

# MEDICARE

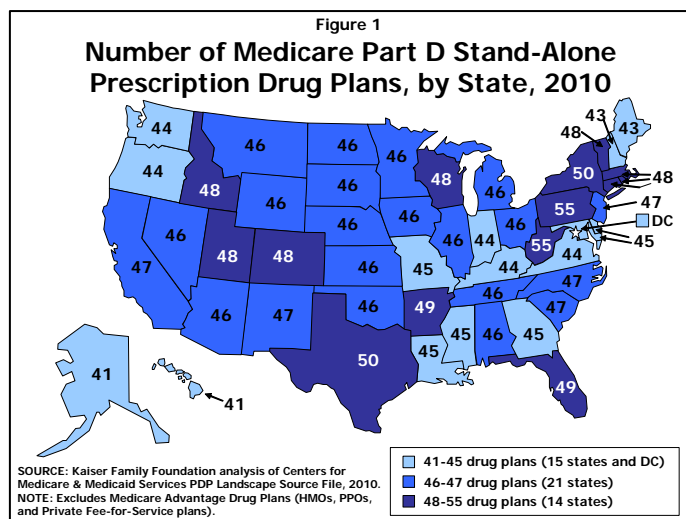
## THE MEDICARE PRESCRIPTION DRUG BENEFIT

November 2009

The Medicare Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for people on Medicare, known as Part D, that went into effect in 2006. All 46 million elderly and disabled beneficiaries have access to the Medicare drug benefit through private plans approved by the federal government. Medicare replaced Medicaid as the primary source of drug coverage for beneficiaries with coverage under both programs ("dual eligibles"). Beneficiaries with low incomes and modest assets are eligible for assistance with Part D plan premiums and cost sharing.

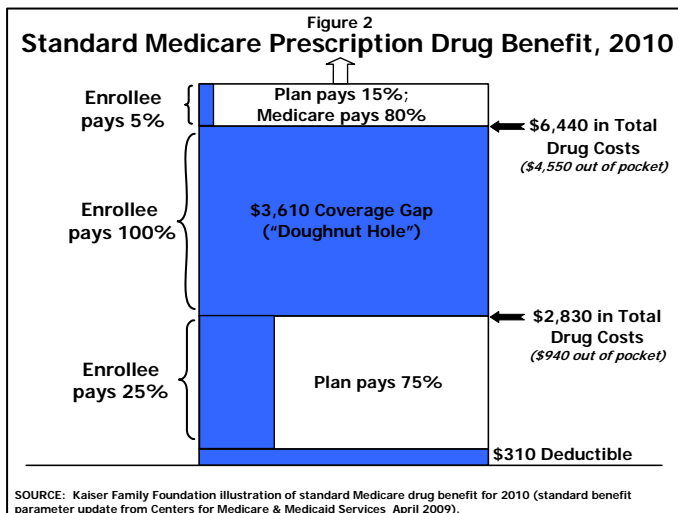
### MEDICARE PRESCRIPTION DRUG PLANS

The drug benefit is offered through stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans, such as HMOs, that cover all Medicare benefits including drugs. In 2010, 1,576 PDPs are offered across the 34 PDP regions nationwide (excluding the territories). Beneficiaries in each state have a choice of at least 41 stand-alone PDPs and multiple MA-PD plans (Figure 1).



### PART D PLAN BENEFITS AND PREMIUMS

Part D sponsors offer plans with either a defined standard benefit or an alternative equal in value ("actuarially equivalent"), and can also offer plans with enhanced benefits. The standard benefit in 2010 has a \$310 deductible and 25% coinsurance up to an initial coverage limit of \$2,830 in total drug costs, followed by a coverage gap (the so-called "doughnut hole") where enrollees pay 100% of their drug costs until they have spent \$4,550 out of pocket, excluding the Part D premium (Figure 2). Thereafter, enrollees pay either 5% of total drug costs or \$2.50/\$6.30 for each prescription. Standard benefit amounts increase annually by the per capita Part D spending growth rate.



Only a small share of PDPs nationwide offer the standard drug benefit in 2010, as in previous years. The majority of PDPs (60%) charge a deductible, with 36% of all PDPs charging the full amount (\$310). Most plans charge tiered copayments for covered drugs rather than 25% coinsurance, and a substantial majority of PDPs use specialty tiers for high-cost medications.

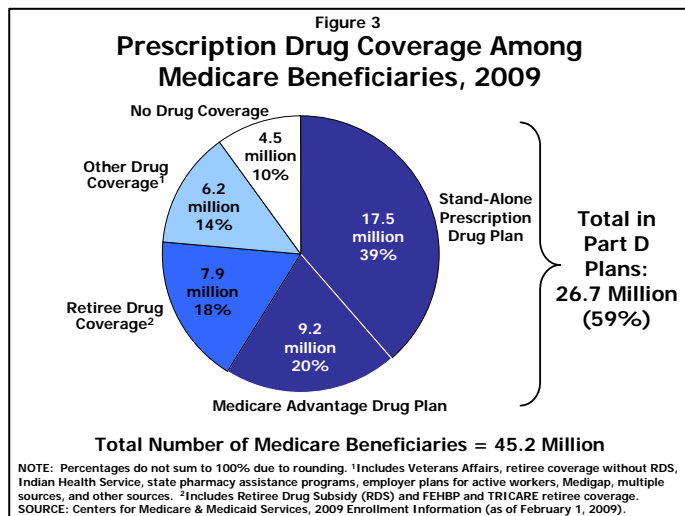
Most PDPs (80%) do not offer gap coverage in 2010. Gap coverage, when offered, is generally limited to generic drugs only (not brands). In 2007, an estimated 3.4 million Part D enrollees reached the coverage gap, most of whom did not qualify for catastrophic coverage before the end of the year.

The monthly Part D premium averages \$38.94 in 2010 (weighted by 2009 enrollment), an 11% increase since 2009. Actual PDP premiums vary across plans and regions, ranging from a low of \$8.80 in Oregon and Washington to a high of \$120.20 in Delaware, Maryland, and DC. Part D plans vary in benefit design, cost-sharing amounts, and utilization management tools (prior authorization, quantity limits, and step therapy). Plans also vary in terms of formularies (covered drugs), provided they comply with requirements established by the Centers for Medicare & Medicaid Services (CMS) to ensure a minimum level of coverage and prohibit formularies that discourage enrollment of certain types of beneficiaries.

### PART D ENROLLMENT

Enrollment in Medicare drug plans is voluntary, with the exception of dual eligibles and certain other low-income beneficiaries who are automatically enrolled in a PDP if they do not choose a plan on their own. However, unless beneficiaries have drug coverage from another source (e.g., an employer plan) that is at least as good as standard Part D coverage (known as "creditable coverage"), they face a penalty equal to 1% of the national average monthly premium for each month they delay enrollment.

As of February 2009, CMS reported 26.7 million beneficiaries enrolled in Medicare Part D plans, an increase of 1.3 million since January 2008 (Figure 3). Of this total, 9.2 million are enrolled in Medicare Advantage drug plans, up from 8.0 million in 2008. Another 7.9 million have creditable drug coverage through retiree plans, including FEHBP and TRICARE. Of this total, 6.0 million retirees are in plans in which their employers receive tax-free subsidies equal to 28% of drug expenses between \$295 and \$6,000 per retiree in 2009. Another 6.2 million are estimated to have other sources of coverage, such as from Veterans Affairs (VA). Based on CMS estimates, 4.5 million beneficiaries, or 10% of the Medicare population, lack creditable drug coverage.

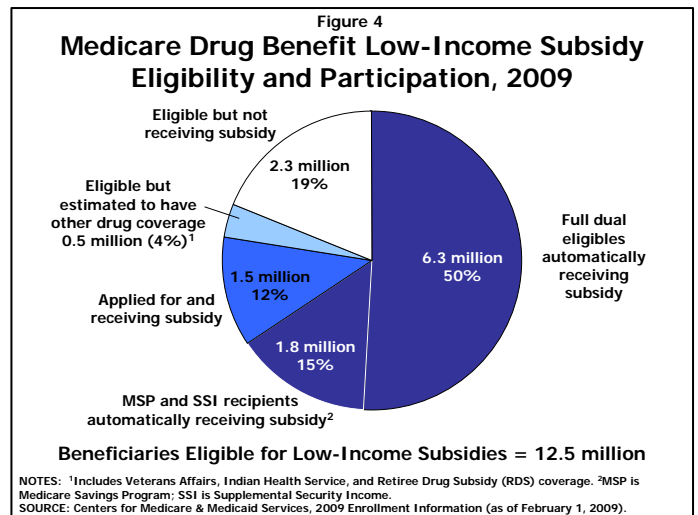


Part D enrollment is highly concentrated: five firms – UnitedHealth Group, Humana, Universal American Corp., Coventry Health Care, and WellPoint – account for 55% of Part D enrollees in 2009.

### ASSISTANCE FOR LOW-INCOME BENEFICIARIES

Part D includes substantial premium and cost-sharing assistance for beneficiaries with low incomes (less than 150% of poverty, or \$16,245 for individuals) and modest assets (less than \$12,510 for individuals). Dual eligibles, QMBs, SLMBs, QIs, and SSI-onlys automatically qualify for the additional assistance, and Medicare automatically enrolls them into PDPs with premiums at or below the regional average if they do not choose a plan on their own. Other beneficiaries are subject to both an income and asset test and need to apply for the low-income subsidy (LIS) through either the Social Security Administration (SSA) or Medicaid, as well as enroll in a Part D plan. Individuals determined eligible for LIS are assigned to a PDP if they do not enroll on their own.

As of February 2009, 12.5 million beneficiaries are estimated to be eligible for low-income assistance; of this total, 9.6 million (77%) are receiving the low-income subsidy, while an estimated 2.3 million eligible low-income beneficiaries (19%) are not receiving these subsidies (Figure 4).



### EXPENDITURES AND FINANCING FOR PART D

HHS estimates that Part D spending will total \$49 billion in 2009 and \$51 billion in 2010 (net of premiums and state transfers). Spending depends on several factors: the number of Part D enrollees, their health status and drug utilization, the number of low-income subsidy recipients, and plans' ability to negotiate discounts and rebates with drug companies and manage use (e.g. promoting use of generic drugs and mail order). The MMA prohibits Medicare from negotiating drug prices directly.

Financing for Part D comes from general revenues (79%), beneficiary premiums (9%), and state contributions (12%). The monthly premium paid by enrollees is set to cover 25.5% of the cost of standard drug coverage. Medicare subsidizes the remaining 74.5%, based on bids submitted by plans for their expected benefit payments. In 2010, private plans are projected to receive average payments of \$710 per enrollee overall and \$2,036 for LIS enrollees; employers are expected to receive, on average, \$628 for retirees in employer-subsidy plans (Trustees, 2009). Plans also receive additional risk-adjusted payments for high-cost enrollees and reinsurance payments for a share of their enrollees' costs above the catastrophic threshold. Part D plans' potential losses or profits are limited by risk-sharing arrangements with the federal government ("risk corridors") that have widened since 2006, shifting greater risk to plans over time.

### FUTURE CHALLENGES

The Medicare drug benefit has helped reduce out-of-pocket drug spending for enrollees, which is especially important to beneficiaries with modest incomes or catastrophic drug expenses. Ongoing monitoring of the Part D plan marketplace and evaluating the impact of the drug benefit on Medicare beneficiaries' out-of-pocket spending and health outcomes, as well as on drug prices and total Medicare spending, will be important to assess how Part D is working and how well it is meeting the needs of people on Medicare.

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