Fact Sheet

Medicare Beneficiary Costs Set to Rise for Part D Drug Benefit in 2010

Medicare beneficiaries who will participate in Part D for 2010 should examine their plan choices carefully during open enrollment, which starts November 15, 2009. Most national plans will require increased cost-sharing, especially for many brand-name medicines. Enrollees who qualify for "extra help" will still be protected from high cost-sharing, but they may have fewer plan choices.

Next year's Medicare Part D enrollees will face higher cost-sharing for many brand-name prescriptions, and may face higher premiums.

A new analysis by the AARP Public Policy Institute (PPI) of most national Part D plans shows increased premiums and greater exposure to drug costs, especially for branded and "specialty" products. With enrollment heavily concentrated in a few national plans, a large majority of Part D enrollees could experience these increases.

For example, PPI found that hardly any of the Part D plans with the highest enrollment will have monthly premiums that will fall below $30, next year's "average" premium estimated by the Centers for Medicare and Medicaid Services (CMS).[1]

"All beneficiaries should compare their current coverage with the plans that will be offered in 2010 when information becomes available,"[2] cautioned CMS Center for Health Plan Choices' Acting Director Jonathan Blum. The annual Part D open enrollment period runs from November 15 to December 31, 2009.

Also, fewer plans will serve low-income Medicare beneficiaries in 2010 compared to in 2009, the Kaiser Family Foundation reported.[3] Thus, the one-third of Part D enrollees who qualify for extra help might face fewer choices for drug coverage.

Increased Cost-Sharing, Especially for Branded Products

According to PPI's review of ten Part D plans with the highest enrollment[4] available across the United States in 2010[5] (see appendix A), only one plan will have a monthly premium under $30. Further, eight will require annual deductibles ranging from $100-$310.

In addition, some enrollees will face substantial cost-sharing for certain medications. Part D plans use tiers that group drugs by similar cost-sharing requirements. For example, Tier 1 drugs, usually generics, have the lowest copayments. Tier 2 drugs, "preferred" brands, have a higher copayment. Tier 3 drugs are "nonpreferred" brand name drugs that are usually more expensive and/or have more safety concerns than "preferred" drugs.

Since Part D plans began in 2006, many have incorporated a fourth tier as well, often known as a "specialty" tier. This includes many biologics and injectable drugs; coinsurance is the

usual form of cost-sharing. Coinsurance represents a percentage of the drug's price, rather than a copayment that is a fixed amount regardless of the drug's price.

In 2010, more plans will require copayments close to $100 for Tier 3 drugs (usually "nonpreferred" brand-name drugs). Other plans will use coinsurance for all medicines (across tiers) except generics.

Enrollees who require "specialty" tier drugs are most likely to face coinsurance. For example, in 2008, rheumatoid arthritis medicines such as Enbrel® and Humira® averaged $1,633 per prescription. The average cost of a multiple sclerosis drug was $2,006.[6] At 33 percent coinsurance, enrollees' cost would exceed $500 per prescription. Most patients with either of these conditions filled at least eight such prescriptions in 2008.[7]

Unique Plan Design Elements

PPI found three noteworthy plan designs for 2010 (see appendix A):

1. While the copayment for generics will be $7 or less, three plans (First Health, AvantraRx Value, Medicare Rx) will require coinsurance for branded drugs regardless of tier.

2. One plan (Humana) will vary the cost-sharing within each tier, depending on whether the drug is purchased at a preferred or nonpreferred pharmacy.

3. Coinsurance for nonpreferred brand-name drugs (on Tier 3) will be as high as 60 to 65 percent in two plans (Community CCRx Basic, AdvantraRx Value).

Thus, while Part D plan choices remain plentiful for most people, it is clear that many plans are placing a greater cost-sharing burden on enrollees.

Table 1
2010 Medicare Part D Benefit Parameters for Defined Standard Benefit

Deductible – After the deductible is met, beneficiaries pay 25 percent of covered costs until they reach the initial coverage limit.	$310
Initial Coverage Limit – Coverage gap (doughnut hole) begins at this point; enrollee is responsible for 100 percent of drug costs while in the gap.	$2,830
Out-of-Pocket Threshold – The maximum out-of-pocket cost prior to catastrophic coverage, excluding plan premiums.	$4,550
Catastrophic Coverage	Minimum cost-sharing of $2.50 for generic drugs and $6.30 for other drugs

Source: U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, "Announcement of Calendar Year (CY) 2010 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies," Memorandum, April 6, 2009.

Declining Number of Plans Offer "Gap" Coverage

As noted in table 1 (see previous page), the Part D benefit includes a coverage gap, also known as the "doughnut hole," where enrollees are responsible for all of their prescription drug costs. In 2010, this gap will start after enrollees have spent $2,830 on prescription drugs and will last until their total drug costs exceed $6,440.

About 3.4 million Medicare Part D enrollees fell into the coverage gap in 2007.[8] In 2010, only 20 percent of plans will offer any type of gap coverage, compared with 25 percent of plans that did so in 2009.[9] Almost all will limit such coverage to generic drugs.

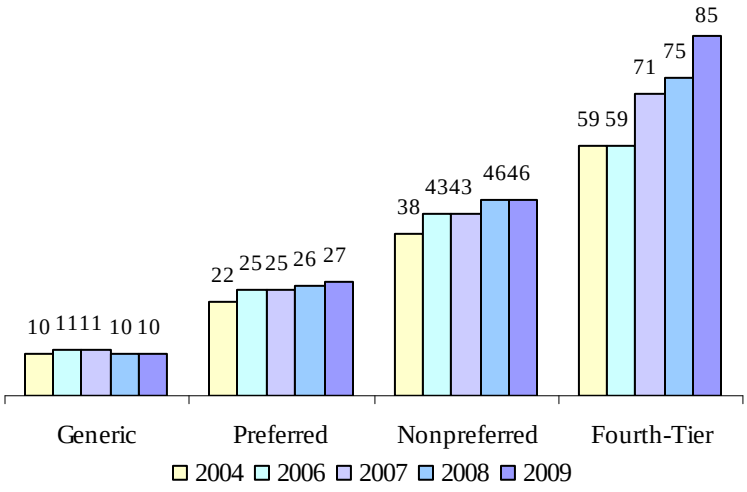
Health care reform legislation now before Congress would (1) provide a 50 percent discount on brand-name drugs for Part D enrollees who fall into the coverage gap, and/or (2) gradually eliminate the coverage gap entirely.

Cost-Sharing in Non-Medicare Plans Usually Less than in Part D

Increased patient cost-sharing for prescription drug expenses is not unique to Medicare beneficiaries. Last year, 78 percent of workers who had employer-sponsored drug coverage were in plans with three or four tiers, versus about 27 percent of workers in 2000. As shown in figure 1 (below), copayments associated with those tiers have been rising steadily as well.

However, Part D enrollees continue to pay more, on average, for preferred and nonpreferred drugs than do people covered under employer-sponsored plans.[10] Research has shown that increased cost-sharing for drugs is associated with increased use of health care services, especially among people with congestive heart failure, lipid disorders, diabetes, and schizophrenia.[11] Because older adults are affected disproportionately by such conditions, Medicare Part D cost-sharing could increase enrollees' use of other health services.[12]

Figure 1
Average Copayments among Covered Workers with Three- or Four-Tier Prescription Drug Cost-Sharing, 2004–2009



Source: Kaiser/HRET, Employer Health Benefits: 2009 Annual Survey, Exhibit 9.4, September 2009.

Extra-Help-Qualified Enrollees Protected, Despite Reduction in Plans Serving Them

In 2009, more than 9.6 million persons received the Part D low-income subsidy.[13] In 2010, they will still be protected from additional cost-sharing, regardless of which Part D plan they select. However, it may be more difficult for this population to find future coverage. The Kaiser Family Foundation found that many Part D plans raised the premiums for their prescription drug plans (PDPs) beyond a government-set median benchmark for 2010, thereby disqualifying them from offering coverage.[14]

Overall, there will be 20 fewer PDPs serving low-income beneficiaries next year, and approximately 800,000 persons will have to be reassigned to a new PDP.[15] The number of beneficiaries needing reassignment is considerably lower than in 2009, when CMS reassigned 1.6 million beneficiaries. In 2008, the number of beneficiaries needing reassignment was 2.1 million; in 2007, it was 1.1 million.[16]

Further, the 288 prescription drug plans that will offer coverage in 2010 to Part D low-income enrollees are not distributed equally among the states. Thus, many low-income enrollees will face limited choices in drug coverage. For example, the number of low-income subsidy (LIS) plans will decline in 19 of 34 regions from 2009 to 2010, while more LIS plans will be available in 10 regions. (New CMS policies that adjusted how the benchmark is calculated in 2010 helped deter further erosion in the number of LIS plans.) These changes could push some low-income Medicare beneficiaries into PDPs that do not meet their medical needs fully—particularly since their choices are extremely limited in certain states.

Open Enrollment a Perfect Time to Review Drug Usage, Plan Choices

With several years of Part D plan experience under their belts, many enrollees can predict their prescription drug needs and costs. Given the challenging economic climate and the zero cost-of-living increase in Social Security in 2010, all Medicare beneficiaries should talk with doctors, pharmacists, and other clinicians about their medicine choices, and should review their Part D plan options before open enrollment ends on December 31.

Appendix A
Characteristics of National Medicare Part D Plans with Highest Enrollment, 2010

Prescription Drug Plan	Monthly Premium	Annual Deductible	Coverage in Gap	Copays ($) or Coinsurance (%)			
				Tier 1	Tier 2	Tier 3	Specialty
AARP MedicareRx Preferred	$37.40	$0.00	No	$7.00	$42.00	$71.25	33%
AARP MedicareRx Saver	$36.40	$310.00	No	$6.00	$25.00	$93.00	25%
SilverScript Value	$31.60	$310.00	No	$8.00	$23.50	$95.00	25%
Community CCRx Basic	$33.40	$310.00	No	$0.00	25%	60%	N/A
Humana Enhanced	$42.70	$0.00	No	$8.00 or $13.00 (preferred vs. nonpreferred pharmacy)	$45.00 or $50.00 (preferred vs. nonpreferred pharmacy)	41% or 46% (preferred vs. nonpreferred pharmacy)	N/A
Humana Standard	$59.90	$310.00	No	15% or 20% (preferred vs. nonpreferred pharmacy)	25% or 30% (preferred vs. nonpreferred pharmacy)	38% or 43% (preferred vs. nonpreferred pharmacy)	N/A
First Health Part D-Premier	$38.20	$150.00	No	$7.00	11%	44%	29%
AdvantraRx Value	$47.10	$100.00	No	$7.00	20%	65%	30%
Advantage Star Plan	$28.80	$310.00	No	$5.00	25%	45%	25%

Prescription Drug Plan	Monthly Premium	Annual Deductible	Coverage in Gap	Tier 1	All Other Drugs
MedicareRx Rewards Standard	$38.70	$310.00	No	$7.00	25%

Note: All data are for 2010. New York (ZIP code 12144) was used as a constant.

Source: AARP Public Policy Institute analysis of Part D plan offerings for 2010. Accessed from plan Web sites, October 8–15, 2009.

[1] U.S. Department of Health and Human Services (U.S. DHHS), Centers for Medicare and Medicaid Services (CMS), "Medicare Prescription Drug Plan Premiums to Increase Slightly, Medicare Beneficiaries May Need to Enroll in New Plans," Press Release, August 13, 2009, available at http://www.cms.hhs.gov/apps/media/press_releases.asp.

[2] Ibid.

[3] J. Hoadley et al., "Medicare Part D Spotlight: Plan D Availability in 2010 and Key Changes Since 2006," Kaiser Family Foundation, October 2009, available at: http://www.kff.org/medicare/upload/7986.pdf

[4] Based on AARP Public Policy Institute analysis of Centers for Medicare and Medicaid Services' monthly enrollment by plan data (September 2009).

[5] Each plan's (1) monthly premium, (2) annual deductible (if applicable), (3) offering of any coverage in the gap ("donut hole"), and (4) the associated copayment or coinsurance level was determined using information provided on each organization's Web site. Since premiums vary by state (even among national plans) but not necessarily within a state, New York (ZIP code 12144) was used as a constant.

[6] Express Scripts, *2008 Drug Trend Report*, April 2009, available at http://www.express-scripts.com/industryresearch/industryreports/drugtrendreport/2008/ Actual Part D plan costs may be different

[7] Ibid.

[8] J. Hoadley et al., "The Medicare Part D Coverage Gap: Costs and Consequences in 2007," Kaiser Family Foundation, August 2008, available at http://www.kff.org/medicare/7811.cfm.

[9] J. Hoadley et al., 2009, op. cit.

[10] J. Hoadley et al., "Medicare Part D 2008 Data Spotlight: Benefit Design," Kaiser Family Foundation, December 2007, available at http://www.kff.org/medicare/upload/7713.pdf.

[11] D. P. Goldman, G. F. Joyce, and Y. Zheng, "Prescription Drug Cost Sharing: Associations with Medication and Medical Utilization and Spending and Health," Journal of the American Medical Association, 298(1): 61–69.

[12] C. P. Thomas, "How Prescription Drug Use Affects Health Care Utilization and Spending by Older Americans: A Review of the Literature," AARP Public Policy Institute, April 2008, available at http://assets.aarp.org/rgcenter/health/2008_04_rx.pdf.

[13] U.S. DHHS, CMS, "LIS-Eligible Medicare Beneficiaries with Drug Coverage as of February 1, 2009," February 2009, available at: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/.

[14] J. Hoadley et al., 2009, op. cit.

[15] CMS has temporarily changed the way it calculates the low-income regional benchmarks. Had this change not been made, roughly 1.6 million beneficiaries would have had to be reassigned in 2010. U.S. DHHS, CMS, "Medicare Prescription Drug Plan Premiums to Increase Slightly, Medicare Beneficiaries May Need to Enroll in New Plans," Press Release, August 13, 2009, available at http://www.cms.hhs.gov/apps/media/press_releases.asp.

[16] L. Summer et al., "Medicare Part D 2009 Data Spotlight: Low-Income Subsidy Plan Availability," Kaiser Family Foundation, November 2008, available at: http://www.kff.org/medicare/7836.cfm.

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