The Medicare Part D Drug Benefit

Reflections on 2007 and what to expect in 2008

by Michael S. Flagstad, MS and Sandy Tan, PharmD

Jan. 1, 2008 marks the commencement of the third year of the Medicare Part D prescription drug benefit program that serves millions of Medicare beneficiaries. Unlike the first few months of 2006 after the launch of the program, the massive confusion that plagued beneficiaries, pharmacies, and providers was not reported in 2007. For the new plan year in 2008, CMS issued a "2008 Part D Readiness Checklist" in September 2007 so that plans could make adequate preparations.

In a survey conducted in March 2007, beneficiaries reported general satisfaction with their Medicare drug benefit and less confusion about Part D. However, the study also revealed that more education is needed for patients to understand gaps in coverage, co-payments, deductibles, and plan alternatives. Another national survey (conducted in 2006 but published in August 2007) concluded that seniors with drug coverage from any source were less likely to face high monthly drug costs or to skip prescribed medications due to cost than seniors who remained without drug coverage.

As of Oct. 1, 2007, more than 24 million seniors and disabled people receiving Medicare benefits were enrolled in private Medicare drug plans, including 17.2 million in stand-alone prescription drug plans (PDPs) and 7.5 million in Medicare Advantage drug plans (MA-PDs). During the open enrollment period for the 2008 plan year (from Nov. 15 to Dec. 31, 2007), most Medicare beneficiaries were able to enroll in a Medicare drug plan or change plans if they were already enrolled. According to CMS, more than 90 percent of PDP enrollees did not switch plans between 2006 and 2007.

A key indicator to watch is the growth of enrollment in MA-PDs as many PDP plan sponsors that also have an MA plan are attempting to move their own PDP lives into an MA plan as a "one-stop shop" and employers are dropping retiree drug subsidy (RDS) programs for their retiree population. MA plans, responsible for the entire health care benefit and thus total Medicare premium dollars, have access to both medical and laboratory data. PDPs currently do not have access to medical and laboratory data and the premiums they charge relate only to the Part D drug benefit. Total costs of care, hospitalization rates and length of stay are crucial measures for MA plans. Many MA plans provide lower Part D premiums and offer enhanced drug benefits to attract and retain beneficiaries. This is important for pharmacists to note as we believe that MA plans (including special needs plans (SNPs)) have the incentive to improve health outcomes and control costs in measurable ways through care management programs and medication therapy management programs (MTMP). In addition, while the average commission for a broker selling a PDP plan to a beneficiary is $40 to $60, the broker would receive a commission of approximately $400 to sell the same beneficiary an MA-PD plan. When CMS releases the enrollment for the 2008 plan year, it will be known if more beneficiaries switched plans than in past years.

Most Part D enrollees pay a monthly premium for Medicare drug coverage. In 2007, approximately nine million Part D enrollees did not pay monthly premiums because they received low-income assistance under Part D and/or were enrolled in Medicare Advantage plans that do not charge a monthly premium for drug coverage.

In 2006 and 2007, Medicare beneficiaries showed that consistency and low monthly premiums were priorities in selecting their Part D plans. CMS Medicare Part D enrollment data for 2007 showed that the vast majority of Part D beneficiaries chose to remain in the plan that they joined in 2006. Furthermore, as in 2006, beneficiaries favored the plan option with

TABLE 1. MEDICARE PDPS BY TOTAL ENROLLMENT IN PARENT ORGANIZATION

As of October 1, 2007 payment:

PARENT ORGANIZATION	# ENROLLED	% OF TOTAL
United HealthCare Group, Inc.*	4,702,247	27.4%
Humana Inc.*	3,465,373	20.2%
Universal American Financial Corp.	1,640,154	9.5%
Wellpoint, Inc.*	1,218,428	7.1%
WellCare Health Plans, Inc.*	974,478	5.7%
Coventry Health Care Inc.*	718,941	4.2%
CVS-Caremark, Inc.*	361,523	2.1%
Health Net, Inc.*	353,479	2.1%
Wellmark, Inc.	342,805	2.0%
Health Care Service Corporation	321,112	1.9%
Medco Health Solutions, Inc.*	316,986	1.8%
CIGNA*	311,658	1.8%
Aetna Inc.*	308,662	1.8%
Longs Drug Stores Corporation*	240,753	1.4%
Sierra Health Services, Inc.	195,877	1.1%
Torchmark Corporation	168,502	1.0%
Horizon BCBS of New Jersey	133,530	0.8%
Total Other	1,405,235	8.2%
GRAND TOTAL	**17,179,743**	**100.0%**

* Indicates national contracts

Source: Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plans Coverage Enrollment – Monthly Enrollment Report by Contract. CMS, released Oct. 15, 2007.

the lowest upfront cost when offered a choice of three or more stand-alone PDPs.

Tables 1 and 2 lists the top PDP sponsors by enrollment as of Oct. 1, 2007. Despite the myriad of plan choices, almost half of all PDP enrollments for 2007 (nearly 48%) were concentrated in just two PDP organizations. These were the PDPs sponsored by United HealthCare (with 27.4% of all PDP enrollees) and Humana (with 20.2% of all PDP enrollees). The lowest-premium plans offered by United HealthCare and Humana together account for nearly one-third of all PDP enrollments in 2007.

Similar to enrollment in PDPs, among the Medicare Advantage plans that offer prescription drug coverage (MA-PDs), three sponsors together dominated nearly 40% of all MA-PD enrollments for 2007. These are the MA-PDs sponsored by United HealthCare (with 17% of all MA-PD enrollees), Humana (with 14.7% of all MA-PD enrollees), and Kaiser Permanente (with 11.3% of all MA-PD enrollees).

OFFERINGS AND PREMIUMS IN 2008

A total of 1,824 stand-alone Medicare Part D plans are offered in markets across the country in 2008. In comparison, Medicare had approved 2,101 stand-alone Part D plans in 2007. The number of national plans available in 2007 remains unchanged in 2008, i.e. 17, although several national Part D sponsors have changed. This is almost twice as many as were approved in 2006.

Premiums charged for Part D plans range widely, from $9.80 per month to $107.50 per month. According to CMS, Medicare beneficiaries in every state will be able to enroll in one of at least five prescription drug plans with premiums lower than $25 per month for 2008. CMS announced that premiums for basic coverage in 2008 average $25 a month — "nearly 40% lower than originally projected when the benefit was established in 2003." Almost 90% of beneficiaries will be able to choose a plan with premiums that cost less than what they paid in 2007. In addition, monthly premiums for drug coverage offered through MA plans on average will be $11 less, and more than 90% of beneficiaries will have access to managed care plan drug coverage that includes no premiums, CMS said.

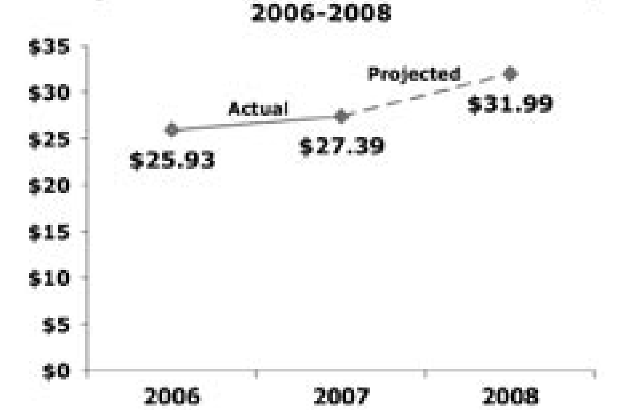
Overall, there is an upward trend in PDP premiums since 2006. If all enrollees remain in the same plans between 2007 and 2008, the average monthly premium would increase from $27.39 in 2007 to $31.99. This represents an increase of 17 percent, with nearly one in five enrollees experiencing an annual increase of at least $120. (see Exhibit 1) It is estimated that 75 percent of Part D enrollees will face higher premiums in 2008 unless they switch to a lower premium plan. This trend is similar for that observed between 2006 and 2007 (before any plan switches). However, the magnitude of PDP premium increases for 2008 is larger (see Exhibit 2) In general, Part D enrollees who have remained in the same plan since 2006 will experience a premium increase of at least 50 percent from 2006 to 2008.

GAP COVERAGE IN 2008

As defined by statute and based on the standard benefit design for Part D sponsors providing prescription drug coverage, Part D enrollees (other than those receiving low-income subsidies) will reach the coverage gap after they incur $2,510 in total drug costs covered under Part D in 2008. At that point, enrollees are required to pay 100 percent of drug costs until they qualify for catastrophic coverage,

Exhibit 1

Weighted Average Monthly PDP Premiums, 2006-2008



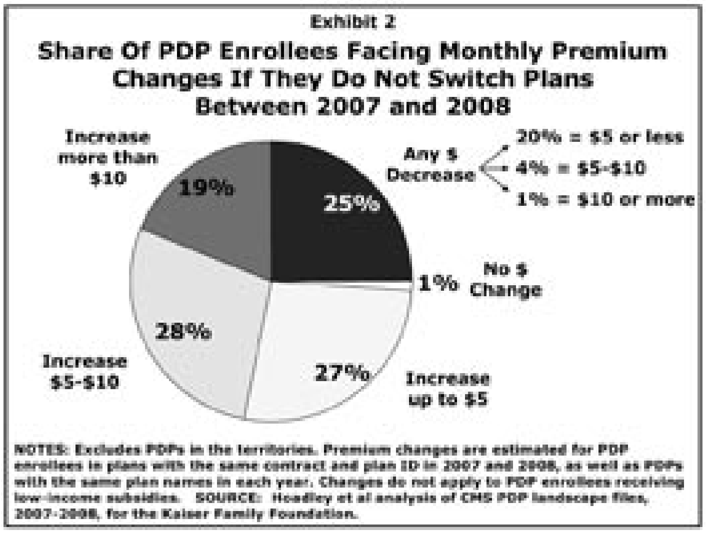
SOURCE: Hoadley et al analysis of CMS PDP landscape files, 2006-2008, for the Kaiser Family Foundation.

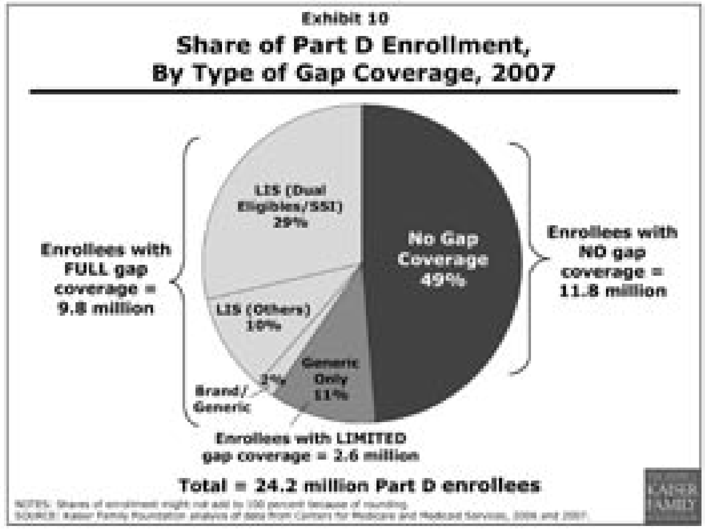
TABLE 2. MA-PDS BY TOTAL ENROLLMENT IN PARENT ORGANIZATION

As of October 1, 2007 payment:

PARENT ORGANIZATION	# ENROLLED	% OF TOTAL
United HealthCare Group, Inc.	1,268,541	17.0%
Humana Inc.	1,093,070	14.7%
Kaiser Permanente	841,266	11.3%
Wellpoint, Inc.	253,147	3.4%
Highmark Inc.	223,129	3.0%
Health Net, Inc.	206,985	2.8%
BCBS of Michigan	179,071	2.4%
Coventry Health Care Inc.	156,423	2.1%
Aetna Inc.	147,671	2.0%
HIP, Health Plan of New York	124,984	1.7%
NewQuest Health Solutions, LLC	119,988	1.6%
Aveta, LLC.	119,740	1.6%
Independence Blue Cross	118,044	1.6%
WellCare Health Plans Inc.	107,236	1.4%
SCAN Health Plan, Inc.	100,806	1.4%
Universal Health Care Inc.	94,564	1.3%
Medical Card System, Inc.	81,731	1.1%
Total Other	2,217,941	29.8%
GRAND TOTAL	**7,454,337**	**100.0%**

Source: Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plans Coverage Enrollment – Monthly Enrollment Report by Contract. CMS, released October 15, 2007.





which occurs when an enrollee's total out-of-pocket costs reach $4,050. (See Exhibit 10.) In lieu of the statute's standard benefit design, plans have the option to offer an actuarially equivalent or enhanced package, for example, by adding gap coverage. However, as in 2006 and 2007, gap coverage is usually accompanied by a much higher monthly premium or essentially, a sponsor's highest-priced plan option.

Based on enrollment data for 2006 and 2007, many beneficiaries do not appear willing to pay premiums of more than $30 per month in order to qualify for gap coverage. Subsequently, such plans have lower enrollment than other plans offered by the same sponsor. Furthermore, nearly half (49%) of Part D enrollees are in plans without gap coverage – with about 11.8 million people potentially at risk for reaching the benefit's coverage gap in 2007 and having to pay the full cost of their drugs.

In 2008, more than a quarter of stand-alone Part D plans and half of Medicare Advantage plans will offer some type of gap coverage, mainly for generic drugs. Nationwide, only one stand-alone PDP in one region (Citrus Healthcare in Florida) and 16 percent of all Medicare Advantage drug plans offer coverage for at least some brand-name drugs in the gap.

Of the 17 national PDP sponsors in 2008, 12 (compared to 11 in 2007) will offer coverage of all or preferred generics in the coverage gap, also known as the "donut hole." Medco and Caremark are two national PDP sponsors that will cover generic drugs in the gap for the first time in 2008. On the other hand, WellPoint and WellCare will discontinue nationally-available gap coverage for generics in 2008. Due to the high cost of providing coverage for brand-name drugs in the gap, no national plan will offer such a coverage benefit in 2008, as in 2007.

PART D DRUG FORMULARY AND COVERAGE CHANGES IN 2008

For the most part, Part D formulary guidelines for the 2008 plan year are similar to those for 2007. One area of change for 2008 is that CMS no longer requires Part D drug formularies to include at least one drug for each formulary key drug type, as listed in the United States Pharmacopeia's Medicare Model Guidelines because this has never been a statutory requirement. However, formularies must still include at least two drugs for each category and class and CMS will continue to use various tools in their formulary review to assure non-discrimination of any group of Medicare beneficiaries.

Another significant change that goes into effect Jan. 1, 2008 is that vaccine administration fees associated with Part D vaccines will now be covered under Part D. This is in accordance with the Tax Relief & Health Care Act of 2006, which amended Sec. 1860D-2(e)(1)(b) to expand statutory definition of Part D drugs to include vaccine administration. The good news for pharmacists is that Part D sponsors are to allow any provider, including a pharmacist, so authorized by a state, to administer a Part D vaccine. In addition, where it is safe to dispense and administer vaccines in a pharmacy, sponsors can explore utilization of their network pharmacists as providers of adult Medicare Part D vaccines.

FOCUS AREAS FOR 2008

In June 2007, CMS announced that seven

STANDARD BENEFIT DESIGN FOR PART D SPONSORS PROVIDING PRESCRIPTION DRUG COVERAGE IN 2007 AND 2008

	2007	2008
Estimated Part D monthly premium	$27.35	$27.93
Deductible	$265	$275
75% coverage by plan, 25% co-insurance by beneficiary	$266 - $2400	$276 - $2510
No coverage by plan	$2401 - $5451.25	$2511 - $5726.25
Catastrophic coverage	Greater of $2.15 for generic, $5.35 for brand, or 5% of the Rx price	Greater of $2.25 for generic, $5.60 for brand, or 5% of the Rx price

private fee-for-service (PFFS) plan sponsors had agreed to voluntarily suspend marketing and sales activities (but not enrollment) for the plans in response to public and congressional concerns that beneficiaries are signing up without a thorough understanding of the products. The seven sponsors, which control 90% of the PFFS market, include Humana, United HealthCare, WellCare, and Universal American Financial Corp. These sponsors are permitted to resume marketing and sales once the agency is satisfied that appropriate procedures and safeguards are in place to avoid confusion on the part of beneficiaries.

At a press conference in September 2007, acting CMS administrator Kerry Weems announced that priorities for the agency include transparency and "compliance" with regulations. Other priorities include strengthening oversight to increase public confidence that the agency keeps an "arm's length" relationship with the health care industry. Weems also said that CMS will publicize the "corrective action plans" reached between the agency and Medicare Advantage plans that have been found to violate Medicare regulations, especially marketing abuses. (Note: CMS has since established a website with detailed information on Medicare Advantage plans that require corrective actions at WWW.CMS.HHS.GOV/MCRADVPARTDENROLDATA/CAP/. The monthly updates to these CAP reports are scheduled to be published to the website around the 1st of each month.)

Five potential areas that Part D plans need to understand and focus on for 2008 and beyond include enforcement, audits, marketing, data submission and coverage determinations. Some of these areas have either changed since the implementation of the Part D program, are new areas that did not exist during implementation, or continue to present problems for plans. Areas that will require additional clarification and/or regulations from CMS include rebates for long-term care pharmacy providers; steerage of beneficiaries in nursing homes to particular plan sponsors or formularies; and use of spread-pricing by plan sponsors, particularly PBMs that serve as PDPs and/or PBMs that serve as delegated entities for Part D plan sponsors.

CMS conducted over 90 audits of plan sponsors in 2007 (note some plan sponsors have multiple contracts that offer Part D benefits). A front page article in the New York Times on Oct. 7, 2007, summarized the common elements of these audits and provided a link to the corrective action plans as well. Due to budget and travel constraints, audits of PDPs were "desk audits" conducted by two CMS subcontractors while MA-PD audits were conducted primarily by the various CMS regional offices. Both types of audits focused on the same areas: sales and marketing activities, beneficiary protections (coverage determinations), appeals and grievances, long-term care pharmacy network coverage and nursing home beds ratios, call center access and accuracy of information provided, and system security for protected health information. The desk audits consisted of a formal request for information, policies and procedures and other documents from plan sponsors in addition to randomly selected sample cases of coverage determinations, appeals and grievances.

CONCLUSION

Although 2006 was a challenging year for many beneficiaries and pharmacists with respect to Part D, the program has operated much more smoothly in 2007. CMS will continue to focus on enforcement, requiring plan sponsors to correct deficiencies and move operational functions within compliance. We expect to see consolidation of plan sponsors in 2008, especially if some organizations have major compliance issues that require substantial investments to correct. The PDE (prescription drug event) process will likely see enhanced scrutiny by CMS during 2008, as data from 2006 are analyzed. Recall that the PDE is the receipt that a plan sponsor submits to CMS as demonstration of providing a Part D covered service.

Congress has been planning to cut physician Medicare reimbursement, but now may reduce the physician cuts and cut reimbursement for MA plans as well. MA plans are closely following the operational and political implications of the cuts they will ultimately receive. In addition, some Democrats in Congress feel that MA plans have excessive margins and are not providing enough of a return on investment in terms of improving health outcomes in measurable ways. The outcome of 2008 elections could have an impact on MA plans and how they operate in the future. It must be remembered that MA plans provide care for many beneficiaries with complex illnesses and/or low incomes. Any political actions will have to carefully consider how care is to be delivered to this population.

The above notwithstanding, pharmacists should pay special attention to MA-PDs and SNPs for MTM opportunities due to aligned incentives and the fact that these plans are often organized on a county by county or regional basis. Long-term care pharmacy issues and infusion therapy needs of beneficiaries are expected to receive additional clarification by CMS in 2008. ●

Michael S. Flagstad is the principal and founder of Visante, Inc, a Minneapolis-based health care consulting firm. Sandy Tan is a pharmacotherapy specialist for Visante, Inc.

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