Medicare Payments and Beneficiary Costs for Prescription Drug Coverage

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Executive Summary

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a voluntary prescription drug benefit to Medicare (Part D). Beneficiaries who choose to enroll in the Part D program obtain coverage through private plans. Medicare provides fixed monthly payments to each plan and makes additional payments to plans with high-cost enrollees. Beneficiaries pay the rest of the cost, which may include a monthly premium charged by the plan, a deductible, and coinsurance or copayments. Federal subsidies for Part D plans are based in part on bids submitted by the plans' sponsors. Each year, a series of calculations based on average bids determines how much Medicare will contribute to each available plan and how much the beneficiary will have to pay for that plan.

This paper provides a basic introduction to the complex reimbursement system for Part D plans. It includes an overview of Part D benefits and an explanation of the bidding and payment system, including special provisions for low-income enrollees. Finally it considers how specific aspects of the payment system may affect the total cost of the Part D program, the affordability of coverage for beneficiaries, and the quality and variety of available plans.

Basics of the Part D benefit

Beneficiaries who choose to enroll in the new Part D program obtain coverage through one of two types of private plans. A stand-alone prescription drug plan (PDP), offered by an insurance company or other plan sponsor, contracts with Medicare only to provide the drug benefit. A Medicare Advantage (MA-PD) plan provides all Medicare-covered services including drugs. Insurers and other plan sponsors commonly offer several Part D plans with different levels of benefits in a given area. Each of these plans is treated as a separate PDP or MA-PD plan. A PDP must be available throughout one of 34 drug plan regions defined by CMS. MA-PD plans generally define their own service areas.

All plans must provide drug benefits at least equal in value to a "standard" benefit defined by the MMA. Plans may develop a formulary, or list of covered drugs, approved by the Centers for Medicare and Medicaid Services (CMS), that excludes or requires prior authorization for specified drugs. For covered drugs, the standard benefit in 2007 is as follows:

- Enrollees pay 100% of their costs until their spending for covered drugs reaches an initial *deductible* of $265. Once the deductible is reached, the

plan pays 75% of the cost and the enrollee pays 25% of the cost in the form of coinsurance or copayments.

- Cost-sharing by the plan and the enrollee continues until their combined spending for drugs reaches the *initial coverage limit* of $2,400 in 2007. The enrollee is then responsible for 100% of drug costs above this limit until his or her out-of-pocket drug spending (not total spending) reaches the *out-of-pocket (OOP) threshold*, $3,850 in 2007. (This provision is known as the coverage gap or the "doughnut hole.")

- For spending above the OOP threshold, the enrollee pays 5% of costs as coinsurance or copayments. The plan pays the rest, but is reimbursed for 80% through federal "reinsurance" payments. The plan's net costs for this catastrophic coverage are therefore 15%.

Sponsors may offer two other types of "basic" coverage (actuarially equivalent coverage and basic alternative coverage) besides the standard plan. These options may have a smaller deductible and/or different cost-sharing rules—for example, fixed copayments instead of 25% coinsurance—so long as the average share of total spending covered by the plan is the same as would be paid under the standard benefit. Sponsors may also offer enhanced alternative plans, which have an overall value greater than the standard benefit; it may have reduced cost-sharing and/or some coverage in the coverage gap.

Low-income beneficiaries, including those who also receive Medicaid (known as "dual eligibles") and others with incomes and assets within specified limits, receive additional help with Part D costs. Full subsidy groups pay no premium for plans with premiums below a limit set for each Part D region, have no deductible or coverage gap, and pay reduced cost-sharing. Higher-income partial subsidy groups may pay part of their own premium and a deductible, but also have no coverage gap and pay smaller coinsurance or copayments.

Part D payments

Plan bids and beneficiary premiums. Each sponsor submits a bid to CMS reflecting its monthly revenue requirements during the coming year for providing each of its proposed plans to a typical Part D eligible. Plans offering enhanced benefits must separately identify the portion of their bid attributable to basic Part D benefits. MA-PD plans may reduce their bids by sharing with the beneficiary savings they expect to realize in furnishing non-drug benefits. (This offset, which can give MA-PD plans a price advantage, is discussed further below.)

CMS computes a *national average bid*, using only the portion of bids attributable to the basic benefit and weighting the bids according to each plan's share of the total Part D population. Because all PDPs were new in 2006, the computation for that year assumed that each PDP would have an equal share of total projected PDP enrollment. (For MA plans that already existed, actual enrollment was used.) For 2007, the calculation was supposed to be based on actual enrollment in each plan. However, so many beneficiaries enrolled in low-cost plans in 2006 that a calculation using actual weighted enrollment would have produced a national average for 2007 well below the 2006 levels. Under its general authority to conduct demonstration projects, for 2007 CMS has instead used a blend of actual PDP enrollment and the equal enrollments across PDPs assumed for 2006. The resulting national average is $80.43 per month.

CMS multiplies the national average bid by a specified percentage, determined each year, to compute the *base beneficiary premium*. For 2007, the percentage is about 34%, resulting in a base beneficiary premium of $27.35. This is the monthly amount beneficiaries would pay to enroll in a plan whose total bid amount was exactly equal to the average of $80.43. Enrollees joining higher-cost plans must pay $27.35 plus the difference between the plan's bid and the national average bid. Those joining lower-cost plans pay less than $27.35. Many MA-PD plans' bids are so low that enrollees pay nothing for drug benefits.

Low-income subsidy calculation. The maximum premium subsidy for low-income beneficiaries is established each of the 34 PDP regions. It is based on the weighted average beneficiary premium for plans in that region. As in the case of the national average premium, subsidy limits for 2006 were computed on the assumption that each PDP in a region would have equal enrollment, while the limits for 2007 were supposed to be based on actual enrollment. This would have produced a low-income subsidy for 2007 well below the 2006 levels, forcing many beneficiaries to change plans or begin paying part of the premium themselves. CMS has again used its demonstration authority; for 2007, enrollment in PDPs is still assumed to be equally divided among all PDPs.

In calculating the regional average, the full premium is counted for MA-PD plans; for a PDP with enhanced benefits, only the part of the premium attributable to basic benefits is used, and the subsidy for enrollees in the plan cannot exceed this basic premium. As a result, many enhanced benefit plans offered by MA-PD plans are available to subsidy recipients at no cost, while recipients must always pay something for an enhanced benefit PDP.

Risk adjustment and risk sharing. Medicare payments to Part D plans are adjusted to take account of the fact that a given plan's enrollees may have a higher or lower need for prescription drugs than the typical Medicare

beneficiary. The risk adjustment factor is based on age, sex, low-income subsidy eligibility, and institutional status as well as any history of illnesses or conditions associated with higher drug use.

The MMA provides for risk-sharing, limiting total potential losses or profits for a Part D plan. If the plan's actual drug spending is 2.5% or more above a target based on the plan's bid, Medicare shares in the losses; if costs are 2.5% or more below the target, Medicare shares in the profit. The MMA allows for further protections risk for plans in regions that would not otherwise have a choice of PDP sponsors. So far, it has not been necessary to make use of these provisions, because multiple sponsors are serving every region in the country.

Employer plans. Before the MMA, many beneficiaries had some form of prescription drug coverage as part of retiree benefits from their former employers. To encourage these employers to continue existing benefits, MMA provides subsidies for part of the cost of an employer plan that includes drug coverage at least actuarially equivalent to standard Part D coverage. The subsidy pays 28% of costs incurred by the employer between the deductible and an upper limit of $5,350 per enrollee in 2007. An employer may instead choose to develop its own Part D plan, available exclusively to its retirees, or offer wrap-around drug coverage, supplementing the Part D benefit.

Key payment issues

Medicare Advantage plans. In 2006, 6 million beneficiaries were receiving Part D benefits through MA-PD plans—HMOs, PPOs, and private fee-for-service plans that provide the full range of Medicare-covered services as well as drugs. MA-PD plans bid separately for Medicare Part A and B benefits (hospital, physician and other non-drug services) and Part D. A plan's bid for Part A and Part B benefits is compared to a CMS-established benchmark for the area served by the plan. If the plan's bid is lower than the benchmark, savings are shared with beneficiaries in the form of supplemental benefits. Many plans have used the savings in part to reduce or eliminate premiums for Part D coverage or to provide enhanced benefits at no additional charge.

In order to encourage participation by MA-PD plans, the benchmarks for all areas have been set higher than the costs of serving typical beneficiaries under the original Medicare program. In addition, MA-PD plans have tended to attract beneficiaries who are healthier than the average beneficiary reflected in the benchmarks. On average, MA-PD plans are paid 115% of what Medicare would have spent for a comparable population served in original Medicare; in some areas, chiefly rural counties, plans receive as much as 126% of expected Medicare costs.

Because MA-PD plans can apply some of the difference between their non-drug bid and the benchmark to the drug benefit, they can offer lower premiums and more generous coverage than stand-alone PDPs. For 2007, the average beneficiary drug premium for an MA-PD will be $17.92, compared to $36.79 for PDPs.

Plan availability for low-income beneficiaries. As of July 2006, of 16.5 million PDP enrollees, 6.1 million were dual Medicare-Medicaid eligibles assigned to plans with below-average costs; another 2.2 million were non-Medicaid beneficiaries eligible for low-income subsidies, who presumably were also drawn to low-cost plans with below average premiums. In effect, half of all PDP enrollees were pushed into the plans in the lower half of the premium range. The effect has been to lower the national average bid, as well as the regional averages used to compute the maximum low-income subsidy. CMS has used its demonstration authority to limit the effects for 2007. However, unless it continues the demonstration indefinitely, the low-income subsidies are likely to ratchet down year after year, limiting plan choices available to subsidy recipients. There are also indications that some national firms have set their bids so as to attract the low-income population, while others have adopted the reverse strategy; incentives and plan responses may warrant further monitoring.

Risk and geographic adjustment. The risk adjustment system developed for Part D plans performs fairly well in predicting variation in beneficiaries' drug spending. (It does about twice as well as the parallel system used to predict use of Part A and B services by MA-PD plan enrollees.) Studies have shown that the system could be improved if it took into account beneficiaries' actual past use of drugs, rather than just medical conditions likely to lead to high drug spending. Even so, plans are likely to be overpaid for the lowest-risk beneficiaries, creating incentives to attract these enrollees and discourage higher-cost ones, perhaps by manipulating plan formularies.

CMS is required to adjust payments if covered drugs have different prices in different areas, but there is no provision for adjustment of rates to account for other geographic variation, such as higher utilization resulting from regional differences in physicians' prescribing patterns. As a result, beneficiaries in different regions are paying different premiums for comparable Part D benefits. Premiums for basic coverage in 2007 average $31.81 in Alaska versus $24.52 in California, a 30% difference. Even national PDP firms—those offering a plan in every state for 2007—are bidding different amounts for basic coverage in different areas.

Future prospects. Before Part D was implemented, there were concerns that the program might not attract enough low-cost enrollees to offset the costs of higher utilizers. Some analysts predicted that "adverse selection" could force plans to raise premiums. If more low-cost enrollees were then induced to drop out, the program might suffer a spiral of shrinking enrollment and rising per capita costs. In fact, first year enrollment, while less than initially projected, was high enough that the program has probably enrolled a representative mix of high and low-cost beneficiaries.

Beneficiaries disproportionately chose or were assigned to low-cost plans. This has meant savings for the government and for beneficiaries; however, because the federal contribution to premiums is based on average bids, beneficiaries' choice of lower-cost plans would have meant a reduced federal premium subsidy for 2007. CMS has used its demonstration authority to prevent this, but there could be a sharp rise in premiums once the demonstration ends. If so, some low utilizers might be driven out of the program, perhaps bringing on the selection spiral that some observers projected in the first place.

A number of other factors could affect future program costs. First, some plan sponsors may be "low-balling," temporarily holding down their premiums in order to build up market share. Their enrollees might see premium spikes in later years. Second, many employers who have continued to provide drug benefits to retirees, receiving federal employer subsidies, are uncertain about their strategy for future years. Some may decide to drop drug coverage and instead help retirees with Part D premiums and cost-sharing. Presumably those employers with the highest-cost retirees would be most prone to shift those enrollees to Part D, raising average program costs. Finally, overpayments to MA-PD plans for their Part A and Part B services will be reduced somewhat in the coming years as payments are better adjusted to reflect enrollees' health risks. Plans may have a smaller surplus with which to subsidize supplemental benefits for enrollees, driving up the average bids on which federal premium subsidies are based.

In sum, the complex payment system for Part D plans means that future costs to beneficiaries and to the federal government will be determined by the interplay of individual decisions by plan sponsors, employers, and the enrollees themselves. As a result, it may be some years before it is clear whether the Part D program is equitable and sustainable.

Medicare Payments and Beneficiary Costs for Prescription Drug Coverage

INTRODUCTION

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added a voluntary prescription drug benefit to Medicare. Beneficiaries who choose to enroll in the new Part D program obtain coverage through one of two types of private plans. A stand-alone prescription drug plan (PDP), offered by an insurance company or other plan sponsor, contracts with Medicare only to provide the drug benefit. A Medicare Advantage (MA-PD) plan provides all Medicare-covered services including drugs.[1]

Medicare provides fixed monthly payments to each plan and makes additional payments to plans with high-cost enrollees. Beneficiaries pay the rest of the cost, which may include a monthly premium charged by the plan, a deductible, and coinsurance or copayments. For low-income beneficiaries, these costs are reduced or eliminated through additional federal subsidies.

While the amounts of Medicare's direct payments for other services, such as hospital and physician care, are fixed by law, the federal subsidies for PDP and MA-PD plans are based in part on bids for standard coverage submitted by the plans' sponsors. Each year, a series of calculations based on average bids determines how much Medicare will contribute to each available plan and how much the beneficiary will have to pay for that plan.

This paper provides a basic introduction to the complex reimbursement system for Part D plans. It begins with an overview of Part D benefits and of how drug costs are shared by the federal government, plans, and enrollees. This is followed by an explanation of the bidding and payment system, including special provisions for low-income enrollees and for non-Medicare retiree drug plans provided by employers. Finally it considers how specific aspects of the payment system may affect the total cost of Part D to the federal government, the affordability of coverage for beneficiaries, and the quality and variety of available plans.

[1] Beneficiaries may enroll in MA plans and obtain only non-drug benefits. However, they are usually precluded from obtaining Part D coverage from a separate PDP. In August 2006, 89% of MA enrollees had drug coverage through the MA plan.

PART D BENEFITS

Insurers, Medicare Advantage organizations, and other plan sponsors commonly offer several Part D plans with different benefit packages in a given geographic area. Each of these plans is treated as a separate PDP or MA-PD. A PDP must be made available throughout one of 34 drug plan regions defined by CMS. MA-PD plans generally define their own service areas, but can be offered on a local (county) or regional level, depending on the type of plan. CMS established 26 MA regions nationwide. All plans must provide drug benefits at least equal in value to a "standard" benefit defined by the MMA. Many plans offer more generous benefits, usually at a higher cost to the enrollee.

Standard and Alternative Part D Benefits

Every Part D plan pays for covered outpatient drugs. Each plan develops its own list of covered drugs known as a "formulary."[2] Proposed formularies are reviewed by the Centers for Medicare and Medicaid Services (CMS) to assure that they provide access to appropriate treatments for all diseases and are not designed to discourage enrollment by any particular group. Plans may exclude some drugs altogether (subject to an exceptions and appeals process) and may cover others only with prior authorization or only after less costly treatments for the same condition have failed to work ("step therapy").

For covered drugs the standard Part D benefit is as follows:

- Enrollees pay 100% of their costs until their spending for covered drugs reaches an initial *deductible*. For 2007, the deductible is $265.

- Once the deductible is reached, the plan pays 75% of the cost and the enrollee pays 25% of the cost in the form of coinsurance or copayments.

- Cost-sharing by the plan and the enrollee continues until their combined spending for drugs reaches the *initial coverage limit*, $2,400 in 2007.

- The enrollee is then responsible for 100% of drug costs above this limit until his or her out-of-pocket drug spending (not total spending) reaches the *out-of-pocket (OOP) threshold*, $3,850 in 2007. (This provision is known as the coverage gap or the "doughnut hole.")[3]

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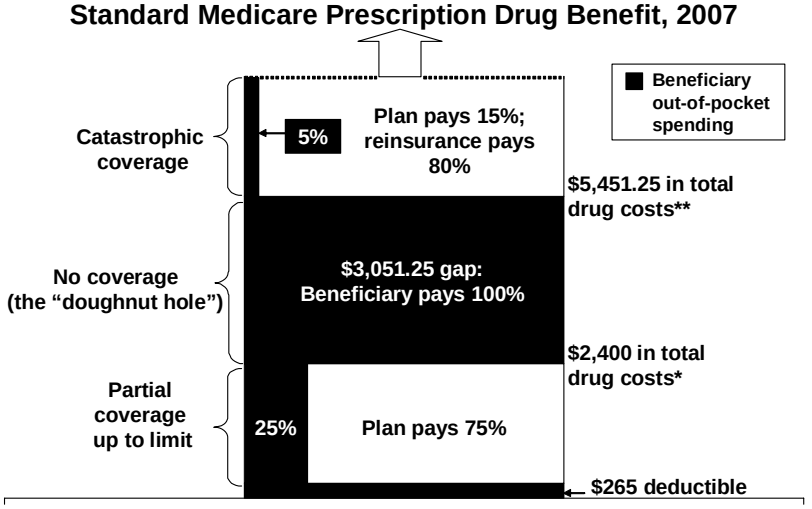
[2] A plan may opt not to have a formulary, but it must then cover every available drug and charge the same cost-sharing for each.

[3] In determining whether the enrollee has reached the threshold, only "true out-of-pocket" (TrOOP) spending, actual payments made by the enrollee (or an agent, such as a legal guardian),

- For spending above the OOP threshold, the enrollee pays the greater of 5% coinsurance or copayments of $2.15 per generic drug and $5.35 per brand name drug. The plan pays the rest of the cost, but is reimbursed for 80% through federal "reinsurance" payments, described in the next section. The plan's net costs for this catastrophic coverage are therefore 15%.

Figure 1

Standard Medicare Prescription Drug Benefit, 2007



*Equivalent to $798.75 in out-of-pocket spending. **Equivalent to $3,850 in out-of-pocket spending.
SOURCE: Kaiser Family Foundation.

For years after 2007, the deductible, the initial coverage limit, and the out-of-pocket threshold will be updated annually, based on increases in average total drug spending per Part D participant.

Plans may offer any of three types of benefit plans that are not standard plans. The first, *actuarially equivalent coverage*, has the same deductible and coverage limit as standard coverage but has different cost-sharing rules. For example, the plan charges fixed copayments for generic and brand-name drugs instead of 25% coinsurance. It is equivalent if projected average payments by the enrollee are the same as would be expected under the standard plan. *Basic alternative coverage* may have a smaller deductible than the standard plan, as well as different cost-sharing, so long as the average shares of total spending covered by the plan and the enrollee are the same as would be paid under the standard benefit. Finally, *enhanced alternative coverage* has an overall value to the enrollee greater than the standard benefit; it may have a reduced deductible, lower cost-

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can be counted. For example, if some of the enrollee's costs were picked up by an employer plan that supplements Part D coverage, these amounts do not count toward the $3,850.

sharing, and/or some coverage in the coverage gap. The enrollee usually pays for these extra benefits through a supplemental premium.

Plan sponsors usually must include one basic plan (standard, actuarially equivalent, or basic alternative) among their offerings in each region. A sponsor of stand-alone PDPs may not offer only enhanced alternative plans. A sponsor of MA-PD plans may do so, but only if the enhanced alternative plans are available to enrollees at no extra cost.

Low-income Subsidies

Low-income beneficiaries are eligible for assistance with Part D plan premiums and for reductions in required cost-sharing (known as "extra help" or low-income subsidy (LIS)). Eligible beneficiaries include those receiving full Medicaid benefits, those enrolled in the Medicare Savings Programs (under which Medicaid helps with Medicare Part B premiums and sometimes cost-sharing, but does not cover non-Medicare services), and others meeting specified income and asset limits. Income limits are defined as a percentage of the federal poverty guidelines, or FPG: $10,210 for a single person and $13,690 for a couple in 2007.

Low-income groups receive premium assistance equal to the lesser of a plan's premium or a regional low-income premium benchmark; for the highest income subsidy-eligible group, this subsidy is phased out on a sliding scale basis. All low-income subsidy recipients have a zero or reduced deductible and pay smaller copayments or coinsurance. There is no coverage gap; instead enrollees pay the same cost-sharing amounts all the way from the deductible (if any) to the OOP threshold. Finally, the lowest-income participants pay no coinsurance above the OOP threshold.

Table 1. Eligibility and Benefits, Part D Low-Income Prescription Drug Subsidies, 2007

Category or income/asset limits	Premium assistance	Deductible	Coinsurance/ copayments	
			Below out-of-pocket threshold	Above out-of-pocket threshold
Full subsidy groups				
Full-benefit Medicaid or Medicare Savings Program beneficiary with income at or below 100% of FPL	100%	$0	$1 generic or preferred, $3.10 other[a]	$0
Full-benefit Medicaid or Medicare Savings Program beneficiary with income above 100% of FPL	100%	$0	$2.15 generic or preferred, $5.35 other	$0
Other beneficiary with income below 135% of FPL assets at or below $6,000 (individual), $9,000 (couple)	100%	$0	$2.15 generic or preferred, $5.35 other	$0
Partial subsidy groups				
Income below 135% of FPL, assets $6,001-11,710 (individual), $9,001-23,410 (couple)	100%	$50	15%	$2.15 generic or preferred, $5.35 other
Income 135%-150% of FPL, assets at or below $11,710 (individual), $23,410 (couple)	Sliding scale, 100%-0%	$50	15%	$2.15 generic or preferred, $5.35 other

[a]No copayments for institutionalized beneficiaries.
[b]135% of the FPG is $13,784 for an individual and $17,820 for a couple in 2007.
[c]150% of the FPG is $18,482 for an individual and $20,535 for a couple in 2007.

PART D BIDDING AND PAYMENT

Plan Bids

Each plan sponsor submits a bid to CMS reflecting its expected monthly revenue requirements during the coming year for providing each of its proposed plans to a typical Part D eligible.[4] The projection is the sum of the plan's expected *net* cost for drugs and its administrative costs and desired profit. The net cost excludes the amounts the plan expects enrollees to pay in the form of coinsurance and copayments, expected federal subsidy payments to reduce cost-sharing for low-income beneficiaries, and projected federal reinsurance payments. If the plan offers enhanced alternative benefits, such as a reduced deductible or lower cost-sharing, it must separately report the portion of its bid amount attributable to the standard Part D benefit and the portion attributable to supplemental benefits.

There may be a further adjustment for plans offered by Medicare Advantage organizations. MA plans bid separately for the drug benefit and for the other Medicare services they cover, such as hospital and physician care. The bid for non-drug services is compared to a CMS-established benchmark (this process is discussed in the section on MA plans, below). If the non-drug bid is below the non-drug benchmark, some of the savings may be used to reduce the plan's bid for the drug benefit.

CMS reviews each bid for reasonableness, comparing projected administrative and total costs to those projected by other bidders or to those under the sponsor's non-Medicare insurance plans; CMS may then negotiate with the sponsor before approving a final bid amount. Once all bids are approved, CMS computes a *national average bid*, using only the portion of bids attributable to the standard Part D benefit and weighting the bids according to each plan's share of the total population enrolled in Part D.

Table 2 illustrates how this process would work if there were just three plan sponsors in the nation. Each sponsor offers a standard plan and an enhanced alternative plan. For the standard plan, the full bid is used, while only the part of the bid attributable to standard benefits is used for the alternative plans. The bids are weighted by each plan's enrollment, and the sum of the weighted bids is divided by the total population to produce the average.

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[4] That is, for a beneficiary with a health and demographic risk score equal to the national average for all beneficiaries, as determined under the scoring system described in the discussion of risk adjustment, below. A plan whose enrollees are higher- or lower-risk than average must adjust its bid up or down to reflect costs for an average beneficiary.

Table 2. Sample Computation of National Average Bid

	Total bid	Component for standard benefit	Enrollment (thousands)	Weighted bid
PDP sponsor A				
Standard plan	$75.80	$75.80	12,000	$909,600
Enhanced plan	$95.00	$75.80	2,500	$189,500
PDP sponsor B				
Standard plan	$108.19	$108.19	1,500	$162,285
Enhanced plan	$140.00	$108.19	500	$54,095
MA-PD plan sponsor C				
Standard plan	$53.08	$53.08	4,500	$238,860
Enhanced plan	$80.00	$53.08	1,000	$53,080
All plans			22,000	$1,607,420
National average bid				**$73.06**

In calculating the weighted average for 2006, CMS had data on the number of enrollees in existing Medicare Advantage plans but no way of knowing how many beneficiaries would select each of the new PDPs. CMS therefore assumed that non-MA beneficiaries in the region would be divided equally among the available PDPs. For 2007, it was expected that the weighted average would be calculated using each plan's actual enrollment as of mid-2006. However, a problem emerged. Because a large number of beneficiaries chose (or were assigned to) low-cost plans in 2006, a calculation using actual weighted enrollment would have produced a national average for 2007 well below the 2006 levels. This would in turn have reduced federal premium subsidies (see below) and raised average premium costs for enrollees.

To prevent this, CMS has adopted a different method for 2007, using its general authority under Medicare law to conduct demonstration projects. For 2007, the average is computed twice, once using actual plan enrollment as of June 2006 and once using the enrollment assumed for 2006 (when enrollees were equally divided among all PDPs in each region). The final average is a blend: 20% of the figure based on actual enrollment and 80% of the figure based on the 2006 methodology. Table 3 shows the effect, using the hypothetical plans from the previous example. The national average bid calculated by CMS using the blended method is $80.43.

Table 3. Sample Computation of Average Bid Using Blended Population Methodology for 2007

	Bid component for standard benefit	Actual 2006 enrollees (thousands)	Weighted bid	Population used for demo (thousands)	2007 weighted bid with demo
PDP sponsor A					
Standard plan	$75.80	12,000	$909,600	4,125	$312,675
Enhanced plan	$75.80	2,500	$189,500	4,125	$312,675
PDP sponsor B					
Standard plan	$108.19	1,500	$162,285	4,125	$446,284
Enhanced plan	$108.19	500	$54,095	4,125	$446,284
MA-PD plan sponsor C					
Standard plan	$53.08	4,500	$238,860	4,500	238,860
Enhanced plan	$53.08	1,000	$53,080	1,000	53,080
All plans		22,000	$1,607,420	22,000	$1,809,858
National average bid			**$73.06**		**$82.27**
Blend used for 2007 (20% of $73.06 + 80% of $82.27)					**$80.43**

Beneficiary Premiums

CMS multiplies the national average bid by a specified percentage, determined each year, to compute the *base beneficiary premium*. The percentage used is set in accordance with a general MMA rule that enrollees (other than low-income subsidy enrollees) should pay premiums equal to 25.5% of covered costs, with federal subsidies paying the remainder. This does not mean that enrollees pay 25.5% of the premium. Because federal reinsurance payments cover most costs above the OOP threshold, the enrollee must pay a larger percentage of the premium in order to pay 25.5% of total costs. For 2007, the percentage is about 34%, resulting in a base beneficiary premium of $27.35.[5]

This is the monthly amount beneficiaries would pay to enroll in a plan whose total bid amount was exactly equal to the average of $80.43. In the example, all of the plans have total bids that are higher or lower than the average. If the plan's bid is higher, the beneficiary pays the base amount plus the difference between the plan's bid and the average. If the plan's bid is lower, the beneficiary pays the base amount minus the difference.

[5] Add cite to CMS memo.

Table 4 shows the computation of the final beneficiary premium for each plan. All but one of the stand-alone PDPs have bids that are higher than the national average. To enroll in these plans, the beneficiary must pay the $27.35 base premium plus the excess bid amount. On the other hand, one PDP and the two MA-PD plans have bid amounts below the national average. The bid for the MA-PD standard plan is low enough that the final beneficiary premium is zero.[6]

Table 4. Sample Computation of Beneficiary Premium

	Bid amount	Difference between plan bid and national average ($80.43)	Plus base beneficiary premium	Final beneficiary premium
PDP sponsor A				
Standard plan	$75.80	($4.63)	$27.35	$22.72
Enhanced plan	$95.00	$14.57	$27.35	$41.92
PDP sponsor B				
Standard plan	$108.19	$27.76	$27.35	$55.11
Enhanced plan	$140.00	$59.57	$27.35	$86.92
MA-PD plan sponsor C				
Standard plan	$53.08	($27.35)	$27.35	$0.00
Enhanced plan	$80.00	($0.43)	$27.35	$26.92

Many beneficiaries choosing an MA-PD plan do not actually pay the calculated drug premium. Instead, they pay a comprehensive premium that covers both drug benefits and the plan's other benefits that supplement Medicare, such as reduced inpatient or part B deductibles, or copayments for physician visits instead of 20% coinsurance. Some MA-PD plans charge little or nothing for these non-drug supplemental benefits. Of 1,629 MA-PD plans offered in 2007, 690—or 42% – charge a comprehensive premium equal to their drug premium. Of these, 520 charge a zero premium for their entire benefit package.[7]

[6] It is possible, once the average bid and base beneficiary premium are established for the year, that a low-bidding plan will wind up with a negative beneficiary premium. In this case the plan may renegotiate its proposal and provide additional benefits at a zero premium.

[7] Author's analysis, based on CMS 2007 landscape of local MA plans, available at http://www.medicare.gov/medicarereform/local-plans-2007.asp, accessed Nov. 2006. The 1,629 total is an unduplicated count of plans, excluding plans available only in U.S. territories and those offered through specific employers.

Risk Adjustment

To assure that plans are not penalized for enrolling beneficiaries with a greater need for prescription drugs—or rewarded for avoiding them—payments are adjusted using factors meant to reflect each enrollee's likely use of drugs. The factors are of two kinds, demographic and health risk. Demographic factors include age, sex, low-income subsidy eligibility, and institutional status. Health risk factors are established by assigning the enrollee to one or more disease groups, known as "hierarchical condition categories" (HCCs), on the basis of diagnoses reported on hospital and physician claims in the preceding year. (Because there is no claims history for new Medicare beneficiaries, demographic factors alone are used in their first year of program participation.)

Table 5 illustrates the computation for a hypothetical 76 year-old woman with diabetes and hypertension who is eligible for full Medicaid benefits, using the factors in effect for 2006.[8] The age/sex and disease factors are totaled to give a preliminary risk factor of 0.8466. This is then multiplied by the low-income factor for full-benefit Medicaid eligibles (1.08) to give a final risk factor of 0.9143.

Table 5. Sample Risk Factor Calculation Using 2006 Factors

Age/sex factor:	
Female, 75-79	0.4343
Disease factors:	
Diabetes without complication	0.1898
Hypertensive heart disease or hypertension	0.2225
Sum of factors--	0.8466
x Low-income multiplier	1.08
Final factor	**0.9143**

Medicare's monthly payment to a plan for each enrollee is equal to:

(Plan bid amount x Risk adjustment factor) – beneficiary premium.

If the woman in this example joined sponsor A's standard plan, with a $75.80 bid amount and a $22.72 beneficiary premium, Medicare would pay the plan ($75.80 x .9143) - $22.72, or $46.58.

[8]Risk adjustment factors are available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/downloads/rxhccsoftware2006.zip, accessed October 2006.

Low-income Premium Subsidy Limits

The maximum premium subsidy for low-income beneficiaries is established separately for each of the 34 PDP regions. It is based on the weighted average beneficiary premium for the PDP and MA-PD plans available in that region. For PDPs with enhanced alternative coverage, only the portion of the beneficiary premium attributable to basic coverage is used in calculating the average. For MA-PD plans on the other hand, the entire beneficiary premium is counted, not just the premium for basic coverage. At a minimum, the subsidy must be high enough to assure that there is at least one stand-alone PDP in the region available to full-subsidy beneficiaries at no cost.

As in the case of the national average bid, in calculating the weighted average beneficiary premium for 2006, CMS had data on the number of enrollees in existing Medicare Advantage plans but no way of knowing how many beneficiaries would select each of the new PDPs. CMS therefore assumed that non-MA beneficiaries in the region would be divided equally among the available PDPs. For 2007, moving to a weighted average based on plans' actual enrollment would have produced a low-income subsidy for 2007 well below the 2006 levels. Consequently, many beneficiaries who relied on the subsidy to pay their entire premium would have had to change plans or begin paying part of the premium themselves. Once again, CMS has used its demonstration authority in order to avoid this outcome; for 2007, enrollment in PDPs is again assumed to be equally divided among all PDPs in the region. (The calculation uses 100% of this amount, rather than the blend used for the national average bid. Some form of blend is contemplated for 2008 and perhaps later years.)

Table 6 shows the effect if all the plans in the previous examples were in one PDP region. If actual enrollment were used, the weighted average beneficiary premium would have been $21.21. Because this amount is too low to pay the full premium for any PDP in the region, the low-income subsidy would have had to be $22.72, enough to pay for Sponsor A's standard plan. Under the 2007 "demonstration," with PDP enrollees assigned equally to each plan, the weighted average rises to $30.41, enough to pay for Sponsor A's standard plan as well as both MA-PD plans.

Table 6. Sample Computation of Maximum Low-Income Premium Subsidy

	Final beneficiary premium	Used in calculation[a]	Enrollees	2007 weighted bid without demo	Population used for demo	2007 weighted bid with demo
PDP sponsor A						
Standard plan	$22.72	$22.72	12,000	$272,640	4,125	$93,7270
Enhanced plan	$41.92	$22.72	2,500	$56,800	4,125	$93,720
PDP sponsor B						
Standard plan	$55.11	$55.11	1,500	$82,665	4,125	$227,329
Enhanced plan	$86.92	$55.11	500	$27,555	4,125	$227,329
MA-PD plan sponsor C						
Standard plan	$ 0	$ 0	4,500	$0	4,500	$0
Enhanced plan	$26.92	$26.92	1,000	$26,920	1,000	$26,920
All plans			22,000	$466,580	22,000	$669,018
Low-income benchmark				**$21.21**		**30.41**

[a] For PDPs, this amount is the portion of the premium attributable to basic benefits; for MA-PD plans it is the entire premium.

Beneficiaries eligible for premium subsidies may choose a plan whose premium is greater than the subsidy amount and pay the difference themselves. For example, a beneficiary choosing sponsor B's standard plan would pay $55.11 minus $30.41, or $24.70. However, if the subsidy-eligible beneficiary chooses a plan with enhanced benefits, different rules apply depending on whether the plan is a PDP or an MA-PD. For a PDP, the available subsidy is the lesser of the maximum subsidy or the amount of the PDP's premium attributable to basic benefits. So, if a beneficiary chose sponsor A's enhanced plan, the enrollee's share of the premium would not be $11.51 ($41.92 minus $30.41), but $19.20 ($41.92 minus $22.72). On the other hand, if the beneficiary chooses an MA-PD, the available subsidy is the lesser of the maximum subsidy or the plan's *total* premium. So a full-subsidy enrollee joining sponsor C's enhanced plan would pay nothing, even though all of the plan's premium is attributable to the enhanced benefits.

This distinction may not matter very much to full-subsidy Part D plan enrollees, who pay only limited copayments and would not save very much by joining an enhanced plan. However, partial-subsidy enrollees, who pay a $50 deductible and 15% coinsurance, might well find an enhanced plan desirable. For these beneficiaries, the subsidy rules confer a significant advantage on MA-PD plans. As Table 7 shows, 74% of MA-PD plans with enhanced benefits are available for a premium at or below the maximum subsidy for their region in

2007. Many of these plans also provide supplemental medical benefits, such as reduced cost-sharing for Part A and B services, with no additional premium.

Table 7. PDP and MA-PD Plans with Premium at or below Maximum Low-Income Subsidy, 2007

		Premium within maximum low-income subsidy		No additional premium for coverage supplementing Parts A and B	
	Total plans	Number	Percent	Number	Percent
PDPs:					
Basic	988	483	49%	NA	NA
Enhanced	887	0	0%	NA	NA
MA-PD plans:					
Basic	428	338	79%	137	32%
Enhanced	1,201	890	74%	550	46%

Source: Author's analysis, based on CMS 2007 landscapes of local PDP and MA plans, available at http://www.medicare.gov/medicarereform/local-plans-2007.asp, accessed Nov. 2006, and low-income subsidy amounts, available at http://www.cms.hhs.gov/medicareadvtgspecratestats/Downloads/PartD2007.zip, accessed Nov. 2006.

Reinsurance

Once a beneficiary's out-of-pocket spending has reached the $3,850 OOP threshold for 2007—representing $5,451.25 in total drug spending—catastrophic coverage begins. For further expenditures beyond the threshold, the enrollee pays 5%, the plan pays 15%, and federal reinsurance payments cover the remaining 80%. In determining reinsurance payments to the plan, CMS counts only net spending by the plan above the threshold. This means that, if the plan receives rebates from pharmaceutical manufacturers on the basis of quantity or cost of drugs purchased, these rebates are subtracted from the plan's spending before the reinsurance amount is computed.

One problem with the catastrophic coverage rules is that they may discourage plans from filling in some of the coverage gap as a supplemental benefit. Table 8 illustrates the effect for an enrollee with $7,500 in total spending in a standard plan and in a plan that provides coverage of 25% of drug costs during the gap. Under the standard plan, reinsurance payments begin when the enrollee has spent $3,850 out of pocket in 2007, out of total drug costs of $5,451.25. Under the enhanced plan, by the time the enrollee's total costs have reached $5,451.25, the enrollee will have paid only $3,087.19 out of pocket. Reinsurance coverage will not begin at this point, because catastrophic coverage is tied by statute to the beneficiary's OOP amount. Instead, the enrollee will go

on paying 75% of costs and the plan 25% until the enrollee has paid the full required out-of-pocket amount of $3,850. In the end, the enrollee in the enhanced plan will have saved just $50.85, while the plan will have spent an extra $864.52. The plan would actually have to charge more in premiums to pay for the gap coverage than the enrollee would save in reduced cost-sharing.

Table 8. Enrollee, Plan, and Federal Reinsurance Shares of Spending under Standard Benefit and Plan with 25% Gap Coverage, Enrollee with $7,500 in Total Spending

	Standard benefit			Enhanced gap coverage		
Spending interval	**Enrollee**	**Plan**	**Federal reinsurance**	**Enrollee**	**Plan**	**Federal reinsurance**
First $265	$265.00	$ 0	$0	$265.00	$0	$0
Next $2,135	$533.75	$1,601.25	$0	$533.75	$1,601.25	$0
Next $3,051.25	$3,051.25	$0	$0	$2,288.44	$762.81	$0
Cumulative spending to this point	**$3,850.00**	**$1,601.25**	**$0**	**$3,087.19**	**$2,364.06**	**$0**
Next $1,017.08	$50.85	$152.56	$813.66	$762.81	$254.27	$0
Remaining $1,031.67	$51.58	$154.75	$825.34	$51.58	$154.75	$825.34
Total spending	**$3,952.44**	**$1,908.56**	**$1,639.00**	**$3,901.58**	**$2,773.08**	**$825.34**
Savings/excess cost under enhanced plan				**($50.85)**	**$864.52**	**($813.66)**

To address this issue, CMS has again used its general Medicare demonstration authority. Under the Reinsurance Payment Demonstration, a plan offering coverage in the gap may opt to receive federal reinsurance in the form of a monthly capitation payment. Instead of being reimbursed for specific enrollees who incur catastrophic costs, the plan receives an extra monthly federal payment for every enrollee. This is set equal to the average per enrollee amount that would have been spent for federal reinsurance if the plan had not offered gap coverage.

Risk Sharing

Because insurers had never offered stand-alone drug benefits prior to 2006 and had to rely on limited data in making their initial bids for 2006 (and, to a lesser degree, 2007), the MMA provides for risk-sharing, limiting total potential losses or profits for a Part D plan. A target amount is established for each plan, equal to the sum of federal premium subsidies and beneficiary premiums minus estimated administrative costs. The plan's actual drug spending, net of any rebates and again excluding administrative costs, is compared to the target after the close of the year. If the plan's drug costs are 2.5% or more above the target,

Medicare shares in the losses; if costs are 2.5% or more below the target, Medicare shares in the profit. Beginning in 2008, plans will assume more risk; Medicare's share of profits or losses will be reduced.

Table 9. Risk Sharing in 2006 and 2007 for a Plan with Target Costs of $1,000

Plan costs	Ratio of plan costs to target amount	Profit/loss sharing	Plan profit (loss)	Medicare profit (loss)
$925	Under 95%	Medicare gets 80% of profit	$15.00	$60.00
$965	95%-97.5%	Medicare gets 75% of profit	$8.75	$26.25
$990	97.5%-100%	Plan keeps profit	$10.00	$ 0
$1,010	100%-102.5%	Plan takes loss	($10.00)	$ 0
$1,035	102.5%-105%	Medicare pays 75% of loss	($8.75)	($26.25)
$1,075	Over 105%	Medicare pays 80% of loss	($15.00)	($60.00)

Plan sponsors can request a limited risk arrangement, under which Medicare would potentially cover a larger share of losses. This is permissible only if necessary to assure that there are at least two plan sponsors in each PDP region, at least one of which is a stand-alone PDP. If there are still not at least two plan sponsors in an area, CMS may contract with a "fallback" plan, which accepts no risk and is reimbursed for the entire cost of providing the drug benefit (minus a 25.5% beneficiary premium). So far, it has not been necessary to make use of these provisions, because multiple national PDP sponsors are serving every region in the country.

Payments to Employer Plans

Before the implementation of Part D, many Medicare beneficiaries had some form of prescription drug coverage as part of retiree benefits offered by their former employers. In order to encourage these employers to continue existing benefits, MMA provides subsidies for part of the cost of an employer plan that provides drug coverage at least actuarially equivalent to standard Part D coverage. The subsidy pays 28% of costs incurred by the employer between the deductible and an upper limit of $5,350 per enrollee in 2007.

Employers providing retiree benefits have two other options (other than dropping drug coverage altogether). An employer may choose to develop its own Part D plan available exclusively to its retirees. It would then receive the larger federal premium and reinsurance subsidies available to other PDPs, but would take on added administrative burdens. Or an employer can offer wrap-around drug coverage, supplementing the Part D benefit—for example, by picking up costs for enrollees during the coverage gap—and perhaps assisting

with retiree's share of the PDP premium. However, if the employer pays some or all of the retiree's cost-sharing, the amounts involved are not counted as true out-of-pocket cost for the purpose of determining when the enrollee has reached the OOP threshold. The enrollee will not qualify for catastrophic coverage until he or she has directly paid the required $3,850. This might mean that federal reinsurance payments would never kick in, while the employer's obligation would continue indefinitely.

As of 2004, there were an estimated 12.9 million Medicare beneficiaries with retiree health benefits; it is not known how many of these had any drug coverage.[9] In July 2006, 6.9 million beneficiaries were in retiree plans that had qualified for federal subsidies.[10] Another 3.5 million were federal retirees; the Federal Employees Health Benefits (FEHB) program and Tricare have opted not to seek Part D subsidies, which would merely shift federal spending from one budget line to another. Only a handful of employers have opted to develop their own Part D plans, covering just 114,348 beneficiaries in August 2006.[11]

PAYMENT ISSUES

Treatment of Medicare Advantage Plans

Of the nearly 24 million beneficiaries receiving Part D benefits in August 2006, 6 million were in MA-PD plans, which provide the full range of Medicare-covered services as well as drugs.[12] There are three types of Medicare Advantage plans: coordinated care plans (CCPs), which are local HMOs or PPOs; regional PPOs; and private fee-for-service (PFFS) plans. CCPs and PFFS plans serve a limited geographic area defined by the plan; regional PPOs serve an entire region defined by CMS. (The 26 PPO regions are not the same as the 34 PDP regions.) In August 2006, 90.3% of MA-PD enrollees were in local CCPs and 8.3% in PFFS plans.[13] Because only 1.4% of enrollees were in regional PPOs, the following discussion focuses on payments to CCPs and PFFS plans.

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[9] Merlis, Mark. *Health Benefits in Retirement: Set for Extinction?* Washington, National Health Policy Forum, Feb. 2006.
[10] CMS estimate, available at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PartDTotalBeneficiariesCoverage.zip, accessed Nov. 2006.
[11] CMS monthly summary data, available at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/MonthlySummaryReport.zip, accessed Nov. 2006.
[12] CCPs and regional PPOs must offer drug coverage; PFFS plans may offer drug coverage. Beneficiaries may enroll in MA plans for non-drug benefits only, but can obtain Part D benefits outside the plan only if they are in a PFFS plan that does not offer drug coverage.
[13] CMS monthly summary data.

MA-PD plans bid separately for Medicare Part A and B benefits (hospital, physician and other non-drug services) and Part D. A plan's bid for Part A and Part B benefits is compared to a CMS-established benchmark, which is different for each county. The overall benchmark for the plan is a weighted by the plan's enrollment in each county. If the plan's bid is higher than the benchmark, enrollees must pay the difference. If the plan's bid is lower than the benchmark, 25% of the savings is retained by the federal government. The other 75% is required to be shared with beneficiaries in the form of supplemental benefits. So, for example, if the benchmark for a plan's service area is $1,000 per month and the plan bids $900, the plan is paid $975 (the bid plus 75% of the difference between the bid and the benchmark) and the plan must provide $75 worth of additional benefits. This might include a rebate of a portion of the Part B premium, waiver of required Part A or B deductibles or coinsurance, or other benefits. The plan may also apply the money toward the Part D benefit, reducing or eliminating its premium or providing enhanced benefits at no additional charge.

The bidding/benchmark system for MA is new in 2006. Previously, payments for MA plans (and comparable organizations before the MMA) were fixed, with county-level payment rates. These were originally based on Medicare fee-for-service (FFS) spending in the same county. There was and is substantial variation in FFS spending by county—between urban and rural areas, between one urban area and another, and even between adjacent counties in the same urban area. As a result, many plans chose to operate in high-paying areas and avoid others. The Balanced Budget Act of 1997 sought to encourage wider availability of plans by setting floor amounts for urban and rural counties and by limiting the annual rate of increase in rates for the highest-paid counties. While the aim was to encourage plans to move into previously unserved areas, the limits on rate increases in areas plans were already serving led many plans to drop out of the program. After a series of legislative adjustments to reverse this trend, MA payment rates by 2005 were above the FFS level in all counties and significantly higher in some. These rates formed the basis for the county-level benchmarks used in 2006. For later years, they will be updated by the estimated annual increase in Medicare Part A and Part B spending. MA plans will therefore continue to be paid more than the cost of furnishing the original Medicare program in the same area.

The overpayment has been temporarily compounded by the way CMS is implementing health risk adjustment for MA plans. As in the case of Part D payments, payment to plans for Part A and B services is adjusted to reflect

demographic characteristics of enrollees and health risk as measured by the hierarchical condition category (HCC) system described earlier. (The classification and weighting are different, because the aim is to predict medical use rather than use of drugs.) On average, the Medicare beneficiaries who have chosen to enroll in MA plans are healthier than those who remained in original Medicare; the health risk adjustment should reduce their payments. However, CMS has been applying a budget-neutrality adjustment to the county benchmarks to prevent any risk-related reduction in aggregate payments to MA plans. A plan with lower-risk enrollees is still paid less than one with higher-risk enrollees, but all plans are paid more than they would be with full risk adjustment. This "hold harmless" rule will be phased out by 2010, but benchmarks for 2007 are still 3.9% higher than they would be if full risk adjustment were in effect.

Overall, the Medicare Payment Advisory Commission estimates that the 2006 benchmarks for MA plans are 115% of FFS costs. Payment rates, based in part on plan bids, are 111% of FFS costs.[14] Because benchmarks are set in different ways for different counties, the disparity varies according to the plan's location. One study has estimated that payment rates for some rural counties may be as much as 126% of FFS costs.[15]

Because MA-PD plans can apply some of the difference between their non-drug bid and the benchmark to the drug benefit, they can offer lower premiums and more generous coverage than stand-alone PDPs. For 2007, the average beneficiary drug premium for an MA-PD will be $17.92, compared to $36.79 for PDPs. As Table 10 shows, the MA-PD plans have lower drug premiums for each benefit type, with the disparity greatest for the enhanced alternative plans.

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[14] Medicare Payment Advisory Commission. *Medicare Advantage Benchmarks and Payments Compared with Average Medicare Fee-for-Service Spending*, Washington, 2006.
[15] Biles, Brian. *Medicare Advantage Plans: Different Payments, Different Benefits.* Presentation at 2006 AcademyHealth annual research meeting, available at http://www.academyhealth.org/2006/604/bilesb.pdf, accessed Nov. 2006.

Table 10. Unweighted Average Beneficiary Premium by Type of Drug Benefit, PDPs and MA-PD Plans, 2007

Drug benefit	PDP	MA-PD Plan	
		Drug premium only	Premium for total benefit package
Defined standard	$32.12	$16.35	$62.24
Actuarially equivalent	$24.88	$19.69	$77.75
Basic alternative	$29.30	$19.46	$60.16
Enhanced alternative	$45.66	$17.58	$49.33
All plans	$36.79	$17.92	$52.67

Source: CMS landscape of local PDP and MA plans.

As was noted earlier, beneficiaries in an MA-PD plan pay the plan's comprehensive premium, not only the drug premium. The two amounts are identical about 42% of the time; in the remaining cases, however, the difference is large enough that the average MA-PD plan comprehensive premium for each drug benefit type is higher than the average PDP premium.

Availability of Plans for Low-income Beneficiaries

The maximum low-income subsidy in each region is supposed to be equal to the weighted average beneficiary premium in the region for basic coverage (in the case of PDPs) or any coverage (in the case of MA-PD plans). At the start of 2006, beneficiaries who previously had drug coverage through Medicaid were automatically enrolled in stand-alone PDPs that offered standard or actuarially equivalent basic benefits, and whose premium was at or below the regional subsidy level. As of July 2006, of 16.5 million PDP enrollees, 6.1 million were assigned dual eligibles; another 2.2 million were non-Medicaid beneficiaries eligible for low-income subsidies, who presumably were also drawn to plans with below average premiums. In effect, half of all PDP enrollees were enrolled (or enrolled themselves) in the plans in the lower half of the premium range. Unless all higher-income enrollees had selected more costly plans, the weighted average premium had to decrease. In fact, this is what occurred in 2006: while CMS had initially projected that the average 2006 premium would be about $37—assuming enrollees were equally like to pick each available plan—the average enrollment-weighted premium was actually $24.

As was discussed earlier, CMS has chosen to depart from its planned methodologies for 2007 in order to prevent sharp drops in both the general premium subsidy and the low-income subsidy. The overall effect on the program is discussed at the conclusion of this report. For low-income beneficiaries, the result has been that an estimated 7 out of 8 would be able to

remain in their current plan without paying any premium.[16] Overall, 49% of PDPs with basic benefits in 2007 are available for a premium at or below the applicable regional subsidy. (No stand-alone plan with enhanced alternative coverage is ever available, because the subsidy cannot cover the part of the plan's premium attributable to supplemental benefits.)

Table 11. Percent of Stand-alone PDPs with Basic Coverage Available to Low-Income Subsidy Recipients at Zero Premium, National Firms and Local Plans

Firm	Basic plans	Available at zero premium	Percent
Aetna	34	21	62%
Caremark	34	20	59%
CIGNA	34	27	79%
Coventry	69	15	22%
EnvisionRx	34	0	0%
Express Scripts	34	0	0%
HealthNet	68	52	76%
Humana	34	34	100%
Longs Drug	68	34	50%
Medco	34	0	0%
Member Health	34	14	41%
New Quest	34	29	85%
NMHC	34	2	6%
Torchmark	34	3	9%
United HealthCare	102	67	66%
WellCare	68	63	93%
Wellpoint	44	32	73%
Local	195	70	36%
Total	988	483	49%

Source: CMS landscape of local PDP plans.

As Table 11 shows, however, availability of plans to subsidy recipients varies widely among national PDPs. Obviously, with subsidy limits based on regional averages, about half of plans in each region would be expected to have premiums above the subsidy level. However, three firms—all associated with major pharmaceutical benefit management (PBM) companies—have no plan with a premium below the subsidy level in any region. On the other hand, all Humana plans and nearly all WellCare basic plans are available at zero premium in every region. While many factors may be at work, it is possible that some

[16] CMS, "National Benchmark Shows Impact of Strong Competitive Bidding and Smart Beneficiary Choices," press release, Aug. 15, 2006.

firms have made a strategic decision to seek low-income participants, while others have made the reverse decision.

It might appear that there are strong incentives for plans to aim for premiums at or below the subsidy level. Low-income subsidy recipients make up about one-third of the total Part D market, and many of these recipients are automatically assigned, meaning that a subsidy-eligible plan can gain market share without incurring additional marketing costs. Why would any firm wish to avoid low-income subsidy recipients?

One possibility is that some plans might be concerned that these enrollees will be unusually costly. The Part D risk adjustment system gives plans higher payments for subsidy recipients: 8% higher for those with Medicaid and 5% higher for other subsidy recipients. However, because most subsidy recipients pay little or no cost-sharing, their utilization cannot easily be controlled through the financial incentives—such as tiered cost-sharing—used for other enrollees. Instead, a plan might seek to control costs through more restrictive formularies or pre-authorization or step therapy requirements.[17] But one study of plans in four states did not find a pattern of more restrictive coverage in lower-priced plans.[18] And plans' ability to limit their formularies may be affected by a CMS decision to require inclusion of nearly all drugs in certain categories, such as drugs for mental illness, that may be disproportionately used by low-income beneficiaries.

Risk Adjustment

The risk adjustment system adopted by CMS for Part D payments is a combination of demographic factors and factors based on the CMS-HCC disease classification system. The system performs fairly well: the factors used account for 23% of variation in beneficiaries' prescription drug spending. In comparison, the separate CMS-HCC based system for adjusting MA plan payments for non-drug benefits accounts for just 9% of variation.[19] The Part D system may reduce plans' incentives to target low-risk beneficiaries.

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[17] Resnick, Jon. *The Long and Winding Road Ahead: Medicare Part D, Post 2006*, IMS Health, Inc., available at http://www.imshealth.com/ims/portal/front/article/0,2775,6599_5266_76819885,00.html, accessed Nov. 2006.

[18] Heaton, Erika, Tanisha Carino, and Heidi Dix. *Assessing Medicare Prescription Drug Plans in Four States: Balancing Cost and Access*, New York, Commonwealth Fund, Aug. 2006.

[19] Wrobel, Marian, et al. "Predictability of Prescription Drug Expenditures for Medicare Beneficiaries," *Health Care Financing Review*, v. 25, no. 2 (winter 2003-04), p. 37-46. Pope, Gregory, et al. *Diagnostic Cost Group Hierarchical Condition Category Models for Medicare Risk Adjustment*,

A potential weakness in the system is that it overpredicts costs—that is, pays more than likely average plan spending—for very low users.[20] Some degree of overpayment is unavoidable. Even though some share of beneficiaries can be expected to cost the plan nothing—because their spending never reaches the deductible—Medicare cannot pay zero for these people.[21] As a result, there remains some incentive for plans to try to enroll beneficiaries likely to be very low users. One way of doing so might be to manipulate a plan's formulary. CMS is supposed to disapprove formularies that are designed to discourage particular classes of enrollees. But the task of reviewing hundreds of different formularies is complex; the CMS approach at this point is simply to identify outliers—plans whose drug lists are conspicuously out of line with those of their competitors.

One study has shown that overall cost prediction can be improved by including actual data on drug utilization in the preceding year, rather than simply data on medical conditions. For example, people using a given medication for a chronic condition are likely to do so year after year. A system that includes drug use data can account for about 55% of variation in drug spending, compared to the 23% accounted for in the current system.[22] Inclusion of drug use factors in the risk adjustment system will only become feasible once there are several years of actual Part D utilization data. A possible concern is that the drugs a plan furnishes to an enrollee in one year could increase its payments for the same enrollee in the next year, reducing incentives to encourage cost-effective therapies. In any event, a system that does better in predicting overall costs will still overpay for the zero utilizers.

Report prepared for Health Care Financing Administration, Waltham, MA, Health Economics Research, 2000.

[20]CMS, *Advance Notice of Methodological Changes for Calendar Year (CY) 2006 Medicare Advantage (MA) Payment Rates*, available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/Advance2006.pdf, accessed Nov. 2006. The system also overpredicts for the high end of spenders (unlike the MA system, which underpredicts for this group). The CMS explanation is that declining plan responsibility, because of reinsurance, as spending mounts cannot be fully accounted for in the coefficients.

[21] In 2000, nearly one-fifth of Medicare beneficiaries had drug spending of less than $250. (Wrobel et al.). The share of current Part D enrollees with spending below the deductible is probably smaller, because of inflation and because simply having drug coverage is likely to increase utilization.

[22] Wrobel et al.

Geographic Adjustment

Beneficiaries in different regions are paying different premiums for comparable part D benefits. Average 2007 bids for basic coverage by stand-alone PDPs range from a low of $77.60 in California to a high of $84.89 in Alaska, a 9% difference. Because beneficiary premiums are based on a comparison of plan bids to a national average, the difference in the amounts paid by beneficiaries are much larger: an average of $31.81 for basic coverage in Alaska versus $24.52 in California, a 30% difference.

Some of the variation might reflect differences in the operating efficiency, formularies, or other characteristics of the sponsors of plans available in different areas. However, many of the national PDP firms--those offering a plan in every state for 2007—are bidding different amounts for basic coverage in different regions. Table 12 shows, for each national firm, the firm's minimum bids for basic benefits in the region with its lowest bid and the region with its highest bid. The difference ranges from a low of 7% for Medco and NMHC to 31% for WellCare.

Part D requires the Secretary to develop a methodology "to take into account differences in prices for covered Part D drugs among PDP regions," unless these differences are minimal.[23] CMS has not yet developed a geographic adjustment and has indicated that it will be a few years before there is enough program data to determine whether there are significant regional price differences. The MMA also directs the Secretary to study regional differences in per capita spending that are attributable to factors other than price and to report to Congress by January 2009 on whether a geographic adjustment is appropriate.

[23] Social Security Act, section 1860D-15(c)(2).

Table 12. Bids for Basic Benefits, National PDP Firms, 2007

Firm	Minimum bid for basic benefit		Percent difference
	Lowest cost region	Highest cost region	
Aetna	$77.88	$83.88	8%
Caremark	$75.48	$86.08	14%
CIGNA	$70.48	$84.38	20%
Coventry	$73.38	$91.38	25%
EnvisionRx	$93.08	$101.08	9%
Express Scripts	$95.28	$107.28	13%
HealthNet	$72.98	$81.28	11%
Humana	$63.28	$71.28	13%
Longs Drug	$71.58	$83.78	17%
Medco	$84.48	$90.48	7%
Member Health	$76.38	$87.38	14%
New Quest	$74.18	$81.38	10%
NMHC	$81.48	$87.58	7%
Torchmark	$78.68	$91.28	16%
United HealthCare	$62.88	$77.78	24%
WellCare	$62.78	$82.48	31%
Wellpoint	$69.98	$86.18	23%

Source: CMS landscape of local PDP plans.

Several studies have found minimal geographic variation in prices of commonly used drugs.[24] However, there are significant differences in per capita utilization, and these persist after correction for health risk or disease classification.[25] This might mean that there are differences in the need for prescription drugs that are not captured by available health risk measures. Or spending might vary because physicians in some regions are more prone to prescribe drugs at all for particular conditions or to prescribe more costly drugs. Further analysis is needed to learn if this is so. But it would not be surprising to find regional differences in prescribing patterns comparable to the well-known differences in rates of surgery and other procedures.

If so, would an adjustment for variation in overall utilization rates be appropriate? In the case of the other Medicare benefits covered by Medicare Advantage plans, Congress in 1997 shifted from a rate-setting mechanism that

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[24] Dinlersoz, Emin, et al. *Information and Drug Prices: Evidence from the Medicare Discount Drug Card Program*, Federal Reserve Bank of St. Louis, 2005, available at http://research.stlouisfed.org/wp/2005/2005-072.pdf. Hoadley, Jack. *Geographic Variation in Prescription Drug Prices and Spending*, report prepared for Office of the Assistant Secretary for Planning and Evaluation (ASPE), DHHS, 2005, available at http://aspe.hhs.gov/health/reports/06/drug06/index4.htm, accessed Nov. 2006.

[25] Hoadley; Wrobel et al.

fully reflected local spending differences to a system meant to gradually reduce geographic rate variation. The rationale was that local fee-for-service spending differences largely reflected differences in relative efficiency, and that it was inappropriate to pay MA plans more for operating in counties with inefficient medical practice patterns.[26]

A similar view might dictate that payments to Part D plans ought not to be affected by local prescribing patterns. But there is one important difference: MA plans can actually influence the prescribing patterns of their participating physicians, while stand-alone PDPs cannot influence the physicians their enrollees see. Through formularies and copayments, they may be able to steer enrollees from more to less costly drugs within a category. But they can do nothing if physicians in Ohio tend to recommend surgery for a particular condition while physicians in Florida tend to recommend a costly drug. The absence of a geographic adjustment may mean, not only that beneficiaries must pay more in some areas than in others for comparable coverage, but also that stand-alone PDPs are further handicapped in their competition with MA-PD plans.

CONCLUSION

Before Medicare Part D was implemented in January 2006, there were concerns that the program would be most attractive to beneficiaries with the greatest need for prescription drugs.[27] Without enough low-cost enrollees to offset the costs of the higher utilizers in 2006, plans would have had to raise their bids for 2007. This might in turn have induced more low-cost enrollees to drop out, perhaps leading to a spiral of shrinking enrollment and rising per capita costs.

In fact, first year enrollment, while lower than initially projected, was high enough that the program has probably enrolled a representative mix of high and low-cost beneficiaries (although no data are public available to confirm if this is the case). In addition, enrollees were disproportionately enrolled in low-premium plans. This is partly because about 6 million Medicaid beneficiaries were automatically assigned to the lower-premium PDPs in their region. But other beneficiaries also chose low-premium plans, so that average monthly beneficiary premiums for 2006 were just $24, instead of the $37 projected by CMS before the program began. Table 13 compares unweighted premiums—a simple

[26] The post-1997 system allowed adjustment for local wage levels.
[27] Avalare Health, *The Impact of Enrollment in the Medicare Prescription Drug Benefit on Premiums*, Washington, Kaiser Family Foundation, 2005.

average of the premiums charged by plans—with actual averages weighted by the proportion of enrollees in each plan. Within each type of organization and type of benefit package, enrollees systematically chose options with lower than average premiums.

Table 13. Part D Enrollment and Premiums by Organization and Benefit Type, July 2006

	Enrollment	Percent	Part D premium		Total premium	
			Unweighted	Weighted	Unweighted	Weighted
Stand-alone PDPs						
Actuarial Equivalent	2,650,691	17.1%	$ 33.14	$ 28.74		
Basic Alternative	6,851,578	44.2%	$ 35.52	$ 26.59		
Defined Standard	3,416,008	22.0%	$ 25.74	$ 15.82		
Enhanced Alternative	2,597,156	16.7%	$ 43.24	$ 35.36		
Total	**15,515,433**	**100.0%**	**$ 37.36**	**$ 26.05**		
MA-PD Plans						
Actuarial Equivalent	243,930	4.6%	$ 21.53	$ 21.46	$ 57.88	$ 65.32
Basic Alternative	1,016,680	19.3%	$ 21.31	$ 14.94	$ 65.74	$ 55.50
Defined Standard	322,663	6.1%	$ 23.22	$ 20.31	$ 52.61	$ 35.02
Enhanced Alternative	3,688,914	70.0%	$ 17.67	$ 8.67	$ 45.89	$ 20.50
Total	**5,272,187**	**100.0%**	**$ 19.47**	**$ 11.18**	**$ 52.08**	**$ 30.21**

Source: CMS landscapes of local PDP and MA plans and July 2006 enrollment data, available at http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/AnnualReportbyPlan.zip.
Note: Data exclude plans offered only to members of specific employer groups.

While the result has been savings for the federal government and for beneficiaries, there was an unforeseen consequence. Because the federal contribution to premiums is based on average bids, beneficiaries' choice of lower-premium plans would have meant a reduced federal premium subsidy for 2007. To prevent this, CMS used its demonstration authority to adopt a blended computation that artificially raises subsidies—and hence reduces beneficiaries' average premium costs--for 2007. The size of the adjustment has not been disclosed and cannot be determined from publicly available data. However, it seems unlikely that CMS would have undertaken a last-minute "demonstration," approved just the day before the 2007 benchmarks were released, unless it was

concerned that many beneficiaries would otherwise have faced sharp premium increases.

CMS has not yet announced its plans for 2008, but has indicated that at some point it will return to the statutory system, under which the federal contribution will be fully based on an enrollment-weighted average of plans' bids for basic benefits. This may mean that spikes in beneficiary premiums have merely been postponed for a year or two. If so, some low utilizers might be driven out of the program, perhaps bringing on the selection spiral that some observers have surmised might occur in Part D.

A number of other factors could affect future program costs:

- Some plan sponsors may be "low-balling," temporarily holding down their premiums in order to build up market share. The beneficiary premium for the average stand-alone PDP rose less than 4% between 2006 and 2007, while CMS's projection of the underlying increase in covered per enrollee drug costs is closer to 7%.[28] If plans are accepting short-term losses to drive out competitors, they may have to raise premiums considerably in future years.

- Most employers who provide drug benefits to retirees opted to continue their current plans with the federal employer subsidies for 2006. However, many were uncertain about what strategy they would adopt in future years. A survey of employers with 1,000 or more workers in late 2006 found that 78% expected to continue providing drug coverage and take the federal subsidy in 2007.[29] The same survey found that among employers taking the subsidy in 2006, 79% were "very" or "somewhat" likely to continue drug benefits and accept the federal subsidy in 2008. Only 54% reported that the same was true for 2010, whereas 25% did not know what they would do in that year. Some employers may decide to drop drug coverage and instead help retirees with Part D premiums and cost-sharing. Presumably those employers with the highest-cost retirees would be most prone to shift those enrollees to Part D.

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[28] Actual increase of 4% was calculated by author from 2006 and 2007 PDP landscape files. This is the unweighted average increase for plans offered in both years; many PDP sponsors dropped and/or added plans for 2007. In developing its 2007 benefit parameters, CMS assumed a 6.86% increase in the actuarial value of the standard Part D benefit; see *Medicare Part D Benefit Parameters for Standard Benefit: Annual Adjustments for 2007*, June 2006, available at http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/Downloads/2007_Part_D_Parameter_Update.pdf.

[29] Kaiser Family Foundation/Hewitt Associates *2006 Survey on Retiree Health Benefits*, December 2006.

- Overpayments to MA plans for their Part A and Part B services will be reduced as CMS phases in full MA risk adjustment. Plans may have a smaller surplus with which to subsidize supplemental benefits for enrollees. They may need to decide whether to cut back on non-drug benefits or raise their quoted premiums for the Part D benefit.

In sum, the complex payment system for Part D plans means that future costs to beneficiaries and to the federal government will be determined by the interplay of individual decisions by plan sponsors, employers, and enrollees themselves. As a result, it may be some years before it is clear whether the Part D program is equitable and sustainable in its current form.

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