional plans also qualify.[27]

CONCLUSION

Medicare Part D plans are an important source of prescription drug coverage for nearly 30 million Medicare beneficiaries in 2011. Beginning this year, initial steps are being taken to close the benefit's coverage gap, as part of changes enacted into law through the 2010 health reform law. CMS has estimated that nearly 1 million beneficiaries benefited from the 50 percent discount on brand-name drugs in the gap during the first half of 2011.[28] Because almost no plans provide additional gap coverage for brand-name drugs, the discounts offer valuable financial protection to Part D enrollees who reach the gap.

Another important change in 2011 was the acceleration of the trend toward fewer plan offerings. Although Part D enrollees in each region have a choice of at least 28 PDPs (and many have a similar number of MA-PD plan choices), the total number of PDPs offered is down one-third in 2011 compared to 2010. Mergers among plan sponsors and regulatory guidance have both contributed to the decline, simplifying choices for Part D enrollees.

Average premiums for PDP enrollees increased more slowly (3 percent) between 2010 and 2011 than in previous years, but average PDP premiums are up by 48 percent since 2006. Among the most popular PDPs by enrollment, the premium for the most popular plan (AARP MedicareRx Preferred) went down slightly between 2010 and 2011; the premium for the second most popular plan (CCRx Basic) went up slightly; and some plans increased premiums by more than 10 percent. MA-PD plan premiums have risen much more slowly over time, but the combined average increase for PDPs and MA-PDs is 37 percent from 2006 to 2011.

Over the last two years, the volatility of the PDP offerings available to beneficiaries receiving the Low-Income Subsidy has decreased. The number of LIS benchmark plans increased from between 2010 and 2011, in part because a new waiver policy allows some plans to retain their LIS enrollees without requiring them to pay a premium. CMS has taken a number of steps 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. However, over 500,000 low-income beneficiaries continue to pay premiums of at least $10 per month in 2011 because they did not follow up on this information and select a no-premium plan.

Further marketplace change and consolidation could occur in the 2012 Part D marketplace as plan sponsors continue to respond to CMS policies intended to reduce the number of plans and to ensure that available plans offer real differences,. 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 annually and make informed decisions based on coverage and costs for the medications they take and to consider the performance ratings of competing plans. At the same time, ongoing research and monitoring are needed to evaluate the impact of both the existing trends and any changes that result from recent statutory and regulatory changes in order to help ensure that the Medicare Part D program serves beneficiaries well.

METHODS

This report presents an analysis of the Medicare Part D 2011 marketplace, 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 a set of CMS files, including the "landscape file" released in October 2010, a second file with additional premium information, and enrollment files released in 2011. We use April 2011 enrollments for all enrollment-based analysis in this report, because April is the single month for which CMS has released separate plan-level enrollment information for LIS enrollees. 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.

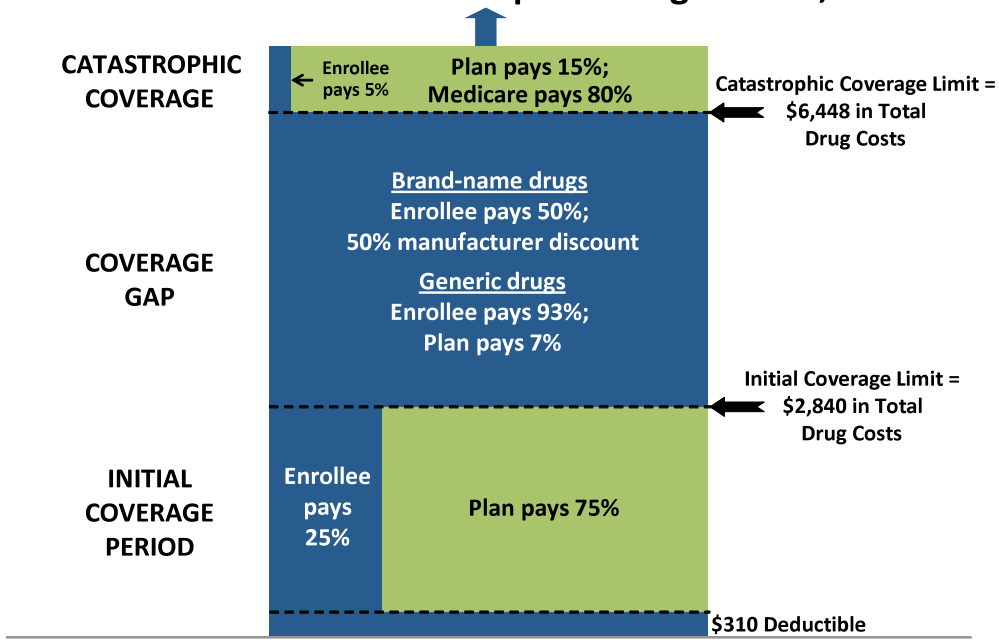
Results on plan benefits and formularies were collected primarily from analysis funded by the Medicare Payment Advisory Commission (MedPAC) and performed by Hoadley, Hargrave, and Katie Merrell (Social & Scientific Systems, Inc.). This analysis used plan benefit and formulary files released by CMS and 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.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the assistance of Katie Merrell of Social & Scientific Systems, Inc., on the MedPAC analysis, and Shinobu Suzuki and Joan Sokolovsky of MedPAC for guidance and support on that project.

Exhibit 1

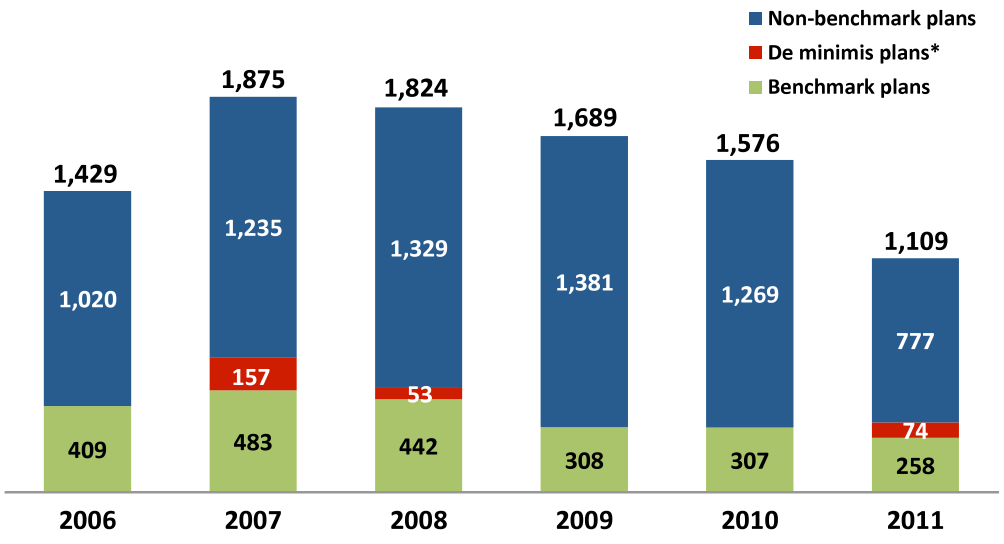
Standard Medicare Prescription Drug Benefit, 2011



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

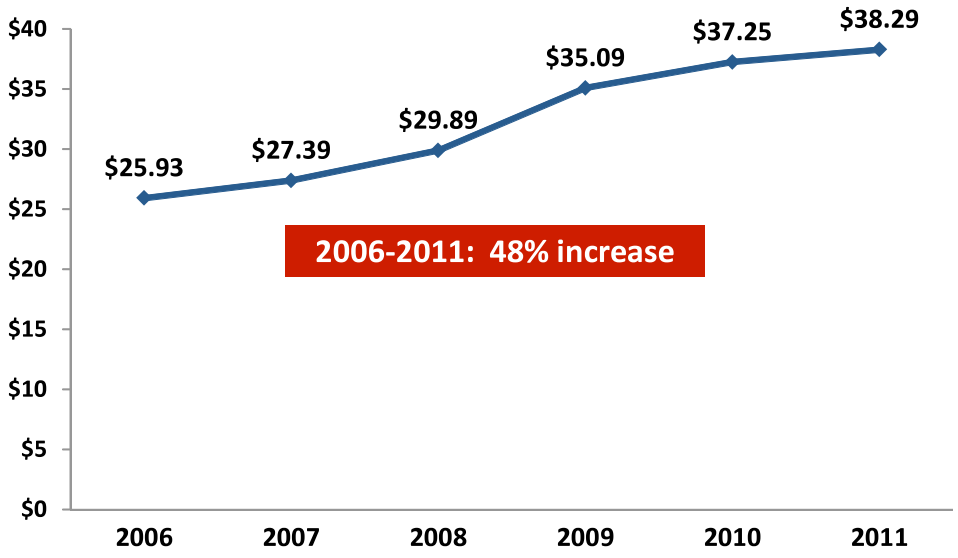
Distribution of Medicare Stand-Alone Prescription Drug Plans, by Benchmark Status, 2006-2011



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, 2006-2011.

Exhibit 3

Weighted Average Monthly Premiums for Stand-Alone PDPs, 2006-2011



SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

Exhibit 4

Premiums in Medicare Stand-Alone Prescription Drug Plans with Highest Enrollment, 2006-2011

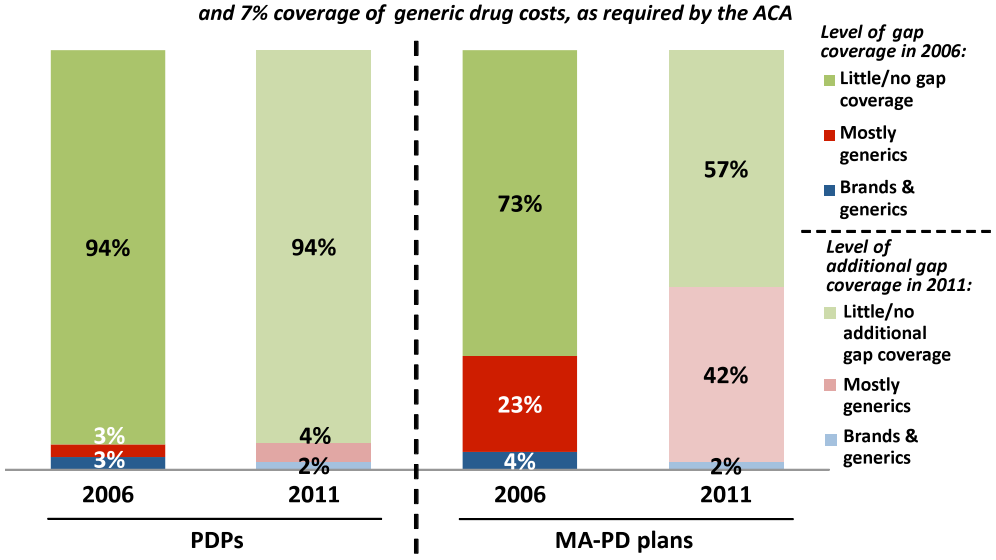
Name of PDP in 2010	2011 Enrollment (of 17.0 million)		Weighted Average Monthly Premium[1]			% Change	
	Number	% of Total	2006	2010	2011	2010-2011	2006-2011
AARP MedicareRx Preferred[2]	4,593,006	27.0%	$26.31	$35.82	$34.73	-3%	+32%
CCRx Basic	1,713,680	10.1%	$30.94	$28.78	$29.71	+3%	-4%
Humana PDP Enhanced	1,397,018	8.2%	$14.73	$41.36	$43.76	+6%	+197%
First Health Premier	1,056,979	6.2%	$24.98	$30.53	$35.65	+17%	+43%
Humana Walmart-Preferred[3]	895,285	5.3%	--	--	$14.80	--	--
WellCare Classic[4]	684,726	4.0%	$15.80	$27.93	$31.79	+14%	+101%

NOTES: [1]Average premiums are weighted by enrollment in each region for each year. [2]The premium amount shown for 2010 is the weighted average of the AARP Saver PDP and AARP Preferred PDP. Plans were consolidated into one for 2011. Saver did not exist in 2006.
[3]Humana Walmart-Preferred PDP was not offered before 2011. [4]WellCare Classic was first offered in 2007; average 2006 premium and percent change from 2006-2011 are based on 2007 data.
SOURCE: Georgetown/NORC analysis of CMS PDP Landscape Source Files, 2006-2011, for the Kaiser Family Foundation.

Exhibit 5

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

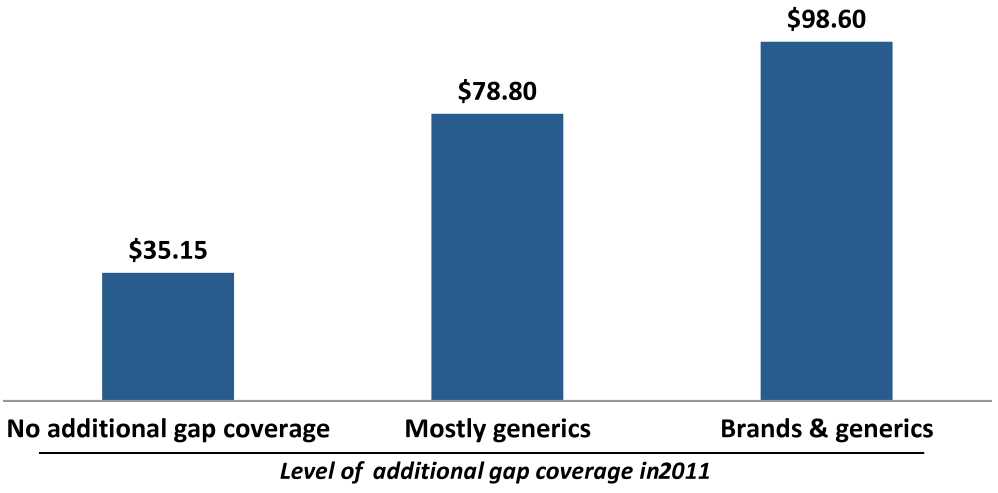


NOTES: Estimates include Part D enrollees receiving low-income subsidies, but who receive coverage for costs in the gap regardless of whether their plan offers it.
SOURCE: Georgetown/NORC analysis of CMS Part D landscape and enrollment files, 2006-11, for the Kaiser Family Foundation.

Exhibit 6

Weighted Average Monthly Premiums for Stand-Alone PDPs, by Level of Gap Coverage, 2011

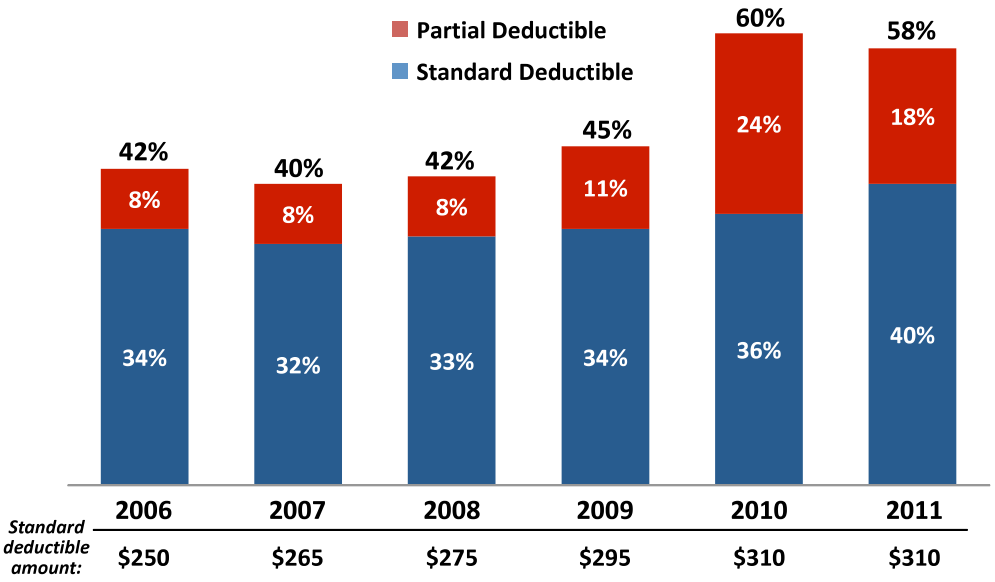
In 2011, the coverage gap is partially filled by a 50% price discount for brand-name drugs and 7% coverage of generic drug costs, as required by the ACA



SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

Exhibit 7

Share of Medicare Stand-Alone Prescription Drug Plans with a Deductible, 2006-2011



NOTE: Estimates may not sum to total due to rounding.
SOURCE: Georgetown/NORC analysis of CMS PDP landscape source files, 2006-2011, for the Kaiser Family Foundation.

Exhibit 8

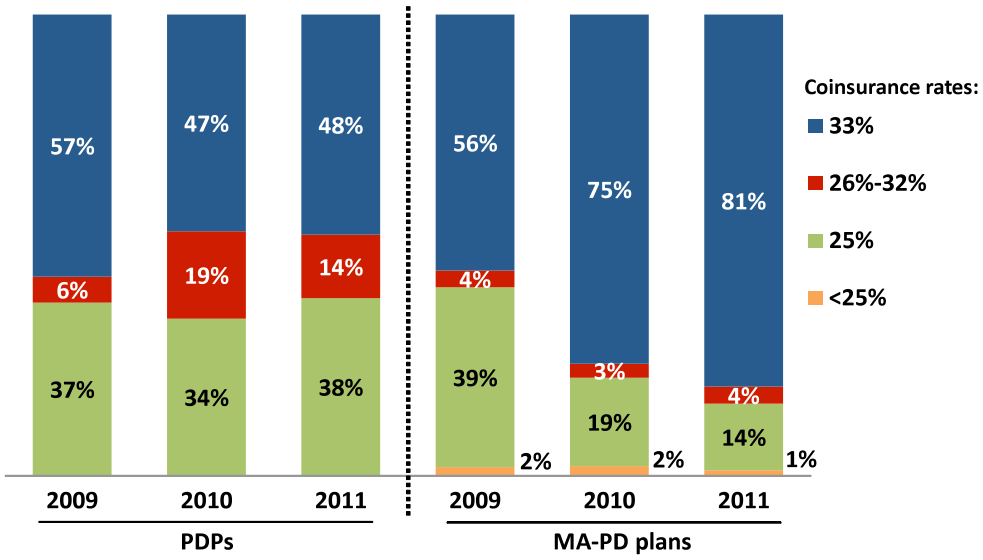
Cost Sharing for Medicare Part D Plans, 2006-2011, and Employer-Sponsored Plans, 2010

FORMULARY TIER	PART D PLAN TYPE	PART D COST SHARING						EMPLOYER PLANS
		2006	2007	2008	2009	2010	2011	2010
Generic	PDP	$5	$5	$5	$7	$7	$7	$11
	MA-PD	$5	$5	$5	$5	$6	$6	
Preferred brand	PDP	$28	$28	$30	$37	$42	$42	$28
	MA-PD	$26.70	$29	$30	$30	$39	$40	
Non-preferred brand	PDP	$55	$60	$71.50	$74.75	$76.50	$78	$49
	MA-PD	$55	$60	$60	$60	$79	$80	
Specialty	PDP	25%	30%	30%	33%	30%	30%	36%
	MA-PD	25%	25%	25%	33%	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, 2010.

Exhibit 9

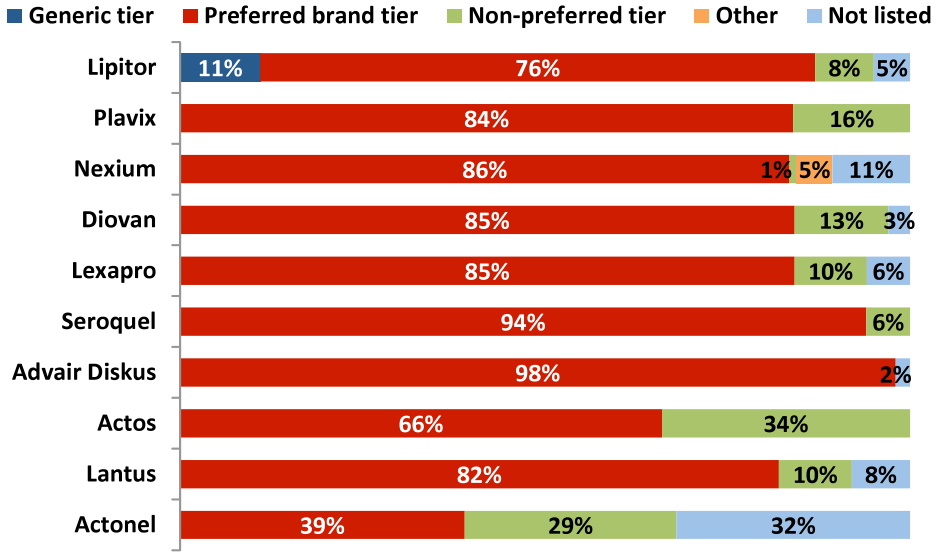
Share of Enrollment in Medicare Part D Plans with Specialty Tiers, by Specialty Tier Coinsurance Rate, 2009-2011



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 10

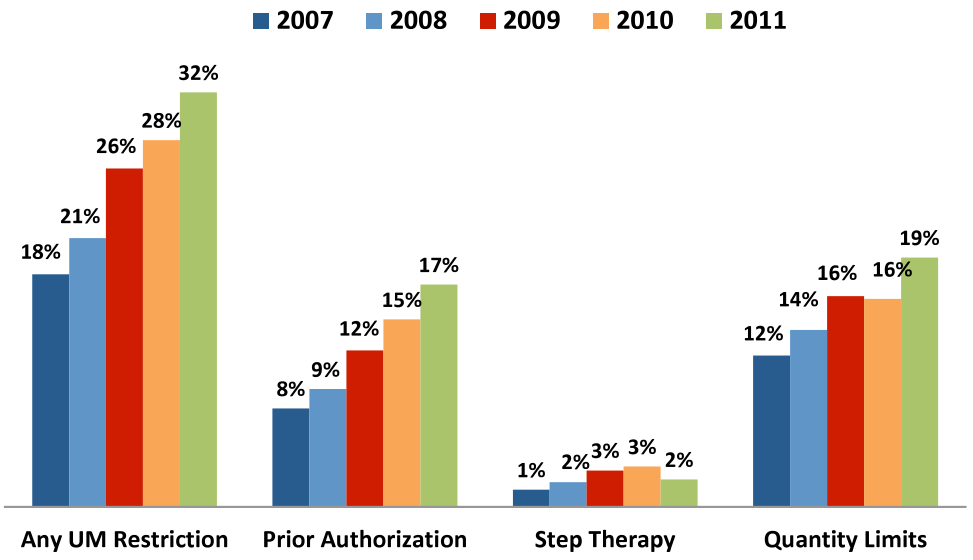
Share of Stand-Alone PDP Enrollees with Coverage of Top Ten Brand-Name Drugs, by Formulary Tier, 2011



NOTES: Enrollment weighted. Preferred brand includes plans using standard benefit without tiers.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

Exhibit 11

Share of Covered Drugs with Utilization Management (UM) Restrictions Across All Stand-Alone PDPs, 2007-2011



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 12

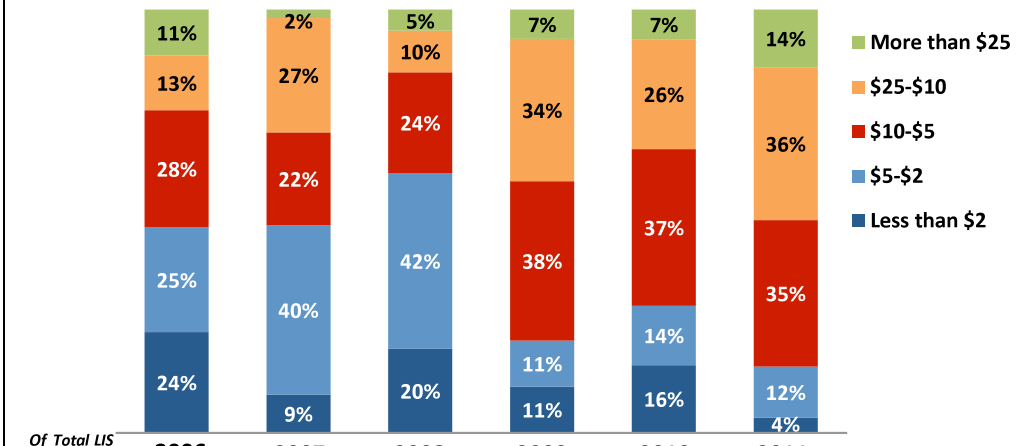
Share of Medicare PDP Enrollees Facing Utilization Management Restrictions for Top Ten Brand-Name Drugs, 2011

Top Brand-Name Drug	% Enrollees with Drug Not Covered	% Enrollees with Any UM	% Enrollees with Prior Authorization	% Enrollees with Step Therapy	% Enrollees with Quantity Limits
Lipitor	5%	90%	0%	8%	90%
Plavix	0%	84%	0%	0%	84%
Nexium	11%	97%	16%	1%	96%
Diovan	3%	83%	0%	12%	82%
Lexapro	6%	97%	0%	9%	97%
Seroquel	0%	69%	2%	0%	69%
Advair Diskus	2%	94%	0%	0%	94%
Actos	0%	87%	0%	61%	59%
Lantus	8%	16%	8%	0%	9%
Actonel	32%	98%	9%	23%	92%

SOURCE: Georgetown/NORC analysis of CMS Formulary Files, 2011, for MedPAC.

Exhibit 13

Distribution of Monthly Part D Premiums for Low-Income Subsidy PDP Enrollees Paying Premiums, 2006-2011

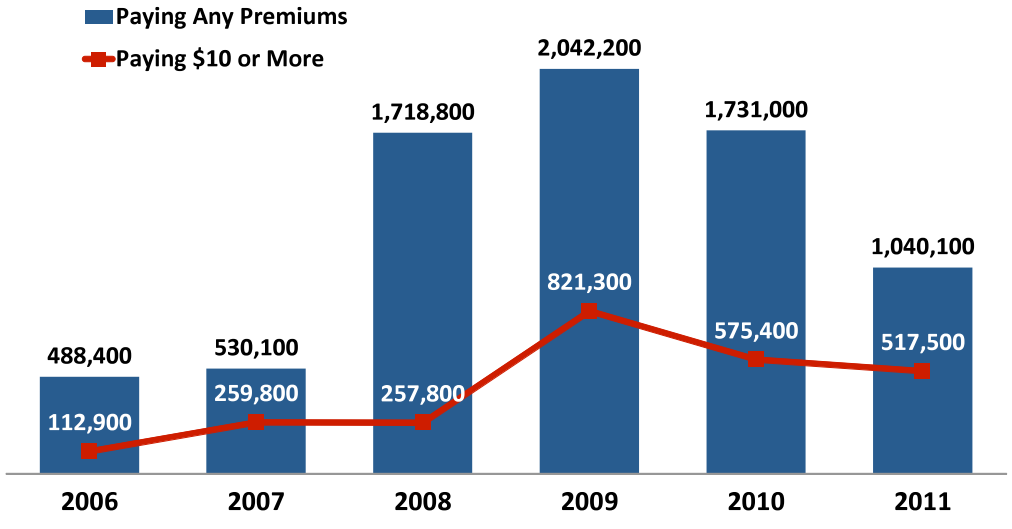


	2006	2007	2008	2009	2010	2011
Of Total LIS Enrollees, Share Paying Premiums:	6%	7%	21%	26%	22%	13%
Number Paying Premiums:	488,400	530,100	1,718,800	2,042,200	1,731,000	1,040,100
Average Premiums:	$9.20	$12.69	$6.87	$11.10	$9.95	$14.71

SOURCE: Georgetown/NORC analysis of CMS 2006-11 PDP Landscape and Enrollment files for the Kaiser Family Foundation.

Exhibit 14

Number of Low-Income Subsidy PDP Enrollees Paying Monthly Premiums, 2006-2011



SOURCE: Georgetown/NORC analysis of CMS 2006-11 PDP Landscape and Enrollment files for the Kaiser Family Foundation.

Exhibit 15

Top 10 Firms Offering Medicare Part D Plans Ranked by 2011 Enrollment

Name of firm	2011			2006	Change in Total Enrollment, 2006-2011
	Rank	Enrollment (in millions)	% of Total Part D in 2011	Rank	
UnitedHealth Group	1	6.90	23.5%	1	+21%
Humana	2	3.95	13.5%	2	-9%
CVS Caremark	3	3.53	12.0%	11	+754%
Coventry Health Care	4	1.38	4.7%	7	+86%
HealthSpring	5	1.16	4.0%	21	+510%
Wellpoint	6	1.16	4.0%	3	-12%
WellCare Health Plans	7	1.06	3.6%	4	+8%
Kaiser Permanente	8	0.99	3.4%	6	+27%
Medco Health Solutions	9	0.71	2.4%	10	+71%
Aetna	10	0.63	2.2%	12	+55%
TOTAL TOP 10 FIRMS		21.5 mil	73.3%		
TOTAL PART D		29.3 mil	100.0%		

NOTES: Includes plans in the territories. Estimates for Caremark reflect acquisition of Universal American.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS Enrollment Files, 2006-2011.

Exhibit 16

Top 10 Medicare Part D Plans Ranked by 2011 Enrollment

Name of plan	2011			2006	Change 2006-2011
	Rank	Enrollment (in millions)	% of Total Part D in 2011	Rank	
AARP MedicareRx Preferred PDP	1	4.60	15.7%	1	+44%
Community CCRx Basic PDP	2	1.72	5.9%	5	+117%
Humana Enhanced PDP	3	1.40	4.8%	3	+45%
First Health Part D Premier PDP	4	1.06	3.6%	18	+298%
Humana Walmart-Preferred PDP	5	0.89	3.1%	N/A	[-56%]
WellCare Classic PDP	6	0.68	2.3%	N/A	N/A
Kaiser Permanente Senior Advantage HMO	7	0.68	2.3%	7	+2%
Advantage Star Plan by RxAmer	8	0.63	2.2%	31	+478%
CVS Caremark Value PDP	9	0.63	2.1%	13	+56%
Humana Gold Plus HMO	10	0.57	1.9%	14	+50%

NOTES: Includes plans in the territories. N/A is not applicable.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS Enrollment Files, 2006-2011.

Exhibit 17

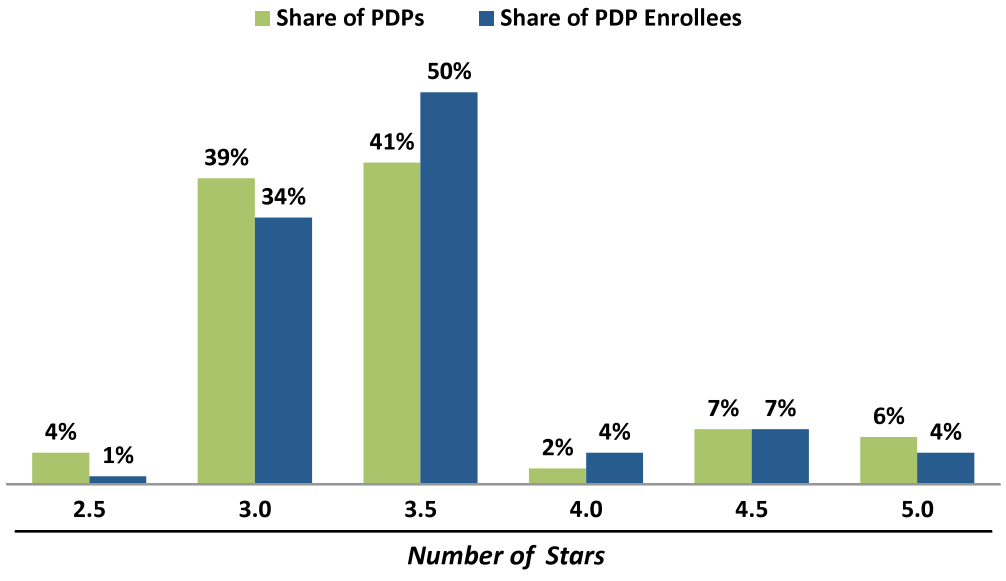
Top 5 Medicare Stand-Alone PDPs, Ranked by 2011 LIS Enrollment and Non-LIS Enrollment

Prescription Drug Plan	Total LIS Enrollment	Share of All LIS Enrollees	Share LIS in Plan	Number of Regions Where PDP is Benchmark Plan
AARP MedicareRx Preferred	1,512,000	18.4%	32.9%	23
Community CCRx Basic	1,414,000	17.2%	82.5%	29
WellCare Classic	625,000	7.6%	91.3%	28
Advantage Star Plan by RxAmerica	585,000	7.1%	92.3%	24
CVS Caremark Value	531,000	6.5%	85.0%	28
TOTAL FOR TOP 5 LIS PDPs	4,667,000	56.8%		
Prescription Drug Plan	**Total Non-LIS Enrollment**	**Share of All Non-LIS Enrollment**	**Share Non-LIS in Plan**	**Number of Regions Where PDP is Benchmark Plan**
AARP MedicareRx Preferred	3,081,000	35.0%	67.1%	23
Humana Enhanced	1,173,000	13.3%	84.0%	0
First Health Part D-Premier	673,000	7.6%	63.7%	15
Humana Walmart-Preferred Rx Plan	592,000	6.7%	66.1%	34
Community CCRx Basic	299,000	3.4%	17.5%	29
TOTAL FOR TOP 5 NON-LIS PDPs	5,818,000	66.0%		

NOTE: LIS is low-income subsidy.
SOURCE: Georgetown/NORC analysis of CMS PDP Landscape and Enrollment Files, 2011, for the Kaiser Family Foundation.

Exhibit 18

Share of Medicare Stand-Alone PDPs and PDP Enrollees, by Plan Star Ratings, 2011



SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS Ratings, 2011.

ENDNOTES

[1] Centers for Medicare & Medicaid Services, Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report - Monthly Summary Report (Data as of April 2011) (accessed at http://www.cms.gov/MCRAdvPartDEnrolData/MCESR/list.asp#TopOfPage, August 16, 2011).
[2] Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010 (HCERA)
[3] Department of Health and Human Services, "The Affordable Care Act Reduces Out-of-Pocket Drug Costs for Millions of People with Medicare," March 22, 2011, http://www.healthcare.gov/center/reports/medicare03222011a.html.
[4] All Medicare Part D Data Spotlights are available at http://www.kff.org/medicare/rxdrugbenefits/partddataspotlights.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 Jack 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 Jack 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. This report also incorporates analysis of Part D data prepared by Jack Hoadley, Elizabeth Hargrave, and Katie Merrell for the Medicare Payment Advisory Commission (MedPAC). See Jack Hoadley et al., "Medicare Part D Formularies, 2006 – 2011: Update to Chartbook," April 2011, http://www.medpac.gov/documents/Aug11_PartDFormularies Chartbook_Updated_CONTRACTOR_ss.pdf.
[5] CMS does not report the number of beneficiaries who switch between particular plans.
[6] In November 2010, HealthSpring completed its acquisition of Bravo Health. In April 2011, CVS Caremark completed its acquisition of Universal American, sponsor of the Community CCRx PDPs.
[7] Although many of these PDPs are regional offerings of plans offered nationally, one near-national PDP sponsor averages fewer than 500 enrollees per plan, and one national sponsor averages fewer than 2,000 per plan (mostly concentrated in just a few regions).
[8] Special Needs Plans are a type of Medicare Advantage Plan that limits membership to beneficiaries with specific diseases or characteristics. In 2011, 409 SNPs are offered; see Marsha Gold et al, 2011, *Medicare Advantage 2011 Data Spotlight: Special Needs Plans: Availability and Enrollment* (http://www.kff.org/medicare/8229.cfm).
[9] The 2011 average reported here ($38.29) is lower than the amount reported in the October 2010 spotlight ($40.72) because the new average is weighted by actual 2011 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 49 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 $187.18/month in 2010).
[11] The overall premium in 2010 for MA plans that include drug coverage is $39 per month, down 10 percent from 2010; see Marsha Gold et al, "Medicare Advantage Enrollment Market Update," September 2011, http://www.kff.org/medicare/8228.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 Jack Hoadley et al. analysis for MedPAC (see note 4). 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 4). 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] The 63 PDPs losing benchmark status includes 12 Fox Value Plans terminated by CMS early in 2010 and 9 non-renewed PDPs for which there was no PDP offered by the sponsor with benchmark status in 2011.
[21] This excludes plans where enrollment was transferred to other benchmark plans offered by the same sponsor as a result of mergers or plan consolidations in response to the new CMS guidance; for example, UnitedHealth dropped its AARP Saver plan and consolidated enrollment in its Preferred plan.
[22] For example, for 2011 enrollees in PrescribaRx Bronze PDPs in 22 regions were transferred into Community CCRx Basic PDPs as a result of the acquisition of MemberHealth, Inc., by Universal American in 2007.
[23] The figures published in the 2010 summary for the program's earlier years have been recalculated because CMS has released actual LIS premiums. This new information affects the premium amounts, but not the number of people paying premiums.

[24] CMS, "Medicare Provides Assistance to Help Low-Income Beneficiaries Get Big Savings on Prescription Drug Costs," August 9, 2011, https://www.cms.gov/apps/media/press/release.asp?Counter=4048.
[25] Market competition among PDPs, as measured by the Herfindahl index, averages 1474 across the 34 regions for overall enrollment, well above the 2010 level of 909. The comparable index value computed nationally is 1051. 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.
[26] Without individual-level enrollment data, it is difficult to examine whether there is any tendency to enroll in more highly rated plans. Aggregate trends show little if any evidence that enrollees are switching based on plan ratings.
[27] For example, the MedicareBlue Rx PDPs in the upper Midwest region and Kaiser Permanente MA-PD plans in Colorado, Oregon, and Hawaii)
[28] CMS, "Medicare prescription drug premiums will not increase, more seniors receiving free preventive care, discounts in the donut hole," Press release, August 4, 2011.

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