Medicare Part D

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Medicare Part D is a federal program to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006.[1]

Program specifics

The drug benefit is not part of the 'Original' Medicare program, which includes Part A for hospital care and Part B for physician, outpatient care and durable medical equipment. The benefit is administered by private insurance plans that are reimbursed by the Centers for Medicare and Medicaid Services (CMS).[2]

Beneficiaries can obtain the Medicare drug benefit through two types of private plans: beneficiaries can join a Prescription Drug Plan (PDP) for drug coverage only or they can join a Medicare Advantage plan (MA) that covers both medical services and prescription drugs (MA-PD).[3] The latter type of plan is actually part of Medicare Part C and has several other differences relative to original Medicare. Not all drugs will be covered at the same level, giving participants incentives to choose certain drugs over others. This is often implemented via a system of tiered formularies in which lower cost drugs are assigned to lower tiers and thus are easier to prescribe or cheaper.

Most Medicare beneficiaries must affirmatively enroll in a Part D plan to participate. Dual eligibles (those also in Medicaid) are automatically enrolled in one of the less expensive Prescription Drug Plan (PDP) in their area, chosen at random. If the dual eligible person is already enrolled in an MA-only plan, then they are automatically removed from the MA plan upon enrollment in a PDP.

Enrollment

Enrollment for most beneficiaries is voluntary. The initial enrollment period took place from November 15, 2005 through May 15, 2006. Potential beneficiaries who did not enroll by the May

15 deadline (or within a given time frame after their initial eligibility date) incurred a late enrollment penalty of 1% per month based on the average cost of the premium until their enrollment.

Annual enrollment periods for Medicare Part D begin on November 15th of the prior plan year. The initial enrollment period for the second year of Medicare Part D started November 15, 2006.[4] In its first year, beneficiaries eligible for both Medicaid and Medicare (dual eligibles) were transferred from Medicaid prescription drug coverage to a Medicare Part D plan on January 1, 2006. Enrollment in January 2008 was 25.4 million, which was 6.2% higher than the 2007 enrollment. (An additional 14.2 million Medicare beneficiaries received drug coverage from other sources such as veterans benefits and retirement plans.[5]

As of 2008 there were 1,824 stand-alone Part D plans available. The number of available plans varied by region. The lowest was 27 (Alaska) and the highest was 63 (Pennsylvania & West Virginia).[6] This allows participants to choose a plan that best meets their individual needs. Plans can choose to cover different drugs, or classes of drugs, at various co-pays, or choose not to cover some drugs at all. Medicare has made available an interactive online tool called the Prescription Drug Plan Finder that allows for comparison of drug availability and costs for all plans in a geographic area. The Prescription Drug Plan Finder can be used to perform a personalized or general search for plans; in either case, the tool allows one to enter a list of medications along with pharmacy preferences. The Plan Finder output includes the beneficiary's total annual costs for each plan, along with a detailed breakdown of the plans' monthly premiums, deductibles, and prices for each drug during each phase of the benefit design (initial coverage period, coverage gap, and catastrophic coverage period). Plans are required to update this site with current prices and formulary information every other week throughout the year. Some enrollees criticize the Prescription Drug Plan Finder as complex to use, especially for many Medicare beneficiaries who have limited computer skills and Internet access[*citation needed*]. Nonetheless, use of this tool is essential in order for people to make an informed choice considering the actual costs for each plan.

Costs to beneficiaries

Beneficiary cost sharing (deductibles, coinsurance, etc.)

The MMA establishes a standard drug benefit that Part D plans may offer.[7] The standard benefit is defined in terms of the benefit structure and not in terms of the drugs that must be covered. In 2008, this standard benefit requires payment of a $275 deductible. The beneficiary then pays 25% of the cost of a covered Part D prescription drug up to an initial coverage limit of $2,510. The defined standard benefit is not the most common benefit offered by Part D plans. Only 10 percent of plans for 2008 offer the defined standard benefit. Most eliminate the deductible and use tiered drug co-payments rather than coinsurance.[8]

Once the initial coverage limit is reached, the beneficiary is subject to another deductible, known officially as the Coverage Gap but referred to more commonly as the "Donut Hole," in which they must pay the full cost of medicine. When total out-of-pocket expenses on formulary drugs for the year, including the deductible and initial coinsurance, reach $4050, the beneficiary then

reaches catastrophic coverage, in which he or she pays $2.25 for a generic or preferred drug and $5.65 for other drugs, or 5% coinsurance, whichever is greater. The $4050 amount is calculated on a yearly basis, and a beneficiary who amasses $4050 in out-of-pocket costs by December 31 of one year will start their deductible anew on January 1. Most low-income subsidy patients are exempt from all or part of the donut hole and the deductible.

The only out-of-pocket costs that count toward getting out of the coverage gap or into catastrophic coverage are True Out-Of-Pocket (TrOOP) expenditures. TrOOP expenditures accrue only when drugs on the enrolled-in plan's formulary are purchased in accordance with the restrictions on those drugs. Any other purchases do not count toward either the coverage gap or catastrophic coverage. Monthly premium payments do not count towards TrOOP.

Among Medicare Part D enrollees in 2007 who were not eligible for low-income subsidies, 26% had spending high enough to reach the coverage gap. Fifteen percent of those reaching the coverage gap (4% overall) had spending high enough to reach the catastrophic coverage level. Enrollees reaching the coverage gap stayed in the gap for just over four months on average.[9]

It should be noted that the thresholds above related only to the "standard" defined benefit structure. Individual health insurance providers often offer their own variations of the standard benefit (sometimes known as "enhanced" benefit plans) that may eliminate the deductible phase completely and/or extend the Initial Coverage limit to shrink the size of the donut Hole. Typically, the premiums for these enhanced plans are higher to offset the increased benefit.

For 2008, the percentage of stand-alone Part D (PDP) plans offering some form of coverage within the doughnut hole rose to 29 percent - this is an increase from 15 percent in 2006. The percentage of Medicare Advantage/Part D plans (MA-PD) plans offering some form of coverage in the coverage gap is 51%, up from 28% in 2006. The most common forms of gap coverage cover generic drugs only.[10]

Most plans use specialty drug tiers, and some have a separate benefit tier for injectable drugs. Beneficiary cost sharing can be higher for drugs in these tiers.[11]

Beneficiary premiums

2008 premiums for plans offering gap coverage are roughly double those of defined standard plans. The average monthly premium for stand-alone Part D plans (PDPs) with basic benefits that do not offer gap coverage are $30.14; the average monthly premium for plans that do offer some gap coverage are average $63.29. Relatively few beneficiaries choose Part D plans with gap coverage. In 2007, eight percent of beneficiaries enrolled in a PDP chose one with some gap coverage. Among beneficiaries in MA-PD plans, enrollment in plans offering gap coverage was 33% (up from 27% in 2006).[10]

Beneficiary premiums for Part D plans vary widely, and increased from 2006 to 2007. Premiums are projected to increase for 2008 as well. Premiums are significantly higher for plans with gap coverage. Major Part D plan sponsors are dropping their more expensive options, and developing lower cost ones.[12]

In August 2008, CMS projected that the average beneficiary premium for 2009 would rise to $38, an increase of $3 over the average 2008 premium. Three reasons were given for the increase: rising drug spending; the expiration of a demonstration project that affected prior years' premiums; and higher than expected catastrophic claim costs. Even with the anticipated increase, average 2009 premiums will be 37% lower than the $44 premium that was projected for 2009 when the program was established in 2003. Factors explaining the lower than anticipated costs include: lower than expected enrollment, lower than expected increases in drug prices, and insurers negotiating deeper than anticipated discounts from drug companies.[13][14][15][16]

Low-income subsidies

One option for those struggling with drug costs is to have a low-income subsidy applied to their existing prescription account. Depending on a variety of factors (including actual income) a member of an existing plan may have their premium paid for, all or in part, and may have a reduced copay for their medication. To request a review for subsidy contact the Social Security Administration at 800-772-1213.

The subsidy award is given a level with the following effects.[*citation needed*];

Level	Deductible	Generic Copay	Brand Copay	Specialty Copay	Catastrophic Coverage
1	$0	$2.25	$5.65	15%	$0 copays on all meds
2	$0	$1.05	$3.10	15%	$0 copays on all meds
3	$0	$0	$0	0%	$0 copays on all meds
4	$56 max	15%	15%	15%	2.25 Generic & $5.65 Brand copays

Note: A common source of confusion; When the award letters were sent out for 06' and 07' subsidies the wording referred to a plan’s premium being paid for 100%. In actuality the amount paid is usually matched to the amount charged for the basic plan offered by the carrier. If this is the plan the customer has then, as expected, the premium is paid for. If the member has selected other than the most basic level of coverage then the premium will likely be higher than the amount paid for by the subsidy. This may result in the member being charged a monthly amount while thinking they have no monthly bill.

Excluded drugs

While CMS does not have an established formulary, Part D drug coverage excludes drugs not approved by the Food and Drug Administration, those not for use in their medically accepted indication, drugs not available by prescription for purchase in the United States, and drugs for which payments would be available under Parts A or B of Medicare.[17]

Part D coverage excludes drugs or classes of drugs which may be excluded from Medicaid coverage. These may include:

- Drugs used for anorexia, weight loss, or weight gain
- Drugs used to promote fertility
- Drugs used for erectile dysfunction
- Drugs used for cosmetic purposes (hair growth, etc.)
- Drugs used for the symptomatic relief of cough and colds
- Barbiturates
- Benzodiazepines
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs where the manufacturer requires as a condition of sale any associated tests or monitoring services to be purchased exclusively from that manufacturer or its designee

While these drugs are excluded from basic Part D coverage, drug plans can include them as a supplemental benefit, provided they otherwise meet the definition of a Part D drug. However plans that cover excluded drugs are not allowed to pass on those costs to Medicare, and plans are required to repay CMS if they are found to have billed Medicare in these cases.[18]

Plan formularies

Part D plans are not required to pay for all covered Part D drugs.[19] They establish their own formularies, or list of covered drugs for which they will make payment, as long as the formulary and benefit structure are not found by CMS to discourage enrollment by certain Medicare beneficiaries. Part D plans that follow the formulary classes and categories established by the United States Pharmacopoeia will pass the first discrimination test. Plans can change the drugs on their formulary during the course of the year with 60 days notice to affected parties.

Typically, each Plan's formulary is organized into tiers, and each tier is associated with a set copay amount. Most formularies have between 3 and 5 tiers. The lower the tier, the lower the copay amount. For example, Tier 1 might include all of the Plan's preferred generic drugs, and each drug within this tier might have a copay of $5–10 per prescription. Tier 2 might include the Plan's preferred brand drugs with a copay of $20–$30, while Tier 3 may be reserved for non-preferred brand drugs which are covered by the plan at a higher copay level - perhaps $40–$50. Tiers 4 and higher typically contain specialty drugs, which have the highest copays because they are generally quite expensive.

The Plan's tiered copay amounts for each drug only apply during the initial period before the coverage gap. Once in the coverage gap, also known as the Donut Hole, the person must pay for 100% of the prescription costs, based on prices established by the Plan.

The primary differences between the formularies of different Part D plans relate to the coverage of brand-name drugs. Nine out of the ten plans with the highest enrollment increased the number of drugs on their formularies in 2007. Plans have generally made fewer changes for 2008. One exception is Silverscript (Caremark Rx), which significantly increased the number of drugs on its 2008 formulary. [20]

Number of participants

At the start of the program in January 2006, it was expected that eleven million people would be covered by Medicare Part D; of those, six million would be dual eligible. About two million people who were covered by employers would likely lose their employee benefits.

As of January 30, 2007, nearly 24 million individuals were receiving prescription drug coverage through Medicare Part D (PDPs and MA-PDs combined), according to CMS.[21] There are other methods of receiving drug coverage when enrolled in Medicare, including the Retiree Drug Subsidy (RDS), Federal retiree programs such as TRICARE and Federal Employees Health Benefits Plans (FEHBP) or alternative sources, such as the Department of Veterans Affairs. Including people in these categories, more than 39 million Americans are covered for prescriptions.

As of April 2006, the primary private insurance plans providing Medicare Part D coverage were UnitedHealth with 3.8 million subscribers, or 27 percent of the total, Humana with 2.4 million, or 18 percent, and WellPoint with 1 million, or 7 percent. Companies with the next largest shares were MemberHealth, with 924,100 subscribers (7 percent); WellCare Health Plans, with 849,700 (6 percent); and Coventry Health Care, with 596,100 (4 percent).[22] CMS offers updated enrollment numbers on their website.[23]

Program costs

As of January 2006, the expected per capita drug spending was $2,250, making the total cost of the program $42.75 Billion.[7] This budget compares with revenues of $54 Billion for Pfizer and $48.6 Billion for Johnson & Johnson, the two largest pharmaceutical companies. Other estimates put the 2006 costs at $37.4 billion.[3] Total costs through 2015 are estimated to be $724 billion. Some of these revenues will be provided by "clawback" of revenues currently provided to the states for Medicaid. The "clawback" is a mechanism by which federal expenditures that benefit states (specifically regarding dual eligibles) are reimbursed back to the federal government. This reimbursement starts at 90%, but then falls to 75% in 2015. Figures also depend on per capita estimates of dual eligible expenditures and the number of dual eligibles that receive benefits.

As of January 2008, total Medicare spending for prescription drug benefits was projected to drop from $40.5 billion in 2007 to $36 billion in 2008. One factor contributing to lower costs is the

increased use of generic drugs.[5] Shortly after the release of the 2008 Medicare Trustees' Report,[24] the Chief Actuary testified that the 10-year cost of Medicare drug benefit is 37% lower than originally projected in 2003, and 17% percent lower than last year's projections.[25]

In August 2008, CMS estimated that the 10-year cost of the program would be $395 billion, down from the original estimate of $634 billion.[26] In late October 2008, USA Today reported that costs were down by $6 billion, or 12%, for the fiscal year ended September 30th. Costs for the program were approximately one third less than originally predicted.[27]

Implementation issues

- Plan and Health Care Provider goals are not aligned: PDP's and MA's are rewarded for focusing on low cost drugs to all beneficiaries, while Providers are rewarded for quality of care – sometimes involving expensive technologies.
- Conflicting goals: Plans are required to have a tiered exemptions process for beneficiaries to get a higher-tier drug at a lower cost, but plans must grant exception when medically necessary. However, the rule denies beneficiaries the right to request a tiering exception for certain high-cost drugs.[*citation needed*]
- Lack of standardization: Drugs appearing on Tier 2 in one plan may be on Tier 3 in another. Tier 2 drugs may have a different co-pay with different plans. There are plans with no deductibles and the coinsurance for the most expensive drugs varies widely. Some plans may insist on step therapy, which means that the patient must use generics first before the company will pay for higher priced drugs. There is an appeal process, but the burden is on the beneficiary, as the insurer will not pay for the desired drug during the appeal process.
- Standards for electronic prescribing for Medicare Part D conflict with regulations in many US states. [28]

Impact on beneficiaries

One study published in April 2008 found that the percentage of Medicare beneficiaries who reported forgoing medications due to cost dropped after the implementation of Medicare Part D, from 15.2 percent in 2004 and 14.1 percent in 2005 to 11.5 percent in 2006. The percentage who reported skipping other basic necessities in order to pay for drugs also dropped, from 10.6 percent in 2004 and 11.1 in 2005 to 7.6 percent in 2006. Among the very sickest beneficiaries there was no reduction in the percentage who reported skipping medications, but fewer reported forgoing other necessities in order to pay for their medicines.[29][30]

Criticisms

By the design of the program, the federal government is not permitted to negotiate prices of drugs with the drug companies, as federal agencies do in other programs. The Veterans Administration, which is allowed to negotiate drug prices and establish a formulary, pays 58% less for drugs, on average, than Medicare Part D.[31] For example, Medicare pays $785 for a year's supply of Lipitor (atorvastatin), while the VA pays $520. Medicare pays $1,485 for Zocor,

while the VA pays $127. Former Congressman Billy Tauzin, R-La., who steered the bill through the House, retired soon after and took a $2 million a year job as president of Pharmaceutical Research and Manufacturers of America (PhRMA), the main industry lobbying group. Medicare boss Thomas Scully, who threatened to fire Medicare Chief Actuary Richard Foster if he reported how much the bill would actually cost, was negotiating for a new job as a pharmaceutical lobbyist as the bill was working through Congress.[32][33]

In response, the Manhattan Institute, a free-market think tank funded in part by pharmaceutical companies, issued a report by Frank Lichtenberg, a business professor at Columbia University, that said the VA National Formulary excludes many new drugs. Only 38% of drugs approved in the 1990s and 19% of the drugs approved since 2000 are on the formulary. He also argues that the life expectancy of veterans "may have declined" as a result.[34] However, Lichtenberg has not published these results in the peer-reviewed medical literature.[35]

Paul Krugman came to the opposite conclusion, by comparing patients in the Medicare Advantage plans, which are administered by private contractors with a subsidy of 11% over traditional Medicare, to the VA system. Mortality rates in Medicare Advantage plans are 40% higher than mortality of elderly veterans treated by the V.A., said Krugman, citing the Medicare Payment Advisory Commission.[36]

The plan requires Medicare beneficiaries whose total drug costs reach $2400 to pay 100% of prescription costs until $3850 is spent out of pocket. (The actual threshold amounts will change year-to-year and plan-by-plan.) This coverage gap is known as the "Donut Hole." While this coverage gap will not affect the majority of program participants, a large minority (~25%) will find themselves without prescription drug coverage for much of the plan year. However, the Washington Post reports that upwards of 80% of enrollees are satisfied with their coverage, despite the fact that nearly half had chosen plans that do not cover the "donut hole"[37].This means that almost 20% are dissatisfied -- including the patients who can't afford the drugs they need. Medical researchers say that patient satisfaction surveys are a poor way to evaluate medical care. Most respondents aren't sick, so they don't need medical care, so they're usually satisfied. The only respondents who can evaluate care are respondents who are sick, who are usually a minority.[38]

Critics, such as Ron Pollack, executive director of Families USA, said in late 2006 that even the satisfied enrollees wouldn't be so satisfied the next year when the prices go up.[39] However, a survey released by the AARP in November 2007 found that 85% of enrollees reported being satisfied with their drug plan, and 78% said that they had made a good choice in selecting their plan.[40]

According to a January 2006 article by Trudy Lieberman of Consumers Union, consumers can have up to 50 choices, in hundreds of combinations of deductibles, co-insurance (the percentage consumers pay for each drug); drug utilization techniques (trying cheaper drugs first); and drug tiers, each with their own co-payments (the flat amount consumers pay for each drug). Co-payments differ on whether people buy generic drugs, preferred brands, non-preferred brands or specialty drugs, and whether they buy from an in-network or out-of-network pharmacy. There is

no standard nomenclature, so sellers can call the plan anything they want. They can also cover whatever drugs they want.[41]

See also

- Health
- Health economics
- Health insurance in the United States
- National pharmaceuticals policy
- Pharmaceutical company
- Pharmacology
- Prescription drug prices in the United States

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External links

Government resources

- Centers for Medicare & Medicaid Services (CMS).
- Medicare.gov, the official website for people with Medicare.
    - Prescription Drug Coverage homepage at Medicare.gov, a central location for Medicare's web-based information about the Part D benefit.
        - "Landscape of Plans", at Medicare.gov, state-by-state breakdown of all Part D plans available by area, including stand-alone (drug coverage only) plans and other coverage plans.
        - State Pharmaceutical Assistance Programsat Medicare.gov, links to contact information for each state's SPAP program.
        - Enroll in a Medicare Prescription Drug Plan at Medicare.gov, the web-based tool for enrolling online in a Part D plan.
    - Official Medicare publications at Medicare.gov, includes official publications about the Part D benefit.
        - Medicare & You handbook for 2006 at Medicare.gov, includes information about the Part D benefit.
    - Information about the 1-800-MEDICARE helpline from Medicare.gov, a 24X7 toll-free number where anyone can call with questions about the Part D benefit.

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- "Medicare Prescription Drug Benefit Weekly Q&A Column", from the Kaiser Family Foundation.
- "My Medicare Matters", sponsored by the National Council on Aging.
- "Medicare Part D Health Issues", from the National Senior Citizens Law Center.
- "Bob Dole On Medicare" - Enrollment/education campaign by former Senator Bob Dole and Pfizer.
- "Medicare Prescription Drug Plan Guide", from America's Health Insurance Plans.
- "Press Gaggle" with Scott McClellan and Dr. Mark McClellan that includes discussion on Medicare prescription drug benefit, August 29, 2005.

Categories: 2003 in law | Medicare and Medicaid (United States) | Pharmaceuticals policy
Hidden categories: All articles with unsourced statements | Articles with unsourced statements since February 2007 | Articles with unsourced statements since April 2007