THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

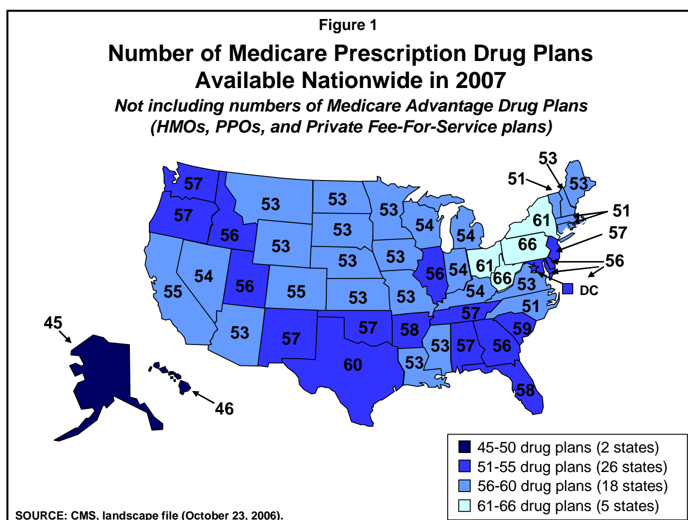
THE MEDICARE PRESCRIPTION DRUG BENEFIT

June 2007

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for people on Medicare, known as Part D. All 44 million elderly and disabled beneficiaries have access to the Medicare drug benefit through private plans approved by the federal government. Medicare replaces Medicaid as the primary source of drug coverage for low-income and disabled people with both Medicare and Medicaid ("dual eligibles"). Assistance with drug benefit premiums and cost sharing is available for beneficiaries with low incomes and modest assets.

MEDICARE PRESCRIPTION DRUG PLANS

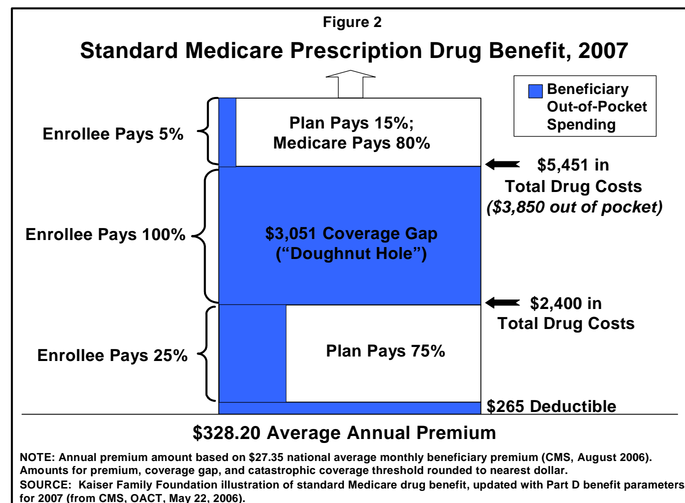
The drug benefit is offered through two types of private plans: stand-alone prescription drug plans (PDPs) that supplement fee-for-service Medicare, and Medicare Advantage prescription drug (MA-PD) plans, such as HMOs or PPOs, that cover drugs and other Medicare benefits. In 2007, a total of 1,875 PDPs are offered across the 34 PDP regions nationwide (excluding the territories), up from 1,429 in 2006. Beneficiaries in most states have a choice of at least 50 stand-alone PDPs and multiple MA-PD plans (Figure 1).



PART D PLAN BENEFITS AND PREMIUMS

Part D plans offer either a defined standard benefit or an alternative equal in value ("actuarially equivalent"), and can also offer enhanced benefits. The standard benefit in 2007 has a $265 deductible and 25% coinsurance up to an initial coverage limit of $2,400 in total drug costs, followed by a coverage gap (the so-called "doughnut hole") where enrollees pay 100% of their drug costs until they have spent $3,850 out of pocket (Figure 2).

Thereafter, the plan pays 95% of total drug costs. The standard benefit amounts are set to increase annually by the rate of per capita Part D spending growth.



In 2007, only a small share (12%) of PDPs nationwide offer the standard drug benefit. The majority of PDPs (60%) have no deductible, and 86% charge tiered copayments for covered drugs rather than 25% coinsurance. However, most PDPs have a coverage gap; less than 2% of PDPs nationwide cover both brand-name and generic drugs in the gap. In 11 states, there are no PDPs available that offer gap coverage for brand-name drugs.

Just over 3 million Medicare beneficiaries are projected to have spending in the coverage gap in 2007, according to analysis by Actuarial Research Corporation for the Kaiser Family Foundation. This includes an estimated 2.2 million beneficiaries who are projected to remain in the coverage gap, and 1.0 million who are projected to qualify for catastrophic coverage.

The monthly Part D premium averages $27.35 in 2007, but actual premiums vary across plans and regions, ranging from a low of $9.50 for a basic benefit PDP to a high of $135.70 for a PDP with enhanced benefits. Part D plans approved by CMS for 2007 vary in benefit design, covered drugs, and utilization management tools, such as prior authorization, quantity limits, and step therapy. CMS established minimum requirements for Part D plan formularies (the list of covered drugs) to help ensure that plans do not offer formularies that discriminate against or discourage enrollment of certain types of beneficiaries.

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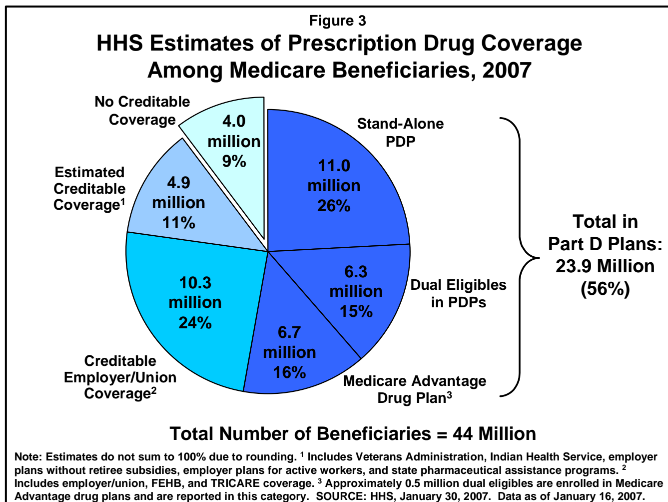
PART D ENROLLMENT

Enrollment in Medicare drug plans is voluntary for most beneficiaries, with the exception of dual eligibles and certain low-income beneficiaries who are automatically enrolled if they do not choose one on their own. However, unless beneficiaries have coverage that is at least as good as standard Part D coverage ("creditable coverage"), they face a penalty equal to 1% of the national average monthly premium ($27.35 in 2007) for each month they delay enrollment.

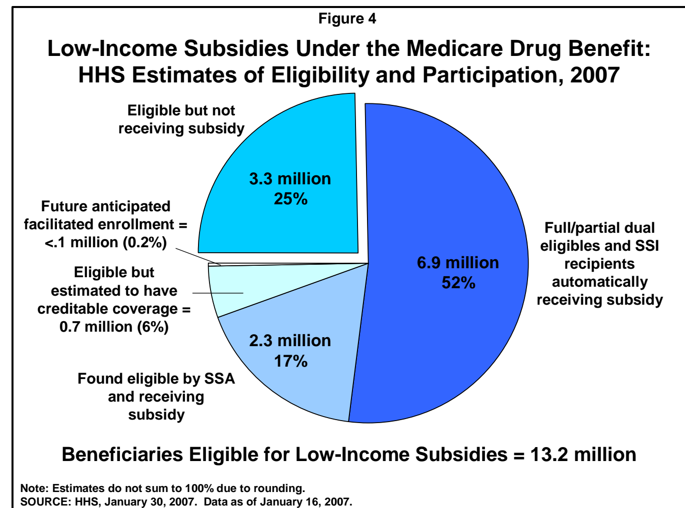
As of January 2007, HHS reported that 23.9 million beneficiaries are enrolled in Medicare Part D plans, and 10.3 million have creditable drug coverage through retiree plans, including FEHB and TRICARE (Figure 3). (Employers offering creditable drug coverage to their retirees can receive tax-free subsidies equal to 28% of drug expenses between $250 and $5,000 per retiree.) Another 4.9 million were estimated to have other sources of creditable coverage, such as the Veterans Administration. Based on HHS estimates, approximately 4 million beneficiaries, or 10% of the Medicare population, have no creditable drug coverage in 2007.



ASSISTANCE FOR LOW-INCOME BENEFICIARIES

Part D includes substantial premium and cost-sharing assistance for beneficiaries with low incomes (less than approximately $15,000 for individuals) and modest assets (less than $11,500 for individuals). Dual eligibles, QMBs, and SLMBs automatically qualify for the additional assistance, and Medicare automatically enrolls them into PDPs with premiums at or below the regional average if they do not choose a plan on their own. Other beneficiaries are subject to both an income and asset test and need to apply for the low-income subsidy (LIS) through either the Social Security Administration (SSA) or Medicaid, along with enrolling in a Part D plan. Individuals determined eligible for LIS are assigned to a PDP if they do not enroll on their own.

As of January 2007, HHS estimated that 13.2 million beneficiaries were eligible for low-income assistance, of which 9.2 million (including dual eligibles) were receiving the subsidy (Figure 4) and an estimated 3.3 million LIS-eligible beneficiaries were not receiving this assistance.



EXPENDITURES AND FINANCING FOR PART D

HHS estimates that benefit payments for the Medicare drug benefit will be $50 billion in 2007 and $933 billion between 2008 and 2016. Costs depend on several factors, including the number of beneficiaries who enroll, their health status, the number of low-income subsidy recipients, and the ability of plans to negotiate drug price discounts and manage utilization. Plans are expected to produce savings by managing use and negotiating price discounts and rebates with drug companies; the MMA prohibits Medicare from negotiating drug prices directly. In 2006, HHS actuaries estimate that plans achieved average savings of 21% from retail discounts and utilization management (Trustees 2007).

Financing for Part D comes from beneficiary premium payments, state contributions (the so-called "clawback"), and general revenues. The monthly premium paid by enrollees is set to cover 25.5% of the cost for standard drug coverage. CMS subsidizes the remaining 74.5%, based on bids submitted to CMS by plans for their expected benefit payments. In 2006, private plans received payments of $766 per enrollee overall and $1,715 for LIS enrollees; and employers received $549 for retirees in employer-subsidy plans (Trustees 2007). Plans can also receive additional risk-adjusted payments for high-cost enrollees and reinsurance payments for 80% of costs above the catastrophic threshold. A Part D plan's total potential losses or profits are limited by risk-sharing arrangements with the federal government.

FUTURE CHALLENGES

The Medicare drug benefit offers beneficiaries help with out-of-pocket drug spending, which is especially important to those with low incomes, those who lacked drug coverage prior to 2006, and people with catastrophic drug expenses. As Part D matures, several areas will be important to monitor, including: enrollment; plan stability; benefit design and formulary changes; cost sharing and access to medications; and low-income subsidy participation. Careful monitoring and oversight by the federal government is important to ensure that Medicare drug plans provide beneficiaries with needed protection against high and rising drug costs.

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