Overview of Current Medicare Part D Offerings

Chris R. Cammisa, MD; Steven Evans, MD; Thomas C. Fenter, MD; Javier Gonzalez, PharmD; Helen Lee, PharmD, MBA; Sonya J. Lewis, RPh, MBA; Mark Noga, PharmD, RPh, CGP; and Charles Stemple, DO, MBA

ABSTRACT

BACKGROUND: Since its initiation in 2006, the Medicare Part D drug benefit has resulted in the development of hundreds of privately sponsored drug benefit plans. The evolution of these plans and of the requirements of the Medicare Modernization Act of 2003 (MMA) requires ongoing analysis and evaluation by managed care organizations who have a stake in the success of the drug benefit.

OBJECTIVE: To review the current state of plan offerings and highlight recent trends in the design of plans and benefits.

SUMMARY: There has been significant growth and change in the number and characteristics of the drug benefit plans available under Medicare Part D since 2006. More than two thirds of beneficiaries currently are enrolled in stand-alone prescription drug plans (PDPs), with increasing numbers moving into Medicare Advantage prescription drug (MA-PD) plans. Although the majority of plans charge tiered flat copayments for drugs, an increasing number are beginning to charge coinsurance for drugs in specialty tiers. Across the United States, the monthly beneficiary premium for Part D coverage is expected to average $27.93 in 2008. As in 2007, just over one quarter of plans offer some form of gap coverage in 2008. Following the large-scale marketing efforts at the initiation of the Part D benefit, plans currently appear to be less focused on marketing their offerings to potential beneficiaries.

CONCLUSION: Although there has been some stabilization among the benefits that are being offered by Part D plans, there continues to be a substantial amount of evolution in the Part D marketplace. Both the PDP and MA-PD markets expanded in 2007, as established plans continued to refine and increase their benefit offerings and new plans entered the market.

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Plan Availability

Since the initiation of the Medicare Part D drug benefit in 2006, there has been a significant amount of evolution in the type and number of plans that are available to beneficiaries. In 2008, across the 34 prescription drug plan (PDP) regions, a total of 1,824 PDPs will be offered, approximately the same number of plans that were available in 2007. Moreover, beneficiaries in most states choose from among at least 50 stand-alone PDPs and multiple Medicare Advantage prescription drug (MA-PD) plans.

At the same time, the availability of MA-PD plans has continued to grow, with at least 1 MA plan available to 98% of all beneficiaries as of 2007. MA-PD plans are health maintenance organizations (HMOs), preferred provider organizations (PPOs), and private fee-for-service (PFFS) plans that provide a wide range of benefits, including, but not limited to, Medicare-covered services and the prescription drug benefit. The availability of MA plans has increased in recent years as a result of the higher payments from the Centers for Medicare & Medicaid Services (CMS) for services from these plans, which are set according to local cost benchmarks. The benchmarks allow plans to underbid for service contracts, with 75% of the savings returned to beneficiaries in the form of enhanced services or reduced premiums.

In addition, there have been dramatic changes in the availability of offerings in other sectors, with significantly more choices in terms of PFFS plans and the introduction of the first Medical Saving Account (MSA)-type choices.

Enrollment Trends

The continuing change in the number of plan offerings is also reflected in the evolving trends in beneficiary enrollment. As of January 2008, the U.S. Department of Health and Human Services (HHS) reported that 25.4 million (57%) Medicare beneficiaries were enrolled in Medicare Part D plans. Of those, more than two thirds (17.4 million) are enrolled in PDPs, with the remaining 8 million receiving drug coverage through MA-PD plans (Figure).

In 2008, 18% (8 million) Medicare enrollees received their benefits through Medicare Advantage plans, a substantial increase from the 5.3 million enrollees in such plans in 2003. As payments to MA-PD plans have increased, enrollees have gravitated toward the enhanced offerings and lower premiums available from these plans.

PFFS plans are the fastest growing type of MA plan. Between 2006 and 2007, the share of beneficiaries with access to a PFFS plan increased from 78% to 97% nationwide. As of early 2007, 86% of Medicare beneficiaries have a choice of at least 3 PFFS plans; 52% can choose from at least 6 PFFS plans. Enrollment in PFFS plans increased 9-fold between March 2005 and November 2006, accounting for 39% of the growth in MA enrollment in
that period. Furthermore, enrollment in PFS plans more than doubled between July 2006 and June 2007, from approximately 765,000 to 1.65 million enrollees.

Benefits and Premium Design

In 2008, most PDPs (88%) have eliminated the standard drug benefit. The majority (approximately 60%) have no deductible and charge tiered copayments for covered drugs rather than a 25% coinsurance. Since 2006, the most common design uses 3 cost-sharing tiers: (1) for generics, (2) for preferred brand-name drugs, and (3) for nonpreferred drugs. Use of this plan structure has increased since 2006 (from 69% to 74% of plans). In addition to the standard 3 tiers, most plans also offer a specialty tier to cover injectable medications; in 2008, 87% of PDPs have a specialty tier (up from 54% in 2006). A few plans are offering a new plan design for 2008 that designates an additional tier for “value” generic drugs that is positioned below the standard generic tier.

While the majority of PDPs (68%) charge flat dollar copayments for drug costs, the number of plans charging some coinsurance has doubled, from 4 in 2006 to 9 in 2008. Compared with flat copayments, coinsurance provides plans with greater assurance that, as drug prices rise, enrollee contributions will increase accordingly. Regardless of copayment type, the average cost-sharing for a 30-day supply of nonpreferred drugs has increased 29% between 2006 and 2008 (from $55.36 to $71.31), while average cost-sharing for preferred brand-name drugs has increased 11% (from $26.87 in 2006 to $29.86 in 2008). As a result, enrollees have to face higher out-of-pocket costs for both preferred and nonpreferred drugs, giving them incentives to switch to lower cost options. Although actual premiums vary across plans and geographic regions, according to the national average bid, the monthly premium for Part D coverage is expected to average $27.93 in 2008.

As noted, MA-PD plans bid separately for Medicare Part A and Part B services and the Part D drug benefit. Savings that are generated by beating the CMS-established benchmark for Part A and Part B services are shared with beneficiaries, frequently by reducing or eliminating premiums for Part D coverage. This allows MA-PDs to offer lower premiums and better drug coverage than stand-alone PDPs.

PPFS plans pay providers on a fee-for-service basis and work with all providers willing to accept their payment rates. The fee-for-service structure results in better reimbursement for health plans, which is why the availability of these plans is increasing. In a PPFS plan, enrollees are not restricted in terms of the providers that they can use. However, providers may limit their availability to see beneficiaries in such plans. Although payment rates are not required to equal those of Medicare, CMS must consider that the rate will permit adequate access to providers.

Trends in Gap Coverage

In 2008, roughly the same proportion of PDPs (29%, or 529 plans) provide some gap coverage compared with what was available in 2007. However, the scope of coverage for generic drugs is becoming more limited, with approximately half of PDPs that offer gap coverage in 2008 covering only preferred or some generic drugs. Importantly, the premiums for PDPs that provide gap coverage are approximately double those for plans that do not offer gap coverage in 2008 ($63.29 for PDPs with some gap coverage vs. $30.14 for PDPs with basic benefits and no gap coverage).

Although the number of MA-PD plans that offer some gap coverage is growing, most do not cover brand-name drugs in the gap. The proportion of MA-PD plans offering gap coverage has increased from 28% (369 plans) in 2006 to 51% (964 plans) in 2008. This increase is primarily among those plans that cover all generics and “some” brand-name drugs in the gap.

MA-PD plans have greater incentives than PDPs to offer gap coverage, since they provide coverage for the full set of Medicare services. As such, they have more incentive to prevent the negative outcomes (and increased costs) that are potentially associated with enrollees who fail to refill their prescriptions when they reach the coverage gap. The ability of MA-PDs to provide
gap coverage is enhanced by the revenues paid to them by the federal government for the provision of other Medicare services, which enables plans to cross-subsidize their prescription drug coverage. To encourage enrollment by beneficiaries, many PDPs are changing their benefits design by reducing or waiving the standard $275 deductible. Many are also opting to eliminate the standard Part D benefit for drugs (25% coinsurance) by offering beneficiaries tiered flat-dollar copayments.

**Drug Utilization**

Since its inception, Medicare Part D has achieved a relatively high level of generic drug use. Increased use of generic drugs in place of brand-name compounds is one of the tools that Part D has used to minimize costs to beneficiaries and maintain affordable coverage. Because generic drugs as a category are on average 71% less expensive compared with brand-name drugs (2007 data), a higher rate of generic substitution for brand-name drugs can have a significant impact on overall drug costs. In fact, the cost of the Part D prescription drug program for 2006 was lower than originally estimated ($59 billion), which, in part, was due to greater than expected use of generic drugs. Also, the use of generic drugs has led to a reduction in the estimates of the future cost of the Part D prescription drug program.

**Generic Utilization Rates**

According to data from the Office of the Inspector General (OIG), about 56% of all drugs dispensed under Part D in the first half of 2006 were for generic medications. The rates of generic drug use varied widely across Part D plans, ranging from 37% to 83% of drugs across all prescriptions.

Generic drug use is measured by the frequency of generic drug substitution at the pharmacy counter, as well as the prescribing of drugs that do not have generic equivalents (single-source drugs). This study also considered the overall utilization rate of generic drugs based on the percentage of generic drugs that were dispensed for multi-source drugs (i.e., generics and branded agents with generic equivalents). In general, the OIG found that generic substitution rates were similar across Part D plans, between MA-PDs and PDPs, and across specific types of MA-PDs. However, there was wide variation in generic drug substitution rates within specific therapeutic classes. Among the top 10 therapeutic classes of drugs, 8 had a difference of at least 50 percentage points between the lowest and highest generic substitution rates. These classes were: thyroid preparations, anticoagulants, lipotropics, diabetes therapies, cardiovascular preparations, psychostimulants/antidepressants, narcotic analgesics, and antiulcer/gastrointestinal preparations.

As drug costs continue to rise, Part D beneficiaries are bearing a greater financial burden through increased cost-sharing. For beneficiaries enrolled in a PDP, the average copayments for preferred and nonpreferred brands were $29.36 and $63.31, respectively, and these copayments were higher than those of employer plans, which had average copays of $25 for preferred brands and $43 for nonpreferred brands. The differences in average cost-sharing between generics and preferred brands were higher for PDP beneficiaries ($25), compared with employer-plan enrollees ($11). This was also true for the differences paid for preferred versus nonpreferred brands, with average cost-sharing of $34 for PDPs and $18 for employer plans. Thus, PDPs have a greater financial incentive for switching to generic drugs.

There are some drug classes that were excluded from Medicare Part D, almost all of which are generic, including the benzodiazepines and barbiturates. Other excluded drugs include agents used for cosmetic purposes, drugs used to treat cold symptoms, and prescription vitamin and mineral preparations.

**Plan Marketing Efforts**

The marketing of Medicare Part D prescription drug plans appears to be at an uncertain juncture, following the intense marketing push at the start of the Part D program. Although marketing of the first Part D plan offerings was successful in attracting enrollees during the initial open enrollment period in 2005–2006, it is not clear to what degree sponsors will continue to invest in the marketing of newer offerings as they develop.

There are some insights from beneficiaries in 4 states (Maryland, Nebraska, Florida, and California), who took part in a survey commissioned by the Kaiser Family Foundation. This survey monitored the experiences of 35 beneficiaries in Medicare Part D and consisted of 4 rounds of interviews, with the first one held in October/November 2005, and follow-ups conducted in March 2006, October 2006, and September/October 2007. In the final report, the experiences of 17 Medicare Part D enrollees were provided. The report noted that after the deluge of direct mail and other information from Part D plans during that first open enrollment period, there has been a dramatic decline in marketing efforts from plans. Furthermore, beneficiaries note that they do not pay much attention to the materials they receive from the plans or from Medicare. Among those beneficiaries surveyed during the open enrollment season for 2008, most participants were not planning to reassess their plan options. In fact, most were generally reluctant to switch plans, and some respondents were adamantly opposed to doing so. The reasons for this reluctance included satisfaction with their current plan, fear that any plan they switch to may be worse than what they currently have, and the stress of revisiting the complex process of choosing a plan.

Today, marketing efforts seem to be shifting toward member retention by focusing on improvements in benefit design and member services, the qualities that are most apparent to their current members.

**Conclusions**

Since its inception, the Medicare Part D drug benefit has continued to evolve in terms of the benefits and services offered to
beneficiaries. This evolution in the number of MA-PD plan offerings is part of plans’ efforts to remain competitive in this changing landscape.

One of the more dramatic changes has been the increased availability of PFFS plans and the emergence of MSAs. Part D plans have also changed their benefits structure and premium design to encourage enrollment. In 2008, most plans have eliminated the standard drug benefit, with 60% having no deductible and charging tiered copayments for covered drugs rather than coinsurance.

The implementation of Medicare Part D has also resulted in a relatively high level of generic drug utilization in an effort to minimize costs to beneficiaries and maintain affordable coverage. This strategy is also responsible for a predicted reduction in future drug costs under Medicare Part D.

The proportion of PDPs offering gap coverage in 2008 is similar to those providing such coverage in 2007. However, coverage for generic drugs is more limited, with approximately half of PDPs only covering preferred or some generic drugs. Importantly, the 2008 premiums for PDPs that provide gap coverage are approximately double the premiums for plans not offering gap coverage. While MA-PD plans have greater incentives to offer gap coverage, most do not cover brand name drugs in the gap.

Initially, plans employed aggressive marketing strategies for enrolling beneficiaries, including direct mail. However, as the market changes, plans have placed a greater focus on member retention (i.e., through improvements in benefit design and member services). With these improvements, plans are hoping to increase member satisfaction, improve the overall health of members, and provide quality, cost-effective care.

REFERENCES