THE HENRY J. KAISER FAMILY FOUNDATION

MEDICARE PART D 2008 DATA SPOTLIGHT: BENEFIT DESIGN

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DECEMBER 2007

The Medicare Modernization Act established a defined standard drug benefit for Part D Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug (MA-PD) plans, while giving plans flexibility to offer an alternative, actuarially equivalent benefit design. In 2008, the defined standard benefit has a $275 deductible, 25 percent coinsurance up to an initial benefit limit, a $3,216 coverage gap (the "doughnut hole") and catastrophic coverage. This Part D Data Spotlight examines the benefit design of Medicare PDPs, based on the authors' analysis of data from the Centers for Medicare and Medicaid Services (CMS) on 47 unique national plans offered by 15 organizations, representing 88 percent of all PDPs nationwide, in 34 PDP regions (excluding plans in Puerto Rico and the territories). This research is part of a broader effort analyzing Medicare Part D plans in 2008 and key trends since 2006, with key findings summarized in a series of data spotlights.[1]

The Defined Standard Benefit Is Not the Typical PDP Design

In 2008, as in previous years, only about 10 percent of national PDPs (5 of 47) offer the defined standard benefit (Exhibit 1). Among this group are two of the 10 plans with the highest enrollment in the program's first two years – Humana Standard and Prescription Pathway Bronze. In lieu of offering the standard benefit, most PDPs eliminate the standard Part D deductible and use tiered, flat dollar copayments rather than 25 percent coinsurance. Similar to all PDPs available in 2008, less than a third of the national PDPs have the standard $275 deductible, while less than 10 percent have a deductible that is less than the standard amount and most (about 60 percent) have no deductible at all.

More PDPs Shift to a Three-Tier Plus Specialty Tier Cost-Sharing Structure

Plans use cost sharing as a means of managing drug utilization and costs. Cost-sharing tiers provide an incentive for enrollees to use generic and "preferred" brand-name drugs. Increased use of preferred drugs could allow plans to negotiate greater discounts and rebates with drug manufacturers, which could result in lower premiums.

Since 2006, the most common plan design has three cost-sharing tiers: one for generic drugs, a second for preferred brand-name drugs, and a third for non-preferred drugs[2] (Exhibit 1). The number of PDP offerings with three tiers has increased somewhat since 2006 (from 69 percent to 74 percent of national plans), while half as many PDPs are offering a two-tier benefit design in 2008 than in previous years (from 26 percent in 2006 to 9 percent of national plans in 2008). A new design among the national PDPs in 2008 adds an additional tier for generic drugs. Caremark, in two of its Silverscript PDPs, adds a "value" generic tier priced below the standard generic tier, while the EnvisionRx Plus Gold plan adds a non-preferred generic tier priced slightly below the non-preferred brand tier.

Most plans also have a specialty tier. The number and share of PDPs with specialty tiers has increased from 19 of 35 in 2006 (54 percent) to 41 of 47 in 2008 (87 percent).[3]

EXHIBIT 1: Benefit Designs and Cost Sharing For National and Near-National PDPs, 2006-08

	NUMBER OF PLANS*		
BENEFIT DESIGN**	**2006**	**2007**	**2008**
Defined standard with 25% coinsurance	2	6	5
Two-tier cost sharing	9	9	4***
Three-tier cost sharing	24	32	35
Four-tier cost sharing	0	0	3
TOTAL	**35**	**47**	**47**
COST SHARING	**2006**	**2007**	**2008**
Defined Standard	2	6	5
All Coinsurance	0	0	1
Some Coinsurance	4	8	9
All Flat Copays	29	33	32
TOTAL	**35**	**47**	**47**

NOTES: *All plans are not offered in each of the three years. **Specialty tiers are not included in these categories. ***Includes one PDP with two tiers in 18 regions and three tiers in 16 regions.
SOURCE: Hoadley et al analysis of CMS data for national and near-national PDPs, 2006-2008, prepared for the Kaiser Family Foundation.

Tiered, Flat Dollar Copayments Are Most Common, But Use of Coinsurance is Rising

The vast majority of plans use flat dollar copayments in lieu of coinsurance, although the number of plans charging coinsurance has increased since 2006 (Exhibit 1). Flat copayments offer consumers greater predictability at the pharmacy, whereas coinsurance provides more certainty for plans that, as drug prices increase, beneficiary contributions rise automatically in accordance.

Upward Trend in Cost Sharing for Brand Drugs

Since 2006, average cost sharing for a 30-day supply of non-preferred drugs has increased by 29 percent, or $15.95, while average cost sharing for preferred brand drugs increased by 11 percent, or $2.99 (Exhibit 2).[4] Cost sharing for generic drugs has remained fairly stable since 2006. These trends suggest that enrollees are facing higher out-of-pocket costs for both preferred and non-preferred drugs and stronger financial incentives to switch to lower-cost alternatives covered by their plan.

Medicare Part D enrollees pay more, on average, for preferred and non-preferred brand drugs than do people covered under employer plans.[5] In 2007, the copayment for preferred brands averaged $29.36 in PDPs, compared to $25 in employer plans, and the average copayment for non-preferred brands was $63.31 in PDPs, compared to $43 in employer plans. In addition, the financial incentives for drug switching appear to be stronger in PDPs than

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in employer plans. In 2007, the difference in average cost sharing between preferred brands and generics was $25 for PDP enrollees, but $14 for those in employer plans; the average cost-sharing difference between preferred and non-preferred brands was $34 in PDPs, but $18 in employer plans.

EXHIBIT 2: Change in Weighted Average Cost Sharing for National and Near-National PDPs, 2006-08, and Employer-Sponsored Plans, 2007

	Medicare PDPs			Employer Plans, 2007
TIER	2006	2007	2008	
Generic	$5.87	$4.77	$5.32	$11
Preferred brand	$26.87	$29.36	$29.86	$25
Non-preferred brand	$55.36	$63.31	$71.31	$43
Fourth tier (specialty)*	26.4%	30.0%	30.2%	36%

NOTES: Medicare PDPs weighted by 2007 enrollment weights (2006 for 2006 plans). Data are based on plans with three tiers of flat dollar copayments and a specialty tier with a coinsurance rate, and includes only plans that will be offered in 2008.
SOURCE: Hoadley et al analysis of CMS data for national and near-national PDPs, 2006-2008, prepared for the Kaiser Family Foundation; Data on employer plans from Kaiser/HRET Employer Health Benefits Survey, 2007.

Unlike PDPs, only a small share of employer plans have a fourth tier (not always for specialty drugs). Although specialty tiers in employer plans typically have higher coinsurance rates, Medicare guidelines for Part D plans explicitly limit specialty tier coinsurance to 33 percent.

Changes in Cost Sharing Among National PDPs, 2007-2008[6]

The vast majority of plans have made changes to their cost-sharing levels from one year to the next (Exhibit 3).

EXHIBIT 3: Change in Cost Sharing for National PDPs, 2007-08

CHANGE IN COST SHARING	Generic Tier	Preferred Brand Tier	Non-Preferred Tier	Specialty/ Injectible Tier
Increased	13	22	20	9
Same	19	9	10	31
Decreased	10	6	7	2
New Design, 2008	0	5	5	0
New Plan, 2008	5	5	5	5
PDP Total, 2007	**47**	**47**	**47**	**47**

NOTES: Five plans with a defined standard benefit are coded as "same" for each tier. Plans that changed from coinsurance to flat copayments or vice versa are not classified.
SOURCE: Hoadley et al analysis of CMS data for national and near-national PDPs, 2007-2008, prepared for the Kaiser Family Foundation.

Generics: No consistent pattern of change emerged for generic drug cost sharing between 2007 and 2008. Many plans made no change, while some increased the amounts and others lowered them. For example, from 2007 to 2008, Wellpoint raised the generic copayment in its Medicare Rx Rewards Value plan from $5 to $10, while Humana lowered the generic copayment in its Enhanced and Complete plans from $5 to $4. Five of the national plans impose higher copayments for generic drugs when they are provided in the coverage gap. For example, the $2 copayment for first-tier generics in Coventry's AdvantraRx Premier Plus plan increases to $15 when enrollees reach the coverage gap.

Preferred Brands: Nearly half of the national PDPs (22 of 47 plans) have increased cost sharing for their preferred brand-name drug tiers between 2007 and 2008, slightly more than three times the number of plans that decreased cost sharing for that tier. For example, between 2007 and 2008, coinsurance for MemberHealth's Community Care Rx Basic plan increased from 25 percent to 30 percent and the copayment in Wellpoint's basic plan increased from $29 to $43, while the copayment for Wellcare's Signature plan dropped from $57 to $45.

Non-Preferred Drugs: A large share of national PDPs (20 of 47 plans), including some of the larger plans, also have increased copayments for non-preferred drugs. For example, between 2007 and 2008, the non-preferred tier copayment increased from $69.10 to $74.85 in UnitedHealthcare's AARP MedicareRx Preferred plan, and from $85 to $107 in Wellcare's Signature PDP, while Humana decreased the non-preferred tier copayment in its Enhanced and Complete plans from $60 to $54. Two PDPs that added a non-preferred tier to their benefit design for 2008 established higher copayments than average ($80 for Wellpoint's basic plan; $93 for Caremark's Silverscript plan).

Discussion

The flexibility in Part D plan benefit design allowed by the MMA has generated substantial variation across plans and across years. As part of the evolving nature of the Part D market, most plans have modified their cost-sharing design from year to year, as well as the specific cost-sharing amounts they charge. In fact, since 2006, nearly half of national PDPs have increased cost sharing for brand-name drugs.

Annual modifications in plan benefit design and cost-sharing amounts may be a result of plans having to maintain actuarial equivalence with the standard Part D benefit design, as well as the need to keep enrollees' share of costs in line with plans' actual or expected costs. Such changes can lead to sizable increases in the out-of-pocket costs that beneficiaries are required to pay for their medications if they stay in the same plan from one year to the next. Moreover, the wide variation in benefit designs that persists in the Part D market adds to the challenge facing beneficiaries in comparing benefits across plans and choosing the plan that will best meet their needs.

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[1] Other Medicare Part D 2008 Data Spotlights, based on the authors' analysis of CMS data, are available at http://www.kff.org/medicare/med102507pkg.cfm.
[2] The non-preferred tier includes primarily brand-name drugs but sometimes also relatively expensive generic drugs.
[3] "Medicare Part D 2008 Data Spotlight: Specialty Tiers" http://www.kff.org/medicare/med102507pkg.cfm.
[4] Plans using percentage coinsurance rather than flat dollar copayments are excluded from these estimates.
[5] "Kaiser/HRET Employer Health Benefits Annual Survey, 2007," Kaiser Family Foundation publication #7672, September 2007.
[6] Two-year changes between 2006 and 2008 are not shown due to shifts in plan offerings across time, which makes it difficult to present comparable changes. Some plans vary cost sharing across regions; median amounts are used in these cases.