THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

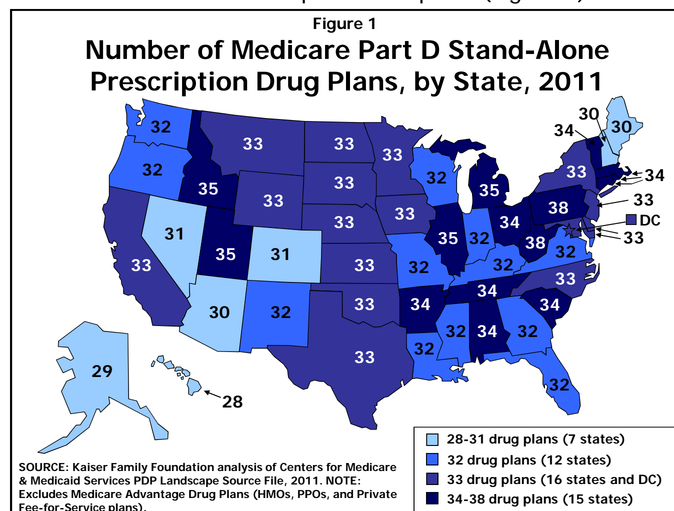
THE MEDICARE PRESCRIPTION DRUG BENEFIT

OCTOBER 2010

The Medicare Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for people on Medicare, known as Part D, that went into effect in 2006. All 47 million elderly and disabled beneficiaries have access to the Medicare drug benefit through private plans approved by the federal government. Medicare replaced Medicaid as the source of drug coverage for beneficiaries with coverage under both programs ("dual eligibles"). Beneficiaries with low incomes and modest assets are eligible for assistance with Part D plan premiums and cost sharing. The Affordable Care Act of 2010 made some important changes to the drug benefit – in particular, phasing out the coverage gap by 2020.

Medicare Prescription Drug Plans

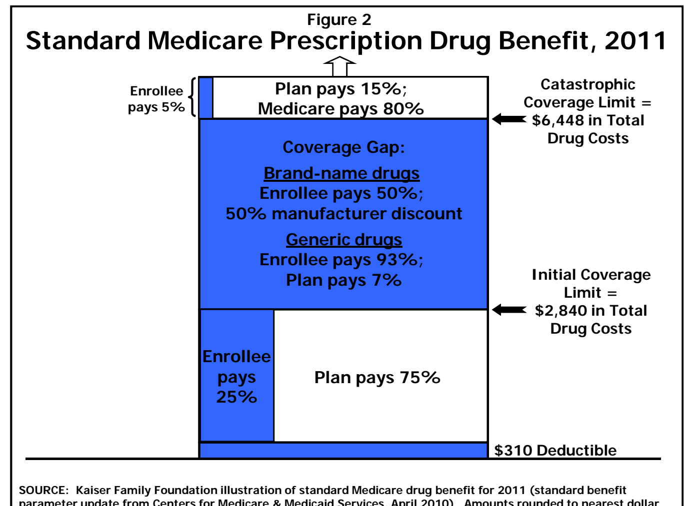
The drug benefit is offered through stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans, such as HMOs, that cover all Medicare benefits including drugs. In 2011, 1,109 PDPs will be offered across the 34 PDP regions nationwide (excluding the territories). Beneficiaries in each state will have a choice of at least 28 stand-alone PDPs and multiple MA-PD plans (Figure 1).



Part D Plan Benefits and Premiums

Part D sponsors offer plans with either a defined standard benefit or an alternative equal in value ("actuarially equivalent"), and can also offer plans with enhanced benefits. The standard benefit in 2011 has a $310 deductible and 25% coinsurance up to an initial coverage limit of $2,840 in total drug costs, followed by a gap in coverage where enrollees have been responsible for 100% of the total cost of their drugs until they reach the catastrophic coverage limit.

The health reform law gradually lowers out-of-pocket costs in the coverage gap. Beginning in 2011, enrollees who reach the gap will receive a 50% manufacturer discount on the total cost of brand-name drugs. Medicare will phase in additional subsidies for brand-name drugs (beginning in 2013) and generic drugs (beginning in 2011), reducing the beneficiary



coinsurance rate in the gap to 25% by 2020. Thus, enrollees who reach the coverage gap in 2011 will pay 50% of the total cost of brands and 93% of the total cost of generics until they reach the catastrophic coverage limit of $6,448 (Figure 2). Thereafter, enrollees pay either 5% of total drug costs or $2.50/$6.30 for each drug. Standard benefit amounts increase annually by the per capita Part D spending growth rate.

Only a small share of PDPs nationwide will offer the standard drug benefit in 2011, as in previous years. Most PDPs (67%) will not offer additional gap coverage in 2011 beyond what is required under the standard benefit. Gap coverage, when offered, is generally limited to generic drugs only (not brands). In 2007, an estimated 3.4 million Part D enrollees reached the coverage gap. The majority of PDPs (58%) charge a deductible, with 40% charging the full amount ($310). Most plans charge tiered copayments for covered drugs rather than 25% coinsurance, and a substantial majority of PDPs use specialty tiers for high-cost medications.

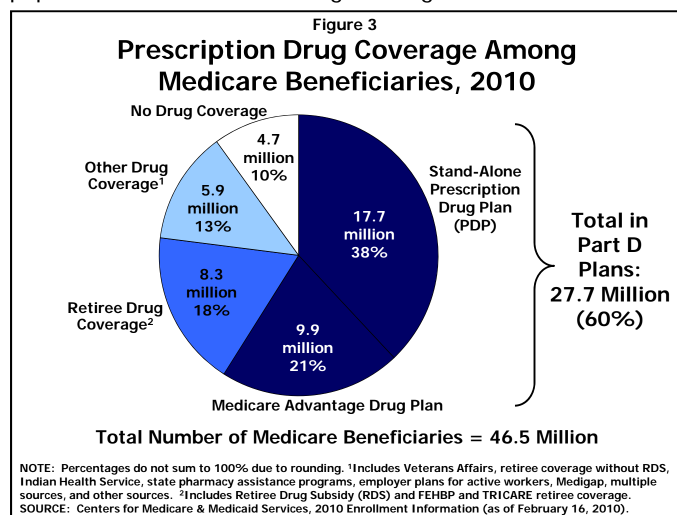
The monthly Part D premium averages $40.72 in 2011 (weighted by 2010 enrollment), a 10% increase since 2010. Actual PDP premiums vary across plans and regions, ranging from a low of $14.80 to a high of $133.40. Part D plans vary in benefit design, cost-sharing amounts, and utilization management tools (prior authorization, quantity limits, and step therapy). Plans also vary in terms of formularies (covered drugs), provided they comply with requirements established by the Centers for Medicare & Medicaid Services (CMS) to ensure a minimum level of coverage and prohibit formularies that discourage enrollment of certain types of beneficiaries.

Part D Enrollment

Enrollment in Medicare drug plans is voluntary, with the exception of dual eligibles and certain other low-income beneficiaries who are automatically enrolled in a PDP if they do not choose a plan on their own. However, unless beneficiaries have drug coverage from another source 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 for each month they delay enrollment.

More than half of all Medicare beneficiaries (60%, or 27.7 million) are enrolled in Medicare Part D plans, as of February 2010 (Figure 3). Of this total, 9.9 million are enrolled in Medicare Advantage drug plans. Another 8.3 million have creditable coverage through retiree plans, including FEHBP and TRICARE, the majority of whom (6.4 million) are in plans in which their employers receive subsidies equal to 28% of drug expenses between $310 and $6,300 per retiree in 2010. Another 5.9 million are estimated to have other sources of coverage, such as from Veterans Affairs (VA). Based on CMS estimates, 4.7 million beneficiaries, or 10% of the Medicare population, lack creditable drug coverage.



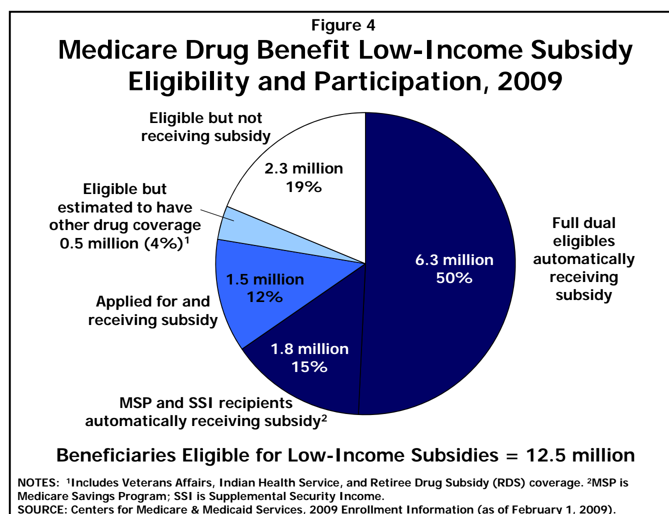
Part D enrollment is highly concentrated, with five firms – UnitedHealth, Humana, Universal American, Coventry Health Care, and WellPoint – accounting for 54% of enrollees in 2010.

Assistance for Low-Income Beneficiaries

Part D includes substantial premium and cost-sharing assistance for beneficiaries with low incomes (less than 150% of poverty, or $16,245 for individuals) and modest assets (less than $12,510 for individuals). Dual eligibles, QMBs, SLMBs, QIs, and SSI-onlys automatically qualify for the additional assistance, and Medicare automatically enrolls them into PDPs with premiums at or below the regional average if they do not choose a plan on their own. Other beneficiaries are subject to both an income and asset test and need to apply for the low-income subsidy (LIS) through either the Social Security Administration (SSA) or Medicaid, as well as enroll in a Part D plan. Individuals determined eligible for LIS are assigned to a PDP if they do not enroll on their own. As of February 2009, 12.5 million beneficiaries were estimated to be eligible for low-income assistance. Of this total, 9.6 million (77%) were receiving the low-income subsidy, while an estimated 2.3 million eligible low-income beneficiaries (19%) were not receiving these subsidies (Figure 4).

Expenditures and Financing for Part D

CBO estimates that Part D spending will total $55 billion in 2011 (net of premiums and state transfers). Total spending



depends on several factors: the number of Part D enrollees, their health status and drug utilization, the number of low-income subsidy recipients, and plans' ability to negotiate discounts and rebates with drug companies and manage use (e.g. promoting use of generic drugs and mail order). The MMA prohibits Medicare from negotiating drug prices directly.

Financing for Part D comes from general revenues (82%), beneficiary premiums (10%), and state contributions (7%). The monthly premium paid by enrollees is set to cover 25.5% of the cost of standard drug coverage. Medicare subsidizes the remaining 74.5%, based on bids submitted by plans for their expected benefit payments. Effective in 2011, Part D enrollees with higher incomes ($85,000/individual and $170,000/couple) will pay an income-related premium, meaning they will pay a greater share of standard Part D costs (35% to 80%, depending on income). The income thresholds are fixed (not indexed to increase annually).

In 2011, private plans are projected to receive average payments of $720 per enrollee overall and $2,159 for LIS enrollees; employers are expected to receive, on average, $646 for retirees in employer-subsidy plans (Trustees, 2010). Plans also receive additional risk-adjusted payments for high-cost enrollees and reinsurance payments for a share of their enrollees' costs above the catastrophic threshold. Part D plans' potential losses or profits are limited by risk-sharing arrangements with the federal government ("risk corridors").

Future Challenges

The Medicare drug benefit has helped reduce out-of-pocket drug spending for enrollees, which is especially important to beneficiaries with modest incomes or catastrophic drug expenses. Closing the coverage gap by 2020 is expected to bring additional relief to millions of enrollees. Ongoing monitoring of the Part D plan marketplace and evaluating the impact of the drug benefit on Medicare beneficiaries' out-of-pocket spending and health outcomes, as well as on drug prices and total Medicare spending, will be important to assess how Part D is working and how well it is meeting the needs of people on Medicare.

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