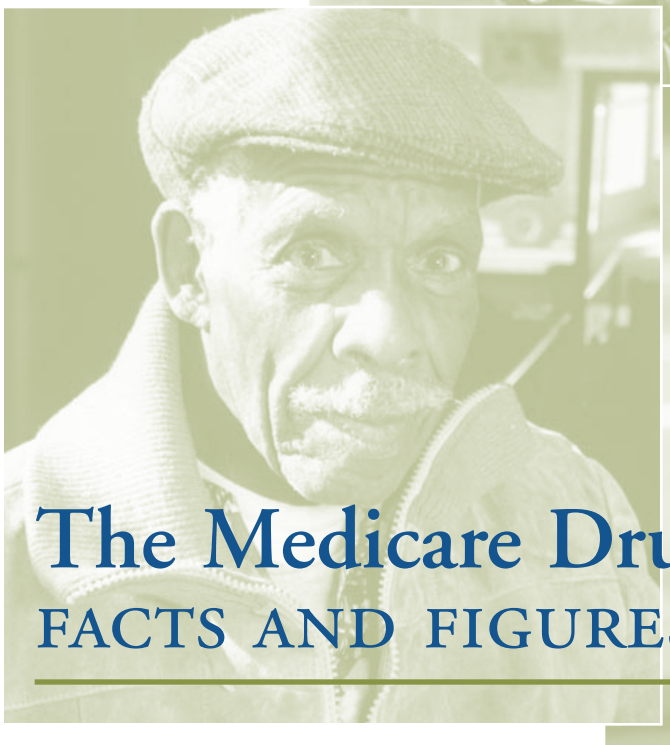

The Medicare Drug Benefit in California

FACTS AND FIGURES

November 2008

California HealthCare Foundation

Introduction

The Medicare drug benefit continues to evolve as it enters its fourth year. This chartbook provides an updated snapshot of the Medicare Part D market in California, including an early look at 2009 plan options. It shows how plan availability, enrollment, premiums, cost sharing, and coverage for beneficiaries have changed in recent years.

The majority of Medicare beneficiaries in California have drug coverage through Part D or other sources. However, there are still more than half a million Medicare beneficiaries in California with no known drug coverage, and many beneficiaries who are eligible for the low-income subsidy (LIS) are not enrolled in this benefit.

For 2009, Medicare beneficiaries in California continue to have a wide range of plan options that varies by their particular county of residence. While the overall number of plan choices in California did not change substantially from the prior year, low-income beneficiaries will have fewer plan options in which their premiums will be fully subsidized.

Premiums for many Part D plans will increase sharply in 2009. Most Medicare beneficiaries in California's stand-alone prescription drug plans (PDPs) will likely see a monthly increase of more than five dollars if they remain in the same plan, while most beneficiaries enrolled in California's Medicare Advantage Prescription Drug (MA-PD) plans will see no change in premiums. In addition, benefit design—including cost sharing, coverage for brand-name and generic drugs, and coverage in the "doughnut hole" gap—now varies substantially among participating plans. For these reasons, beneficiaries and their advocates should carefully evaluate their 2009 plan options to ensure they choose the coverage that best meets their needs.

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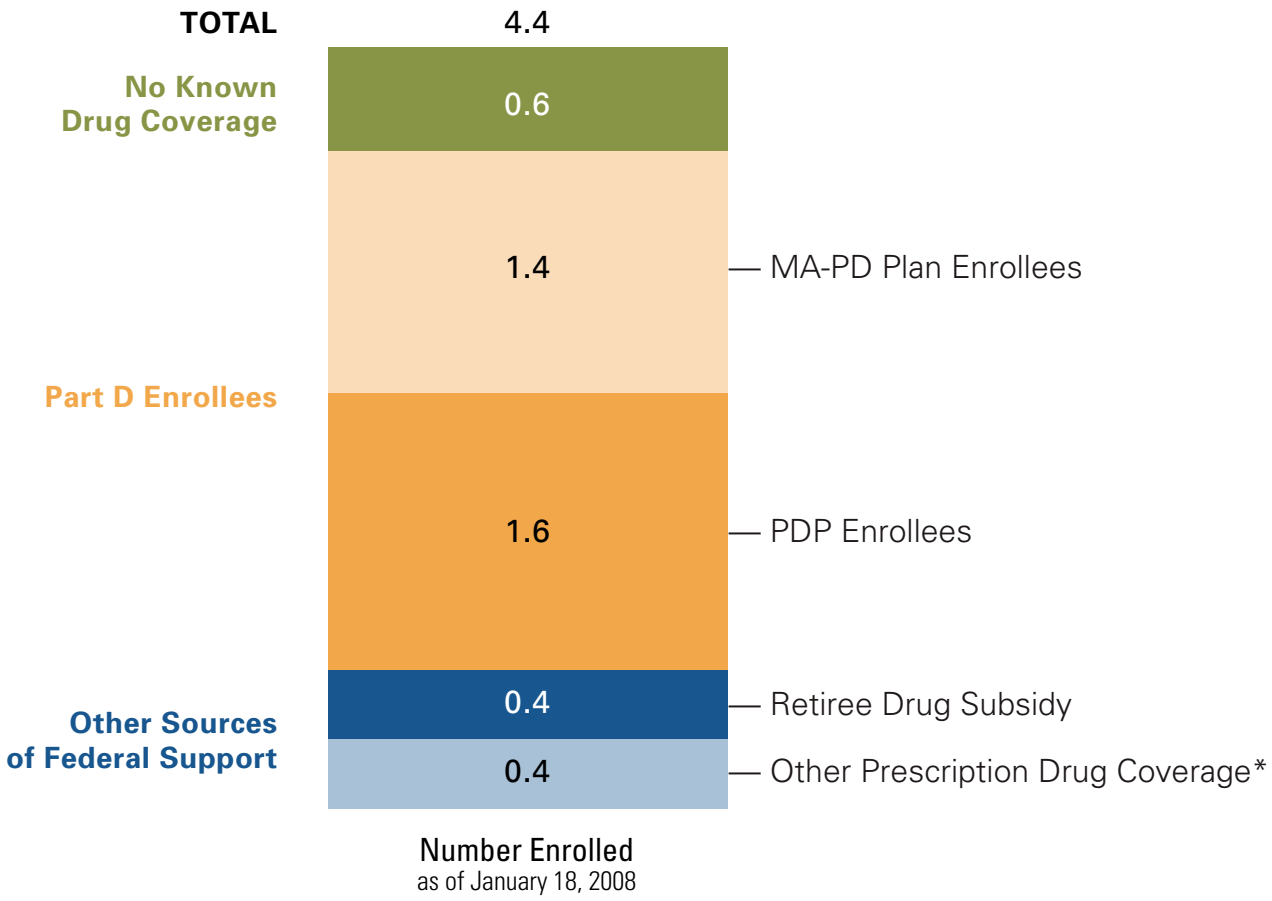
Drug Coverage, by Source and Plan Type

California's Medicare Beneficiaries (in millions)

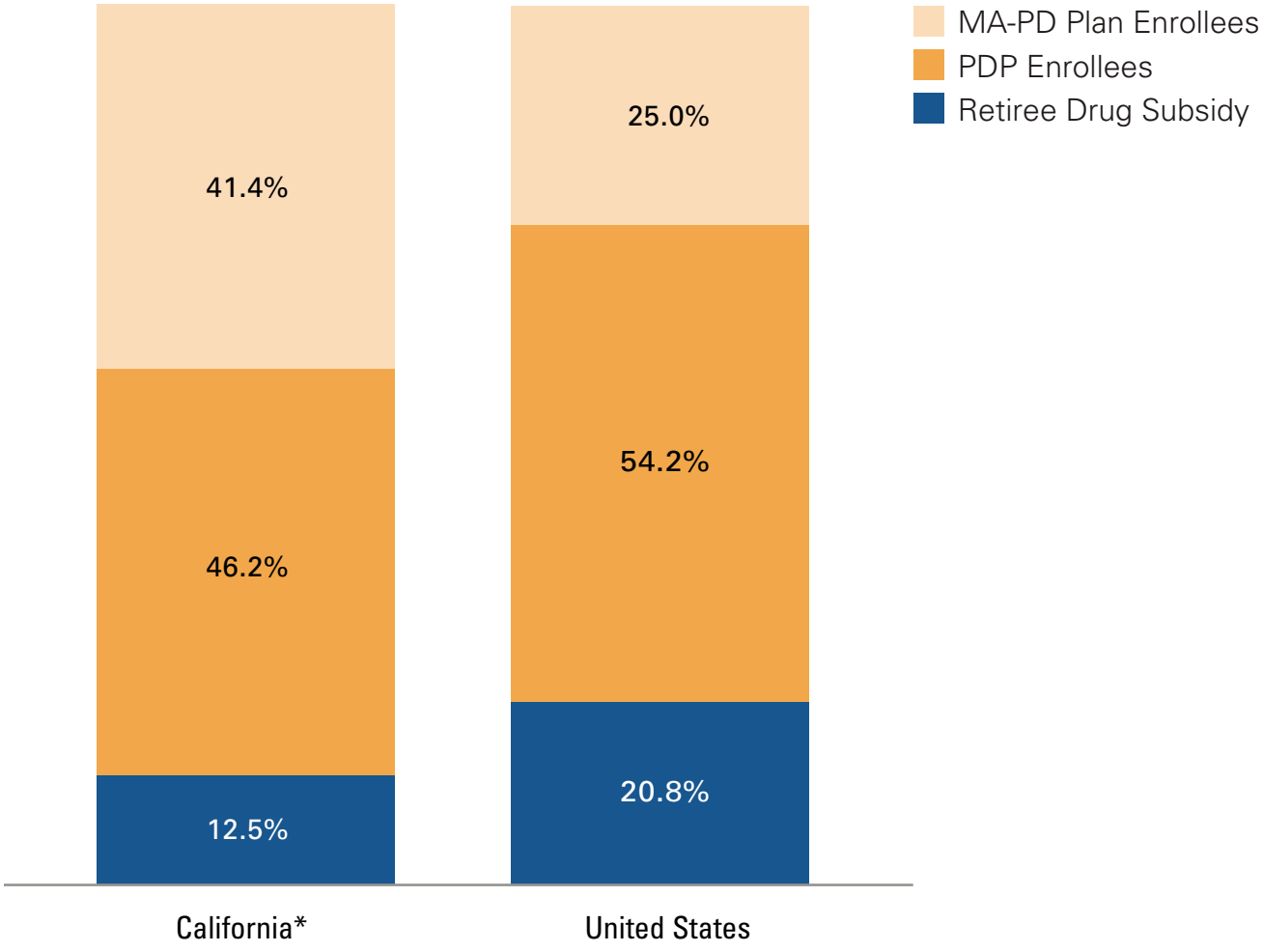


Of California's 4.4 million Medicare beneficiaries, 68 percent are enrolled in Part D, 19 percent have drug coverage from other sources, and 13 percent have no known drug coverage.

*Includes health care programs that provide health insurance to military retirees (TRICARE), federal civilian retirees (FEHB), veterans (VA), and active workers.

Source: Avalere Health analysis of Centers for Medicare and Medicaid Services (CMS) annual enrollment report released January 2008.

Share of Part D Enrollment, by Type,
California vs. United States

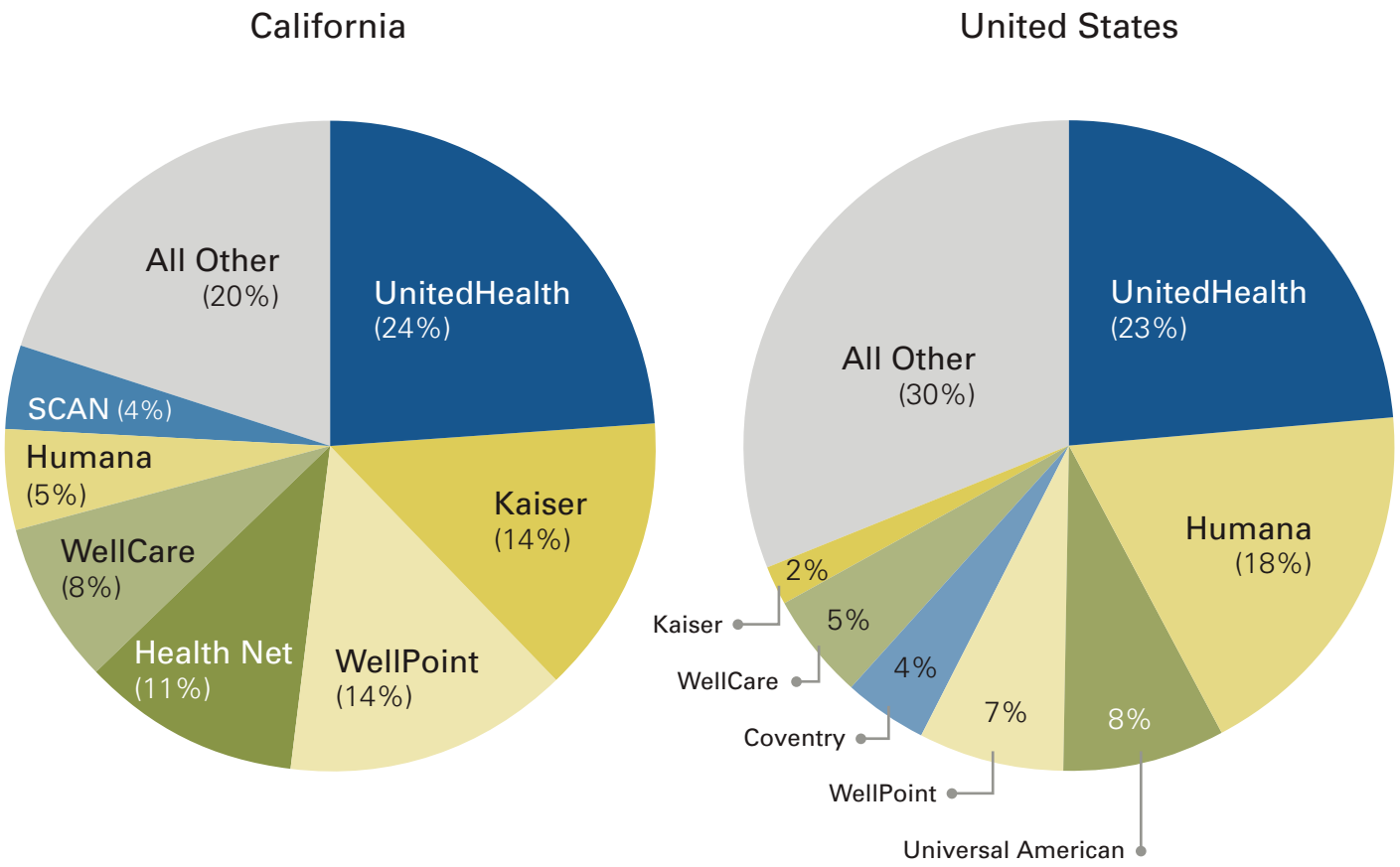


*Totals do not add up to 100 percent due to rounding.

Source: Avalere Health analysis of CMS enrollment data released January 2008. U.S. totals include residents of U.S. territories and beneficiaries whose address information is being updated.

Compared with the national average, a greater share of Part D beneficiaries in California have enrolled in MA-PD plans and a smaller share are enrolled in either PDPs or employer plans receiving the Retiree Drug Subsidy.

Share of Enrollment,* by Plan Sponsor,
California vs. United States



*Includes PDP and MA-PD plan enrollees, with enrollment combined by plan sponsor. Excludes people in employer/union group plans and county-level plan enrollment if the Part D plan has fewer than ten enrollees in a given county.

Source: Avalere Health analysis of CMS enrollment data released in September 2008, reflecting enrollment in August 2008.

Medicare Part D
Plan Availability / Enrollment

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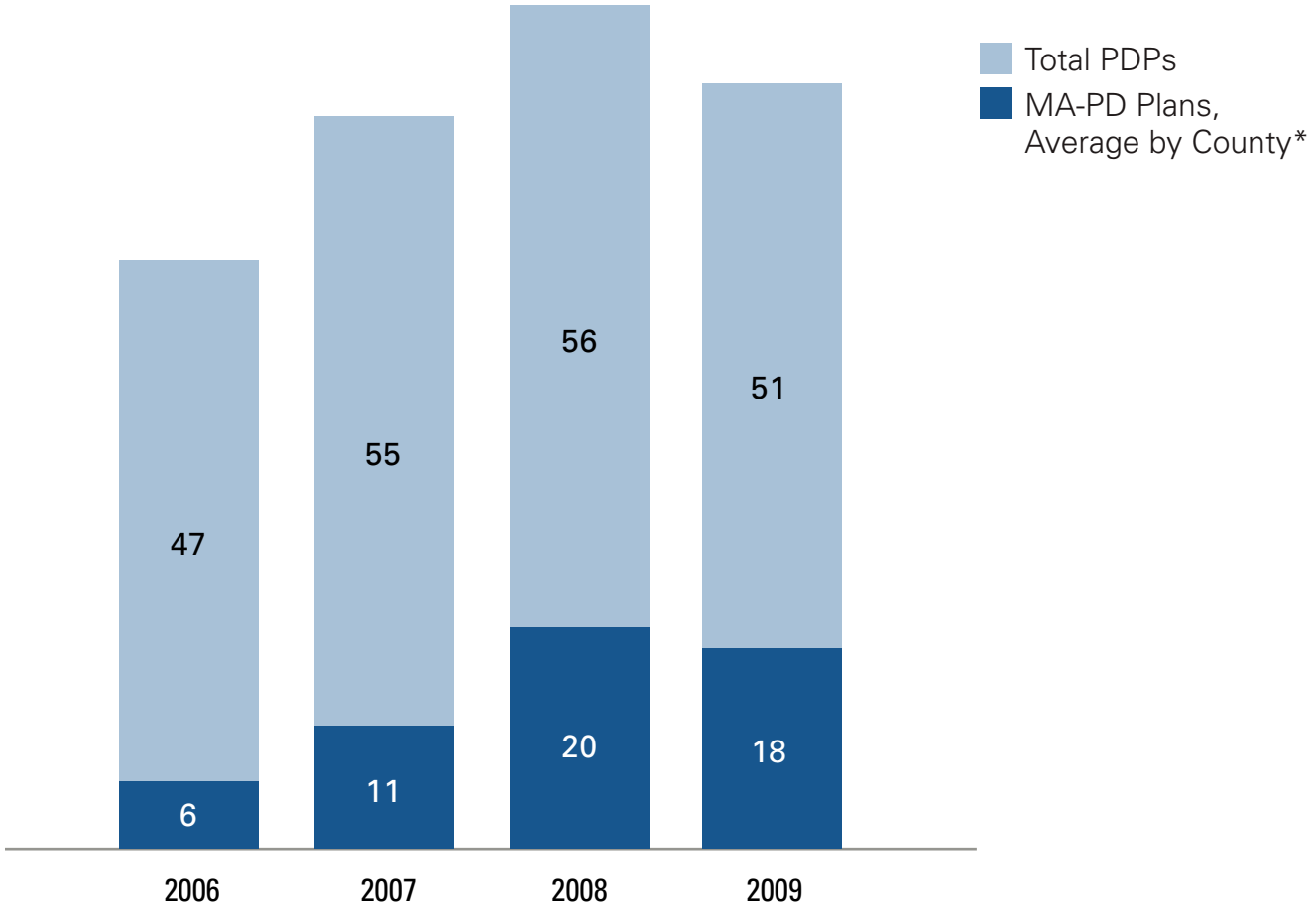
In California, United HealthCare and Kaiser Permanente are the largest Part D sponsors. Nationally, United HealthCare and Humana have the largest share of Part D enrollees.

Availability of Part D Plans

Total Number of Plans Participating in California, 2006–2009



*A total of 51 PDPs and 180 MA-PD plans will be offered in California in 2009. However, MA-PD plans do not serve the entire state, so the average number of plans available in each county is shown here. Excludes Special Needs Plans (SNPs) and MA-PD plans serving only select areas of a county.

Source: Avalere Health analysis of CMS data released November 2005, October 2006, September 2007, and September 2008.

Medicare beneficiaries in California will have many plans from which to choose; however, the number of participating plans will decrease slightly in 2009 following two years in which the number of plans increased. The total number of PDPs and MA-PD plans available in 2009 ranges from 60 in Lassen County to 113 in Los Angeles County.

Part D Monthly Plan Premiums,
California and the United States, 2008–2009

PLAN TYPE	AVERAGE 2008	AVERAGE 2009	AVERAGE CHANGE	ENROLLMENT-WEIGHTED AVERAGE* 2008	ENROLLMENT-WEIGHTED AVERAGE* 2009	ENROLLMENT-WEIGHTED AVERAGE* CHANGE
CALIFORNIA						
PDPs	$37.65	$46.86	24%	$24.50	$33.02	35%
MA-PDs†	$35.87	$44.16	23%	$29.37	$27.31	–7%
UNITED STATES						
PDPs	$40.02	$45.45	14%	$29.89	$37.10	24%
MA-PDs†	$47.38	$51.81	9%	$36.74	$41.43	13%

*Based on enrollment data released in September 2008 reflecting enrollment in August 2008, matched to 2008 and 2009 offerings. Does not include U.S. territories.

†Does not include Special Needs Plans (SNPs). Includes consolidated Parts C and D premium.

Source: Avalere Health analysis of CMS data released October 2007 and September 2008.

In California, the enrollment-weighted average premium will increase 35 percent for PDPs and decrease 7 percent for MA-PD plans. Nationally, enrollment-weighted average premiums will increase for both PDPs and MA-PDs.

Part D Premium Changes
California, 2008–2009*

CHANGE	PERCENT OF ENROLLEES PDPS	MA-PD PLANS†
DECREASE		
$5 or more	0.1%	19.0%
Less than $5	2.0%	8.0%
No Change	0.0%	67.0%
INCREASE		
Up to $5	17.0%	0.5%
$5.01 to $10	49.0%	0.3%
$10.01 to $20	31.0%	1.0%
More than $20	1.0%	4.0%

*Assuming enrollees remain in the same Part D plan as 2008.

†Does not include Special Needs Plans (SNPs) or employer/union group plans.

Source: Avalere Health analysis of CMS data released September 2008. Enrollment based on CMS data released in September 2008 reflecting enrollment in August 2008, matched to 2008 and 2009 offerings.

Over 80 percent of California PDP enrollees will see their monthly premiums increase by more than $5 if they remain in their same plan. Most MA-PD plan enrollees will see no change to their premium.

Premiums for Top 10 Plans
California, 2008–2009

PLAN NAME	PDP/ MA-PD	2008 ENROLLMENT	MONTHLY PREMIUM* 2008	MONTHLY PREMIUM* 2009	CHANGE IN PREMIUM (2008–2009) AMOUNT	CHANGE IN PREMIUM (2008–2009) PERCENT
Health Net Orange Option 1	PDP	177,442	$16.70	$24.00	$7.30	44%
WellCare Classic	PDP	169,245	$19.00	$24.00	$5.00	26%
AARP MedicareRx Preferred	PDP	164,304	$28.60	$34.40	$5.80	20%
AARP MedicareRx Saver	PDP	148,004	$21.00	$33.50	$12.50	60%
Blue Cross MedicareRx Value	PDP	115,853	$17.60	$28.90	$11.30	64%
Kaiser Permanente Senior Advantage†	MA-PD	95,088	$0.00	$0.00	$0.00	0%
Advantage Star Plan by RxAmerica	PDP	74,587	$14.70	$19.80	$5.10	35%
Blue Cross MedicareRx Gold	PDP	68,077	$59.00	$65.40	$6.40	11%
Humana PDP Standard S5884-090	PDP	66,331	$23.00	$40.90	$17.90	78%
Kaiser Permanente Senior Advantage‡	MA-PD	63,058	$74.00	$60.00	–$14.00	–19%

*MA-PD plan premium is consolidated C+D premium.

†Plan is available in Los Angeles and Orange counties.

‡Plan is available in San Joaquin, Santa Clara, Solano, and Stanislaus counties.

Source: Avalere Health analysis of CMS data released September 2008. Enrollment based on CMS data released in September 2008 reflecting enrollment in August 2008.

The ten largest Part D plans in California raised monthly premiums by an average of 21 percent from 2008 to 2009, but there are big differences among these plans in both premium levels and premium changes for 2009.

Deductibles and Coverage Gap Structure*
California, 2008–2009

PLAN TYPE	$0 DEDUCTIBLE		COVERAGE IN THE GAP FOR... ANY DRUGS		BRAND-NAME DRUGS	
	2008	2009	2008	2009	2008	2009
PDPs	59%	57%	27%	24%	0%	0%
MA-PD Plans†	89%	96%	43%	48%	9%	11%

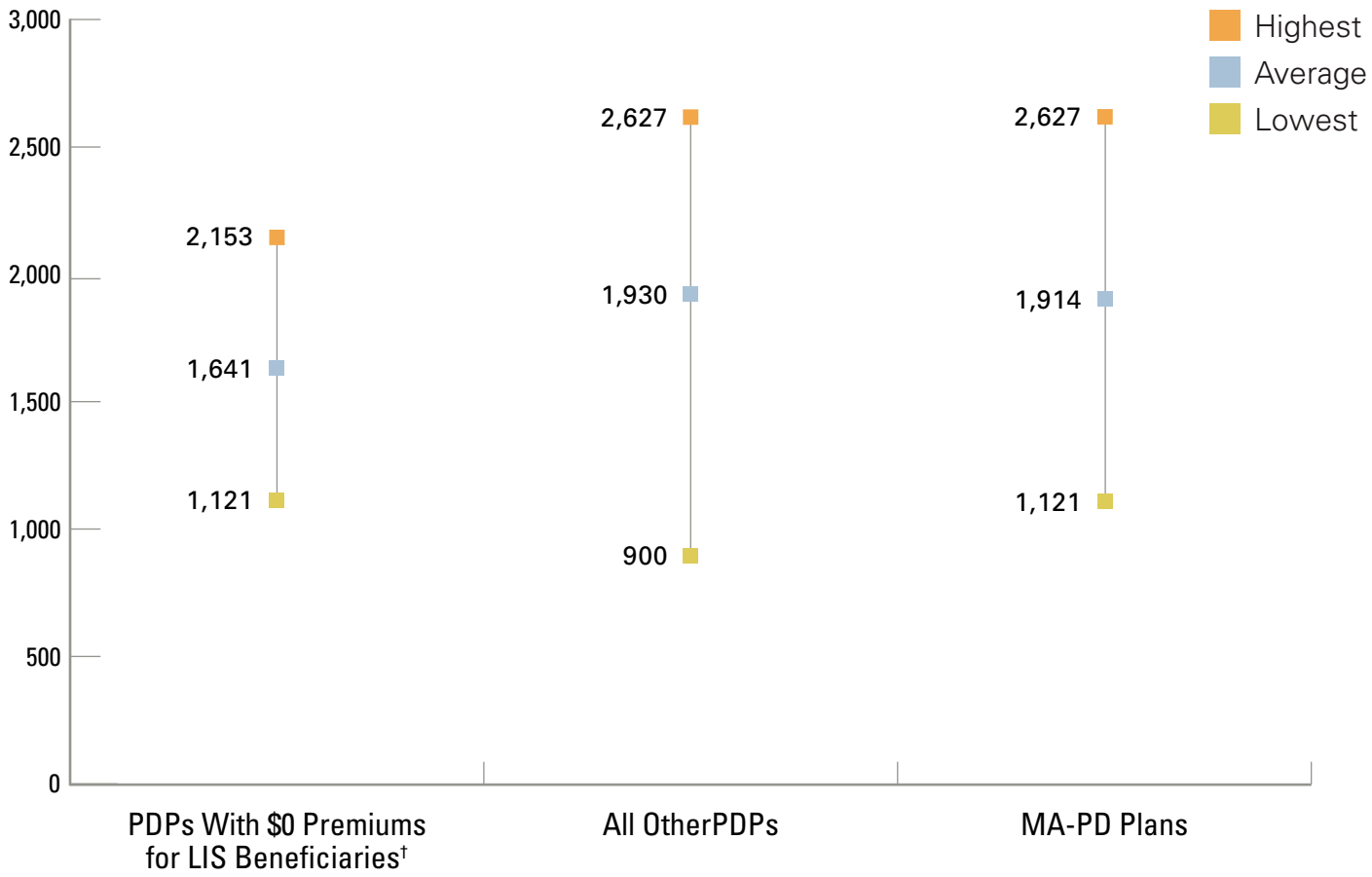
*In 2009, beneficiaries with standard Part D coverage must pay 100 percent of their drug costs between $2,700 and $6,153.75 in total drug spending. This period is often referred to as the "doughnut hole" or "coverage gap." Plans have the option of enhancing their benefit packages in order to provide coverage during this gap.

†Does not include Special Needs Plans (SNPs) or employer/union group plans.

Source: Avalere analysis of CMS data released September 2007 and September 2008.

In 2009, the frequency of both drug coverage in the gap and $0 deductibles decreased slightly among PDP plans and increased slightly among MA-PD plans.

Number of Drugs Covered, by Plan
California, 2008*



*Formulary information for 2009 was not released in time to conduct an analysis for this publication.

†Plans in which beneficiaries receiving the full low-income subsidy (LIS) do not pay a premium. Count of 2008 plans includes "de minimis" plans—plans with premiums within $1 of the LIS benchmark premium. De minimis plans were eligible to retain LIS-eligible beneficiaries, but did not receive new beneficiaries through CMS' auto-enrollment process. CMS discontinued its de minimis policy for 2009.

Source: Avalere analysis of CMS data released November 2007.

The number of drugs covered within each plan type varied widely in 2008.

Benefit Designs of Top 10 PDPs
California, 2008*

PLAN NAME	PART D PREMIUM	NUMBER OF TIERS†	NUMBER OF DRUGS COVERED		
			ALL	BRAND NAME	GENERIC
Blue Cross MedicareRx Gold	$59.00	5	2,558	1,618	940
AARP Medicare Rx Preferred	$28.60	4	2,627	1,683	944
Humana PDP Standard S5884-090	$23.00	4	2,623	1,682	941
AARP Medicare Rx Saver	$21.00	4	2,184	1,246	938
First Health Part D-Premier	$19.60	4	1,592	853	739
WellCare Classic	$19.00	4	1,121	541	580
MedicareRx Rewards Value‡	$18.20	5	1,818	903	915
Blue Cross MedicareRx Value	$17.60	5	1,829	914	915
Health Net Orange Option 1	$16.70	4	2,153	1,285	868
Advantage Star Plan by RxAmerica	$14.70	4	1,370	748	622

*Formulary information for 2009 was not released in time to conduct an analysis for this publication.

†Many plans require different cost sharing based on whether a drug is a brand name or generic, preferred or non-preferred; each level of cost sharing is known as a tier.

‡MedicareRx Rewards Value will not operate in California in 2009.

Source: Avalere Health analysis of CMS enrollment data released September 2008, reflecting enrollment as of August 2008; formulary data released May 2007 and November 2007.

Plan benefit design changes from year to year. Among the ten PDPs with the highest enrollment in California for 2008, those with higher premiums tended to cover more brand-name drugs and more drugs overall than those with lower premiums.

Low-Income Beneficiary Tiered Subsidy Levels, January, 2009

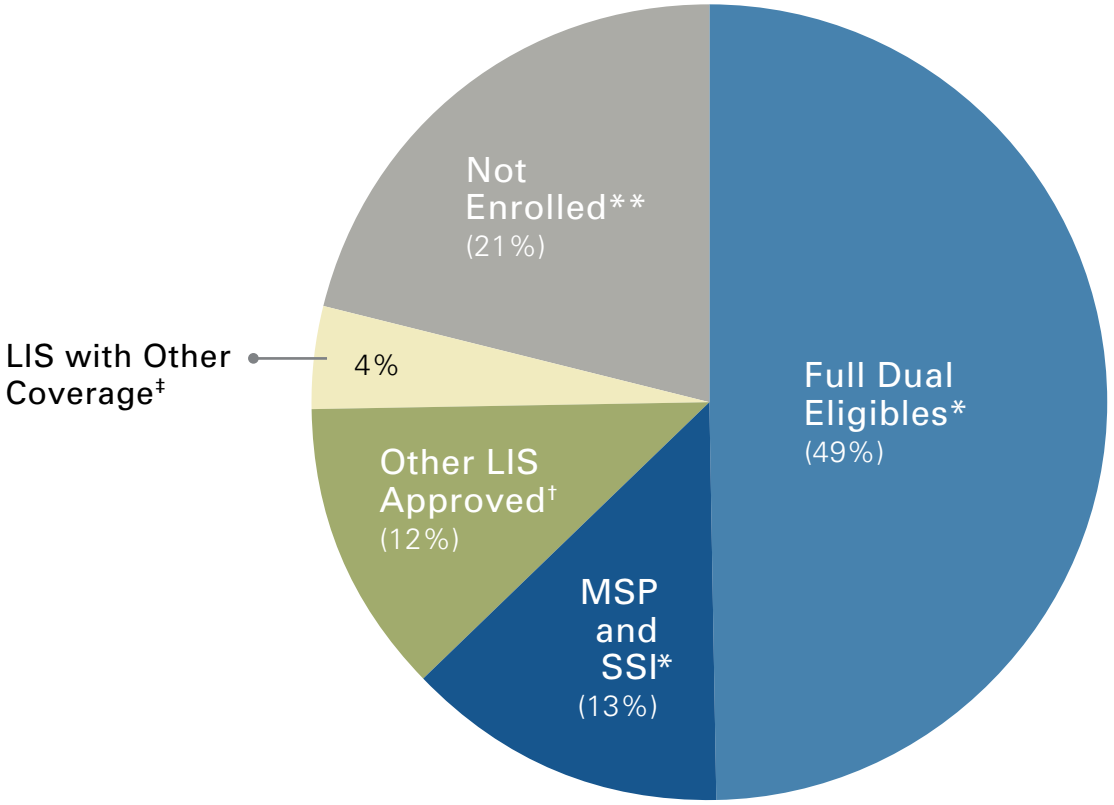
	PREMIUM	DEDUCTIBLE	DRUG CO-PAYS	COVERAGE GAP
Income up to 100% of the federal poverty level (FPL) and a dual eligible	None	None	$1.10 generic/ $3.20 brand; none after $6,153.75	None
Those eligible for Medicare Savings Programs and individuals with incomes up to 135% FPL and assets of less than $6,290 (individual) or $9,440 (couple)*	None	None	$2.40 generic/ $6.00 brand; none after $6,153.75	None
Income from 135 to 150% FPL and assets of less from $10,490 (individual) or $20,970 (couple)*	Sliding Scale	$60	15%	None
Over 150 percent FPL	Varies by PDP	$295	25%	Yes (between $2,700 and $6,153.75)

*Asset limits for 2008; 2009 limits have not been released. CMS exempts up to $1,500 per person for savings for burial expenses. The asset limits listed here do not include this exemption.

Source: CMS Release, "Announcement of Calendar Year (CY) 2009 Medicare Advantage Capitation Rates and Medicare Advantage and Part D Payment Policies." April 7, 2008.

As of January 2009, low-income beneficiaries face different cost-sharing levels based on their income and assets. Those who qualify for both Medicare and Medicaid (dual eligibles) and others below 150 percent of the federal poverty level continue to be eligible for the low-income subsidy—provided they meet certain asset tests.

Enrollment in the Low-Income Subsidy, United States, 2008



*Individuals who are dual eligibles, recipients of the Medicare Savings Program, or Supplemental Security Income (SSI) recipients are automatically deemed eligible for the LIS.

†Individuals who were not automatically "deemed" eligible for the LIS, but applied and were approved for the subsidy.

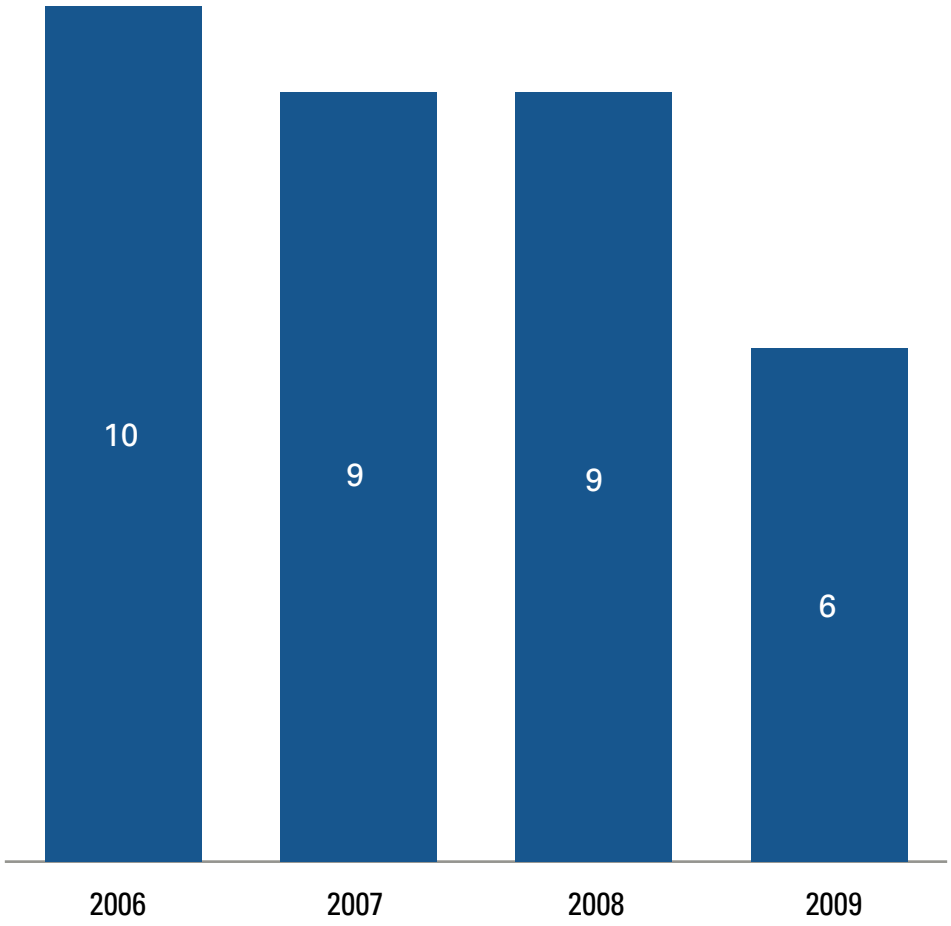
‡Other includes Veterans Affairs (VA), Indian Health Service, and those with drug coverage from a former employer (RDS).

**Not Enrolled includes anticipated facilitated enrollments and unenrolled LIS-eligible beneficiaries.

Source: Avalere Health analysis of CMS annual enrollment report released January 2008.

The Medicare Part D Low-Income Subsidy (LIS) offers low-cost prescription drug coverage for low-income beneficiaries. In 2008, 2.6 million beneficiaries, or just over one-fifth of those eligible for this benefit nationally, were not enrolled in the LIS.

Number of PDPs with $0 Premiums for LIS Beneficiaries,* California, 2006–2009

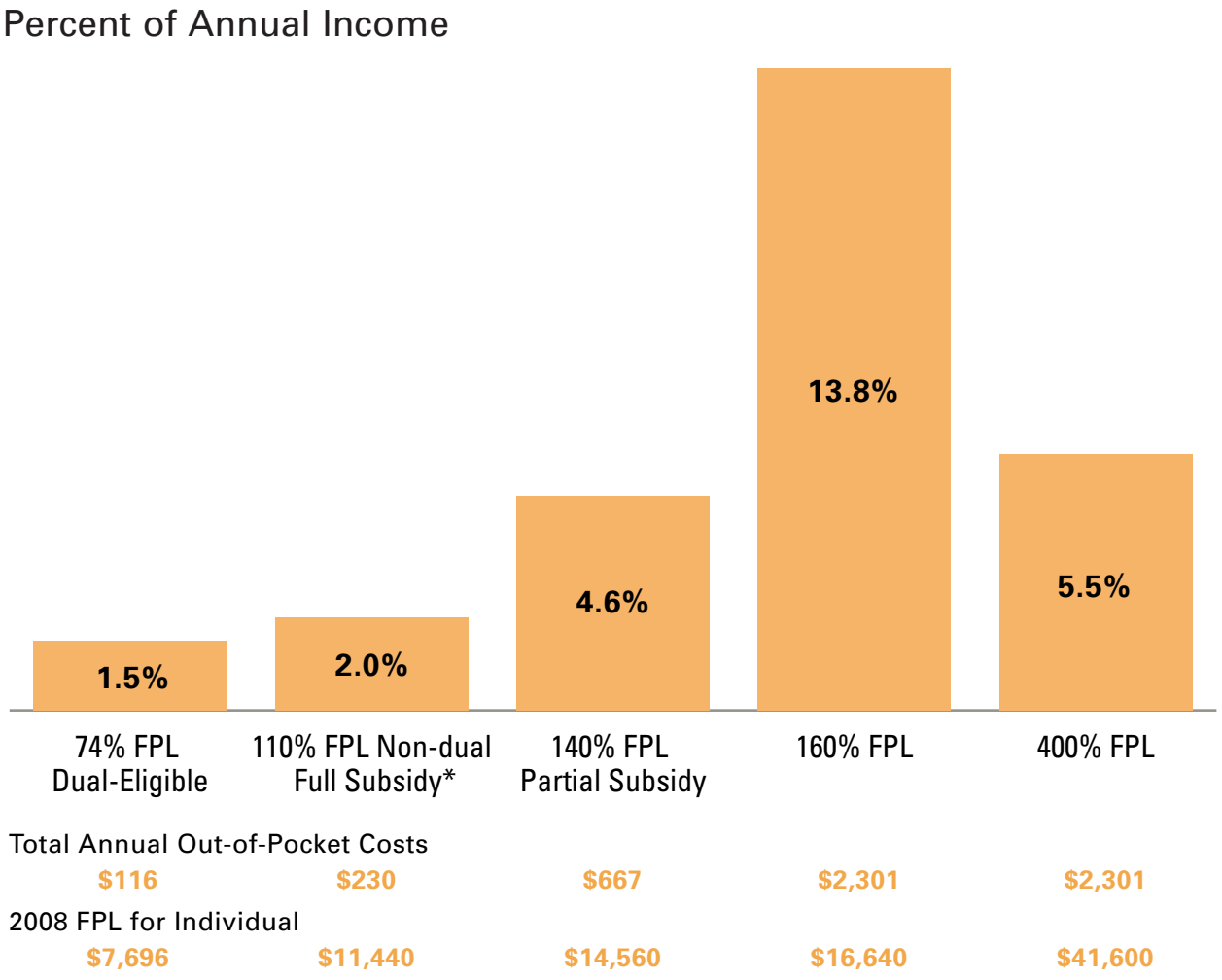


*Plans in which beneficiaries who receive the full LIS do not pay a premium. Count of 2008 plans includes "de minimis" plans, which were eligible to retain LIS-eligible beneficiaries but did not receive new beneficiaries through the CMS auto-enrollment process.

Source: Avalere Health analysis of CMS data released July 2006, October 2006, September 2007, and September 2008.

In 2009, dual eligibles and other LIS-eligible beneficiaries in California will have fewer choices of plans in which they will pay $0 premiums.

Cost Sharing, by Income Level



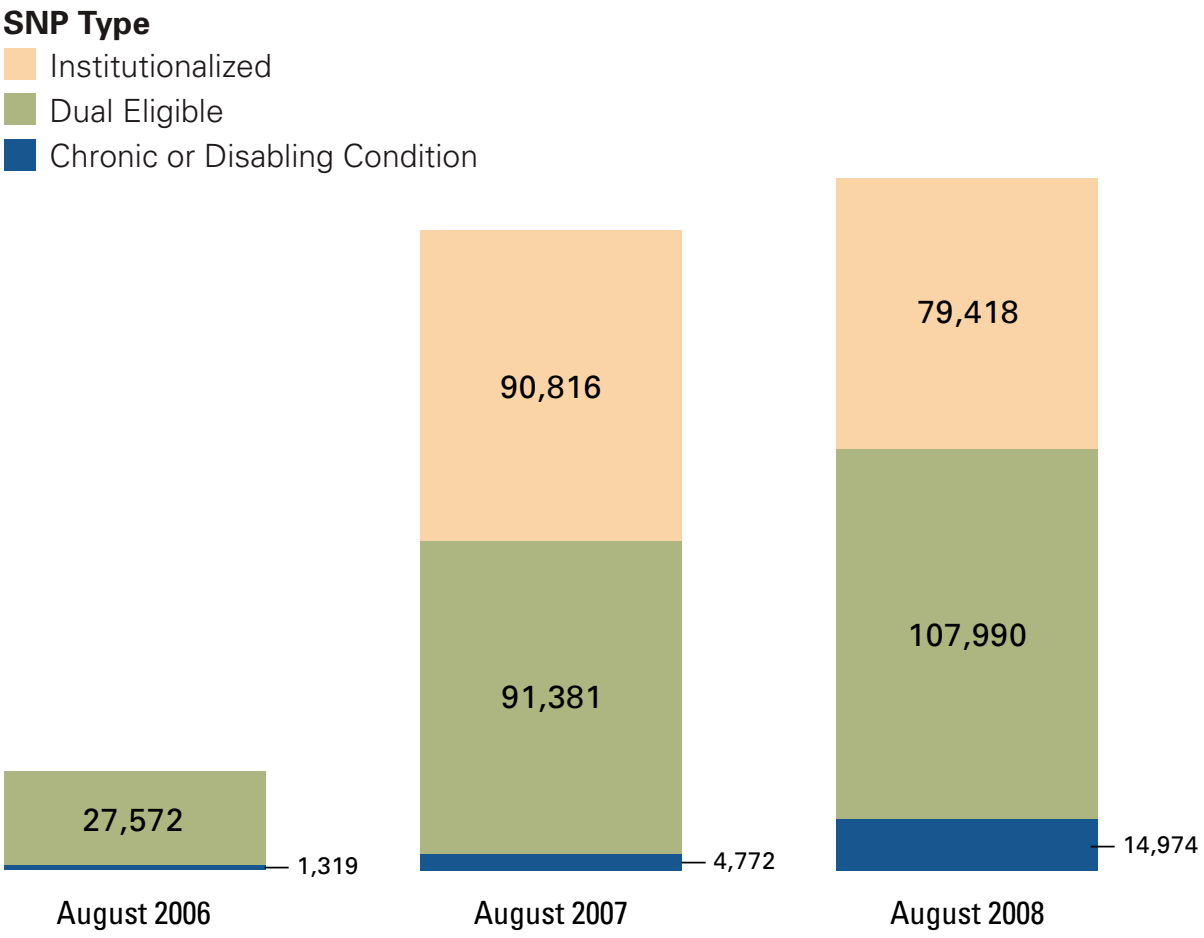
Note: Cost based on patient taking five medications (three generics and two brand drugs) and the average costs of these drugs. Beneficiary out-of-pocket costs include premiums. Predictions assume standard benefit design.

*Full Subsidy assumes the beneficiary meets the asset requirements.

Sources: Avalere estimates based on National Association of Chain Drug Stores, Industry Facts at a Glance. Available at www.nacds.org/wmspage.cfm?parm1=507.

Part D costs are most onerous for those low-income beneficiaries just above the LIS income limit.

Enrollment in Special Needs Plans
California, 2006–2008



Note: Beneficiaries may qualify for enrollment in more than one SNP.

Sources: Centers for Medicare and Medicaid Services, September 2006 and Special Needs Plans enrollment data released September 2007 and 2008.

Certain Medicare beneficiaries are eligible to enroll in Special Needs Plans (SNP), a type of managed care plan that tailors benefits to the needs of dual-eligible beneficiaries, insitutionalized beneficiaries, or beneficiaries with chronic conditions. In 2008, total enrollment in California's SNPs grew by 8 percent; however, the enrollment in institutionalized SNPs declined.

Issues for Consideration

FINDING	IMPLICATION
Most beneficiaries enrolled in PDPs will face a Part D premium increase of more than $5 if they remain in their current plans. Premiums for most beneficiaries enrolled in MA-PD plans will not change.	Beneficiaries should evaluate their current plan's 2009 premium in light of other changes to the benefits offered and compare their current plan with others to make appropriate plan choices.
Historically, there is wide variation in benefit structure and number of drugs covered among individual plans.	All beneficiaries should re-evaluate their plan options during the annual open enrollment period—from November 15 to December 31, 2008—to identify the plan with the combination of coverage and cost that best meets their needs.
Over one-fifth of low-income beneficiaries eligible for the low-income subsidy (LIS) are not enrolled in this benefit.	Policymakers, program officials, and other stakeholders should consider expanding outreach efforts, particularly to beneficiaries eligible for the low-income subsidy.
The number of plans available to California beneficiaries eligible for the LIS with $0 premium has dropped from ten in 2006 to six in 2009.	A significant number of CA's dual eligibles will be automatically reassigned to a new plan if they do not actively choose one. These beneficiaries and their advocates should carefully consider the drugs covered by each plan to find one that best meets their needs.
Those beneficiaries whose income or assets are just above the limits for the LIS are likely to face relatively high out-of-pocket costs for their prescriptions.	Policymakers and program officials should consider strategies to reduce the cost-sharing burden for these low-income beneficiaries.

Authors

This report was compiled by Avalere Health, LLC, a strategic advisory firm in Washington D.C. that specializes in health policy issues involving Medicare and Medicaid. Much of the analysis was completed using DataFrame®, Avalere Health's proprietary database of Medicare Part D plan features.

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