

MEDICARE

THE MEDICARE PRESCRIPTION DRUG BENEFIT

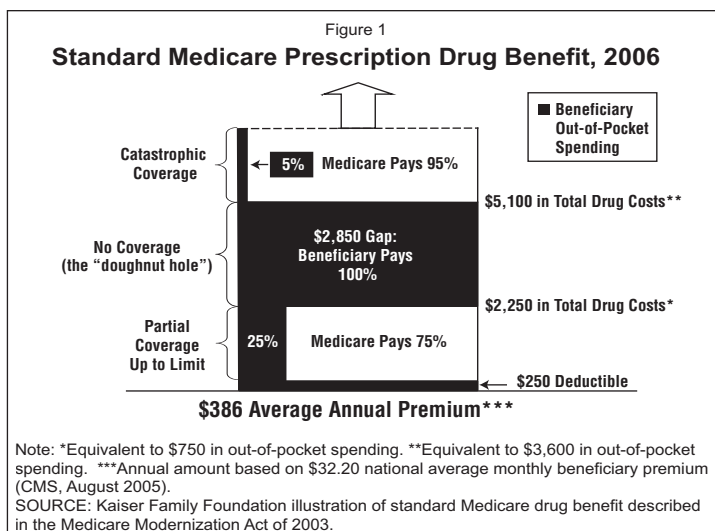
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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) added prescription drug coverage to Medicare, beginning on January 1, 2006. Medicare's elderly and disabled beneficiaries can enroll in private plans that contract with Medicare to provide the drug benefit. The net federal cost of the benefit is projected to be \$37.4 billion in 2006 and \$724 billion from 2006 to 2015 (HHS, February 2005).

MEDICARE PRESCRIPTION DRUG PLANS

People on Medicare can obtain the Medicare drug benefit through two types of private plans. Beneficiaries can join a prescription drug plan (PDP) for drug coverage only and get their other Medicare benefits through the fee-for-service program, as the majority of people with Medicare currently do. Alternatively they can join a Medicare Advantage (MA) plan, such as an HMO or regional PPO, that covers drugs and all other Medicare benefits. Private plans can operate in one or more of 34 PDP regions and 26 MA regions nationwide.

In addition to the monthly Part B premium, beneficiaries who join a Medicare drug plan will pay a monthly premium that is set to cover about 25% of the cost of the standard drug benefit (Figure 1). The average monthly beneficiary premium for 2006 is \$32.20, but this amount will vary across plans and regions.



MEDICARE DRUG BENEFIT DESIGN

Under the standard benefit design, Medicare drug plan enrollees pay a monthly premium, annual deductible, and coinsurance or copayments for their covered drugs. Plans can offer either the standard benefit or an alternative benefit structure that is actuarially equivalent to the standard benefit and does not increase the standard deductible or change the catastrophic threshold.

Deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Medicare drug benefit spending (Figure 2). The gap between partial and catastrophic coverage is projected to increase from \$2,850 in 2006 to \$4,984 in 2014.

Figure 2

Medicare Prescription Drug Benefit Premiums and Cost-Sharing Amounts for Selected Years

	2006	2010	2014
Average Monthly Premium*	\$32.20	\$48.49	\$64.26
Annual Deductible	\$250	\$331	\$437
Initial Coverage Limit	\$2,250	\$2,980	\$3,934
Coverage Gap (difference between initial coverage limit and catastrophic threshold)	\$2,850	\$3,774	\$4,984

Note: *2006 premium amount is national average monthly Part D beneficiary premium, based on bids received from Medicare prescription drug plan applicants (CMS, August 2005); 2010 and 2014 premium amounts are estimated monthly national averages.
SOURCE: CMS; 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

By law, Medicare drug plans must cover at least two drugs in each therapeutic class or category of covered Part D drugs, but the Centers for Medicare and Medicaid Services (CMS) expects plans to provide access to a "broad range of medically appropriate drugs," including a majority of drugs within the following classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals, immunosuppressants, and antineoplastics. Drug plans can use tiered cost-sharing arrangements, prior authorization, and other cost management tools, as long as they do not "substantially discourage enrollment by certain Part D eligible individuals" (MMA Final Rule, Section 423.272). Plans are expected to produce savings by negotiating price discounts and rebates with drug companies; the MMA prohibits Medicare from negotiating drug prices.

LOW-INCOME ASSISTANCE

Medicare will provide additional premium and cost-sharing assistance to beneficiaries with limited incomes and resources (Figure 3). Medicare beneficiaries with Medicaid drug coverage, QMBs, and SLMBs automatically qualify for this assistance. Others are subject to both an income and asset test and must apply separately for the additional assistance through either Social Security or their state Medicaid program. An estimated 2.4 million Medicare beneficiaries with incomes below 150% of poverty (\$14,355 for an individual in 2005) will not qualify for additional assistance in 2006 because their assets exceed the eligibility threshold (Rice and Desmond, 2005).

Figure 3
**Medicare Prescription Drug Benefit Subsidies
for Low-Income Beneficiaries, 2006**

Low-Income Subsidy Level	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligibles Income <100% of poverty (\$9,570/individual; \$12,830/couple)	\$0	\$0	\$1/generic \$3/brand-name; no copays after total drug spending reaches \$5,100
Full-benefit dual eligibles Income ≥ 100% of poverty	\$0	\$0	\$2/generic \$5/brand-name; no copays after total drug spending reaches \$5,100
Institutionalized full-benefit dual eligibles	\$0	\$0	No copays
Individuals with income <135% of poverty (\$12,920/individual; \$17,321/couple) and assets <\$6,000/individual; \$9,000/couple	\$0	\$0	\$2/generic \$5/brand-name; no copays after total drug spending reaches \$5,100
Individuals with income 135%–150% of poverty (\$12,920–\$14,355/individual; \$17,321–\$19,245/couple) and assets <\$10,000/individual; \$20,000/couple	sliding scale up to \$32.20*	\$50	15% of total costs up to \$5,100; \$2/generic \$5/brand-name thereafter

Note: Poverty level dollar amounts are for 2005. Additional assets of up to \$1,500/individual and \$3,000/couple for funeral or burial expenses are permitted. *\$32.20 is the national monthly Part D base beneficiary premium for 2006.
SOURCE: Kaiser Family Foundation summary of Medicare prescription drug benefit low-income subsidies in 2006.

INTERACTION WITH OTHER COVERAGE

Employer-sponsored plans provide drug coverage to more than 11 million beneficiaries. To encourage employers to continue offering coverage, Medicare will provide tax-free subsidies equal to 28% of costs between \$250 and \$5,000 in drug expenses per retiree to employers providing drug coverage that is on average at least as good as the standard Medicare drug benefit.

Medicaid currently provides drug coverage for 6.3 million Medicare beneficiaries (the “dual eligibles”). This coverage ends December 31, 2005, and Medicare will automatically enroll dual eligibles into PDPs with premiums at or below the regional average if they do not sign up on their own by January 1, 2006.

Medicare Advantage plans are a source of coverage for nearly 6 million beneficiaries and will be required to offer standard drug coverage in 2006 (except private FFS and Medicare Savings Account plans).

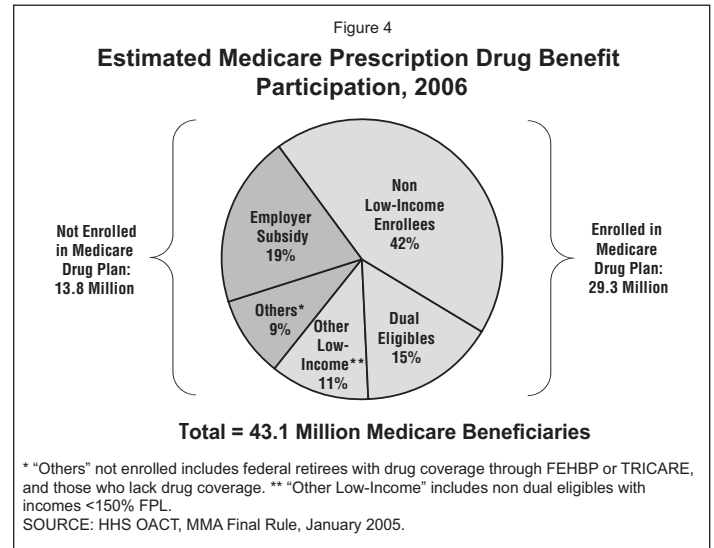
Medigap plans (H, I, and J) provide drug coverage to less than 10% of the Medicare population. Beginning in 2006, Medigap insurers may not issue new policies that include drug coverage.

State Pharmacy Assistance Programs can continue to provide coverage and can supplement or wraparound Medicare drug coverage for eligible enrollees.

ENROLLMENT

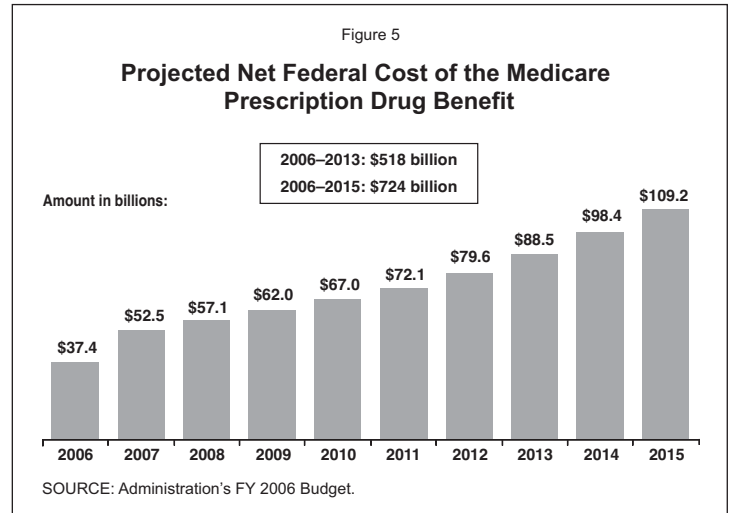
Enrollment in Medicare drug plans is voluntary for most beneficiaries, with the exception of certain low-income beneficiaries who will be automatically enrolled if they do not join a plan on their own. However, unless beneficiaries have drug coverage at least as good as the standard Medicare drug benefit (known as “creditable coverage”), those who join a plan after their initial eligibility enrollment period will pay a penalty equal to 1% of the average monthly premium for each month they delayed enrollment, for as long as they are enrolled in a Medicare drug plan.

Of an estimated 43.1 million Medicare beneficiaries in 2006, HHS expects 29.3 million to enroll in Medicare drug plans, with 10.9 million beneficiaries receiving low-income subsidies (out of 14.5 million eligible) (Figure 4). Another 9.8 million are expected to have creditable drug coverage through an employer plan.



EXPENDITURES AND FINANCING

The net federal cost of the Medicare prescription drug benefit is estimated to be \$724 billion between 2006 and 2015 (Figure 5). Financing for the Medicare drug benefit will come from several sources, including premiums paid by beneficiaries, state contributions (known as the “clawback”), and general revenues.



FUTURE CHALLENGES

The Medicare drug benefit offers help to beneficiaries with rising out-of-pocket drug costs, especially those with limited incomes. Beneficiary education and counseling will be critical to promote informed decision-making and a smooth transition as the drug benefit is implemented. Successful implementation depends on new Medicare drug plans emerging across the country that provide beneficiaries with access to needed medications and a stable, affordable source of drug coverage over time, while controlling drug costs.

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