

MEDICARE

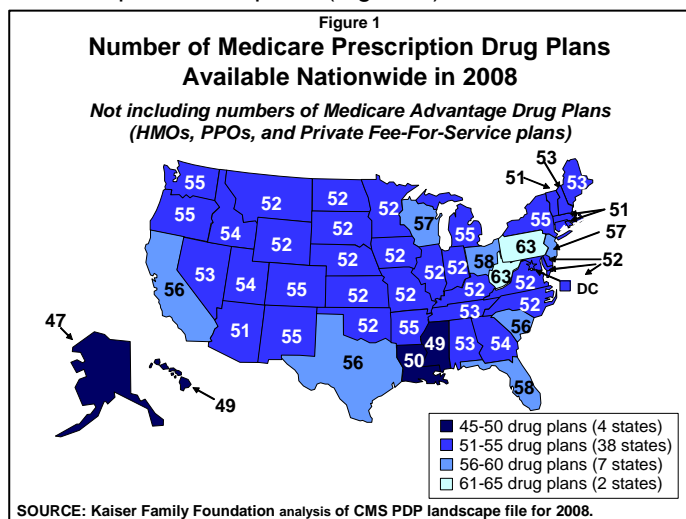
THE MEDICARE PRESCRIPTION DRUG BENEFIT

February 2008

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 44 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 premiums and cost sharing under Part D plans.

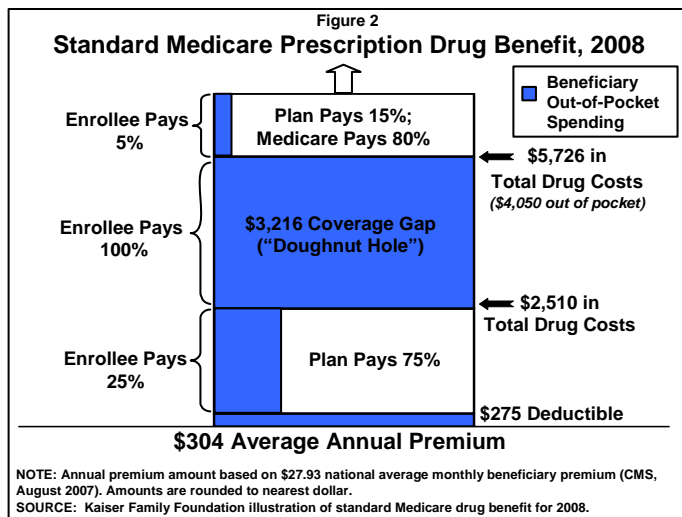
MEDICARE PRESCRIPTION DRUG PLANS

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 2008, a total of 1,824 PDPs are offered across the 34 PDP regions nationwide (excluding the territories), about the same number available in 2007. Beneficiaries in most states have a choice of at least 50 stand-alone PDPs and multiple MA-PD plans (Figure 1).



PART D PLAN BENEFITS AND PREMIUMS

Part D plans offer either a defined standard benefit or an alternative equal in value ("actuarially equivalent"), and they can also offer enhanced benefits. The standard benefit in 2008 has a \$275 deductible and 25% coinsurance up to an initial coverage limit of \$2,510 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 \$4,050 out of pocket, excluding the Part D premium (Figure 2). Thereafter, enrollees pay either 5% of total drug costs or



\$2.25/\$5.60 in 2008. The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth.

Only a small share (12%) of PDPs nationwide offers the standard drug benefit in 2008. The majority of PDPs (59%) has no deductible, and most charge tiered copayments for covered drugs rather than 25% coinsurance. Most PDPs do not help pay for prescriptions in the coverage gap (71%). Among the 29% of PDPs with some gap coverage, all but one plan covers only generic drugs (i.e., virtually all plans offering gap coverage cover no brand-name drugs in the gap). Just over 3 million Medicare beneficiaries were projected to have spending in the coverage gap in 2007, according to analysis by Actuarial Research Corporation for the Kaiser Family Foundation.

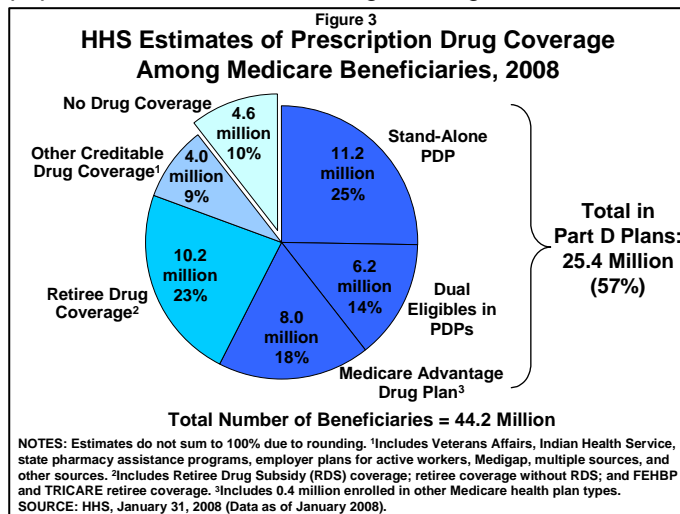
The monthly Part D premium averages \$27.93 in 2008, based on the national average bid. However, actual premiums vary across plans and regions, ranging from a low of \$9.80 for a basic benefit PDP to a high of \$107.50 for a PDP with enhanced benefits. Part D plans vary in benefit design, covered drugs, and utilization management tools (prior authorization, quantity limits, and step therapy). CMS established requirements for Part D plan formularies (the list of covered drugs) to help ensure that plans do not offer formularies that discriminate against or 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 permanent penalty equal to 1% of the national average monthly premium for each month they delay enrollment.

As of January 2008, HHS reported that 25.4 million beneficiaries are enrolled in Medicare Part D plans, an increase of 1.5 million since January 2007. Another 10.2 million have creditable drug coverage through retiree plans, including FEHBP and TRICARE (Figure 3). Of this total, 6.7 million retirees are in plans in which their employers receive tax-free subsidies equal to 28% of drug expenses between \$275 and \$5,600 per retiree in 2008. Another 4.0 million are estimated to have other sources of creditable coverage, such as from Veterans Affairs (VA). Based on HHS estimates, as of January 2008, 4.6 million beneficiaries, or 10% of the Medicare population, lack creditable drug coverage.

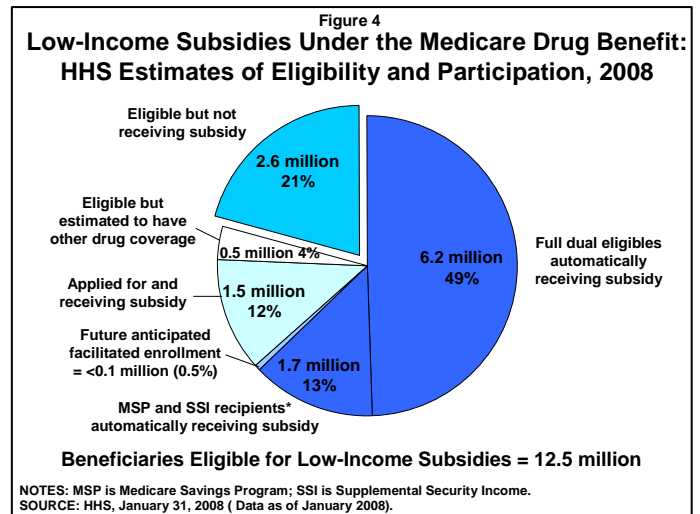


Part D enrollment is highly concentrated, with the top two firms—UnitedHealthcare and Humana—accounting for more than 40% of Part D enrollees in 2007. According to a recent study, the drug benefit has resulted in fewer seniors without drug coverage, although those in Part D plans have higher out-of-pocket spending and cost-related non-adherence than those who received their prescriptions through employer plans or the VA (Neuman et al., *Health Affairs*, 2007).

ASSISTANCE FOR LOW-INCOME BENEFICIARIES

Part D includes substantial premium and cost-sharing assistance for beneficiaries with low incomes (less than \$15,600 for individuals) and modest assets (less than \$11,990 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 January 2008, 12.5 million beneficiaries are estimated to be eligible for low-income assistance; of this total, an estimated 2.6 million beneficiaries (21%) are not receiving these low-income subsidies (Figure 4).



EXPENDITURES AND FINANCING FOR PART D

HHS estimates that Part D spending will total \$45 billion in 2008 and \$55 billion in 2009. 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 the ability of plans to negotiate discounts and rebates with drug companies and manage use (e.g. promoting use of generic drugs and mail order pharmacies). The MMA prohibits Medicare from negotiating drug prices directly.

Financing for Part D comes from beneficiary premiums, state contributions (the so-called “clawback”), and general revenues. 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 2008, private plans are projected to receive average payments of \$770 per enrollee overall and \$1,909 for LIS enrollees; employers are expected to receive, on average, \$627 for retirees in employer-subsidy plans (Trustees, 2007). 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 that will be phased out over time.

FUTURE CHALLENGES

The Medicare drug benefit offers help with out-of-pocket drug spending, which is especially important to people on Medicare with low incomes, those without other sources of drug coverage, and people with catastrophic drug expenses. Monitoring PDP and MA-PD plan enrollment; market stability; cost sharing and formularies; low-income subsidy participation; and the impact of Part D on total drug expenditures and on out-of-pocket spending by people on Medicare will be important to assess how Part D is working over time.

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