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ANALYSIS OF MEDICARE PRESCRIPTION DRUG PLANS IN 2012 AND KEY TRENDS SINCE 2006

Jack Hoadley and Laura Summer, Georgetown University
Elizabeth Hargrave, NORC at the University of Chicago
Juliette Cubanski and Tricia Neuman, Kaiser Family Foundation

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 enrolled beneficiaries. 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. In 2012, about 31.5 million Medicare beneficiaries are enrolled in Medicare drug plans, including 19.7 million in PDPs and 11.7 million in MA-PD plans.[1] Nearly 11 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 2010, the law provided a $250 rebate to 3.8 million Part D enrollees who reached the coverage gap.[3] In 2011, pharmaceutical manufacturers started 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 cost-sharing level that applies before the gap, thus eliminating the coverage gap in 2020. In addition, the Centers for Medicare & Medicaid Services (CMS) has implemented other statutory and regulatory changes that have resulted in some consolidation of Part D plan offerings, along with a degree of greater standardization, in 2011 and 2012.

This report presents findings from an analysis of the Medicare Part D marketplace in 2012 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 10.

KEY FINDINGS

PLAN AVAILABILITY

Fewer PDPs are offered in 2012 than in any previous year. There are 1,041 PDPs in 2012, about 6 percent fewer than in 2011 and one-third fewer than in 2010. Even with this decline, at least 25 PDPs are offered in every region this year (excluding plans in the territories). While the number of PDPs rose sharply between 2006 and 2007, the number has decreased each year since then **(Exhibit 2)**. Both marketplace and policy factors have contributed to the decline. The Part D plan market has witnessed several mergers between sponsoring organizations and consolidation of plan offerings by sponsors. Through regulations issued in 2010, CMS started a process to eliminate duplicative plan offerings and plans with low enrollment. For example, most sponsors now offer two plan options (one basic and one enhanced) instead of the three options offered in past years.

The average number of PDPs per region has come down from a high of 56 in 2007 to 32 in 2012 (weighted by regional enrollment). In 2012, virtually all beneficiaries have at least one Medicare Advantage (MA) option as well – 20 on average, the majority of which also offer drug coverage.[5] Thus beneficiaries participating in Part D continue to have a wide array of choices. Current CMS policies suggest that the number of PDPs may continue to decline in future years. Corporate acquisitions completed in 2012 will lead to further consolidation of the PDPs currently offered (although changes could be deferred beyond 2013) in order for sponsors to remain compliant with CMS limits on plan offerings by the same sponsor.[6] The call letter issued by CMS to solicit plan participation for 2013 reiterates the agency's authority not to renew plans with low enrollment. Currently, 201 PDPs have fewer than 1,000 enrollees, the level at which CMS urges sponsors to consider withdrawal or consolidation; 45 of these PDPs have fewer than 100 enrollees.[7]

In 2012, 1,541 Medicare Advantage drug plans are offered. The number of MA-PD plans 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 has fallen since then; the 1,541 MA-PD plans currently offered is about 23 percent fewer than at the peak.

PREMIUMS

Since 2006, the average PDP premium, weighted by enrollment, has increased by 46 percent, but the 2012 average is 1 percent lower than in 2011. Monthly PDP premiums vary widely. The weighted average premium paid by beneficiaries for stand-alone Part D coverage has increased by 46 percent since the start of the program, from $25.93 in 2006 to $37.78 in 2012 **(Exhibit 3)**.[9,10] Between 2011 and 2012, the average PDP enrollee paid 1 percent less in premiums – the first year-to-year decrease since the program began. A key factor driving lower premiums in 2012 is the availability of generic versions of several key drugs. In 2010, Lipitor, Zyprexa, Seroquel, and Plavix – four of the seven drugs with the highest Part D drug costs – represented 11 percent of total Part D drug costs.[11] Generic versions of all four drugs entered the market between the fourth quarter of 2011 and the second quarter of 2012, creating the opportunity for substitution of the less costly generic version. A conservative assumption that the average price of these drugs was reduced by half in 2012 would suggest a 5 percent reduction in total drug costs from these four drugs alone.

Enrollment in two of the program's newer PDPs, offered at below-average premiums, also helped lower the average premium in 2012. In 2012, there was a net increase of about 200,000 non-LIS enrollees in the Humana Walmart-Preferred Rx PDP – the PDP with the lowest premium in every region ($15.10). In addition, about 370,000 non-LIS beneficiaries enrolled in Coventry's First Health Part D Value Plus PDP, a new entry in 2012 with an average premium of $25.43. Nationwide, the least expensive PDP has a $15.10 monthly premium, while the most expensive PDP has a $131.80 premium, a nearly nine-fold difference. Although some differences can be explained by the relative generosity of the benefits offered or the relative efficiency across plans, other differences are not so easily explained.

Trends in monthly PDP premiums vary across the different organizations that sponsor PDPs. The reduction in the average premium hides larger changes (both increases and decreases) at the plan level **(Exhibit 4)**. Among the PDPs with the highest enrollment, four charged higher average premiums in 2012 compared to 2011, whereas three had lower average premiums. The plan with the highest enrollment, UnitedHealth's AARP MedicareRx Preferred, had a 15 percent increase in the monthly premium for 2012. 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. Between 2006 and 2012, the premium for AARP MedicareRx Preferred plan increased by 51 percent, from $26.31 to $39.85. By contrast, the average monthly premium for Humana's Enhanced PDP in 2012 is nearly three times its 2006 average ($39.58 versus $14.73).

Enrollment trends among the largest PDPs do not appear to be particularly related to premium changes, as might be expected in a competitive marketplace, with enrollees dropping plans where premiums increase and shifting to plans where premiums drop. This pattern is not apparent in Part D. For example, between 2011 and 2012, premiums for AARP MedicareRx Preferred PDP increased by 15 percent, but enrollment also increased by 2 percent. During the same period, premiums for Humana's Enhanced PDP decreased by 9 percent, but enrollment only increased by 1 percent.

The trend in the Part D premium average, combined across stand-alone PDPs and Medicare Advantage drug plans, has been essentially flat since 2009, hovering between $29 and $31.[12] This is influenced by lower average premium for the drug benefit offered by MA-PD plans. The average 2012 monthly premium amount attributable to drug benefits in MA-PD plans is $12.27, more than $25 below the PDP average and down 8 percent from 2010.[13] Many MA-PD plans reduce or eliminate their premiums by using a portion of rebates from the Medicare Advantage payment system.[14] Nearly half of all MA-PD plans charge no premium for their drug benefit. The average monthly MA-PD premium, essentially unchanged since 2011, is only about 2 percent higher than the average in 2006. Despite considerably lower premiums for MA-PD plans across this time period, the overall share of enrollees in MA-PD plans has grown modestly since the start of Part D – from about 23 percent to 33 percent of enrollees not participating through employer group Part D plans.

As with PDPs, average premiums vary considerably by MA-PD plan sponsor. Plans offered by United Healthcare, with about 22 percent of the MA-PD market, have a weighted average premium of $1.96. By contrast, the second largest company in this market segment is Humana, with about 19 percent of MA-PD enrollees. Its average premium is $12.19. The next two largest MA-PD sponsors are Anthem Wellpoint, with a 7 percent market share and a $7.69 average premium, and Kaiser Permanente, with a 6 percent market share and a $2.74 average premium.

Part D premiums vary by geography. Average premiums are considerably higher in certain regions than in others in 2012. These geographic differences generally have persisted from year to year. Beneficiaries enrolled in a basic PDP in New Mexico in 2012 pay an average of $23.76 per month, while those in the Idaho/Utah PDP region pay $39.09 **(Exhibit 5)**, 65 percent more than in New Mexico.[15] This regional difference in premiums has mostly persisted from year to year. New Mexico, Arizona, and Hawaii were all among the regions with the lowest average premiums in 2010, 2011, and 2012. Wisconsin, Delaware/DC/Maryland, and Idaho/Utah were among the five most expensive regions in all three years.

Some regions, however, have seen significant changes in their premiums relative to other regions. New York had an average premium below the national median in 2010, but is now the second most expensive region. Conversely, Missouri was one of the five most expensive regions in 2010 but now has an average premium below the national average. Reasons for these changes are not readily apparent, but may be attributable to both shifts in the mix of plan enrollment in these regions and regional differences in the premiums charged by specific plans. The Humana Walmart-Preferred PDP – the least expensive PDP in all regions since being introduced in 2011 – accounts for 10 percent of all 2012 PDP enrollment in Missouri but only 3 percent in New York. Community CCRx Basic, with a large share of PDP enrollment in both regions, had a 2012 premium in Missouri that was down 23 percent from 2010 and a 2012 premium in New York that was 31 percent higher than in 2010.[16]

Geographic variation in premiums characterizes all national plan sponsors. Some plan sponsors charge as much as two or three times more for the identical basic PDP from one region to another. Twelve plan sponsors offer a basic PDP in at least 32 of the 34 PDP regions. For seven of these national or near-national PDPs, premiums for the identical plan design are more than two times greater in one region than in another **(Exhibit 6)**. The largest absolute difference is for the Health Net Orange Option 1 PDP, which charges beneficiaries $24.00 in New Mexico and $63.70 in Alaska for the same coverage. The largest relative difference is in CVS Caremark Value, which charges $15.80 in New Mexico and $50.60 in neighboring Colorado – more than a threefold difference. By contrast, the Wellcare Classic PDP has a difference of only $16.90 between its New Mexico and Idaho/Utah regions, the smallest difference among plans not new to the program.[17]

In the competitive Part D market, premiums for basic PDPs with equivalent benefits vary widely across different sponsors. Within each region, some plan sponsors charge more than twice as much as other sponsors for their basic PDPs **(Exhibit 7)**. By law, all basic PDPs provide a benefit with the same actuarial value. Furthermore, within the same region, they all could be expected to face similar prescribing patterns from local physicians. Therefore, the observed premium variations likely result from different utilization patterns by plan enrollees. For example, the Humana Walmart-Preferred PDP has the lowest monthly premium for basic coverage nationwide, at $15.10 per month in every region. As a relatively new plan, it is not yet subject to the requirement that its plan premiums reflect the actual use of enrollees. Conversely, the highest premium for a PDP offering basic coverage ranges by

region from $39.30 for the Community CCRx Basic plan in Hawaii to $87.10 for the BlueRx Standard plan in Delaware/Maryland/Washington, DC, nearly five times the minimum.

Beneficiaries selecting PDPs with an enhanced benefit package pay higher premiums on average for their Part D coverage, even for the part attributable to the basic benefit package. The weighted average monthly premium for PDPs with enhanced benefits is $57.89, compared to $33.03 for PDPs offering the basic benefit package. Thus, enrollees pay about 75 percent more to get enhanced benefits. Enhanced plans typically lower or eliminate plan deductibles and may have lower cost sharing for enrollees' prescriptions. Some enhanced plans also expand the coverage of drugs during the coverage gap beyond the amount included in the basic benefit. But analysis of enhanced PDPs in earlier years sometimes revealed only small benefit differences compared to the same sponsor's basic PDPs.[18]

Starting with PDPs offered in 2011, CMS has required sponsors to ensure that benefits in enhanced PDPs are meaningfully different than the basic benefits. An enhanced PDP must now have cost-sharing differences that result in $22 lower monthly out-of-pocket costs than the corresponding basic PDP. As a result the spread between premiums for enhanced PDPs and basic PDPs is higher in 2011 and 2012 than in earlier years. Also, as part of the policy for meaningful differences, CMS now allows sponsors to offer a second enhanced PDP only if expected out-of-pockets costs for cost sharing are even lower (by $16 per month) than for the first enhanced PDP and the second enhanced PDP has coverage for at least some brand drugs in the coverage gap. As a result of these stricter requirements, average monthly premiums for enhanced PDPs offered as a second option are considerably higher: $107.08 versus $53.68 for enhanced PDPs not meeting this stricter standard.

Higher premiums for enhanced PDPs partly reflect the cost of offering the enhanced benefits. But in addition, the portion of the premium that corresponds to the basic benefit is often considerably different than the premium for the same sponsor's basic PDP. For the 13 plan sponsors offering both basic and enhanced PDPs in at least 16 regions, an enrollee in the basic PDP pays an average monthly premium of $32.32, whereas one in the same sponsor's enhanced plan pays a similar amount ($31.07, or 4 percent less on average) for the basic portion of the benefit, in addition to the amount ($17.10) corresponding to the enhanced benefits **(Exhibit 8)**.[19] This pattern, however, is not consistent across plan sponsors. Several sponsors charge a premium for the basic benefit in the enhanced PDP that is considerably higher – often by $20 more per month – than the premium for the basic PDP. .

THE COVERAGE GAP

In 2012, 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 86 percent of the cost for generics (plans pay the remaining 14 percent). Most PDPs offer little or no coverage in the gap in 2012 beyond that which is required by the ACA. A substantial majority of Part D enrollees are in plans that offer no additional gap coverage in 2012 beyond the required discount. But regardless of the level of gap coverage offered by their plans, changes enacted in the ACA mean that all enrollees who reach the gap receive a 50 percent discount on the price of brand-name drugs and a plan payment for generic drugs of 14 percent of the drug's cost. If current law remains in place, beneficiaries will face average cost sharing of only 25 percent for all drugs in the gap by 2020 – the same as in the initial coverage period – effectively eliminating the coverage gap. In 2012, most PDPs (76 percent) offer little or no gap coverage beyond what is required; those with coverage cost more and have attracted fewer enrollees.[20]

While 94 percent of all PDP enrollees are in plans without additional gap coverage beyond the price discounts required by law, only 47 percent actually face a gap in coverage beyond what the ACA requires, because enrollees receiving Low-Income Subsidies do not pay the full drug costs when they reach the gap. In 2012, the vast majority of non-LIS Part D enrollees (90 percent) are in PDPs with no 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 2012 (50 percent), but only 29 percent have additional gap coverage for more than a "few" drugs). A much larger share of MA-PD plan enrollees than PDP enrollees are in such plans. Nearly four in ten (38 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 9)**, but lower than the level of gap coverage in 2011 (43 percent).[21] The higher level of

additional gap coverage among enrollees in MA-PD plans occurs 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.[22] 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 some generic drugs in the gap. In 2012, only about 2 percent of PDP and MA-PD plan 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 2012, only 9 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 **(Exhibit 10)**. Plans with gap coverage for at least some brands are the most expensive, with average premiums about $24 per month higher than those covering only 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. The number of plans that offer the defined standard benefit is small; in 2012, only 9 percent of PDPs and 2 percent of MA-PD plans make no use of formulary tiers (with 5 percent and 1 percent of enrollment, respectively).

A relatively new model for tiered cost sharing has become common in 2012, the five-tier approach, which adds a second generic tier to the four-tier arrangement that has been most common in recent years. Now nearly half of all plans use five cost-sharing tiers: preferred and non-preferred tiers for generic drugs, preferred and non-preferred tiers for brand drugs, and a tier for specialty drugs. About 49 percent of PDPs and 37 percent of MA-PD plans (with roughly half of enrollees) use this five-tier approach, while 42 percent of PDPs and 59 percent of MA-PD plans (with roughly the other half of enrollees) continue to use the four-tier approach.[23]

Use of a deductible by stand-alone PDPs is considerably higher in 2012 than in the first few years of the program, but down somewhat since 2010 **(Exhibit 11)**. About 53 percent of PDPs charge a deductible this year, compared to between 40 percent and 45 percent from 2006 and 2009 and 60 percent in 2010. Most PDPs with a deductible use the standard deductible allowed by law ($320 in 2012). A far smaller number of MA-PD plans (11 percent) use a deductible in 2012.

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 2012, 30 percent of PDPs (with 35 percent of enrollment) 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, and a few also use a flat copayment 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 67 percent, from $55 to $92, while cost sharing for "preferred" brand drugs increased by 46 percent, from $28 to $41. From 2011 to 2012, the spread between tiers widened modestly. In 2012, MA-PD plans generally have similar cost-sharing levels as the PDPs. Median cost sharing for generic drugs in PDPs is $5 in 2012, returning to the same level as the program's first years, after being as high as $7 for several years **(Exhibit 12)**. For PDPs with two generic tiers (representing about half of PDP enrollment), the median cost sharing was $4 for the preferred generic tier and $8 for the non-preferred tier. Some PDPs set cost sharing for their non-preferred generic tier as high as $25 or $33.

Cost-sharing amounts for commonly used brand-name drugs without generic equivalents vary widely across Part D plans in 2012, as they have in previous years. For preferred brand tiers, PDPs set copayment levels as low as $27 and as high as $45; for non-preferred tiers, the copayments range from $48 to $95. These ranges are less than in some previous years because of new CMS guidance on allowable copayment levels. The median, especially for the non-preferred brand tier, has increased over time. Meanwhile, 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. The median coinsurance percentages for PDPs in 2012 for the two brand tiers are 25 percent and 40 percent.

Medicare Part D plans generally charge more than employer plans do for preferred and non-preferred brand drugs, but somewhat less for generics. At the median, PDPs charge $41 per month for a preferred brand in 2012, well above the average $29 charged by employer plans **(Exhibit 12)**.[24] Cost-sharing differences are even greater for non-preferred brands ($92 for PDPs vs. $51 for employer plans). Thus the spreads between cost sharing for brands and generics and between preferred and non-preferred brand drugs are greater in Medicare Part D plans – increasing the incentives for plan enrollees to choose generics or preferred brand drugs.

SPECIALTY TIERS

Most Part D plans use a specialty tier for high-cost medications in 2012, and many Part D enrollees are in plans with a 33 percent coinsurance rate for specialty tier drugs. In 2012, among Part D enrollees in plans using tiered cost sharing, 90 percent of PDP enrollees and 99 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 2012). 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. Thus, cost sharing in these plans in similar to that in plans with specialty tiers.

In 2012, about 40 percent of PDP enrollees and 87 percent of MA-PD plan enrollees are in plans charging 33 percent coinsurance for specialty drugs in the initial coverage period **(Exhibit 13)**. 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 (up to 33 percent) for specialty tier drugs if offset by a lower deductible.[25] The only national PDP (Humana Walmart-Preferred) without a specialty tier places most specialty drugs on a non-preferred brand tier with 35 percent coinsurance on that tier (higher if drugs are purchased outside the preferred pharmacy network).

Placing a drug on the specialty tier can have serious cost implications for plan enrollees. A specialty drug priced at the $600 threshold will cost the beneficiary between $150 and $200 per month during the initial coverage period prior to the coverage gap. But monthly cost sharing for other common specialty drugs, such as Copaxone (for multiple sclerosis), Enbrel (for rheumatoid arthritis), Gleevec (for certain cancers), and Truvada (for HIV) can range from $300 to $2,000, before a beneficiary reaches the coverage gap or qualifies for catastrophic coverage.

FORMULARIES AND UTILIZATION MANAGEMENT

The scope of formulary coverage continues to vary widely across PDPs in 2012. Part D plan formularies typically include more drugs than CMS standards require, but formulary coverage varies considerably across plans.[26] Some plans list all drugs from the CMS drug reference file on their formularies, while other plans list as few as 60 percent of these drugs.[27] (The five largest PDPs range in formulary coverage from 75 percent to 92 percent of drugs in the reference file.) In 2012, 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 (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.

Examining coverage of the top ten brand-name drugs commonly used by Medicare beneficiaries illustrates the variation in formulary coverage **(Exhibit 14)**.[28] In 2012, five of the top ten brand drugs are off formulary for at least 5 percent of all PDP enrollees. All of the top ten brands are on a preferred cost-sharing tier for a majority of PDP enrollees. The two drugs from this list least likely to be available on a preferred tier are Celebrex and Lyrica, both of which are prescribed for pain relief. Celebrex is off formulary for about one-fourth of PDP enrollees, who will pay the full price (about $300 per month, depending on dosage) to obtain the drug. Lyrica is on a non-preferred tier for over one-third of PDP enrollees – raising monthly cost sharing from $41 to $92 per month.

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.[29] The presence of such rules has increased since 2007, with 36 percent of drugs subject to some utilization management in 2012, up from 18 percent in 2007 **(Exhibit 15)**. Quantity limits are applied to 21 percent of drugs in 2012, prior authorization is applied to 20 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 restrictions to a similar share of drugs.

The top ten brand-name drugs illustrate the variations in utilization management **(Exhibit 16)**. At least 80 percent of PDP enrollees face UM restrictions for nine of the top ten brand-name drugs. Most restrictions are quantity limits (e.g., limiting a prescription to 30 pills for 30 days) that create limited concerns for most enrollees. Four of the top drugs (Celebrex, Cymbalta, Nexium, and Lyrica) have prior authorization required for at least 10 percent of PDP enrollees. Three drugs (Celebrex, Lyrica, and Zetia) have step therapy requirements for at least 19 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 – decreased marginally between 2011 and 2012. The benchmark market remains volatile, however. The total number of benchmark plans for Part D Low-Income Subsidy (LIS) enrollees nationwide decreased by just 5 plans between 2011 and 2012, despite the overall decrease in the number of PDPs **(Exhibit 2)**. Several policies that have been 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, account for the small change in the number of benchmark plans. The number of LIS benchmark plans varies by region, ranging from 2 in Nevada and 3 in Florida to 15 in Arkansas.

The benchmark plan market has changed considerably over the program's seven years, which has generated some instability for low-income enrollees. Of the 409 benchmark plans offered in 2006, only 37 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.[30] Of the 332 benchmark plans available to LIS recipients for zero premium at the start of 2011, 67 lost benchmark status for 2012, similar to the situation between 2010 and 2011.[31,32]

As of the open enrollment period for the 2011 plan year (October 15 to December 7, 2011), about 2.5 million people – one of every four LIS beneficiaries – were enrolled in benchmark PDPs in 2011 that failed to qualify as benchmark plans in 2012. CMS reassigned about 800,000 beneficiaries to new PDPs for the 2012 benefit year. But another 1.7 million beneficiaries were not eligible for reassignment because at some point they had switched plans on their own.

About 1.4 million LIS beneficiaries remain in non-benchmark PDPs in 2012 and are paying premiums for Part D coverage this year, a number that is nearly one-third lower than in 2009. The proportion of LIS beneficiaries in PDPs paying premiums rose from 6 percent in 2006 to 26 percent in 2009, declined to 13 percent in 2011, but was back up to 17 percent in 2012 **(Exhibit 17)**. (Another 200,000 LIS beneficiaries enrolled in MA-PD plans also pay a Part D premium for their plans.) Without the de minimis premium waiver; about 1.6 million LIS beneficiaries in these PDPs would either pay a small premium or would have been reassigned to different PDPs to avoid a premium.

Nearly three-fourths of the LIS beneficiaries paying premiums in 2012 are enrolled in PDPs offered by just three sponsors: United Healthcare, Humana, and Wellpoint. In fact, over half are enrollees in United's AARP MedicareRx Preferred PDP, which lost benchmark status in many regions over the past two years. This is further evidence of beneficiaries' apparent reluctance to switch plans even when it could save them money.

About 550,000 LIS beneficiaries are paying monthly premiums of $10 or more in 2012, representing about 40 percent of the 1.4 million LIS beneficiaries who pay any premium **(Exhibit 18)**. 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.

THE PART D MARKETPLACE, 2006-2012

Over the program's first seven years, the Part D marketplace has been moderately concentrated, with the ten largest firms that sponsor Part D plans accounting for more than three-fourths of all enrollees in 2012. The ten largest Part D plan sponsors in 2012 have enrolled 24.4 million beneficiaries in either a stand-alone PDP or an MA-PD plan **(Exhibit 19)**. Their share of enrollment (78 percent) is higher than in either 2006 (72 percent) or 2011 (73 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 and Express Scripts/Medco, both of which offer only PDPs. Other than Kaiser Permanente, at least 40 percent of each of the top firms' enrollment is in PDPs.

Enrollment growth since 2006 for CVS Caremark, CIGNA, and Express Scripts is due largely to acquisitions of other plan sponsors. CVS Caremark has used an acquisitions strategy to become the third largest player in the Part D marketplace. The current company includes 5 of the 18 firms with the most enrollees in the program's first year. Beyond these acquisitions, initial projections that considerable consolidation would occur 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 45 percent in 2006 to 36 percent in 2012. 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. United's enrollment, however, is down slightly since 2011. 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 45 percent increase in the firm's Part D enrollment from 2010 to 2012.

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 2012 were among 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 four of the top ten plans in 2006 have retained their top-ten ranks as of 2012 **(Exhibit 20)**. Two of the top plans in 2012 (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 differ considerably for non-LIS and LIS beneficiaries. In addition to being the largest plan overall, AARP MedicareRx Preferred PDP (offered by UnitedHealth) has enrolled over a third of all non-LIS enrollees nationally and has the most non-LIS enrollees in 30 of 34 PDP regions. Although this PDP has experienced a significant loss in LIS enrollment, it continues to have 10.5 percent of national LIS enrollment and the largest share of LIS enrollment in four regions **(Exhibit 21)**. Community CCRx Basic has the largest share nationally of LIS enrollees, but only a small share (3.5 percent) of non-LIS enrollees. It also has the most LIS enrollees in 19 regions. By contrast, Humana's Walmart-Preferred PDP has attracted enrollment in nearly equal shares from both non-LIS and LIS beneficiaries, and is among the top five by enrollment in each category.

Concentration of enrollment among PDPs, nationally, in 2012, as measured by a statistical measure of market competition, is down somewhat from 2011.[33] But concentration is greater within regions than at the national level. If non-LIS and LIS beneficiaries are treated as separate markets, the latter is considerably more concentrated – especially within regions.[34] The system of assigning LIS beneficiaries to a limited, but changing, 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 2012, 74 percent of PDP enrollees are in plans with a rating of 3 or 3.5 stars, while 6 percent of enrollees are in plans with 4 or more stars. In 2012, the Part D ratings are based on 17 measures in 4 categories. CMS has started to move toward more use of outcome and patient experience measures, rather than process measures (such as call center performance). This year's ratings include five on patient safety or medication adherence. 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.

Overall ratings are lower in 2012 than they were in 2011. Whereas 43 percent of PDPs had ratings of 3.0 stars or lower in 2011, the vast majority of PDPs (83 percent) were at that level in 2012. It is unclear whether this reflects poorer performance by the PDPs or changes by CMS in the rating measures used. Moreover, based on the pattern of enrollment by plan ratings, there is little evidence to suggest that beneficiaries use ratings to guide their enrollment decisions. In 2012, the share of enrollees (22 percent) in low-rated PDPs (fewer than 3 stars) is much smaller than the share of PDPs (44 percent) with these low ratings **(Exhibit 22)**. But the share of PDP enrollees (16 percent) in plans with relatively high ratings (3.5 stars or more) is somewhat lower than the share of PDPs (18 percent) with those ratings. The pattern is similar for MA-PD plans, although the distribution is skewed slightly more toward the more highly rated plans. About 24 percent of enrollees are in MA-PD plans with high ratings, compared to 21 percent of MA-PD plans with those ratings. About 12 percent of MA-PD enrollees are in low-rated plans (fewer than 3 stars), compared to 20 percent of MA-PD plans. More research is needed to determine the relative importance of premiums, overall drugs costs, and performance ratings on individual beneficiary choices.

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 Medicare Plan Finder website and may have their contracts terminated. Although only one sponsor of a small PDP (Alliance Medicare Rx in Michigan) appears to be vulnerable to termination next year, the MedicareRx Rewards Standard and Plus PDPs, operated by Wellpoint have a rating of 2 stars and in 2012 after a 2.5 rating in 2011. These PDPs have about 130,000 enrollees across 23 regions.

Starting in 2012, beneficiaries are eligible at any time outside the regular open enrollment period to switch from their current drug plan to a PDP with a five-star rating (or a MA-PD plan with an overall five-star rating). In 2012, only four PDPs have five-star ratings: two offered by MedBlue in the seven-state upper Midwest region and two offered by Simply Prescriptions in New York. Among MA-PD plans, Kaiser Permanente earned five stars in most regions it serves, as did smaller plans in Iowa, Maine, Oregon, and Washington. Information is not available on how many people have used this special enrollment period, but aggregate enrollment numbers suggest that Part D enrollees are not aware of or have not acted on this option.

CONCLUSION

Medicare Part D plans are an important source of prescription drug coverage for more than 31 million Medicare beneficiaries in 2012. Program improvements, such as closing the benefit's coverage gap, are occurring because of changes specified in the 2010 health reform law. CMS has estimated that in 2011, about 3.6 million beneficiaries benefited from the 50 percent discount on brand-name drugs in the gap and a 7 percent discount on generic drugs in the gap.[35] 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.

Ongoing efforts by CMS to streamline the program have led to a smaller and better-defined set of plan options for Part D enrollees. The number of PDPs is down by nearly one-half since the peak level of offerings in 2007. The

program still guarantees considerable choice, with an average of 32 PDPs and about 16 MA options. Mergers among plan sponsors and regulatory guidance from CMS have contributed to the decline, simplifying choices for Part D enrollees. And yet, the Part D marketplace remains somewhat volatile, as mergers and acquisitions continue to reshape the market and as premium changes vary across plans. Plan consolidations that result from acquisitions lead to enrollment shifts, but evidence is lacking for a clear linkage between enrollment shifts and either premium changes or plan performance ratings.

Growth in average premiums has nearly flattened since 2010 after rising about 10 percent per year before then. Rising use of generic drugs, triggered by patent expirations for many popular brand-name drugs, has been a major factor in slowing premium growth – paralleling slower growth in the broader health system.[36] The result has been savings for both the government and Part D plan enrollees. It remains unclear whether slower growth can continue as the rate of patent expirations slows. And although premiums have been flat in recent years, enrollees have faced increases in cost sharing for individual drugs purchased over the program's seven years. Cost-sharing increases are especially notable for brand-name drugs and are generally higher than for enrollees in employer-sponsored plans. Cost sharing for generic drugs has come down modestly, increasing incentives to select generics.

CMS has taken various steps to decrease the volatility of the PDP offerings available to beneficiaries receiving the Low-Income Subsidy without paying a premium. Still, many LIS beneficiaries must change plans regularly to remain in a plan without a premium. The number of LIS benchmark PDPs has stabilized over the past four years, even while there are fewer PDPs in the program. Decisions by various plan sponsors have shifted their plan offerings in and out of the LIS market, however. One result of this instability is that about 550,000 LIS beneficiaries continue to pay premiums of at least $10 per month in 2012.

CMS has strengthened its system of plan performance ratings over a period of several years. In 2012, most PDPs received 2.5 to 3 stars, while only a few plans received the maximum 5-star rating. About one in four enrollees are in PDPs with fewer than 3 stars – a level at which plans may be subject to termination.

Further marketplace change and consolidation could occur in the 2013 Part D marketplace as many market analysts anticipate further mergers and acquisitions in this market. As CMS continues its efforts to ensure that available plans offer real differences and to improve the performance ratings of competing plans, it will be important to better understand the dynamics of this market. Consumers are urged to compare plans annually, make informed decisions based on coverage and costs for the medications they take, and consider the performance ratings of competing plans. Moving forward, policymakers would benefit from a solid understanding of how often enrollees make decisions to change plans and how these decisions relate to plan costs and features.

ACKNOWLEDGMENTS

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.

METHODS

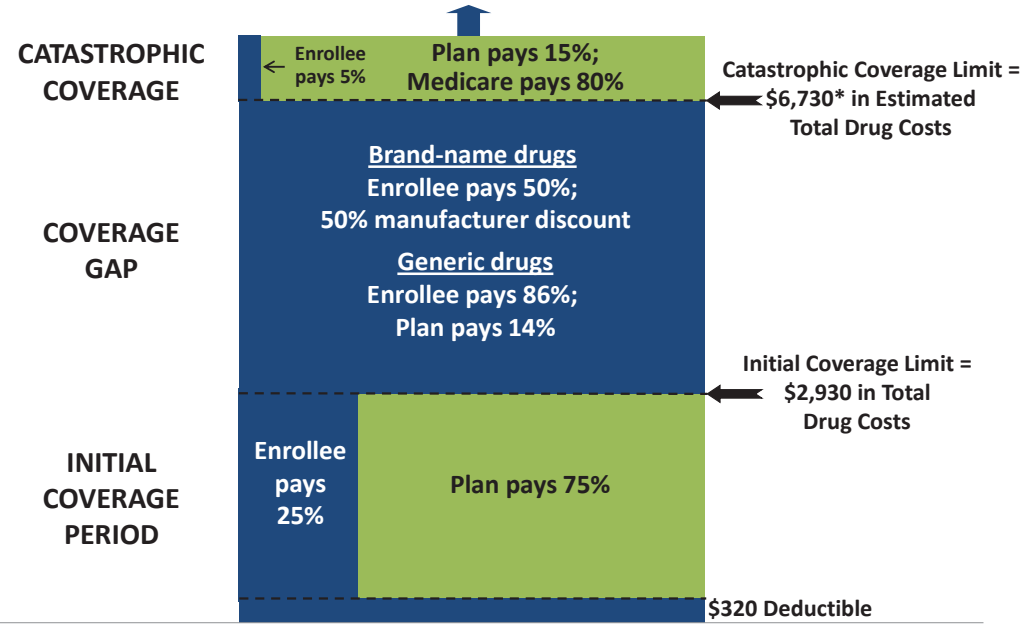
This report presents an analysis of the Medicare Part D 2012 marketplace, prepared by Jack Hoadley and Laura Summer (Health Policy Institute, Georgetown University), Elizabeth Hargrave (NORC at the University of Chicago), and Juliette Cubanski and Tricia Neuman (Kaiser Family Foundation), as well as previous work by Hoadley, Hargrave and others.

Data on plan availability and premiums were collected primarily from a set of CMS files, including the plan "landscape file" and related premium files released in the fall of 2011 and monthly enrollment files released in 2012. We use April 2012 enrollments for 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 based primarily on 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, in addition to the plan landscape and enrollment files. 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. Portions of this analysis are published in MedPAC's annual reports to Congress and databooks. More complete analysis of formularies for 2010 and 2011 is available under contractor reports on MedPAC's website.

Exhibit 1

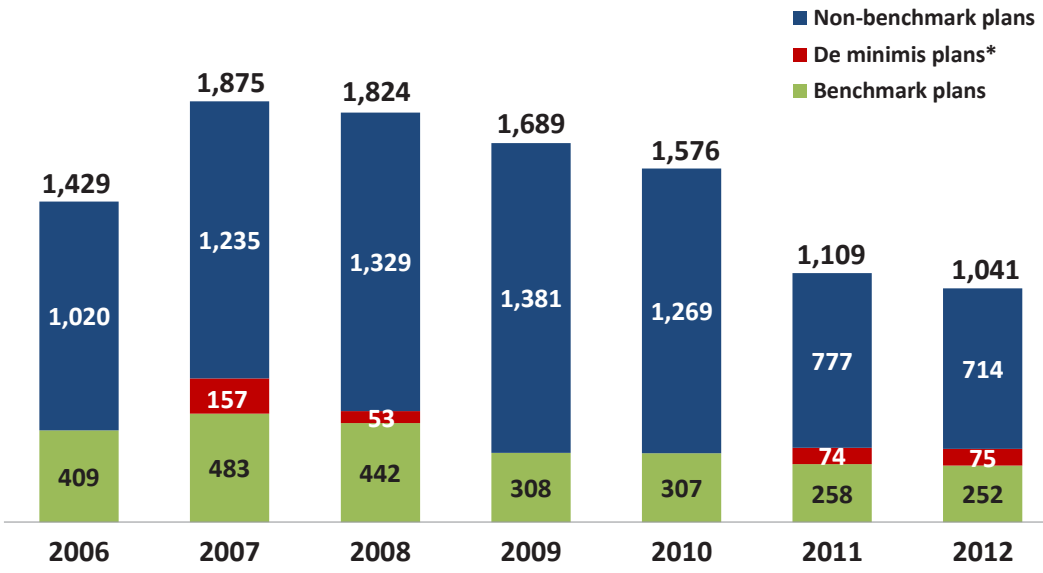
Standard Medicare Prescription Drug Benefit, 2012



NOTE: *Amount corresponds to the estimated catastrophic coverage limit for non-low-income subsidy enrollees ($6,658 for LIS enrollees), which corresponds to True Out-of-Pocket (TrOOP) spending of $4,700 (the amount used to determine when an enrollee reaches the catastrophic coverage threshold.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2012 (standard benefit parameter update from Centers for Medicare & Medicaid Services, 2011). Amounts rounded to nearest dollar.

Exhibit 2

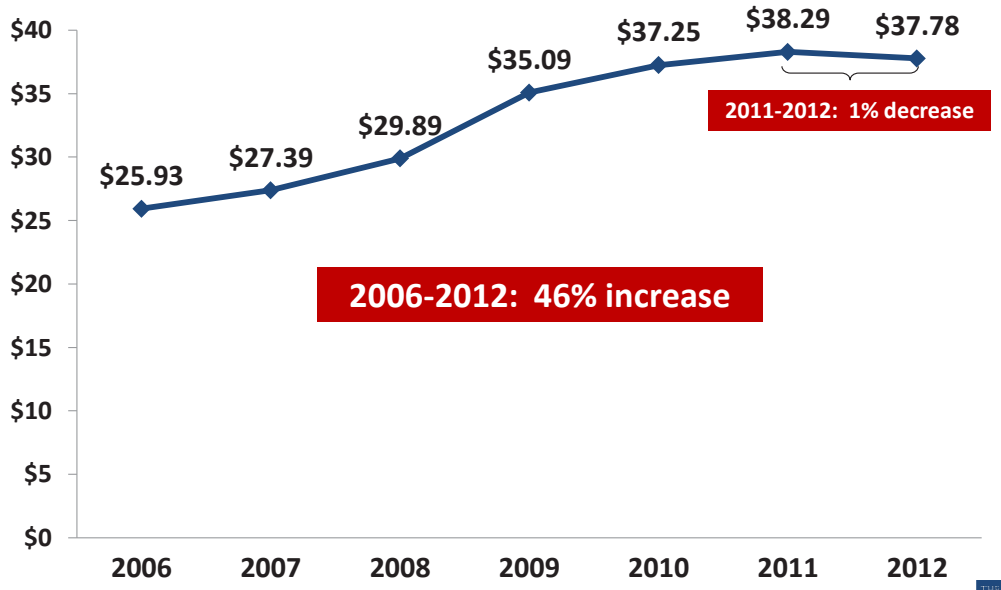
Distribution of Medicare Part D Stand-Alone Prescription Drug Plans, by Benchmark Status, 2006-2012



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, 2006-2012.

Exhibit 3

Weighted Average Monthly Premiums for Medicare Part D Stand-Alone Prescription Drug Plans, 2006-2012



SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.
NOTE: Average premiums are weighted by enrollment in each year (February for 2012). Excludes Part D plans in the territories.

Exhibit 4

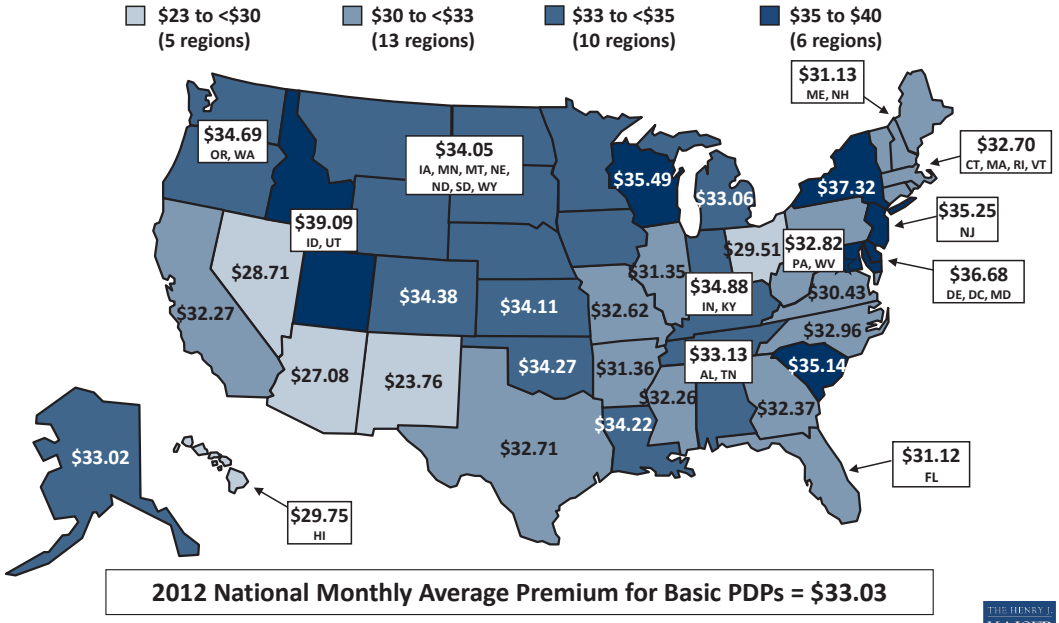
Premiums in Medicare Part D Stand-Alone Prescription Drug Plans with Highest 2012 Enrollment, 2006-2012

Name of PDP in 2012	2012 Enrollment (of 17.5 million)		Weighted Average Monthly Premium[1]			% Change	
	Number	% of Total	2006	2011	2012	2011-2012	2006-2012
AARP MedicareRx Preferred	4,016,446	22.9%	$26.31	$34.72	$39.85	+15%	+51%
CCRx Basic	1,798,712	10.3%	$30.94	$29.71	$30.75	+4%	-1%
Humana Walmart Preferred[2]	1,430,223	8.2%	--	$14.80	$15.10	+2%	--
Humana PDP Enhanced	1,381,177	7.9%	$14.73	$43.74	$39.58	-9%	+169%
CVS Caremark Value	1,328,878	7.6%	$28.32	$30.54	$30.24	-1%	+7%
First Health Premier	997,402	5.7%	$24.98	$35.53	$32.56	-8%	+30%
WellCare Classic[3]	681,692	3.9%	$15.80	$31.83	$32.87	+3%	+108%

SOURCE: Georgetown/NORC analysis of CMS 2006-2012 PDP Landscape Source Files for the Kaiser Family Foundation.
NOTES: [1]Average premiums are weighted by enrollment in each region for each year. [2]Humana Walmart-Preferred PDP was not offered before 2011. [3]WellCare Classic was first offered in 2007; average 2006 premium and percent change from 2006-2012 are based on 2007 data.

Exhibit 5

Weighted Average Premium for Medicare Part D Basic Stand-Alone PDPs, by Region, 2012

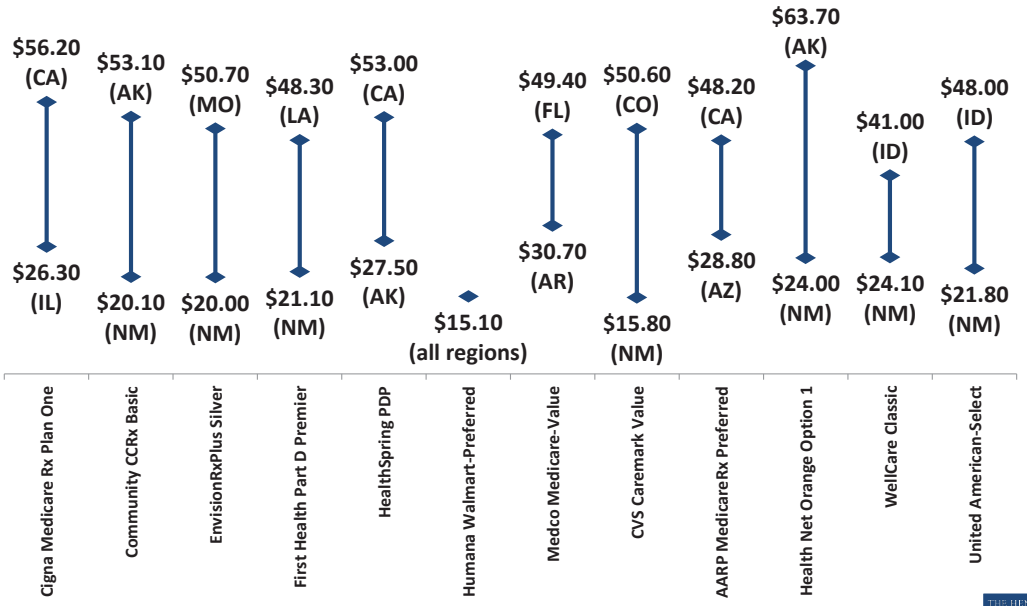


2012 National Monthly Average Premium for Basic PDPs = $33.03

SOURCE: Georgetown/NORC analysis of CMS 2012 PDP Landscape Source File for the Kaiser Family Foundation.
NOTE: PDP is stand-alone prescription drug plan. Average premiums are weighted by enrollment.

Exhibit 6

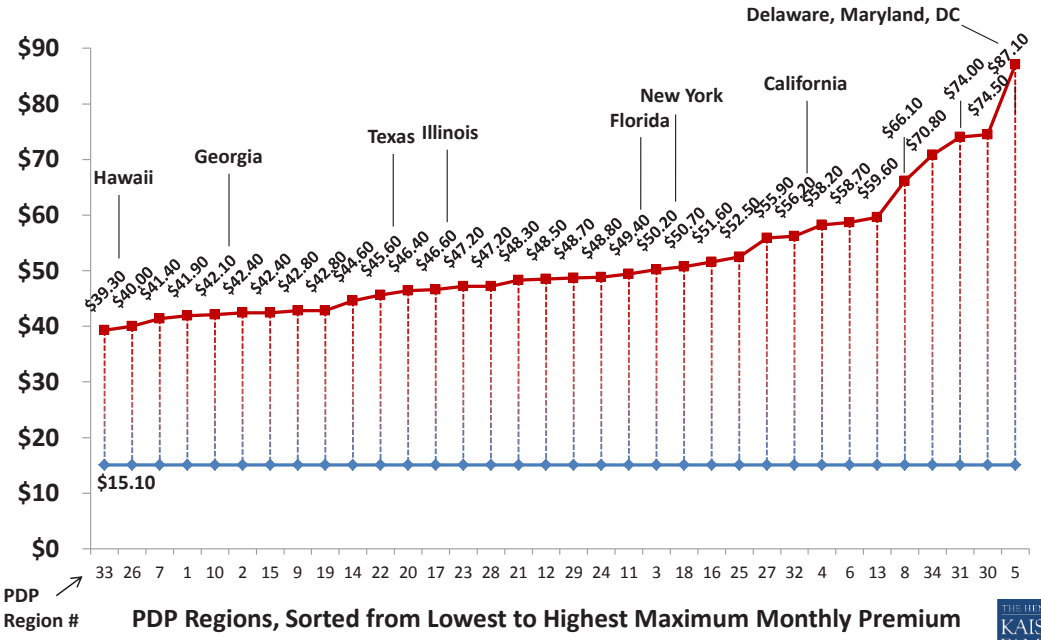
Range of Monthly Premiums for National and Near-National Medicare Part D Basic Stand-Alone PDPs, 2012



SOURCE: Georgetown/NORC analysis of CMS 2012 PDP Landscape Source File and Plan Crosswalk for the Kaiser Family Foundation.
NOTE: PDP is stand-along prescription drug plan.

Exhibit 7

Minimum and Maximum Monthly Premiums for Medicare Part D Basic Stand-Alone PDPs, by Region, 2012



SOURCE: Georgetown/NORC analysis of CMS 2012 PDP Landscape Source File and Plan Crosswalk for the Kaiser Family Foundation.

Exhibit 8

Monthly Basic Premiums for Basic and Enhanced PDPs, National Sponsors, 2012

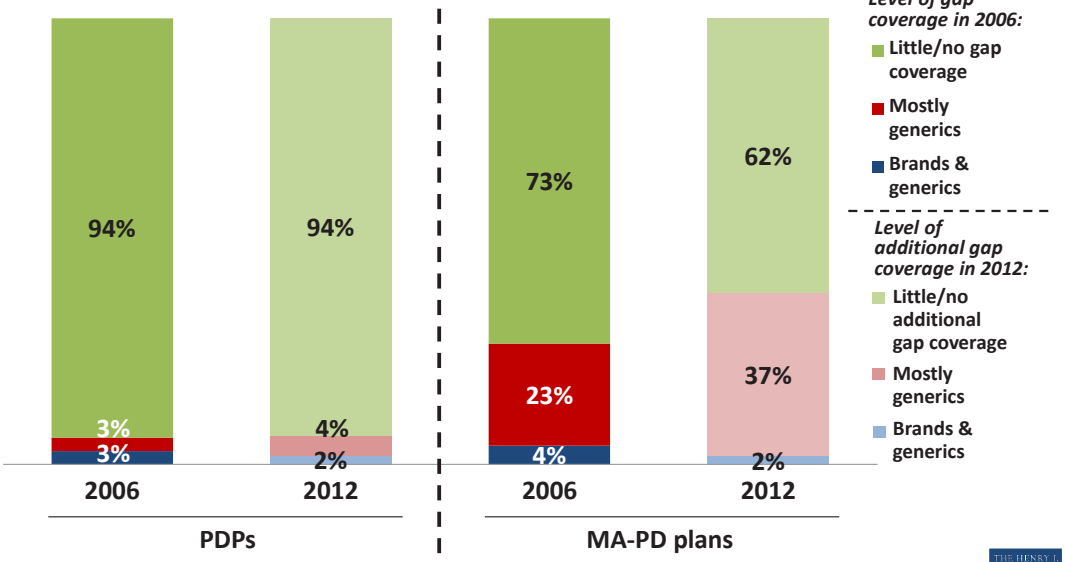
Plan Sponsor	Basic Premium for Basic Plan	Basic Premium for Enhanced Plan	Percentage Change for Enhanced Plan
Average, all sponsors	$32.32	$31.07	-4%
Humana	$15.10	$31.97	112%
Aetna	$26.00	$48.37	86%
CVS Caremark	$30.29	$50.21	66%
United Healthcare	$39.85	$64.51	62%
MedicareRx Rewards	$39.54	$60.39	53%
Community CCRx	$30.75	$45.96	49%
United American	$32.04	$44.04	37%
Medco	$34.10	$44.68	31%
Health Net	$29.89	$38.18	28%
CIGNA	$32.00	$34.82	9%
EnvisionRxPlus	$30.66	$30.61	0%
WellCare	$32.87	$24.43	-26%
First Health	$32.58	$2.90	-91%

SOURCE: Georgetown/NORC analysis of CMS 2012 PDP Landscape Source File and Plan Crosswalk for the Kaiser Family Foundation.
NOTE: Excludes the second enhanced PDP offered by the same sponsor.

Exhibit 9

Share of Enrollment in Medicare Part D Plans, By Level of Gap Coverage, 2006 and 2012

In 2012, the coverage gap is partially filled by a 50% price discount for brand-name drugs and 14% coverage of generic drug costs, as required by the ACA

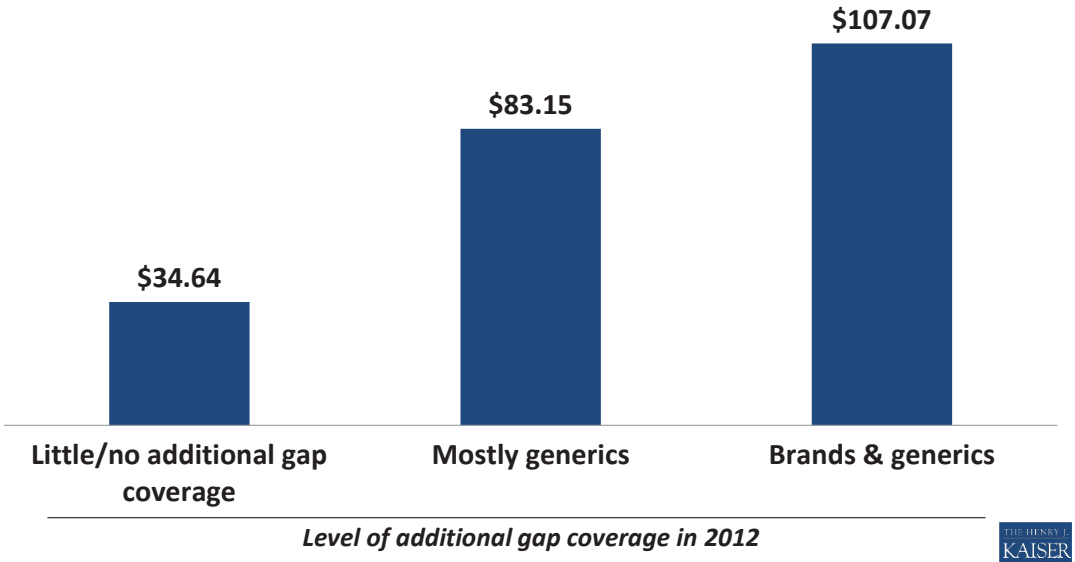


NOTES: Estimates include Part D enrollees receiving low-income subsidies, but who receive coverage for costs in the gap regardless of whether their plan offers it.
SOURCE: Georgetown/NORC analysis of CMS Part D landscape and enrollment files, 2006-2012, for the Kaiser Family Foundation.

Exhibit 10

Weighted Average Monthly Premiums for Stand-Alone PDPs, by Level of Gap Coverage, 2012

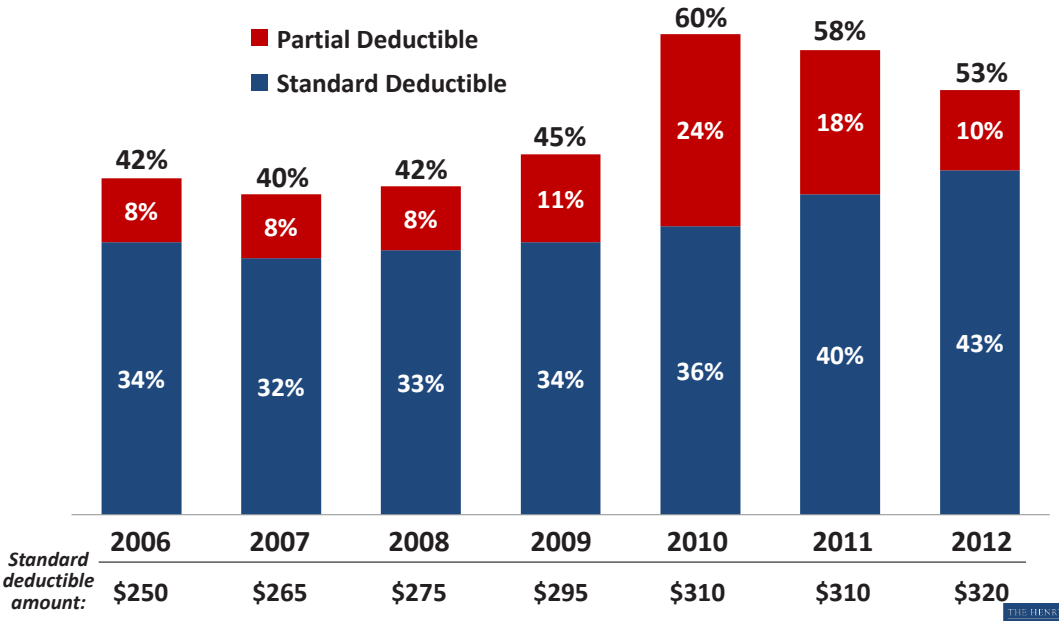
In 2012, the coverage gap is partially filled by a 50% price discount for brand-name drugs and 14% coverage of generic drug costs, as required by the ACA



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

Exhibit 11

Share of Medicare Part D Stand-Alone Prescription Drug Plans with a Deductible, 2006-2012



NOTE: Estimates may not sum to total due to rounding and are unweighted.
SOURCE: Georgetown/NORC analysis of CMS PDP landscape source files, 2006-2012, for the Kaiser Family Foundation.

Exhibit 12

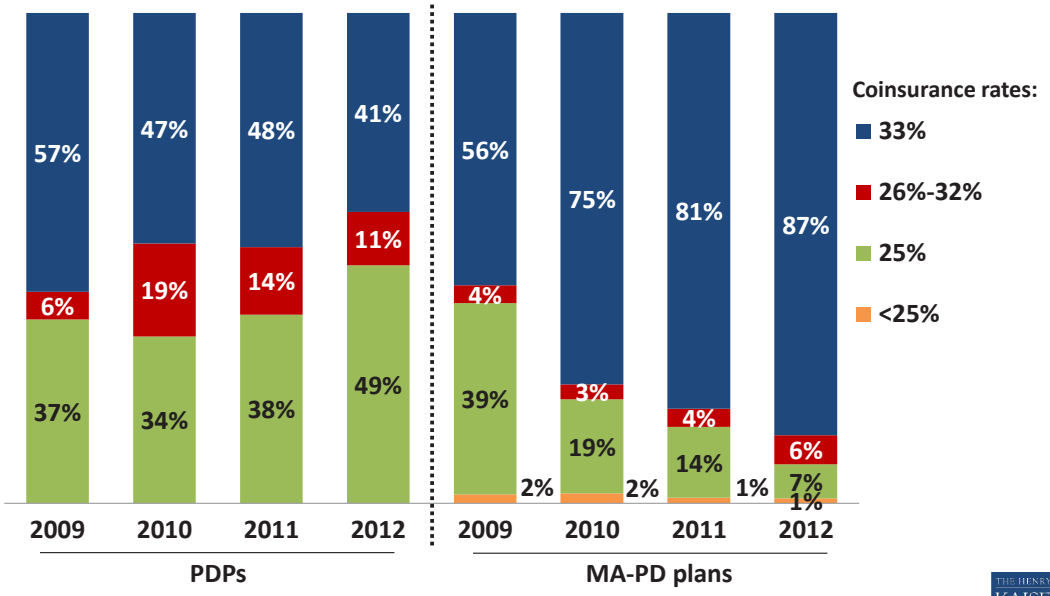
Cost Sharing for Medicare Part D Plans, 2006-2012, and Employer-Sponsored Plans, 2012

FORMULARY TIER	PART D PLAN TYPE	PART D COST SHARING							EMPLOYER PLANS
		2006	2007	2008	2009	2010	2011	2012	2012
Generic	PDP	$5	$5	$5	$7	$7	$7	$5	$10
	MA-PD	$5	$5	$5	$5	$6	$6	$6	
Preferred brand	PDP	$28	$28	$30	$37	$42	$42	$41	$29
	MA-PD	$26.70	$29	$30	$30	$39	$40	$42	
Non-preferred brand	PDP	$55	$60	$71.50	$74.75	$76.50	$78	$92	$51
	MA-PD	$55	$60	$60	$60	$79	$80	$84	
Specialty	PDP	25%	30%	30%	33%	30%	30%	29%	32%
	MA-PD	25%	25%	25%	33%	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, 2012.

Exhibit 13

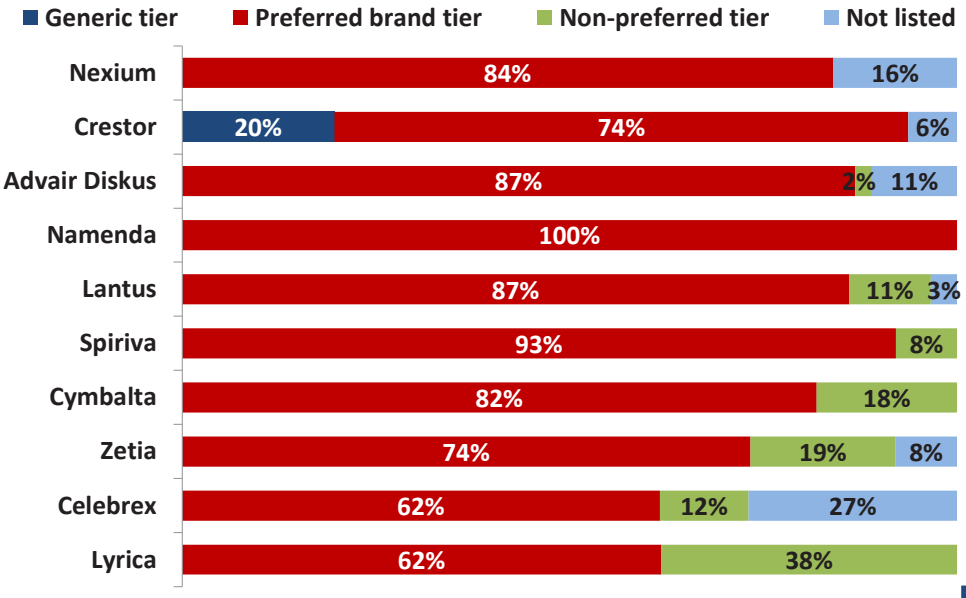
Share of Enrollment in Medicare Part D Plans with Specialty Tiers, by Specialty Tier Coinsurance Rate, 2009-2012



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 14

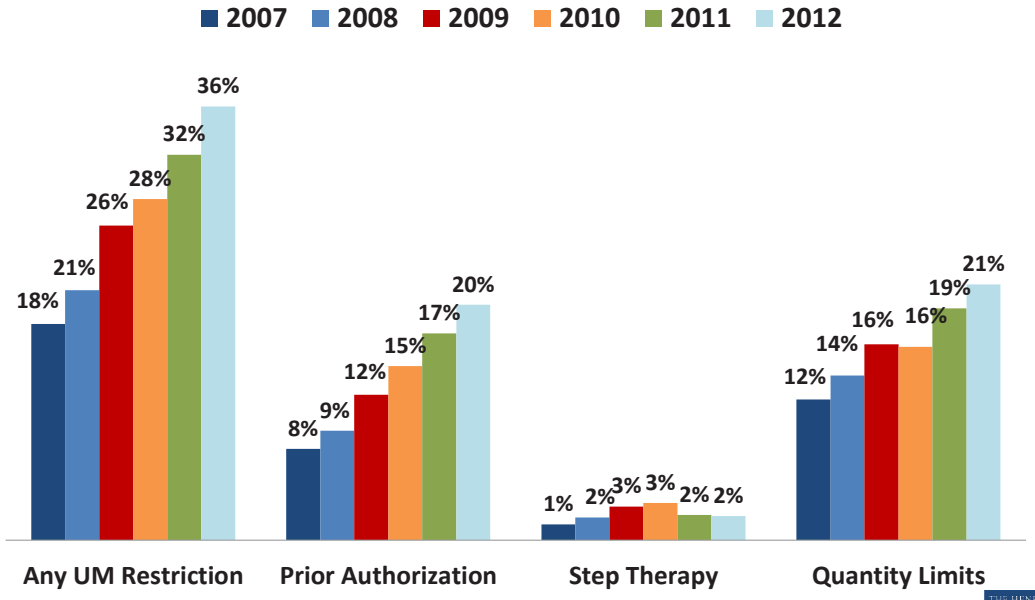
Share of Stand-Alone PDP Enrollees with Coverage of Top Ten Brand-Name Drugs, by Formulary Tier, 2012



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 15

Share of Covered Drugs with Utilization Management (UM) Restrictions Across All Stand-Alone PDPs, 2007-2012



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 16

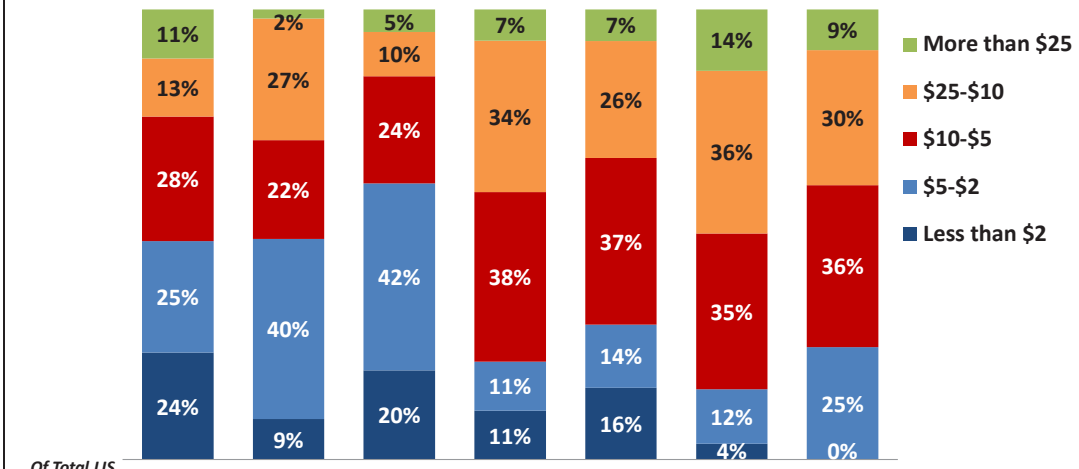
Share of Medicare PDP Enrollees Facing Utilization Management Restrictions for Top Ten Brand-Name Drugs, 2012

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
Nexium	16%	98%	15%	0%	98%
Crestor	6%	98%	0%	4%	97%
Advair Diskus	11%	93%	0%	2%	93%
Namenda	0%	80%	0%	0%	80%
Lantus	3%	19%	9%	2%	10%
Spiriva	0%	94%	0%	0%	94%
Cymbalta	0%	98%	14%	7%	92%
Zetia	8%	97%	3%	24%	96%
Celebrex	27%	97%	19%	29%	95%
Lyrica	0%	94%	18%	19%	88%

NOTES: Presence of utilization management (UM) restrictions is measured as a share of plans with the drug listed on formulary.
SOURCE: Georgetown/NORC analysis of CMS Formulary Files, 2011, for MedPAC.

Exhibit 17

Distribution of Monthly Part D Premiums for Low-Income Subsidy PDP Enrollees Paying Premiums, 2006-2012

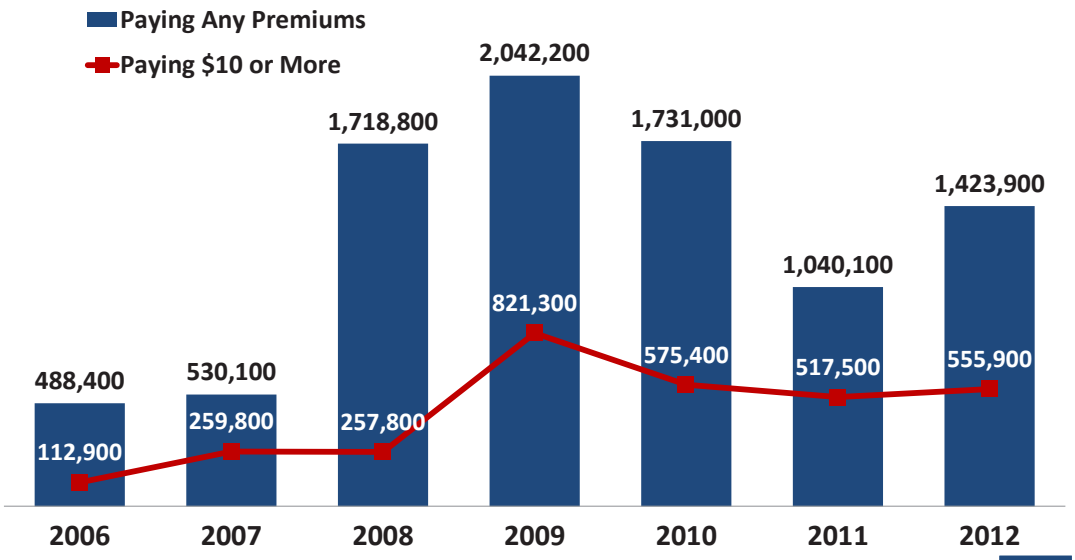


	2006	2007	2008	2009	2010	2011	2012
Of Total LIS Enrollees, Share Paying Premiums:	6%	7%	21%	26%	22%	13%	17%
Number Paying Premiums:	488,400	530,100	1,718,800	2,042,200	1,731,000	1,040,100	1,433,900
Average Premiums:	$9.20	$12.69	$6.87	$11.10	$9.95	$14.71	$12.45

SOURCE: Georgetown/NORC analysis of CMS 2006-2012 PDP Landscape and Enrollment files for the Kaiser Family Foundation.

Exhibit 18

Number of Low-Income Subsidy PDP Enrollees Paying Monthly Premiums, 2006-2012



SOURCE: Georgetown/NORC analysis of CMS 2006-2012 PDP Landscape and Enrollment files for the Kaiser Family Foundation.

Exhibit 19

Top 10 Firms Offering Medicare Part D Plans Ranked by 2012 Enrollment

Name of firm	2012			2006	Change in Total Enrollment, 2006-2012
	Rank	Enrollment (in millions)	% of Total Part D in 2012	Rank	
UnitedHealth Group	1	6.69	20.9%	1	+18%
Humana	2	4.67	14.8%	2	+7%
CVS Caremark	3	4.03	12.9%	11	+876%
Coventry Health Care	4	1.72	5.4%	7	+131%
Express Scripts	5	1.68	5.3%	10	+305%
CIGNA	6	1.66	5.3%	17	+682%
Wellpoint	7	1.20	3.8%	3	-9%
Kaiser Permanente	8	1.06	3.3%	6	+35%
WellCare Health Plans	9	1.05	3.3%	4	+7%
Aetna	10	0.67	2.1%	12	+63%
TOTAL TOP 10 FIRMS		24.4 mil	77.5%		
TOTAL PART D		31.5 mil	100.0%		

NOTES: Includes plans in the territories. Estimates for CVS Caremark reflect acquisition of HealthNet's PDPs. Estimates for Express Scripts reflect acquisition of Medco Health Solutions. Estimates for CIGNA reflect acquisition of HealthSpring.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS Enrollment Files, 2006-2012.

Exhibit 20

Top 10 Medicare Part D Plans Ranked by 2012 Enrollment

Name of plan	2012			2006	Change 2006-2012
	Rank	Enrollment (in millions)	% of Total Part D in 2012	Rank	
AARP MedicareRx Preferred PDP	1	4.03	12.8%	1	+26%
Community CCRx Basic PDP	2	1.80	5.7%	5	+127%
Humana Walmart-Preferred PDP	3	1.43	4.5%	N/A	N/A
Humana Enhanced PDP	4	1.38	4.5%	3	+43%
CVS Caremark Value PDP	5	1.33	4.2%	13	+232%
First Health Part D Premier PDP	6	1.00	3.2%	18	+276%
Kaiser Permanente Senior Advantage HMO	7	0.73	2.3%	7	+9%
Medco Medicare Value PDP	8	0.69	2.2%	N/A	N/A
WellCare Classic PDP	9	0.68	2.2%	N/A	N/A
Humana Gold Plus HMO	10	0.64	2.0%	14	+68%

NOTES: Includes plans in the territories. Listings for Kaiser Permanente and Medco include employer group enrollment. N/A is not applicable.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS Enrollment Files, 2006-2012.

Exhibit 21

Top 5 Medicare Stand-Alone PDPs, Ranked by 2012 LIS Enrollment and Non-LIS Enrollment

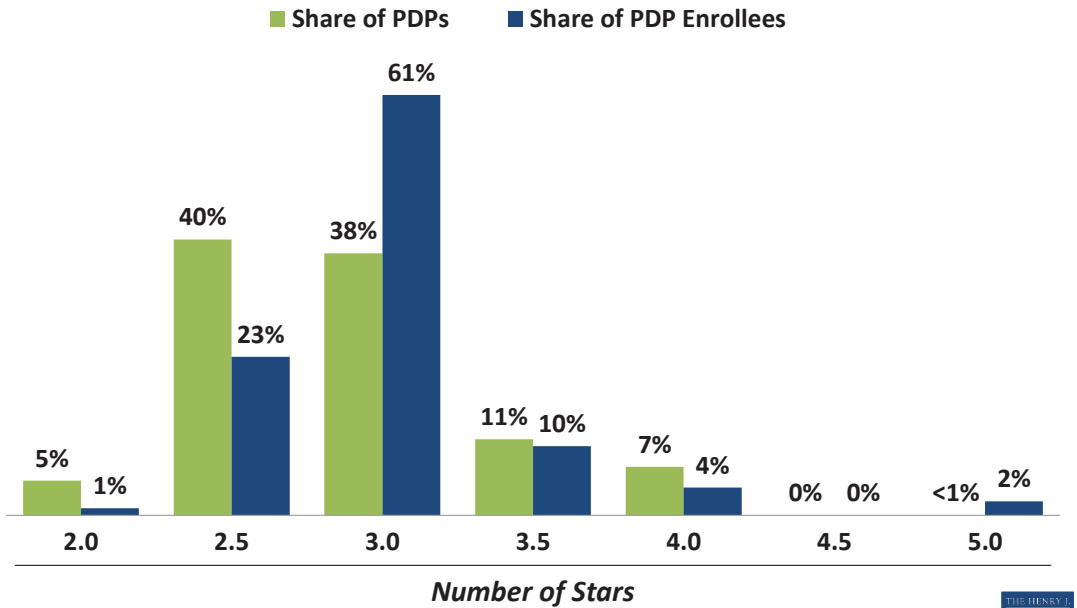
Prescription Drug Plan	Total LIS Enrollment	Share of All LIS Enrollees	Share LIS in Plan	Number of Regions Where PDP is Benchmark Plan
Community CCRx Basic	1,475,000	17.8%	82.0%	30
CVS Caremark Value	1,194,000	14.4%	89.8%	28
AARP MedicareRx Preferred	868,000	10.5%	21.6%	4
WellCare Classic	624,000	7.5%	91.5%	22
Humana Walmart-Preferred Rx Plan	531,000	7.4%	43.2%	34
TOTAL FOR TOP 5 LIS PDPs	4,779,000	57.6%		

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	3,148,000	34.1%	78.4%	4
Humana Enhanced	1,183,000	12.8%	85.7%	0
Humana Walmart-Preferred Rx Plan	812,000	8.8%	56.8%	34
First Health Part D-Premier	524,000	5.7%	52.6%	23
First Health Part D-Value Plus	367,000	4.0%	96.8%	0
TOTAL FOR TOP 5 NON-LIS PDPs	6,034,000	65.3%		

NOTE: LIS is low-income subsidy. Excludes employer group plans and plans in the territories.
SOURCE: Georgetown/NORC analysis of CMS PDP Landscape and Enrollment Files, 2012, for the Kaiser Family Foundation.

Exhibit 22

Share of Medicare Stand-Alone PDPs and PDP Enrollees, by Plan Star Ratings, 2012



NOTE: Unrated plans are excluded from estimates.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS Ratings, 2012.

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 2012) (accessed at http://www.cms.gov/MCRAdvPartDEnrolData/MCESR/list.asp#TopOfPage).

[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 methods note.

[5] Marsha Gold et al., "Medicare Advantage 2012 Spotlight: Plan Availability and Premiums," Kaiser Family Foundation, November 2011 http://www.kff.org/medicare/8258.cfm. The authors report that the average beneficiary has 20 MA plans available. But they include plans offered without drug coverage (19 percent of plans offered), so we reduced the average to project the number of MA plans with drug coverage.

[6] In February 2012, CIGNA completed its acquisition of HealthSpring, including its Bravo Health subsidiary. In April 2012, Express completed its acquisition of Medco, and CVS Caremark completed its acquisition of Health Net's Part D business.

[7] Although many of these PDPs are regional offerings of plans offered nationally, the enhanced PDP offered by one national sponsor averages about 150 per region.

[8] This count excludes drug plans offered by Special Needs Plans, a type of Medicare Advantage Plan that limits membership to beneficiaries with specific diseases or characteristics. In 2012, 500 SNPs are offered; see Marsha Gold et al., "Medicare Advantage 2012 Spotlight: Plan Availability and Premiums," November 2011, http://www.kff.org/medicare/8258.cfm.

[9] The 2012 average reported here ($37.78) is lower than the amount reported in the 2012 "First Look" spotlight ($39.40) because the new average is weighted by actual 2012 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. Averages for some previous years differ by small amounts because different months are used for comparability.

[10] This increase is similar to the 47 percent increase in the monthly premium between 2006 and 2012 for a single person enrolled in FEHB BC/BS (from $125.82/month in 2006 to $185.42/month in 2012).

[11] In addition, Actos, another of the top ten drugs in 2010 by costs, will be available in generic form in August 2012.

[12] The combined average monthly Part D premium in 2012 is $29.43.

[13] The average premium excludes Special Needs Plans. The overall premium in 2012 for MA plans that include drug coverage is $35 per month, down 20 percent from 2010; see Marsha Gold et al., "Medicare Advantage Data Spotlight: Enrollment Market Update," June 2012, http://www.kff.org/medicare/8323.cfm.

[14] 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.

[15] Like the national averages, other averages presented here are weighted based on April 2012 enrollment.

[16] Comparisions include both Community CCRx Basic and its merger partner, PrescribaRx Bronze.

[17] Plans new to the market are not required to base premium bids on actual plan experience until the third year the plan is offered. The Humana Walmart-Preferred PDP, in its second year in 2012, charges the same premium in all regions.

[18] Jack Hoadley et al., "Medicare Part D 2010 Data Spotlight: A Comparison of PDPs Offering Basic and Enhanced Benefits," December 2009, http://www.kff.org/medicare/8034.cfm.

[19] The average for these two groups of plans is weighted by enrollment. Not surprisingly, enrollment is much higher in those enhanced plans with lower premiums, thus skewing the average downward.

[20] 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.

[21] This estimate excludes enrollees in plans covering only a "few" drugs in the gap.

[22] Medicare Payment Advisory Commission, Report to the Congress: Medicare Payment Policy, Chapter 3, March 2009.

[23] In the program's first two years, a small subset of enrollees were in PDPs with one tier each for brand and generic drugs, but use of this model had nearly disappeared by 2012.

[24] For 2012 estimates for employers, see Kaiser Family Foundation/HRET Survey of Employer-sponsored Health Benefits, available at http://ehbs.kff.org/ (accessed September 11, 2012).

[25] CMS, "Medicare Part D Manual, Chapter 6, Part D Drugs and Formulary Requirements" March 9, 2007.

[26] 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.

[27] 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.

[28] Brand-name drugs are based on counts of drugs by number of fills for all beneficiaries in Part D plans in 2010, as reported by CMS. For purposes of this analysis, we excluded all drugs for which a generic drug will be available by the end of 2012.

[29] 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.

[30] 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.

[31] The 67 PDPs losing benchmark status include 2 non-renewed PDPs for which there was no PDP offered by the sponsor with benchmark status in 2012.

[32] 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, the Advantage Star Plan was merged with CVS Caremark Value, and enrollment in the two plans was consolidated.

[33] Market competition among PDPs, as measured by the Herfindahl index, averages 1291 across the 34 regions for overall enrollment, down from the 2011 level of 1474, but above the 2010 level of 909. The comparable index value computed nationally for 2012 is 914. According to current guidelines used by the Department of Justice and the Federal Trade Commission, markets in which the index is between 1500 and 2500 points are considered to be moderately concentrated, and those in which the index is in excess of 2500 points are considered to be highly concentrated.

[34] In 2012, the non-LIS population reaches the level considered concentrated in 20 of 34 regions and highly concentrated in another 7 regions.

[35] CMS, "3.6 million in Medicare saved more than $2.1 billion on prescription drugs in the donut hole in 2011," Fact sheet, February 2, 2012.

[36] Jack Hoadley, "Medicare Part D Spending Trends: Understanding Key Drivers and the Role of Competition," May 2012, available at http://www.kff.org/medicare/8308.cfm.

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Headquarters: 2400 Sand Hill Road Menlo Park, CA 94025 650.854.9400 Fax: 650.854.4800 Website: www.kff.org
Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW Washington, DC 20005 202.347.5270 Fax: 202.347.5274

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