Fact Sheet

Medicare Part D Open Enrollment for 2014: Popular Plans Continue to Evolve

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Premiums for many popular stand-alone Medicare Part D plans will be noticeably higher in 2014, although the average Part D premium is expected to remain stable. Plan designs also continue to evolve, with all of the most popular stand-alone Part D plans now relying on preferred pharmacy networks. In combination with wide variation in cost-sharing and the increasing use of utilization management tools, choosing a Part D plan is becoming increasingly complicated.

Medicare beneficiaries enrolling in Part D for 2014 will find a wide variety of plans to choose from, with an average of 35 plans available in each state.[1]

Premiums for Medicare Part D plans will remain stable for the fourth year in a row, averaging $31 in 2014.[2] However, premiums for many popular stand-alone plans will be considerably higher. Part D enrollees will also benefit from additional savings on prescriptions filled while they are in the coverage gap—commonly known as the doughnut hole—as part of the Affordable Care Act.[3]

Enrollees will also continue to face a mix of out-of-pocket costs and utilization management tools for commonly used prescription drugs (see appendices A and B). In addition, all of the most popular stand-alone Part D plans (PDPs) are now relying on preferred pharmacy networks that provide preferential cost-sharing for prescriptions filled at certain pharmacies.

This growing plan complexity may make it increasingly difficult for enrollees to determine which plan best suits their needs.

Wide Variety of Plan Benefit Designs

Among the stand-alone Part D plans with the highest enrollment[4] in 2013,[5] three will have monthly premiums well below $31. Low-premium PDPs have successfully gained market share over the past few years, as evidenced by three popular plans with monthly premiums of roughly $20. Premiums for the other plans range from $46.10 to $75.00.[6]

PPI found several notable benefit design features among popular stand-alone Part D plans (see table 1):

- All of the plans now include preferred pharmacy networks, whereas only four popular plans included one in 2013.[7]
- More than two-thirds of popular Part D plans now have five cost-sharing tiers (preferred generics, nonpreferred generics, preferred brands, nonpreferred brands, and a specialty tier).
- Two plans will require coinsurance of 15 percent to 44 percent for brand name drugs—which can result in high levels of cost-sharing—but will charge low copayments for generics.

Table 1
Cost and Benefit Design of National Medicare Part D Plans with Highest Enrollment, 2014[1]

Prescription Drug Plan	Monthly Premium 2013	Monthly Premium 2014	Annual Deductible	Coverage in Gap	Copays ($) or Coinsurance (%) Preferred Pharmacy/Nonpreferred Pharmacy				
					Tier 1	Tier 2	Tier 3	Tier 4	Tier 5
AARP MedicareRx Preferred*	$41.40	$46.10	$0	No	$4/$8	$7/$12	$40/$45	$85/$95	33%
AARP MedicareRx Saver Plus*	$15.00	$21.00	$310	No	$1/$2	$2/$3	$25/$30	$45/$60	25%
CIGNA Medicare Rx Secure*	$45.80	$59.10	$310	No	$0/$10	$9/$33	$43/$45	$91/$95	25%
First Health Part D Value Plus*	$33.90	$51.20	$0	No	$3/$10	$11/$33	$37/$45	$88/$95	33%
Humana Enhanced*	$45.70	$49.50	$0	Yes**	$2/$6	$5/$10	$42/$45	$92/$95	33%
Humana Preferred Rx*	$18.50	$21.80	$310	No	$1/$3	$2/$4	20%/25%	35%/39%	25%
WellCare Classic*	$28.50	$22.40	$0	No	$0/$8	$14/$29	$40/$45	$90/$95	33%
Aetna CVS/pharmacy PDP*	$32.50	$75.00	$310	No	$2/$7	$45/$45	$95/$95	25%	
First Health Part D Essentials*	$60.60	$60.60	$310	No	$1/$3	15%/16%	44%/45%		

Note: All data are for 2014. Florida (ZIP code 33313) was used as a constant. Popular plan Silverscript Basic is currently under enrollment sanctions and has been excluded from this analysis. Five-tier plans commonly include a preferred generics tier, a nonpreferred generics tier, a preferred brands tier, a nonpreferred brands tier, and a specialty tier.

* Plan utilizes preferred pharmacy network.

** Humana Enhanced will provide gap coverage for "few brands," defined as less than 10 percent of the brand name drugs on its formulary.

[1] Avalere Health, "Avalere Analysis Reveals First Drop in Medicare Advantage Offerings Since 2011," Press Release, September 23, 2013.

Source: AARP Public Policy Institute analysis of Part D plan offerings for 2014. Accessed from plan websites and the Medicare Plan Finder, October 15, 2013.

All of the popular Part D plans rely on utilization management techniques for a majority of commonly prescribed brand name prescription drugs and some generic prescription drugs (see appendices A and B). The use of utilization management tools in Part D has grown in the past few years.[8] These techniques include:

- quantity limits, which limit the quantity of drugs that are covered over a certain period;
- prior authorization, which requires prescribers to verify that the prescribed drug is medically necessary before the plan will provide coverage; and
- step therapy, which requires patients to first try one or more drugs before the originally prescribed drug will be covered.

Medicare Part D utilization management programs are designed to assist in preventing overutilization and underutilization of prescribed medications and to reduce costs when medically appropriate.[9]

Cost-Sharing Can Vary Dramatically

Medicare Part D plans continue to require substantial cost-sharing for certain brand-name medications. In 2014, many popular plans will require copayments of about $90 for nonpreferred brand-name medications. Other plans will require coinsurance of 35 percent to 44 percent of a drug's price rather than a fixed copayment.

In addition, many Part D plans have a specialty tier with coinsurance for expensive biologics and injectable drugs. The use of coinsurance for high-priced drugs can leave enrollees with markedly higher costs than a typical copayment. For example, the monthly out-of-pocket cost of the biologic Enbrel 25 mg (for rheumatoid arthritis) ranges from $583 to $1,072, depending on the plan's coinsurance level and original drug cost.

Cost-sharing under Medicare Part D is considerably higher than what is typically required under employer-sponsored health coverage. Copayments are far more common than coinsurance in employer-sponsored plans, and the average copayment for nonpreferred brand name medications is considerably lower. Further, unlike Medicare Part D, employer plans' coinsurance rates for prescription drugs often have maximum or minimum coinsurance dollar amounts.[10]

Preferred Pharmacy Networks

Enrollee cost-sharing can also be affected by preferred pharmacy networks that are increasingly being utilized by stand-alone Part D plans.

Cost-sharing in Part D plans with preferred pharmacy networks can vary substantially within a given tier. Among the most popular stand-alone Part D plans, cost-sharing differentials for preferred versus nonpreferred pharmacies range from $1 to more than $20 for copayments and from 1 percent to 5 percent for coinsurance (see table 1).

It is unclear how preferred pharmacy networks will impact enrollee access and costs. They may be particularly problematic for Part D enrollees who reside in rural areas, if the preferred network retail pharmacy is some distance away. Part D enrollees' willingness to simply stick with their plan year after year[11] could also result in them belatedly realizing that their plan has moved to a preferred pharmacy network after they try to fill a prescription in 2014.

Gap Coverage Mostly for Generics; Most Popular Plans Skip Gap Coverage Entirely

The Part D benefit includes a coverage gap where enrollees who do not receive the Part D low-income subsidy (LIS) are responsible for all of their prescription drug costs. About 3.8 million non-LIS enrollees fell into the coverage gap in 2012.[12]

The coverage gap is slowly being eliminated through a series of escalating discounts as part of the Affordable Care Act. In 2014, non-LIS Part D enrollees will receive a 52.5 percent discount on their brand name and biologic prescription drugs and a 28 percent discount on their generic prescription drugs while they are in the coverage gap.[13]

The percentage of stand-alone prescription drug plans that offer any coverage in the gap has decreased markedly (33 percent in 2013 vs. 21 percent in 2014),[14] presumably due to the increasing value of the coverage gap discounts. Almost all plans limit such coverage to generic drugs. In 2014, only one of the most popular Part D plans will offer gap coverage.

'Extra Help' Enrollees Still Protected from High Prescription Drug Costs in 2014

Currently, almost 11 million Part D enrollees receive the LIS, also known as Extra Help.[15] The subsidy, which varies based on income, covers some or all of beneficiaries' monthly Part D premiums, plan deductible, copayments, and the cost of drugs in the coverage gap.

Enrollees who receive Part D's low-income subsidy will have slightly more plans available that will not require them to pay a monthly premium, known as benchmark plans, in 2014. However, nearly one in four LIS beneficiaries will need to select a new plan in order to avoid paying a premium because their current plan will no longer be available with no monthly premium.[16]

The Centers for Medicare and Medicaid Services automatically notifies and reassigns LIS beneficiaries whose current plan will no longer be a benchmark plan to a new plan. However, some LIS beneficiaries, known as "choosers" because they chose a plan on their own in the past, are no longer reassigned by CMS and will have to switch plans on their own to avoid paying a premium. These beneficiaries often end up paying a premium.[17]

About one-fourth of the 352 benchmark plans in 2014 qualified under CMS's new de minimis policy that allows plans to waive up to $2 of their monthly premium for LIS beneficiaries.[18] If this policy were not in place, LIS enrollees in these plans would have to find a new plan for 2014 or pay a premium.

Enrollee Plan Choices Are Increasingly Complicated

The wide variety of benefit designs and out-of-pocket costs under Medicare Part D provides enrollees with a multitude of choices. However, growing plan complexity may make it difficult for enrollees to determine which plan best suits their needs.

For example, research indicates that enrollees already mistakenly place much more weight on premium costs than total out-of-pocket costs.[19] Now, in order to make an informed decision, enrollees must also evaluate plan formularies—including any relevant utilization management—and whether their usual pharmacy is within a given plan's preferred pharmacy network. This amount of information is extremely

difficult to present in a simple manner, making it possible for users to inadvertently miss important details.

Further complicating this task is the fact that the Medicare Part D Plan Finder has been unable to keep pace with the constantly changing plan designs found in the Part D market. For example, Plan Finder currently only allows users to choose two pharmacies when they are examining their plan options—and only those within a few miles of where they live. This likely will not be adequate if plans' preferred pharmacy networks include a limited number of pharmacies.

Concerns for the Future

The growing complexity of choosing among Medicare Part D plans may help explain why only 13 percent of Part D enrollees voluntarily switch plans every year,[20,21] even in the face of relatively large premium increases.[22] Research indicates that this inertia has undermined the competition that was expected in the Part D marketplace, allowing plan sponsors to price existing plans higher than comparable new plans.[23]

More important, a growing body of research suggests that a majority of Part D enrollees are spending more than necessary on their prescription drug coverage because they are not choosing the most cost-effective plan for their medication needs.[24]

Given that Medicare Part D is consistently used as an example of a successful market-based health care system, policymakers should pay attention to the unforeseen challenges that can arise when enrollees are faced with a broad array of plan options and choose not to switch plans.

Appendix A

2014 Plan Coverage, Out-of-Pocket Costs, and Utilization Management Tools for Five Popular Brand Name Drugs and One Popular Specialty Drug among Medicare Part D Plans with Highest Enrollment[1]

Prescription Drug Plan	Monthly Out-of-Pocket Costs and Utilization Management (UM)											
	Crestor 10 mg		Evista 60 mg		Novolog inj 100/ml		Namenda 10 mg		Spiriva Handihaler		Enbrel 25 mg	
	$	UM	$	UM	$	UM	$	UM	$	UM	$	UM
AARP MedicareRx Preferred	$40.00		$40.00		$40.00		$40.00		$40.00	√	$769.66	√
AARP MedicareRx Saver Plus	$25.00		$25.00		$25.00		$25.00		$25.00	√	$583.08	√
Aetna CVS/pharmacy PDP	$45.00	√	$45.00		$45.00		$45.00		$45.00	√	$604.60	√
CIGNA Medicare Rx Secure	$43.00	√	$43.00		$177.20*		$43.00	√	$43.00		$601.57	√
First Health Part D Essentials	$26.64	√	$28.01	√	$23.81		$41.19	√	$120.82	√	$1,072.39	√
First Health Part D Value Plus	$37.00	√	$37.00	√	$37.00		$37.00	√	$1,190.63*		$804.29	√
Humana Enhanced	$42.00	√	$42.00	√	$42.00		$42.00	√	$42.00	√	$781.83	√
Humana Preferred Rx	$34.54	√	$36.31	√	$30.86		$53.40	√	$156.59	√	$592.29	√
WellCare Classic	$90.00	√	$40.00	√	$90.00	√	$40.00	√	$90.00	√	$816.84	√

Note: All data are for 2014. Florida (ZIP code 33313) was used as a constant. Out-of-pocket costs are based on enrollee costs during the initial coverage period and based on purchase at a preferred pharmacy; costs at a nonpreferred pharmacy would be higher. Popular plan Silverscript Basic is currently under enrollment sanctions and has been excluded from this analysis. Common utilization management tools include: quantity limits (plan limits the quantity of drugs that are covered over a certain period of time); prior authorization (prescriber must verify that the prescribed drug is medically necessary before the plan will provide coverage); and step therapy (patient must first try one or more drugs before the originally prescribed drug will be covered).

* Drug is not on the plan's formulary. Payments for off-formulary drugs do not count toward the deductible, initial coverage limit, or out-of-pocket costs unless the plan approves a formulary exception.

[1] Avalere Health, "Avalere Analysis Reveals First Drop in Medicare Advantage Offerings Since 2011," Press Release, September 23, 2013.

Source: AARP Public Policy Institute analysis using the Medicare Plan Finder, October 15, 2013. Popular prescription drugs were drawn from CMS data file, "2010 Part D Top 100 Drugs by Total Fills for Non-LIS Beneficiaries and 2010 Part D Top 100 Drugs by Total Sales for Non-LIS Beneficiaries," February 2012, available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/ProgramReports.html.

Drug indications: Crestor 10 mg tablets (high cholesterol); Evista 60 mg tablets (osteoporosis); Novolog inj 100/ml (diabetes); Namenda 10 mg tablets (dementia); Spiriva Handihaler (chronic obstructive pulmonary disease); Enbrel 25 mg inj (rheumatoid arthritis/psoriasis).

Appendix B

2014 Plan Coverage, Out-of-Pocket Costs, and Utilization Management Tools for Five Popular Generic Drugs among Medicare Part D Plans with Highest Enrollment[1]

Prescription Drug Plan	Monthly Out-of-Pocket Costs and Utilization Management (UM)									
	amlodipine besylate 5 mg		atorvastatin calcium 10 mg		levothyroxine sodium 100 mcg		lisinopril 10 mg		omeprazole 20 mg	
	$	UM	$	UM	$	UM	$	UM	$	UM
AARP MedicareRx Preferred	$1.56		$3.78		$4.80		$1.59		$4.04	
AARP MedicareRx Saver Plus	$1.00		$2.00		$2.00		$1.00		$2.00	
Aetna CVS/Pharmacy PDP	$2.00		$2.00		$2.00		$1.00		$2.00	√
CIGNA Medicare Rx Secure	$0.00	√	$0.00	√	$0.00		$0.00		$9.00	√
First Health Part D Essentials	$1.00		$1.00	√	$1.00		$1.00		$1.76	
First Health Part D Value Plus	$3.00		$11.00	√	$3.00		$3.00		$3.00	
Humana Enhanced	$2.00		$5.00	√	$2.00		$2.00		$5.00	√
Humana Preferred Rx	$2.00		$2.00	√	$1.00		$0.01		$2.00	√
WellCare Classic	$0.00		$0.00	√	$0.00		$0.00		$0.00	

Note: All data are for 2014. Florida (ZIP code 33313) was used as a constant. Out-of-pocket costs are based on enrollee costs during the initial coverage period and based on purchase at a preferred pharmacy; costs at a nonpreferred pharmacy would be higher. Popular plan Silverscript Basic is currently under enrollment sanctions and has been excluded from this analysis. Common utilization management tools include: quantity limits (plan limits the quantity of drugs that are covered over a certain period of time); prior authorization (prescriber must verify that the prescribed drug is medically necessary before the plan will provide coverage); and step therapy (patient must first try one or more drugs before the originally prescribed drug will be covered).

[1] Avalere Health, "Avalere Analysis Reveals First Drop in Medicare Advantage Offerings Since 2011," Press Release, September 23, 2013.

Source: AARP Public Policy Institute analysis using the Medicare Plan Finder, October 15, 2013. Popular prescription drugs were drawn from CMS data file, "2010 Part D Top 100 Drugs by Total Fills for Non-LIS Beneficiaries and 2010 Part D Top 100 Drugs by Total Sales for Non-LIS Beneficiaries," February 2012, available at http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/ProgramReports.html.

Drug indications: amlodipine besylate 2.5 mg tablets (high blood pressure/angina); atorvastatin calcium 10 mg tablets (high cholesterol); levothyroxine sodium 100 mcg tablets (hypothyroidism); lisinopril 10 mg tablets (high blood pressure); omeprazole 20 mg capsules (acid reflux).

Endnotes

[1] J. Hoadley, J. Cubanski, E. Hargrave, and L. Summer, *Medicare Part D: A First Look at Plan Offerings in 2014* (Menlo Park, CA: Kaiser Family Foundation, October 2013).

[2] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), "Medicare Drug Premiums Remain Stable Four Years in a Row," Press Release, July 30, 2013, http://www.cms.hhs.gov/apps/media/press_releases.asp.

[3] The Affordable Care Act phases out the coverage gap by 2020 through a series of escalating discounts.

[4] Avalere Health, "Avalere Analysis Reveals First Drop in Medicare Advantage Offerings Since 2011," Press Release, September 23, 2013. Popular plan Silverscript Basic is currently under enrollment sanctions and has been excluded from this analysis.

[5] Because premiums vary by state (even among national plans), Florida (ZIP code 33313) was used as a constant. Each plan's (1) monthly premium, (2) annual deductible (if applicable), (3) offering of any coverage in the doughnut hole, and (4) associated copayment or coinsurance level was determined using information provided on each organization's website.

[6] Higher-income Part D enrollees pay a larger share of their Medicare Part D plan premium, increasing their monthly costs by $12.10 to $69.30 (CMS, Office of the Actuary, "Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Related Information," July 30, 2013). Similar to Medicare Part B, "higher-income" is defined as enrollees with incomes of more than $85,000 for an individual and $170,000 for a married couple. These income limits are frozen until 2020, meaning a larger percentage of Medicare beneficiaries will be paying higher premiums over time.

[7] L. Purvis and N. L. Rucker, "Open Enrollment 2013: Medicare Part D Benefits Improve but Premiums and Cost-Sharing Rise in Many Popular Plans" (Washington, DC: AARP Public Policy Institute, November 2012).

[8] MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 15: Status Report on Part D* (Washington, DC: MedPAC, March 2013).

[9] CMS, *Prescription Drug Benefit Manual, Chapter 7 – Medication Therapy Management and Quality Improvement Program* (Rev. 11, 02-19-10).

[10] Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits 2013: Annual Survey" (Washington, DC: Kaiser Family Foundation, August 2013).

[11] S. Suzuki, "Medicare Part D's Competitive Design: Do Part D Enrollees Switch Plans?" MedPAC, Presentation at AcademyHealth Annual Research Meeting, June 23, 2013.

[12] CMS, "Part D Gap Discounts through June 30, 2013 for Benefit Year 2012," June 2013, http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/ProgramReports.html.

[13] In 2013, non-LIS Part D enrollees received a 52.5 percent discount on their brand-name and biologic prescription drugs and a 21 percent discount on their generic prescription drugs while they were in the coverage gap.

[14] AARP PPI calculation based on 2014 prescription drug plan data released by CMS on September 17, 2013.

[15] MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 15: Status Report on Part D* (Washington, DC: MedPAC, March 2013).

[16] J. Hoadley, J. Cubanski, E. Hargrave, and L. Summer, *Medicare Part D: A First Look at Plan Offerings in 2014* (Menlo Park, CA: Kaiser Family Foundation, October 2013).

[17] MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 13: Status Report on Part D* (Washington, DC: MedPAC, March 2012).

[18] AARP PPI calculation based on 2014 prescription drug plan data released by CMS on September 17, 2013.

[19] J. Abaluck and J. Gruber, *Choice Inconsistencies among the Elderly: Evidence from Plan Choice in the Medicare Part D Program*¸ National Bureau of Economic Research Working Paper Series (Cambridge, MA: National Bureau of Economic Research, February 2009).

[20] S. Suzuki, "Medicare Part D's Competitive Design: Do Part D Enrollees Switch Plans?" MedPAC, Presentation at AcademyHealth Annual Research Meeting, June 23, 2013.

[21] MedPAC, *Report to the Congress: Medicare Payment Policy, Chapter 15: Status Report on Part D* (Washington, DC: MedPAC, March 2013).

[22] J. Hoadley et al., *To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans to Save Money?* (Menlo Park, CA: Kaiser Family Foundation, October 2013).

[23] K. M. Marzilli Ericson, *Consumer Inertia and Firm Pricing in the Medicare Part D Prescription Drug Insurance Exchange*, National Bureau of Economic Research Working Paper Series (Cambridge, MA: National Bureau of Economic Research, September 2012).

[24] C. Zhou and Y. Zhang, "The Vast Majority of Medicare Part D Beneficiaries Still Don't Choose the Cheapest Plans That Meet Their Medication Needs," *Health Affairs 31*(10) (2012): pp. 2266–75; F. Heiss, A. Leive, D. McFadden, and J. Winter, *Plan Selection in Medicare Part D: Evidence from Administrative Data*, National Bureau of Economic Research Working Paper Series (Cambridge, MA: National Bureau of Economic Research, June 2012); R. A. Patel et al., "Cost Minimization of Medicare Part D Prescription Drug Plan Expenditures," *The American Journal of Managed Care 15*(8) (2009): pp. 545–53; J. Gruber, *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?* (Menlo Park, CA: Kaiser Family Foundation, March 2009).

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