



THE BASICS

JANUARY 15, 2009

The Medicare Drug Benefit (Part D)

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for Medicare beneficiaries that began January 1, 2006. Medicare subsidizes the cost of the program, generally paying about 75 percent of program costs. Total expenditures for the Medicare drug benefit are expected to exceed \$60 billion in 2009.¹ Beneficiaries enrolling in Part D pay a monthly premium in addition to cost sharing and any deductible for their drugs. Low-income beneficiaries pay lower or no premiums, cost sharing, and deductibles.

The Medicare drug benefit is administered through private entities called prescription drug plans (PDPs) for beneficiaries in fee-for-service (also known as traditional) Medicare and through Medicare Advantage prescription drug (MA-PD) plans for beneficiaries enrolled in Medicare managed care. PDPs and MA-PDs perform such functions as:

- Designing and marketing drug benefit plans
- Negotiating drug prices with manufacturers and pharmacies
- Building and managing a network of pharmacies
- Enrolling and disenrolling beneficiaries
- Tracking beneficiary drug spending
- Managing a drug formulary and beneficiary appeals process

Employers and unions offering retiree coverage that is at least as generous as Medicare's drug benefit and meeting other requirements may qualify for Retiree Drug Subsidies (RDS) to help defray the cost of providing a drug benefit to their Part D-eligible

National Health Policy Forum

2131 K Street, NW
 Suite 500
 Washington, DC 20037

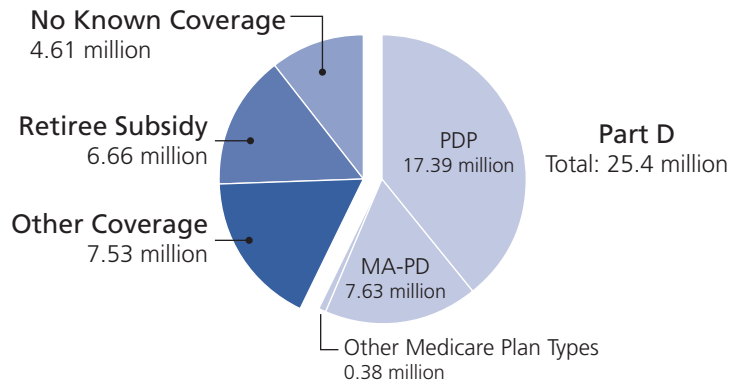
T 202/872-1390
F 202/862-9837
E nhpf@gwu.edu
www.nhpf.org

retirees. (See “Employers and Part D” section below for more on these plans.)

BENEFICIARY PARTICIPATION

Medicare beneficiaries who are eligible for Medicare Part A or enrolled in Part B may enroll in a Medicare drug plan.² In 2008, 25.4 million beneficiaries enrolled in a PDP or MA-PD, about 58 percent of those who were eligible. An additional 6.66 million beneficiaries enrolled in a drug plan through a former employer or union qualifying to receive RDS. About 7.53 million beneficiaries received drug coverage from sources that do not receive Medicare subsidies including TRICARE, the Federal Employee Health Benefits Program for retirees, Veterans Administration coverage, and employer-sponsored insurance for active workers with Medicare as a secondary payer. Lastly, 4.61 million Medicare beneficiaries have no known source of drug coverage.

SOURCES OF MEDICARE BENEFICIARY DRUG COVERAGE, 2008



Source: Centers for Medicare & Medicaid Services, “Prescription Drug Coverage, General Information,” updated September 25, 2008; available at www.cms.hhs.gov/PrescriptionDrugCovGenIn.

BENEFIT STRUCTURE

The Part D **standard benefit** for 2009 includes a \$295 deductible, 25 percent coinsurance³ for covered drug spending between \$295 and \$2,700, and 100 percent coinsurance for drug spending

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between \$2,700 and \$6,153.75 (a gap in coverage popularly known as the “donut hole”). After \$4,350 in beneficiary true out-of-pocket (or “TrOOP”)⁴ spending is reached, catastrophic coverage begins and beneficiaries are only responsible for limited cost-sharing. All drug plans must offer a standard benefit plan.

Medicare drug plans may offer **nonstandard** benefit plans that vary from this standard benefit. For example, Medicare drug plan sponsors may offer drug plans that are actuarially equivalent to the Medicare drug benefit. They may also offer plans that are more generous, or enhanced, as long as they also offer a basic benefit package. Nonstandard plans are popular with beneficiaries because they may have lower deductibles or cost-sharing, albeit generally at higher premiums. The majority of beneficiaries are enrolled in nonstandard plans.

BENEFICIARY PREMIUMS AND PLAN PAYMENTS

Beneficiaries enrolled in PDPs typically pay a monthly premium for Medicare prescription drug coverage, which averages \$28 per month in 2009.⁵ Beneficiary premiums are determined by bids submitted annually to Medicare by drug plans wanting to offer a Medicare drug benefit, which are compared to the average bid from all plans. Plans with lower bids have lower beneficiary premiums, and plans with higher bids have higher premiums.⁶

Medicare Advantage plans have flexibility to allocate premium dollars between the drug benefit and other health benefits they offer. As a result, many Medicare Advantage plans are able to offer drug coverage for \$0 premium. In 2009, about one-third of MA-PDs will offer a \$0 premium. They are also more likely than PDPs to offer coverage in the gap and a \$0 deductible.

In addition to receiving beneficiary premiums (estimated to amount to \$6.1 billion in 2009⁷), Medicare drug plans receive payments from Medicare to subsidize the cost of providing the benefit.

- **Direct premium payments** represent Medicare’s major subsidy to plans for all beneficiaries (estimated \$19.9 billion in 2009⁸)
- **Reinsurance** subsidizes catastrophic expenses above \$6,153.75 for a beneficiary in 2009 (estimated \$9.6 billion in 2009)

- **Low-income subsidy payments** subsidize premium and cost-sharing assistance for low-income beneficiaries (estimated \$21.1 billion in 2009)

ASSISTANCE FOR LOW-INCOME BENEFICIARIES

About 30 percent of Part D enrollees qualify for assistance in paying premiums, deductibles, and cost sharing. These individuals have incomes below 150 percent of the federal poverty level (\$15,600 for an individual and \$21,000 for a couple in 2008) and few assets (\$11,990 for an individual and \$23,970 for a couple in 2008), and include beneficiaries dually eligible for Medicare and Medicaid (often referred to as “dual eligibles”). The level of extra benefits Medicare provides depends on the person’s income: lower income individuals receive more generous extra benefits including no or low premiums, deductibles, and cost sharing. The lowest income beneficiaries, dual eligibles, pay no premiums for drug plans with premiums below the average in an area, only very modest cost-sharing for prescriptions, no deductible, and are not subject to the coverage gap.

Private plans are paid extra by Medicare for low-income enrollees to compensate for the additional benefits they receive. Private plans were paid an estimated \$1,056 per enrollee for drug benefits in 2008, and an additional \$1,944 per low-income enrollee.⁹

Many low-income beneficiaries, including dual eligibles, received drug coverage through Medicaid prior to the implementation of the Medicare drug benefit in 2006. In order to help finance their participation in Part D, the MMA requires states to contribute 90 percent of the expected state cost of drugs for this population, phasing down over 10 years to 75 percent. This provision is commonly called the “clawback.”

EMPLOYERS AND PART D

Employers have several options for interacting with the Medicare drug benefit. Employers and union groups that provide prescription drug insurance to their Medicare-eligible retired workers that is at least as generous as Part D coverage may apply to receive retiree drug subsidies from Medicare. These payments are intended

to help employers maintain drug coverage for their retirees, and are less expensive for Medicare than enrolling these beneficiaries in a Part D drug plan. In 2008, the average RDS payment was about \$600 per beneficiary.¹⁰ Employers not receiving the retiree drug subsidy may choose to “wrap around” Part D coverage by paying Part D premiums or contributing toward deductibles and/or cost sharing for their retirees. A few large employers have also formed their own Medicare drug plans for retirees, and receive the full direct premium subsidy from Medicare.

FORMULARIES AND APPEALS

The law permits Medicare drug plans to pay for most drugs approved by the Food and Drug Administration (FDA). However, virtually all PDPs use formularies, or lists of covered drugs, that effectively limit the number and type of drugs paid for by the plan. Plans are required to include a relatively broad range of drugs on their formularies to help prevent a plan from systematically discouraging beneficiaries with certain health conditions from enrolling. Beneficiaries may appeal the decision of a plan to not pay (or require a higher co-payment) for a particular drug.

ENDNOTES

1. 2008 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, March 25, 2008, p. 163; available at www.cms.hhs.gov/ReportsTrustFunds/downloads/tr2008.pdf.
2. For more information on Medicare Parts A and B, see the National Health Policy Forum Basic on Medicare, available at www.nhpf.org/library/details.cfm/2545.
3. Plans in the standard benefit category may have cost sharing below the initial coverage limit that is actuarially equivalent to 25 percent.
4. Not all drug spending counts toward TrOOP. Actual out-of-pocket spending by the beneficiary counts toward TrOOP, but payments made by other insurers or third parties generally do not count toward TrOOP.
5. Centers for Medicare & Medicaid Services, “CMS Reminds Medicare Beneficiaries To Review and Compare Their Current Drug Coverage,” press release, September 25, 2009; available at www.cms.hhs.gov/apps/media/press/release.asp?Counter=3276&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=350.

6. For more information on how beneficiary premiums are calculated and how drug plans are paid, see Mary Ellen Stahlman, "The Nuts and Bolts of PDPs," National Health Policy Forum, Issue Brief No. 817, November 8, 2006, available at www.nhpf.org/library/details.cfm/2535 and Medicare Payment Advisory Commission, "Part D Payment System," *paymentbasics*, revised October 2008, available at www.medpac.gov/documents/MedPAC_Payment_Basics_08_PartD.pdf.
7. *2008 Annual Report of the Boards of Trustees*, p. 163.
8. *2008 Annual Report of the Boards of Trustees*, p. 163.
9. *2008 Annual Report of the Boards of Trustees*, p. 161.
10. *2008 Annual Report of the Boards of Trustees*, p. 161.