MEDICARE PART D 2009 DATA SPOTLIGHT:

LOW-INCOME SUBSIDY PLAN AVAILABILITY

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The Medicare Part D drug benefit provides premium and cost-sharing assistance to beneficiaries who qualify for the program's low-income subsidy (LIS). Medicare beneficiaries who qualify for full Medicaid benefits (dual eligibles), those enrolled in Medicare Savings Programs (MSP), and those receiving Supplemental Security Income (SSI) automatically qualify for the LIS. Other beneficiaries must apply for the LIS through the Social Security Administration (SSA) or Medicaid and qualify for full or partial subsidies if their income and assets are below specified levels.[1] Full-benefit dual eligibles are randomly assigned to certain stand-alone prescription drug plans (PDPs) (auto-enrollment), while other LIS beneficiaries can choose a Part D plan on their own but are randomly assigned to a PDP if they do not enroll on their own (facilitated enrollment). Unlike other Part D enrollees, those receiving the LIS can switch plans at any time during the year. The federal government pays plans for the monthly premiums, deductibles, and coverage gap expenses of LIS beneficiaries with full subsidies, while LIS beneficiaries pay modest copayments for each on-formulary prescription and the full cost of any drugs not on their plan's formulary.

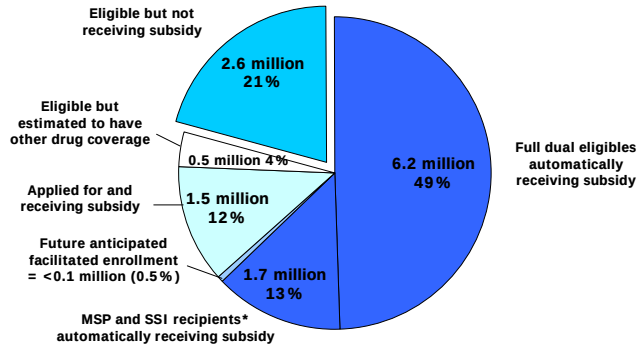
Issues of particular interest with regard to the LIS program include lower-than-expected take-up of LIS, the declining availability of plans that can enroll LIS beneficiaries for no monthly premium from year to year, variation in plan availability across regions, and the instability for beneficiaries that results from the annual process for reassigning certain LIS beneficiaries to new plans. This Part D Data Spotlight focuses on the market dynamics for Part D plans related to these issues and implications for LIS beneficiaries. This research, based on the authors' analysis of data from the Centers for Medicare & Medicaid Services (CMS), is part of a broader effort analyzing Medicare Part D plans in 2009 and trends since 2006, with key findings summarized in a series of data spotlights.[2]

ENROLLMENT IN THE LOW-INCOME SUBSIDY

The most recent data available indicate that an estimated 12.5 million beneficiaries are eligible for the LIS in 2008, of whom 9.4 million are actually receiving it (Exhibit 1).[3] Most LIS recipients (7.9 million) did not have to apply for the subsidy because they were automatically qualified ("deemed" eligible) through Medicaid, MSP, or SSI, while 1.5 million applied on their own and were determined eligible by SSA. Another 0.5 million LIS eligibles have creditable drug coverage from some source other than Part D, such as the Department of Veterans Affairs. The remaining 2.6 million beneficiaries (21 percent of total eligibles) are not receiving the LIS, some of whom may be enrolled in a Part D plan, while others may be going without drug coverage entirely.

Exhibit 1

Eligibility and Participation in Medicare Drug Benefit Low-Income Subsidies, 2008



Beneficiaries Eligible for Low-Income Subsidies = 12.5 million

NOTES: MSP is Medicare Savings Program; SSI is Supplemental Security Income.
SOURCE: US Department of Health and Human Services, January 31, 2008 (Data as of Jan 2008).

Eligibility for the LIS is not always continuous from year to year. LIS beneficiaries who lose eligibility for Medicaid, MSP, or SSI during the year are not automatically qualified for LIS the following year, and must apply for the LIS on their own. This is the case for 447,000 beneficiaries who are losing their deemed status between 2008 and 2009.[4] Another 253,000 LIS beneficiaries are required to provide updated income and assets information to SSA in order to maintain their LIS eligibility for 2009.[5]

THE AVAILABILITY OF BENCHMARK PLANS FOR LIS BENEFICIARIES

Although LIS beneficiaries can enroll in any Part D plan, either a stand-alone PDP or a Medicare Advantage prescription drug (MA-PD) plan, they are only auto-assigned to PDPs. Just 18 percent of all PDPs in 2009 qualify for automatic or facilitated enrollment of LIS beneficiaries (Exhibit 2). This is the lowest share since the inception of the Part D benefit. These "benchmark" plans have monthly premiums below a benchmark amount calculated for each region, enabling LIS beneficiaries to enroll and pay no monthly premium. The number of benchmark plans for 2009 varies greatly across regions, from one PDP in Nevada (out of 49 PDPs in the region) and two PDPs in Arizona (out of 49 PDPs) to 16 PDPs in Wisconsin (out of 53 PDPs). In six states, there are five or fewer benchmark plans.

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Calculating the LIS Benchmark. The variation in benchmark plan availability across regions is a function of variation in the regional benchmarks, which average nearly $30 for 2009 but range from a low of $16.22 in Arizona to a high of $38.15 in Wisconsin. Regional benchmarks are calculated based on the average premium for stand-alone PDPs and MA-PD plans offering basic (or actuarially equivalent) Part D benefits. If no plan has a monthly premium below the benchmark amount for a specific region, the benchmark is increased to the lowest monthly premium for a basic plan offered in that region. This rule was invoked for the first time in Nevada for 2009 to guarantee the availability of one benchmark plan in that region.

On average, MA-PD plan premiums are lower than stand-alone PDP premiums, in part because Medicare Advantage plans can use savings from other health services (rebates) to reduce their drug benefit premiums. Because MA-PD plan premiums are included in the calculation of the benchmark, lower regional benchmarks are observed in regions with a higher penetration of MA-PD plans. Although MA-PD plan premiums are included in the benchmark calculation, MA-PD plans cannot qualify as benchmark plans (plans in which LIS beneficiaries can enroll without paying premiums) for purposes of assignment of beneficiaries to plans, even if their premiums are below the benchmark; however, LIS beneficiaries may opt to enroll in MA-PD plans. This is also the case for Part D plans offering enhanced benefits. LIS beneficiaries who enroll in enhanced plans pay the portion of the premium corresponding to the enhanced benefits, even if the total premium is below the benchmark.

Regional variation in the benchmarks is also affected by the use of enrollment-weighted average premiums in calculating the benchmark amounts, which are lower than the non-weighted averages. Plans with lower premiums tend to have higher enrollment, which gives them greater weight in the benchmark calculation, thereby reducing the regional benchmark amounts. The overall result is a smaller number of plans available to LIS recipients, causing even more concentrated enrollment in low-premium plans.[6]

For the 2007 and 2008 plan years, CMS used its demonstration authority to phase in enrollment weighting in calculating regional benchmarks, and also used demonstration authority to implement a "de minimis" policy.[7] Under this policy, LIS beneficiaries who were enrolled in a plan losing benchmark status were allowed to stay in that plan and retain the full premium subsidy as long as the new monthly premium did not exceed the regional benchmark by more than a small (de minimis) amount.[8] Starting in 2009, the de minimis rule is not in effect and CMS is using full enrollment weighting in calculating the regional benchmarks. However, CMS issued a regulation specifying that for 2009 and future years, enrollment weighting will only factor in the number of LIS enrollees in a plan, as opposed to total enrollment.[9] This rule is intended to promote stability in benchmark plan availability from year to year by reducing the impact of lower MA-PD plan premiums on the benchmark calculation.

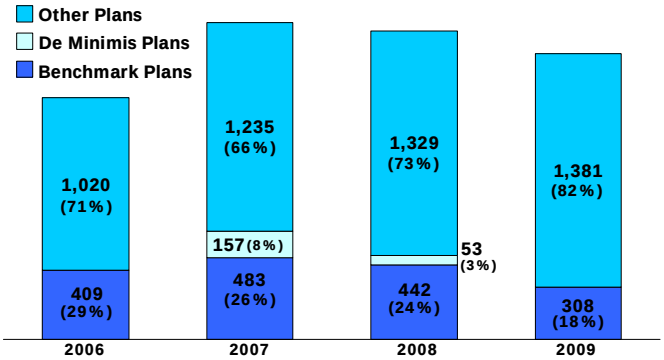
ANNUAL VARIATION IN THE NUMBER OF BENCHMARK PLANS, 2006-2009

As a result of annual changes in the regional benchmarks and changes in Part D plan offerings, the overall number of benchmark plans has declined substantially from 483 plans (26 percent) in 2007 to 308 plans (18 percent) in 2009 (Exhibit 2). For 2009, LIS beneficiaries will have 134 fewer benchmark plans available to them for no monthly premium than in 2008.

Changes occur from year to year not only in the overall number of benchmark plans, but also in the specific benchmark plans available as plans lose or gain benchmark status and as plans enter or leave the market. Just over half (54 percent, or 267 plans) of the 495 zero-premium plans for LIS beneficiaries in 2008 (442 benchmark plans and 53 de minimis plans) are benchmark plans in 2009. The remaining 46 percent either no longer qualify as benchmark plans or are no longer offered.

Exhibit 2

Distribution of Medicare Prescription Drug Plans, by Benchmark Plan Status, 2006-2009



NOTE: Excludes PDPs in the territories.
SOURCE: Georgetown/NORC analysis of CMS PDP Landscape files, 2006-2009, for the Kaiser Family Foundation.

LIS beneficiaries who are enrolled in a plan that does not qualify as a benchmark plan in 2009 will either be automatically reassigned by CMS to a new plan or need to take action to switch into a different benchmark plan if they want to avoid paying premiums and other cost-sharing requirements.

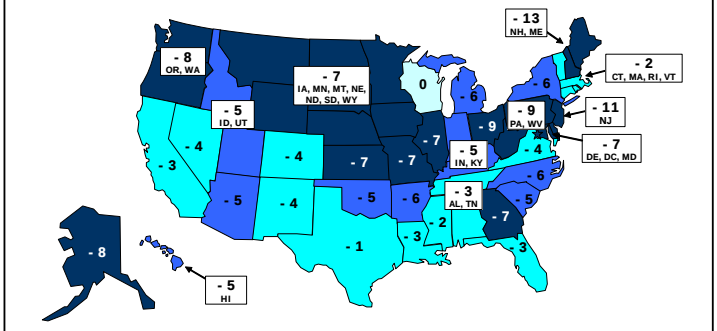
Of the 409 benchmark plans offered in 2006 (the program's first year), only 96 plans (23 percent) have qualified as benchmark plans each year since then.[10] Thus, a relatively small share of LIS beneficiaries enrolled in Part D since 2006 are likely to have had stable coverage from the same PDP over the four-year period.

Variation in Benchmark Plan Availability by Region. The number of benchmark plans by region has varied annually since the start of the program. In the majority of regions, at least 10 benchmark plans were available in 2006, 2007, and 2008. The phasing in of enrollment-weighting and the use of the "de minimis" rule created more benchmark plans than would otherwise have been the case in 2007 and 2008. Between 2008 and 2009, however, the number of benchmark plans decreased by 187 (211 plans lost their benchmark status, 17 benchmark plans left the market, 23 existing plans gained benchmark status, and 18 new plans entered the market and qualified as benchmark plans). As a result, the number of benchmark plans available to LIS recipients declined in all but one of the 34 regions (Wisconsin) for 2009 (Exhibit 3). The decline in the number of benchmark plans per region ranges from 1 plan to 13 plans.

Exhibit 3

Decrease in Benchmark Plans, By Region, 2008-2009

Net Decrease in Benchmark Plans Across All Regions = -187



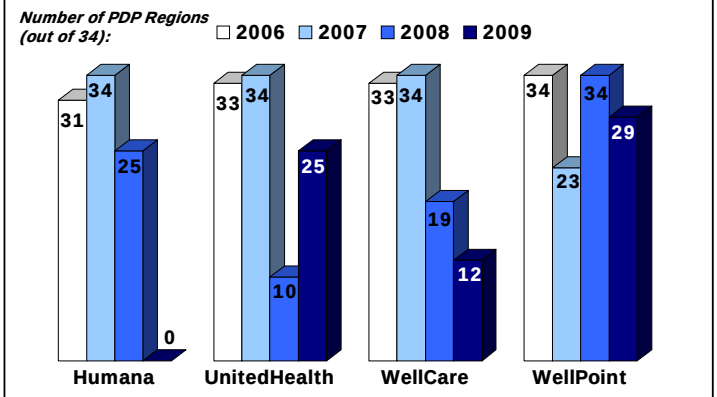
SOURCE: Georgetown/NORC analysis of CMS PDP Landscape files, 2006-2009, for the Kaiser Family Foundation.

Variation in Benchmark Plan Availability by Organization. Variation in benchmark plan availability partly reflects strategic decisions by sponsoring organizations in setting their premiums. Some organizations may actively seek the enrollment of LIS beneficiaries and the guaranteed subsidy payments they bring, and thus may attempt to ensure that their premiums come in lower than the regional benchmarks. Other organizations, hoping to avoid LIS beneficiaries out of concern that risk-adjusted payments will not adequately compensate for these enrollees' drug expenses, may aim to set their premiums higher than expected benchmarks.

The uneven availability of benchmark plans from year to year can be illustrated by examining changes over time among the four major organizations with benchmark plans in all or most of the 34 PDP regions in 2006 (excluding the territories): Humana, UnitedHealth, WellCare, and WellPoint (Exhibit 4). The regional availability of benchmark plans offered by WellPoint has been the most stable across the four-year period. Humana and WellCare offered benchmark plans in far fewer regions after 2007, while UnitedHealth is the only one of the four organizations to offer more benchmark plans in 2009 than in 2008, following a sharp decline between 2007 and 2008. Humana no longer offers benchmark plans in any region in 2009, which is expected to result in a loss of nearly 10 percent of its enrollees between 2008 and 2009.[11]

Exhibit 4

Regional Variation in Benchmark Plans Offered by Four Major Part D Organizations, 2006-2009



SOURCE: Georgetown/NORC analysis of CMS PDP Landscape files, 2006-2009, for the Kaiser Family Foundation.

RANDOM ASSIGNMENT OF LIS BENEFICIARIES TO BENCHMARK PLANS

Each year, LIS beneficiaries who were auto-enrolled by CMS in plans that will lose benchmark status in the coming year are randomly reassigned to a new benchmark plan. For some beneficiaries, the reassignment may be to a different plan offered by the same sponsoring organization, while for others it may be to a different plan offered by a different organization. All LIS beneficiaries retain the right to switch plans at any time for any reason, but CMS does not re-assign LIS beneficiaries who selected their Part D plan on their own or made a decision to switch out of their original auto-assigned PDP (a group referred to as "choosers"). These "choosers" may have switched plans (either on their own or with the assistance of others) because they were auto-assigned to a PDP that did not provide the best coverage for the prescription drugs they take. "Choosers" whose plans are losing benchmark status receive a notice from CMS informing them that they must enroll in a new benchmark plan on their own or pay the amount of the premium that exceeds the benchmark.

Although LIS beneficiaries who are assigned to new benchmark plans maintain the same level of subsidy, they may face disruptions in filling their prescriptions because random assignment does not match an individual's prescription drug use with the list of drugs covered by benchmark plans. The new benchmark plan may have different drugs on

formulary or different utilization management (UM) requirements.[12] Because LIS beneficiaries are at risk for the cost of off-formulary drugs, assignment to a plan not listing their drugs means they must either pay out of pocket or work with their doctor to make a switch, or possibly skip filling their prescriptions. In the event of a particularly ill-suited random assignment, a beneficiary who takes many drugs can face potential out-of-pocket costs of over $6,000, as shown in examples developed for the Medicare Payment Advisory Commission (MedPAC).[13]

Benchmark Plan Reassignments, 2006-2009. Between 2006 and 2007, CMS reassigned 1.1 million beneficiaries to new benchmark plans. With the phasing in of enrollment-weighted regional benchmarks, the number of reassignments between 2007 and 2008 was much higher; CMS reassigned 2.1 million beneficiaries (22 percent of all LIS enrollees), to new benchmark plans. CMS also notified about 443,000 beneficiaries (the "choosers") that they needed to choose a new benchmark plan in order to avoid paying a premium for Part D coverage in 2008. Between 2008 and 2009, 1.6 million LIS beneficiaries will be reassigned to a new plan by CMS, while another 620,000 "choosers" will be notified about the premium increase for their current plan but will not be reassigned.[14]

DISCUSSION

The number of Medicare drug plans available to LIS recipients for no monthly premium has steadily declined since 2007, a decline which has been more dramatic in some regions than others. For 2009, LIS beneficiaries in most states have only a handful of PDPs available to them for no monthly premium, compared to all other beneficiaries who have dozens of drug plans to choose from. Although LIS beneficiaries have the right to switch plans at any time, those who choose to shop around are faced with increasingly limited options if they want to maintain their full premium subsidy.

The system used to designate plans for LIS recipients has resulted in a disruption in drug coverage for low-income Part D enrollees, affecting more than one million low-income beneficiaries between 2006 and 2007, 2.1 million between 2007 and 2008, and 1.6 million between 2008 and 2009. This does not include the growing number of low-income beneficiaries (the "choosers"), totaling more than 600,000 for 2008, who switched out of the plan to which they were originally assigned and who will need to enroll in another plan to avoid paying premiums and cost-sharing. The disruption in coverage for low-income beneficiaries, such as those dually eligible for Medicare and Medicaid who have higher than average medical and pharmaceutical needs, can pose significant challenges.

Furthermore, the process for assigning low-income recipients to Part D plans has raised concerns because it does not take into account the specific drug needs of the individual, which can have unintended negative consequences on enrollees' access to medications. CMS has recently taken steps to help stabilize the availability of benchmark plans from one year to the next, but policymakers may want to consider additional strategies to promote continuous coverage from year to year in plans that are most likely to meet the medication needs of Medicare's low-income beneficiaries. One option would be for CMS to increase the pool of plans available to LIS recipients to include plans that offer enhanced benefits if their premiums are below the regional benchmarks. Another approach would be to adopt a more beneficiary-centered way to assign beneficiaries to plans, based on their individual drug needs.[15]

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[1] In 2008, LIS eligibility for an individual is determined by income less than $15,600 (150 percent of poverty) and assets less than $7,790 (amounts are higher for married couples).
[2] Other Medicare Part D 2009 Data Spotlights, based on the authors' analysis of CMS data, are available at http://www.kff.org/medicare/med110608pkg.cfm.
[3] U.S. Department of Health and Human Services (HHS), "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop", January 31, 2008 (data as of January 2008).
[4] CMS, "State Counts: Grey Loss of Deemed Status Notice Sent to Those Who No Longer Automatically Qualify for Extra Help (Low Income Subsidy) in 2009," (as of September 2008); accessible at http://www.cms.hhs.gov/LimitedIncomeandResources/Downloads/2008_Re-Deeming_Data_Loss_Status.zip.
[5] CMS, National Medicare Training Program Audio-Conference Training, October 28, 2008.
[6] For more on the impact of enrollment weighting, see "A Closer Look at the Medicare Part D Low-Income Benchmark Premium: How Low Can It Go?" National Health Policy Forum, http://www.nhpf.org/pdfs_ib/IB813_LowIncomeBenchmark_08-02-06.pdf.
[7] CMS Memorandum to All Part D Plan Sponsors and MA Organizations, June 8, 2006.
[8] CMS Memorandum to All Part D Plan Sponsors, August 30, 2006. The de minimis amounts were $2 in 2007 and $1 in 2008.
[9] HHS, CMS. Medicare Program; Modification to the Weighting Methodology Used to Calculate the Low-Income Benchmark Amount. 42 CFR Parts 422 and 423. Federal Register 73(65):18176-18182. April 3, 2008.
[10] Of the 96 plans, 77 were consistently benchmark plans and 19 of them sometimes qualified on a de minimis basis. For another 69 benchmark plans in 2006 that lost benchmark status in subsequent years, LIS beneficiaries were automatically switched to other benchmark plans offered by the same organization that were similar in most regards to their predecessors.
[11] "Humana to Lose Some Medicare Enrollees," The Wall Street Journal, September 10, 2008.
[12] CMS requires plans to allow beneficiaries to refill any prescription for 30 days without imposing UM requirements and to provide a 90-day period before applying rules that were not imposed by the beneficiary's previous plan. Beneficiaries also can request an exception or appeal a plan's decision regarding coverage of a particular drug.
[13] Georgetown University and NORC at the University of Chicago, Contractor Report: The Role of Beneficiary-Centered Assignment for Medicare Part D. Conducted for the Medicare Payment Advisory Commission, June 2007; accessible at http://www.medpac.gov/documents/June07_Bene_centered_assignment_contractor.pdf. See also "Beneficiary-Centered Assignment and Medicare Part D," Presentation at MedPAC meeting, September 4, 2008; accessible at http://www.medpac.gov/transcripts/Hoadley%20MedPAC%20presentation%2009%2004%2008.pdf.
[14] CMS communication to authors; "CMS Mailing to People with Medicare Who Receive Extra Help," November 3, 2008; accessible at http://www.cms.hhs.gov/limitedincomeandresources/.
[15] Ibid.