THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

THE MEDICARE PRESCRIPTION DRUG BENEFIT

June 2006

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. The drug benefit, which took effect in January 2006, is available to all 43 million elderly and disabled beneficiaries who enroll in private plans approved by Medicare to offer coverage. 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 to beneficiaries with low incomes and modest assets.

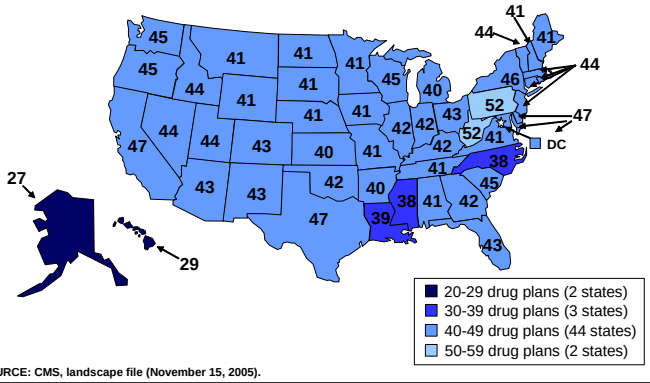
MEDICARE PRESCRIPTION DRUG PLANS

The drug benefit is offered through two types of private plans: stand-alone prescription drug plans (PDPs) for people getting other Medicare benefits through the fee-for-service program, and Medicare Advantage prescription drug (MA-PD) plans, such as HMOs or PPOs, that cover drugs and other Medicare benefits. In 2006, a total of 1,429 PDPs and 1,314 MA-PD plans are offered across the 34 PDP regions and 26 MA regions nationwide (excluding the territories). Beneficiaries in most states have a choice of at least 40 stand-alone PDPs and one or more MA-PD plans (Figure 1).

Figure 1

Number of Medicare Prescription Drug Plans Available Nationwide in 2006

Not including numbers of Medicare Advantage Drug Plans (HMOs, PPOs, and Private Fee-For-Service plans)



SOURCE: CMS, landscape file (November 15, 2005).

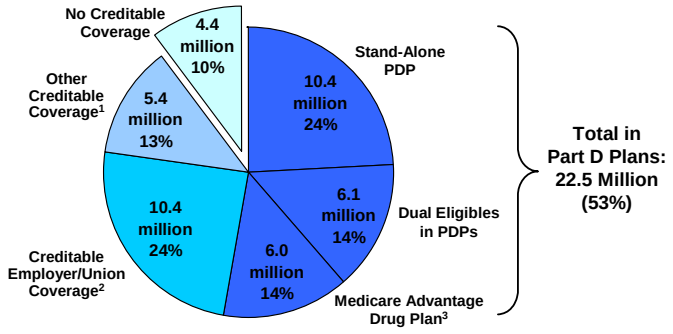
PART D ENROLLMENT

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 in a drug plan if they do not choose one on their own. However, unless beneficiaries have coverage that is at least as good as the standard Medicare drug benefit ("creditable coverage"), they face a penalty equal to 1% of the national average monthly premium for each month they delay enrollment. To encourage employers to offer creditable drug coverage to retirees, Medicare provides employers with tax-free subsidies equal to 28% of costs between $250 and $5,000 in drug expenses per retiree.

As of June 2006, HHS reported that 22.5 million beneficiaries enrolled in Medicare Part D plans prior to the 2006 enrollment deadline, and 10.4 million have creditable drug coverage through retiree plans, including FEHB and TRICARE (Figure 2). HHS estimates that another 5.4 million have alternative sources of creditable drug coverage, such as the Veterans Administration.

Figure 2

HHS Estimates of Prescription Drug Coverage Among Medicare Beneficiaries, 2006



Total Number of Beneficiaries = 43 Million

Note: Numbers do not sum to 100% due to rounding. [1] Includes coverage from Veterans Administration, Indian Health Service, employer plans without retiree subsidies, and employer plans for active workers. [2] Includes employer/union, FEHB, and TRICARE coverage. [3] Approximately 0.5 million dual eligibles are enrolled in Medicare Advantage drug plans and are reported in this category.
SOURCE: HHS, June 14, 2006. Data as of June 11, 2006.

Most beneficiaries with creditable drug coverage in 2006 had coverage previously, either through Medicaid, Medicare Advantage, or employer plans. Of the 11.6 million individuals who are new enrollees in Part D plans (10.4 million in PDPs and 1.2 million in MA-PD plans), it is unknown how many lacked drug coverage prior to 2006. Based on HHS estimates, between 4 million and 5 million beneficiaries, or more than 10% of the Medicare population, have no drug coverage in 2006.

ASSISTANCE FOR LOW-INCOME BENEFICIARIES

The Medicare drug benefit 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) (Figure 3). 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 through either the Social Security Administration (SSA) or Medicaid, along with enrolling in a Part D plan.

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** ($9,800/individual; $13,200/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 ($13,230/individual; $17,820/couple) **and resources <$7,500/individual; $12,000/couple**	$0	$0	$2/generic $5/brand-name; no copays after total drug spending reaches $5,100
Individuals with income 135%-150% of poverty ($13,230-$14,700/individual; $17,820-$19,800/couple) **and resources <$11,500/individual; $23,000/couple**	sliding scale up to $32.20*	$50	15% of total costs up to $5,100; $2/generic $5/brand-name thereafter

Note: Resources include $1,500/individual and $3,000/couple for funeral or burial expenses. *$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.

HHS recently estimated that 13.2 million beneficiaries are eligible for the low-income subsidy in 2006 (including dual eligibles), of which 9.3 million are currently receiving the subsidy. As of May 26, SSA had received over 5.1 million low-income subsidy applications and found 1.8 million to be eligible. Most of those who were ineligible had assets too high to qualify. Based on HHS estimates, roughly 1 in 4 (3.3 million) beneficiaries are eligible but not receiving this assistance. This is a majority (75%) of the estimated 4.4 million beneficiaries who did not enroll in a Part D plan by May 15, 2006.

MEDICARE DRUG BENEFIT DESIGN

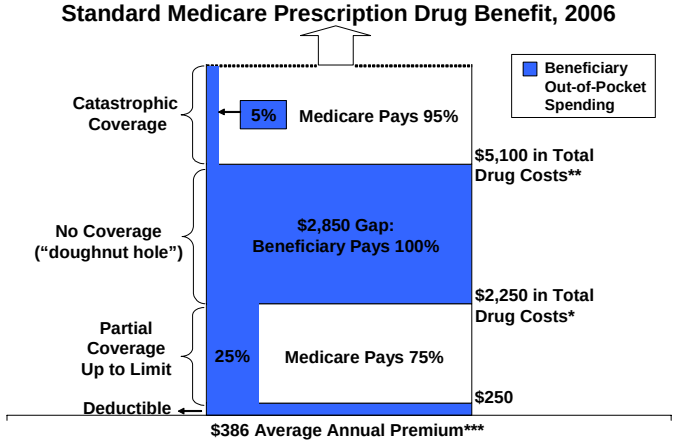
Part D plans must offer either a statutorily defined standard benefit or an alternative that is equal in value ("actuarially equivalent"). Plans can also offer enhanced benefits. The standard benefit in 2006 has a $250 deductible and coinsurance of 25 percent after the deductible up to a coverage limit of $2,250 in total drug costs, followed by a gap in coverage where enrollees pay 100% of the costs of their drugs (the so-called "doughnut hole"). After out-of-pocket spending reaches $3,600, the plan pays 95 percent of drug costs for catastrophic coverage (Figure 4). Standard Part D benefit amounts will be updated annually with the growth in per capita Part D spending; amounts for 2007 will increase by 7% over 2006 levels.

In 2006, only a small share of PDPs and MA-PD plans nationwide offer the standard drug benefit. For example, almost all PDPs and MA-PD plans charge different copayments for covered drugs rather than the standard 25% coinsurance. More than half of all PDPs (58%) and more than three-quarters of MA-PD plans (79%) have no deductible. However, most PDPs (85%) and MA-PD plans (72%) have a coverage gap; only a small share of plans (2% of PDPs and 5% of MA-PD plans) cover brand-name and generic drugs in the coverage gap.

Part D plans approved by CMS for 2006 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 these plans do not offer formularies that discriminate against certain types of beneficiaries.

Figure 4

Standard Medicare Prescription Drug Benefit, 2006



*Equivalent to $750 in out-of-pocket spending. **Equivalent to $3,600 in out-of-pocket spending. ***Annual amount based on $32.20 national average monthly beneficiary premium (CMS, August 2005).
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit, as described in the MMA of 2003.

EXPENDITURES AND FINANCING

The Administration estimates the net federal cost of the Medicare drug benefit to be $31 billion in 2006 and $768 billion between 2007 and 2016. Actual costs will 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 negotiating price discounts and rebates with drug companies; the MMA prohibits Medicare from negotiating drug prices directly.

Financing for the Part D benefit comes from premiums paid by beneficiaries, state contributions (the so-called "clawback"), and general revenues. The monthly premium paid by enrollees is set to cover 24.5% of the cost of the standard drug benefit. CMS subsidies the remaining 74.5% of the premium, based on bids submitted to CMS by plans for their expected benefit payments. Actual payments from CMS to plans will take into account health status and other characteristics of a plan's enrollees. The beneficiary share of the national average monthly premium for 2006 is $32.20, but actual Part D plan premiums vary across plans and regions.

FUTURE CHALLENGES

The Medicare drug benefit offers beneficiaries help with out-of-pocket drug spending, which is especially important to those with low incomes and those who lacked drug coverage prior to 2006. 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 meet minimum standards to provide beneficiaries with needed protection against high and rising drug costs.

Additional copies of this publication (#7044-04) are available on the Kaiser Family Foundation's website at www.kff.org.