Kaiser "Spotlights" Medicare Part D Trends, 2006–2008

The Medicare Part D prescription drug plans (PDPs), which were created by the Medicare Modernization Act, are now in their third year. The Kaiser Foundation has developed a series of two-page data "spotlights" analyzing key aspects of PDPs available to beneficiaries in 2008 and examining relevant trends since their inception in 2006. Four spotlights are currently available—on premiums, the coverage gap (commonly referred to as the "doughnut hole"), benefit design, and specialty tiers.

As of July 2007 more than 24 million beneficiaries were enrolled in a Medicare Part D plan—17 million in stand-alone PDPs and seven million in Medicare Advantage drug plans, which do not charge a premium. The Kaiser spotlight on premiums examines amounts charged by the 1,824 stand-alone PDPs being offered nationwide in 2008. As in previous years, 2008 premiums range widely, from $9.80 to $107.50 per month. A central idea behind the structure of Part D is that participants will respond to marketplace changes to minimize out-of-pocket costs—typically by switching plans. However, 90% of enrollees did not switch plans between 2006 and 2007, according to data from the Centers for Medicare and Medicaid Services. The Kaiser analysis estimates that if enrollees remain in their current plans in 2008, the average monthly premium would increase from $27.39 in 2007 to $31.99—a 17% increase. Three-quarters of enrollees will face higher premiums in 2008 unless they switch to a lower-premium plan.

A key factor influencing premiums is whether the plan helps pay for drugs in the coverage gap, a period during which enrollees must pay the full cost of all medications after reaching an initial benefit limit ($3,216 in 2008) and until they qualify for catastrophic coverage. Under most plans, beneficiaries who are dually eligible for Medicare and Medicaid are not responsible for costs in the coverage gap. Roughly 70% of PDPs offer gap coverage, but in 2008 only one stand-alone plan will cover brand-name drugs in the gap. The rest provide gap coverage only for generics. From 2007 to 2008 the average premium for PDPs that provide gap coverage increased by 23%. Monthly premiums in these plans are about double those of PDPs with no gap coverage (in 2008 about $63 and $30, respectively). The Kaiser spotlight on premiums notes that although many beneficiaries are interested in plans that offer gap coverage, it is not clear whether the enhanced benefits, which cover only generic drugs, provide added value commensurate with the higher premiums.

The Kaiser spotlight on the coverage gap provides additional details. PDPs that offer gap coverage have relatively low enrollment (about 8% of all 2007 enrollees), and enrollment is not expected to increase significantly in 2008. About 1.5 million beneficiaries (6% of enrollees) reached the coverage gap in 2006, and the estimate for 2007 is three million.

The Kaiser spotlight on benefit design examines products offered by 15 organizations, representing 88% of all PDPs. In 2008, as in previous years, only about 10% offer the standard benefit defined by CMS: a $275 deductible, 25% coinsurance up to the $3,216 coverage gap, and catastrophic coverage. Most plans eliminate the deductible and charge flat dollar copayments rather than coinsurance. The copayments reflect three cost-sharing tiers—generic drugs, preferred brand-name drugs, and nonpreferred drugs. Since 2006 most plans have had the three-tier design—69% of plans in 2006 and 74% in 2008. Since 2006 average cost sharing has increased by 29%, or $15.95, for a 30-day supply of nonpreferred drugs and 11%, or $2.99, for preferred brand-name drugs. Cost sharing for generics has remained stable since 2006. These trends reflect stronger financial incentives to switch to generics. The Kaiser spotlight on benefit design notes that in 2007 Part D enrollees paid more, on average, for preferred and nonpreferred drugs than did people in employer-sponsored insurance plans—$29.36 compared with $25 for preferred brands and $63.61 compared with $43 for nonpreferred brands.

A key trend in benefit design is an increase in the number of plans with a fourth tier, or specialty tier—from 54% of plans in 2006 to 87% in 2008. Specialty tiers are for high-cost drugs—$600 or more per month in 2008. In general, if an enrollee can establish that a nonpreferred drug is medically necessary and no preferred drug would be as effective, the enrollee can pay the lower cost sharing that applies to the preferred drug. Enrollees do not have the right to ask for an exception if a drug is in the specialty tier. In 2007 PDPs with a specialty tier included 150 drugs on that tier, accounting for 12% of all covered drugs, according to the Kaiser spotlight, which notes that selection effects may drive nearly all plans to adopt specialty tiers and to assign more drugs to them.

The Kaiser spotlights are available at www.kff.org/medicare/med102507pkg.cfm.

MHA Report Links States' Mental Health Status and Access to Care

Among all 50 states and the District of Columbia, South Dakota has the lowest prevalence of depression and Utah has the highest, according to a new report by Mental Health America (MHA). Hawaii was the second healthiest state with respect to depression, and New Jersey ranked third. Joining Utah at the bottom of the rankings were West Virginia, ranked 50th, and Kentucky, ranked 49th. The 46-page report, *Ranking America's Mental Health: An Analysis of Depression Across the States,* presents find-

ings of statistically significant associations between several indicators of access to mental health care and depression levels and suicide rates.

The study found that, on average, states with more psychiatrists, psychologists, and social workers per capita had lower suicide rates. Rates of suicide and levels of depression were also significantly lower in states where a smaller proportion of residents reported that they could not obtain health care because of costs and where the percentage of residents reporting unmet mental health care needs was lower. Significant associations were also found for treatment utilization: the higher the percentage of the population receiving mental health treatment, the lower the suicide rate. In addition, suicide rates were lower and depression status better in states where the population had more years of education. States where a greater percentage of residents had health insurance had lower suicide rates. The study also found that in states with more generous mental health parity coverage a greater proportion of the population received mental health services.

The study, conducted for MHA by Thomson Healthcare in Washington, D.C., and supported through an unrestricted educational grant from Wyeth Pharmaceuticals, had two main purposes—to inaugurate the development of a public health surveillance system to monitor the mental health of Americans and to stimulate action by communities, public health professionals, federal and state policy makers, and others to reduce depression and suicide.

Four different measures of depression and mental health status were used to develop one composite measure of a state's level of depression. Data were from the National Household Survey on Drug Use and Health, conducted by the Substance Abuse and Mental Health Services Administration, and the Behavioral Risk Factor Surveillance System, conducted by the Centers for Disease Control and Prevention in conjunction with states. The four measures were the percentage of the adult population experiencing at least one major depressive episode in the past year, the percentage of adolescents experiencing at least one major depressive episode in the past year, the percentage of adults experiencing serious psychological distress, and the average number of days in the past 30 days in which individuals reported that their mental health was not good.

Rates of depression among the states varied from around 7% to more that 10%.

"Despite the fact that some states do better than others on rates of depression and suicide, no state can be satisfied with its current status," said David Shern, Ph.D., MHA president and chief executive officer. "These rates can be driven lower by encouraging state policies designed to improve coverage, end discriminatory practices in insurance, and assure that qualified mental health professionals are available to serve everyone in need."

The full report and ranking of the 50 states are available at www.mentalhealthamerica.net.

NEWS BRIEFS

SAMHSA awards funds to enhance transformation: Ten states and the commonwealth of Puerto Rico have received Transformation Transfer Initiative program funding awards from the Substance Abuse and Mental Health Services Administration (SAMHSA). The states selected are Alabama, Florida, Iowa, Illinois, Kentucky, Minnesota, North Carolina, North Dakota, Pennsylvania, and Tennessee. Each of the ten states and Puerto Rico will receive an award of up to $105,000 for one year. The Transformation Transfer Initiative supports new and expanded efforts to improve the capacity and effectiveness of mental health systems that foster recovery and meet the multiple needs of consumers. The initiative's pilot programs will implement several innovative approaches, including comprehensive peer support services for adults with serious mental illness and youths with serious emotional disturbances and enhanced juvenile forensic mental health services that allow judges to order involuntary examinations of youths in outpatient settings, such as community mental health centers, rather than in traditional inpatient settings, such as psychiatric wards. "The Transformation Transfer Initiative will build a wealth of experience in the steps it takes to improve mental health services for consumers and their families," said SAMHSA Administrator, Terry Cline, Ph.D. "The knowledge gained through these individual awards will be shared with other states and territories working to provide more coordinated and effective care."

AHRQ toolkit to enhance medication adherence: The Agency for Healthcare Research and Quality (AHRQ) has released 17 new toolkits designed to help physicians, nurses, hospital managers, patients, and others. The toolkits focus on an array of medical practices and settings. One of them, Improving Medication Adherence, is designed to help hospitals implement a multimodal educational intervention for patients about medications they receive during their stay so that they will remain adherent after they are discharged. The intervention, which draws on the theory of health behavior change, focuses on reducing 30-day hospital readmissions and improving patient satisfaction. Additional resources promote administrative support and staff training and the use of established quality improvement techniques. The toolkit includes classroom training materials, training CDs, and pocket and wallet-sized cards to promote health behavior change. The toolkits were developed through AHRQ's Partnerships in Implementing Patient Safety program. More information is available on the AHRQ Web site at www.ahrq.gov/qual/pips.