



Issue Brief

How Medicare Part D Fares and What Lies Ahead

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Introduction

The new Medicare prescription drug law was created under great controversy and implemented with confusion and uncertainty. In public policy circles, the early assessments of its success are a matter of great debate.

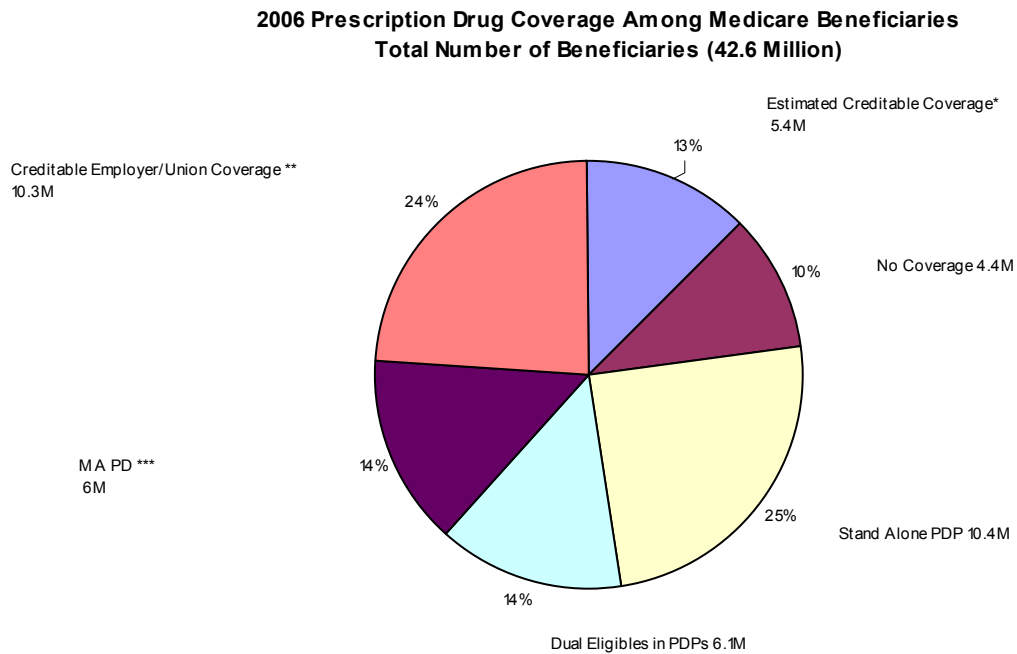
In this report, the Alliance for Retired Americans Educational Fund examines the issues seniors faced in enrolling in a drug plan, and the subsequent economic and health care ramifications of this new law. The initial reports show that insurance companies and pharmaceutical giants have fared far better than seniors have. While retirees have struggled with unexpected and staggering out-of-pocket costs, the proponents of the 2003 law — drug companies and private businesses — are reaping windfall profits.

The report concludes with recommendations for steps Congress and the Bush administration can take to help our nation's seniors with their prescription drug needs.

Implementation

The initial enrollment period for the Medicare prescription drug benefit was from November 15, 2005, to May 15, 2006. According to Department of Health and Human Services (HHS) figures released after the enrollment period ended, 22.5 million or 52 percent of beneficiaries are in Part D plans. Another 15.7 million (37 percent) have other creditable coverage and 4.4 million (10 percent) have no coverage.¹ The breakdown in prescription drug coverage for Medicare beneficiaries is shown in Chart 1.

Chart 1



Source: U.S. Department of Health and Human Services

*Includes VA, Indian Health Service, employee plans without retiree subsidies, and employer plans for active workers

**Includes employer/union, FEHBP, and TRICARE coverage

***Approximately 478,000 dual eligibles enrolled in MA-PD plans and are reported in this category

Implementation of the Part D benefit was a frustrating and confusing process for many beneficiaries in a number of ways as described below.

1. Choosing a plan. Although nearly 4 in 10 Medicare beneficiaries already had drug coverage at the beginning of 2006, others were inundated with plan choices. In 2006, nearly 80 organizations offered over 1,400 stand-alone prescription drug plans (PDPs) nationwide. Each of these organizations provided several options, further multiplying the plan choices. Most beneficiaries

faced a choice of over 40 PDPs plus a number of Medicare Advantage prescription drug (MA-PD) plans in their region. There are 1,314 MA-PD plans nationally.ⁱ

Most Medicare beneficiaries faced with the decision whether to join a plan made the decision on their own or with the assistance of family and friends.ⁱⁱ According to a Medicare Payment Advisory Commission (MedPAC) survey, two-thirds of beneficiaries researched and made the decision about whether to sign up without assistance from any one. Of those who had assistance, about half (49 percent) relied on family or friends. Insurance agents (17 percent) and health plans (8 percent) were the next most common sources of help. In contrast, only 1 percent received assistance from their doctor and only 3 percent received assistance from their pharmacist. Three percent received assistance from staff of nursing homes and senior housing facilities.²

Among other key findings in the MedPAC report, relatively few people with Medicare relied on the Medicare web site (11 percent) or its 1-800 MEDICARE number (19 percent) to make their plan selections.³ This was just as well. Many of the materials Medicare prepared to help beneficiaries understand Part D lacked clarity and were beyond their comprehension, according to a report from the U.S. Government Accountability Office (GAO). Additionally, the accuracy rate for calls to the Medicare help line concerning the drug plan that would cost the least for a specified beneficiary was only 41 percent.⁴

The “dual eligibles”—those who have both Medicare and Medicaid benefits—and those in MA-PD plans were automatically enrolled in a plan. These account for 12 million Medicare beneficiaries. As the dual eligibles were auto assigned to a plan, they had to decide whether to remain with that plan or choose another that better fit their needs. Similarly, beneficiaries in MA-PD plans had to decide whether to receive drug coverage through their plan or find another option.ⁱⁱⁱ

The Centers for Medicare & Medicaid Services (CMS), the agency that administers those programs, has announced that it will limit the number of plans that an organization can offer in a region in 2007.

2. Applying for Assistance.

Medicare beneficiaries with incomes below 150 percent of poverty and assets below \$10,000 can apply for assistance with their premiums, deductibles and the coverage gap. Although 13.2 million Medicare beneficiaries have income below the level, an estimated 2.4 million are ineligible because of an asset test.⁵ To obtain the low-income subsidy (LIS), an applicant must first apply for the assistance at a Social Security Administration (SSA) or state Medicaid office, and then enroll in a plan separately. Modest savings and the cash value of a life insurance policy are the most common assets that make applicants ineligible.

ⁱ Medicare Advantage plans are an updated version of the former Medicare+Choice plans under Part C. The Medicare program allows private companies to offer a managed care health plan to Medicare eligible beneficiaries, typically through health maintenance organizations (HMO) and preferred provider organizations (PPO). They may offer prescription drug coverage as a MA Prescription Drug Plan (MA-PD).

ⁱⁱ As seen in Chart 1, 37 percent of Medicare beneficiaries, or nearly 16 million, already had “creditable” prescription drug coverage that continued from other sources such as an employer, Veterans Administration and TRICARE and did not have to choose whether to join a plan.

ⁱⁱⁱ Other beneficiaries receiving Supplemental Security Income (SSI) and Medicare Savings Program benefits who do not have full Medicaid were “deemed eligible,” i.e., qualified for the LIS and did not need to apply for it. They were auto-enrolled after the enrollment deadline if they did not choose a plan before then.

Outreach to the low-income Medicare population is difficult due to a variety of language, cultural, and geographical barriers. Major obstacles are the enrollment form and process. Applicants must provide documentation and are confronted with the threat of legal consequences for misstating information on the form. Consequently, three-quarters (3.3 million) of the 4.4 million Medicare beneficiaries still without any drug coverage in 2006 are low-income. Elimination of the asset test and improved methods of outreach and enrollment to this population are essential steps to bringing prescription drug assistance to this vulnerable segment of the Medicare population.^{iv}

Since the MMA went into effect, several states dropped their pharmaceutical assistance programs and many drug companies stopped donating prescriptions. Thus, millions of low-income beneficiaries are now adrift, not in any plan and paying more for their drugs without state or drug company assistance. Those fortunate to live in a state with an assistance program must still qualify but that eligibility could change each year. Some states require applicants to apply for and be rejected by the Part D subsidy program in order to qualify for the state assistance program. The result is that the MMA program has created a system of uneven and unequal treatment: depending on where they live some beneficiaries may get extra help in their states, others cannot.

3. Contacting plans and dealing with their requirements

Once enrolled, many beneficiaries experienced problems with requirements for prior authorization; step therapy; quantity limits;^v and exception^{vi} and appeals procedures that prevented them from getting coverage for the prescriptions they take. When they tried to find out about these rules, they were confronted with busy customer service phone lines. If they were able to get their calls answered, they were often given incomplete or incorrect information.⁶ Many doctors' offices were too short-staffed to file the prior authorization forms and appeals for patients. Eventually, uniform forms were developed and disseminated which alleviated the congestion somewhat.

A positive step was the CMS ruling that plans must continue coverage of drugs for beneficiaries even when the plans change their formularies. This is a significant relief for beneficiaries who feared formulary changes once they joined a plan.

Many beneficiaries learned to their surprise that the drugs they need are classified into as many as four tiers, and that their medications in the higher tiers usually require higher co-payments than other drugs placed on a lower tier. Forty percent of Medicare beneficiaries are subjected to four tiers, whereas only 4 percent of workers with health insurance through their jobs have a fourth tier.⁷ Some MMA plans have as many as eight tiers. Part D plans are barred from covering certain drugs, such as benzodiazepines and barbiturates, which is a hardship particularly for dual eligibles unless their state continues coverage.

^{iv} CMS allows beneficiaries who are eligible for the LIS to enroll in a Part D plan after the May 15th deadline.

^v These are utilization management tools that insurance plans use to make more costly medicines inaccessible.

^{vi} The exception process is used to make a plan cover a non-formulary drug or to reduce cost-sharing for a formulary drug.

4. At the pharmacy

Once a beneficiary selected a plan, the process often broke down between enrollment and notification to pharmacies. This breakdown caused a number of beneficiaries to either pay more than they could afford for their prescriptions or to leave their pharmacy without their medication.

The most at risk population, the dual eligibles, had numerous problems particularly with pharmacies that did not have a record of their auto enrollment in any plan. Many plans failed to implement the required “transition policies” providing coverage for initial fills of prescriptions that would not otherwise be covered. A number of dual eligibles were confronted at the pharmacy with deductibles and co-payments at the regular rates instead of subsidy rates. Ninety percent of the states had to declare an emergency and step in to cover the prescription costs of dual eligibles. CMS promised reimbursement in January, but did not begin reimbursement until May and then to just a few states. Full reimbursement should be completed by the end of the year.

5. The Doughnut Hole

Many Part D participants are beginning to encounter the “doughnut hole” or coverage gap, when total drug costs fall between \$2,250 and \$5,100 and beneficiaries are responsible for all drug costs. Under the standard benefit plan in 2006, in addition to paying a monthly premium averaging \$25, beneficiaries pay a deductible of \$250, then 25 percent of drug costs between \$251 and \$2,250 until they reach the doughnut hole. At that point—when total drug costs are between \$2,251 and \$5,100--they must pay the full cost of their prescriptions while continuing to pay their monthly premiums. After reaching the catastrophic limit of \$5,100 or \$3,600 in out-of-pocket costs, beneficiaries pay 5 percent of drug costs. See Table 1 for projected increases in the doughnut hole for 2007. The average premium for 2007 is projected to be \$32.

Table 1. Medicare Drug Benefit Out-of-Pocket Costs 2006 and 2007

Standard Benefit	2006	2007
Deductible	\$250	\$265
Initial Coverage Limit- Doughnut Hole Begins	\$2,250	\$2,400
Out-of-Pocket Threshold	\$3,600	\$3,850
Doughnut Hole Ends	\$5,100	\$5,451.25

Source: Centers for Medicare & Medicaid Services. Annual Adjustments for Standard Benefit in 2007.

Insurers and CMS itself downplayed the doughnut hole when promoting the benefit. Prior to the launch of the enrollment period an extensive article placed by CMS in *Parade* magazine, a Sunday supplement in most newspapers, failed to mention the doughnut hole altogether. A number of polls prior to and shortly after the benefit began in January, 2006, indicated that the gap in coverage was not understood. It was a foreign concept for most as even beneficiaries who previously had prior health insurance through work had never experienced a coverage gap.

A survey of beneficiaries found that the factors considered by beneficiaries in choosing a particular plan were: the drugs on the formulary, monthly premiums, overall savings, ability to use a local pharmacy and the reputation of the company offering the plan. They were not as concerned about the doughnut hole or the utilization management procedures, an indication that either insufficient information was transmitted on these or that their relevance was not understood.⁸

Consequently, many beneficiaries were not prepared for the MMA coverage gap. Several expensive plans provide some coverage in the gap but beneficiaries who sought out plans with low premiums and deductibles are unlikely to have those plans. Only 15 percent of PDPs and 28 percent of MA-PDs include coverage in the doughnut hole, typically for generic drugs.⁹

Estimates project that about 7 million beneficiaries will fall into the doughnut hole before the end of the year.¹⁰ They will be particularly hard-pressed while in the coverage gap, since many states and pharmaceutical companies have discontinued their drug assistance programs. Those who take a number of medications and cannot pay for all of them will be forced to stop taking some. Consequently, they will never climb out of the doughnut hole if they cease to buy their medications.

A study by the Kaiser Family Foundation points to the harmful effect the doughnut hole can have on beneficiaries. A 2003 study of 200,000 Medicare enrollees in health maintenance organizations (HMOs) found that patients whose medications were capped at \$1,000 or reduced upon reaching a certain cost level stopped taking medicines they couldn't afford. Their blood pressure, glucose and cholesterol levels worsened and the savings in drug costs were offset by increases in the cost of hospitalization and emergency department care.¹¹

The Congressional Budget Office projects that the doughnut hole will expand 78 percent between 2006 and 2013. In addition, the average premiums will increase by 66 percent and the deductibles by 78 percent.¹²

6. Increased Costs

Polls show that a significant proportion of Medicare beneficiaries are paying more under Part D. A Kaiser Family Foundation poll found that one in six (17 percent) Medicare beneficiaries will pay more under the MMA and another 34 percent will pay about the same as they did last year. A New York Times/CBS News poll found that 30 percent said they were not saving money.¹³

Many of those paying more are most of the 6.5 million dual eligibles who were transferred from their state Medicaid drug programs where they had no co-payments. Even when state Medicaid programs required co-payments, Medicaid law required pharmacies to dispense drugs to Medicaid recipients who could not afford the Medicaid co-payments. Now they must pay between \$1-\$5 in co-payments for each drug, a significant expenditure for those below the federal poverty level, and pharmacies are precluded from dispensing medicines on a routine basis to beneficiaries who cannot pay.^{vii}

Two studies have found that the benefit is doing little to control drug costs and may even be contributing to drug price inflation. The costs of drugs most frequently used by Medicare beneficiaries have risen faster than the rate of inflation during the first months since the benefit became available. One study found that prices charged by pharmaceutical companies for brand-name drugs jumped four times the general inflation rate during the first three months of 2006, the largest quarterly price increase in six years. The other study found that the Department of Veterans Affairs, which negotiates prices with manufacturers, pays 46 percent less for the most popular brand-name drugs than the Part D plans pay for the same drugs.¹⁴

^{vii} In 2007, CMS projects that co-payments for those under 100 percent of the FPL will be \$1-3.10; for others receiving the LIS, it will be \$2.15-\$5.35.

Yet the MMA explicitly prohibits the federal government from negotiating with pharmaceutical companies for lower prices. Without reining in rising costs, higher drug prices will likely lead to higher premiums next year, which in turn may discourage beneficiaries from joining plans or staying with the program. If that occurs, fewer enrollees could drive premiums even higher.

7. Led-In and Locked-In

As of July 1, beneficiaries in a Medicare Advantage plan are locked in for the remainder of the year. This policy is in contrast to the earlier version of Medicare Advantage, Medicare+Choice, where beneficiaries had the ability to leave the plan and return to original Medicare at any time. Due to questionable marketing by some of the organizations, many beneficiaries who thought they were signing up for a PDP have found that they are not only in Medicare Advantage but are locked-in for the remainder of the year with the possibility of a high level of cost-sharing. The HHS Inspector General is investigating the sales tactics of some health insurance agents who, in order to earn higher commissions, were directing seniors into Medicare Advantage plans when they are only seeking a basic drug benefit plan. The insurance companies in turn gain from reimbursements from Medicare at several times the monthly reimbursement for a stand-alone drug plan.¹⁵

8. Social Security Withholding for Part D Premiums

A number of beneficiaries found that their requests to have premiums withheld from their Social Security checks were misplaced and they were billed for several months' worth of premiums at once. Some learned this through letters from their insurer threatening disenrollment if they did not pay promptly. In other cases, the government withheld three or four months of Medicare premiums from a single Social Security check.¹⁶ This procedure hits seniors living on a fixed income particularly hard. Attempts to resolve these problems by CMS are ongoing.

Another on-going problem involves individuals for whom Social Security is deducting a premium from their check even though they did not request premium deduction. Many of these individuals are dual eligibles and should not be paying any premium. Some are having premiums withheld for plans in which they did not want to enroll, or in which they are no longer enrolled. CMS, SSA, and the plans all blame each other for the problem. Some beneficiaries have been trying since February to have premium deductions stopped without any success.

What's Ahead?

The next enrollment period will be November 15-December 31, 2006 with coverage beginning January 1, 2007. Marketing of plans begins October 1 although plans may not sign up enrollees until mid-November. If plans are discontinued, enrollees will be notified in October and will have until the end of the year to choose a new plan during the open enrollment period.

Future of Plans and Pharmacies

Whether employers will continue to provide creditable coverage and insurers continue to offer plans are crucial questions. Employer/union plans ultimately will have to assess whether the subsidy they receive for continuing their coverage is worthwhile. A survey of public sector employer plans found that of those that took the retiree drug subsidy in 2006, just over half (54 percent) have decided to take it again in 2007. Twenty-one percent will not take the subsidy next year and 26 percent are undecided. Fourteen percent of the plans are considering contracting with a PDP or MA-PD and 7 percent anticipate providing wrap-around coverage to Part D.¹⁷

The Part D program has been a profitable venture for large insurers, drug companies and pharmacy chains. Nearly 90 percent of PDPs are offered by 16 organizations in 2006, two of which account for nearly half (45 percent) of enrollment in PDPs. United Health Group Inc., which includes the AARP-sponsored Part D plan, has the largest enrollment, accounting for 27 percent of enrollment followed by Humana Inc, which has 18 percent. No other organization exceeds 7 percent enrollment. The United Health Group, Humana and Kaiser Permanente account for 47 percent of enrollment in MA-PDs. No other sponsor exceeds 4 percent.¹⁸ The market share is very lucrative: the United Health Group reports that its second quarter profit in 2006 has risen 26 percent.¹⁹

Similarly, pharmaceutical companies are reporting an upsurge in sales and profits in 2006 largely attributed to Part D. Dual eligibles were previously covered under the Medicaid program, which requires drug companies to give best-price rebates to that program. Under Part D, drug companies are free from state price negotiation and from rebates, yet they will see an increase in sales as the dual eligible population tends to have more chronic conditions than other Medicare recipients and usually take several medications. Health care experts estimate that the pharmaceutical industry may receive a windfall as much as \$2 billion or more in 2006 alone.²⁰

The Part D program may be the death knell for many small and independent community pharmacies while large chains prosper. Part D plans are allowed to present pharmacies with non-negotiable contracts, which pharmacies have to accept in order to participate. If the plans do not pay pharmacies according to the terms of their contracts, there is no penalty. In addition, the reimbursement rates are too low for small pharmacies to survive. Many independent pharmacies previously relied on higher and more prompt reimbursements from Medicaid. Consequently, a survey of independent community pharmacies found that over 90 percent said that their cash flow is worse now than before Medicare Part D. More than 60 percent had to obtain outside financing from banks and other sources in order to cover financial shortfalls caused by the federal drug program—the average balance owed to pharmacies by Part D plans is just under \$70,000.²¹

In contrast, Walgreens, which has an agreement with the UnitedHealth Group, is prospering. Due to volume and co-branding—the placement of pharmacy logos on plan prescription drug cards—the Part D benefit is projected to add \$70 million to Walgreen's annual pretax profit and \$6 billion in annual revenue over the next several years.²² The co-branding practice led many beneficiaries to believe that they could fill prescriptions only at the pharmacy on their card.

In new marketing guidelines, CMS will no longer allow pharmacy logos on prescription cards. Nevertheless, it is expected that large chains will continue to profit and small pharmacies will disappear particularly in rural areas. According to the National Community Pharmacists Association, 275 independent pharmacies have closed this year due to Part D-related issues and more are anticipated.

Conclusion

For proponents of MMA, their primary justification for bringing private market competition into the Medicare program was that it would keep costs down, offer more choices, and allow each beneficiary to find the coverage that meets their particular needs. However, events during the first year of implementation prove otherwise.

Already it is possible to identify the winners and losers in the marketplace. As pharmacies close, plans withdraw, formularies change, and cost-sharing rises, many beneficiaries, including the dual

eligibles and those receiving the LIS, face the prospect of having to select a plan all over again and hope for the best.

The implementation of the drug benefit is costly nationally as well as individually. The high cost of prescription drugs will not produce savings until the Secretary of Health and Human Services has the authority and duty to negotiate prices with pharmaceutical companies. If Medicare could negotiate directly with drug companies, the savings over the first eight years of the Part D program would be almost \$560 billion, enough to close the doughnut hole and leave a surplus of \$40 billion.²³ The authority to negotiate is essential to reduce the overall cost of the program, and to prevent windfall profits to drug companies.

The ultimate solution is to have Medicare provide and administer the prescription drug benefit, just as it does Medicare Part A and Part B. Coupled with negotiating power, a Medicare-run prescription drug benefit will produce enough savings to provide a universal, comprehensive and affordable benefit. This is the prescription drug benefit Medicare beneficiaries want and deserve.

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¹ U.S. Department of Health and Human Services. Over 38 million People with Medicare Now Receiving Prescription Drug Coverage. News Release. June 14, 2006.

² Medicare Payment Advisory Commission (MedPAC). Report to the Congress: Increasing the Value of Medicare. June 2006.

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These statistics do not include employer-sponsored plans.

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