THE HENRY J. KAISER FAMILY FOUNDATION

FACT SHEET

MEDICARE

THE MEDICARE PRESCRIPTION DRUG BENEFIT

March 2005

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) (P.L.108-173) gives elderly and disabled people on Medicare access to drug coverage beginning in 2006. Until then, it provides temporary help through Medicare-approved drug discount cards and transitional assistance for low-income beneficiaries. The net federal cost of the new benefit is projected to be $37.4 billion in 2006 and $724 billion from 2006 to 2015 (HHS, February 2005).

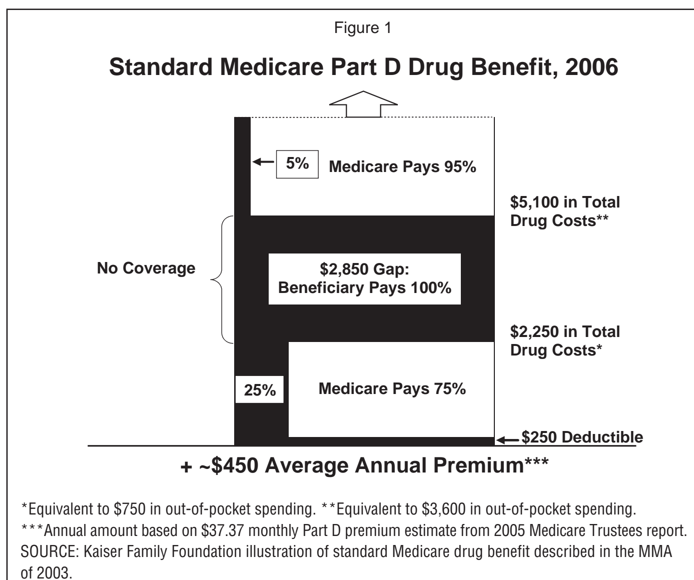
The Part D Prescription Drug Benefit

Beginning in 2006, beneficiaries will have access to two or more plans that contract with Medicare to provide the new drug benefit. Beneficiaries can enroll in new prescription drug plans (PDPs) and get all other Medicare benefits from the traditional fee-for-service (FFS) program, or they can enroll in Medicare Advantage (MA) plans, such as HMOs or regional PPOs, that cover all Medicare benefits, including drugs.

Medicare drug plan enrollees will pay a monthly Part D premium, in addition to the monthly Part B premium, that is set to cover about 25% of the cost of the standard drug benefit (Figure 1). The Part D premium for the standard benefit is estimated by HHS to average $37 per month in 2006 but will vary across plans. Plans can offer either the standard benefit or an alternative benefit design that is actuarially equivalent to the standard benefit and does not increase the standard deductible or the catastrophic threshold.

Figure 1

Standard Medicare Part D Drug Benefit, 2006



*Equivalent to $750 in out-of-pocket spending. **Equivalent to $3,600 in out-of-pocket spending. ***Annual amount based on $37.37 monthly Part D premium estimate from 2005 Medicare Trustees report.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit described in the MMA of 2003.

Standard amounts for deductibles, benefit limits, and catastrophic thresholds are indexed to rise with the growth in per capita Part D spending. The coverage gap between partial and catastrophic coverage is projected to increase from $2,850 in 2006 to $4,984 in 2014 (Figure 2).

Figure 2

Medicare Part D Premiums and Cost-Sharing Amounts for Selected Years

	2006	2010	2014
Monthly Premium (Estimated Average)	$37.37	$48.94	$64.26
Annual Deductible	$250	$331	$437
Initial Coverage Limit	$2,250	$2,980	$3,934
Coverage Gap (difference between initial coverage limit and catastrophic threshold)	$2,850	$3,774	$4,984

SOURCE: 2005 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

Part D Plan Design

Medicare will contract with risk-bearing drug plans in each of 34 regions to provide the new benefit. If two or more risk-bearing plans are not available (including at least one PDP), Medicare will contract with a "fallback" plan to serve beneficiaries in that area.

Plans must cover at least two drugs in each therapeutic class or category of covered Part D drugs, but can establish formularies and tiered cost-sharing amounts as long as they do not "substantially discourage enrollment by certain Part D eligible individuals" (MMA Final Rule, Section 423.272). Part D plans can also establish networks of preferred pharmacies that charge lower cost-sharing than out-of-network pharmacies.

Plans are expected to produce savings by negotiating price discounts and rebates with drug companies; the MMA prohibits Medicare from negotiating drug prices.

Low-Income Assistance

Medicare will provide premium and cost-sharing subsidies to assist low-income beneficiaries (Figure 3). Medicare beneficiaries with Medicaid drug coverage, and QMBs and SLMBs, are automatically deemed eligible for these subsidies. Other low-income beneficiaries will have to meet both an income and asset test to receive additional assistance. Of the 7.8 million non dual eligible beneficiaries with incomes below 150% of poverty ($14,355 for an individual in 2005) who would otherwise qualify for assistance in 2006, CBO estimates that 1.8 million beneficiaries will not qualify as a result of the asset test.

Beneficiaries may apply for low-income assistance at local Social Security or state Medicaid offices.

Figure 3

Overview of Low-Income Part D Benefits, 2006

Low-Income Subsidy Levels	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligible; Income up to 100% FPL ($9,570/individual in 2005)	$0	$0	$1/generic $3/brand-name; no copays after total drug costs reach $5,100
Full-benefit dual eligible; Income greater than 100% FPL	$0	$0	$2/generic $5/brand-name; no copays after total drug costs reach $5,100
Income less than 135% FPL ($12,920/individual in 2005) and assets <$6,000/individual; $9,000/couple	$0	$0	$2/generic $5/brand-name; no copays after total drug costs reach $5,100
Income 135%–150% FPL ($12,920–$14,355/individual in 2005 and assets <$10,000/indiv; $20,000/couple	sliding scale up to~$37	$50	15% of total costs up to $5,100 catastrophic limit; $2/generic $5/brand-name thereafter
All others (non-subsidy eligible)	~$37	$250	25% up to initial coverage limit; 100% up to $3,600 out-of-pocket spending

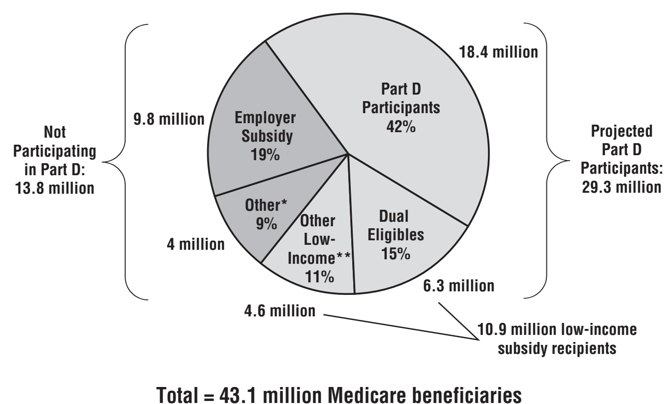
SOURCE: Kaiser Family Foundation summary of Part D low-income subsidies in 2006.

Participation

Of the estimated 43.1 million Medicare beneficiaries, 29.3 million are expected to enroll in Part D plans in 2006 (Figure 4). Of 14.5 million beneficiaries eligible for low-income subsidies in 2006, HHS expects 10.9 million to receive them. Another 9.8 million are expected to receive drug coverage comparable to Part D under an employer plan.

Figure 4

Estimates of Medicare Part D Participation, 2006



*"Other" non-participants includes federal retirees with drug coverage through FEHBP or TRICARE, and those who lack drug coverage. **"Other Low-Income" includes non-dual eligibles with incomes <150% FPL. SOURCE: HHS OACT, MMA Final Rule, January 2005.

Enrollment in Medicare Part D plans is voluntary, however, individuals who delay enrollment after their initial eligibility enrollment period will pay a lifetime premium penalty equal to 1% of the base premium for each month they delay enrollment.

Interaction With Other Coverage

Employer-sponsored plans currently cover drugs for more than 11 million beneficiaries. To encourage employers to maintain these benefits, Medicare will provide tax-free subsidies equal to 28% of costs between $250 and $5,000 in drug expenses per retiree to employers providing drug benefits that are at least comparable to the standard Part D benefit.

Medicaid provides drug coverage for 6.3 million Medicare beneficiaries, known as "dual eligibles." As of January 1, 2006, dual eligibles will get drug coverage from Medicare Part D plans, rather than Medicaid. The HHS Secretary is responsible for automatically enrolling individuals into Part D plans if they do not sign up on their own.

Medicare Advantage plans are a source of coverage for nearly 5 million beneficiaries in 2004 and will be required to offer standard drug coverage in 2006 (except private FFS and Medicare Savings Account plans).

Medigap plans provide drug coverage to less than 10% of the Medicare population. Beginning in 2006, Medigap insurers may not issue new policies that include drug coverage or supplement Part D.

State Pharmaceutical Assistance Programs can continue to provide coverage and can supplement Part D coverage for eligible enrollees.

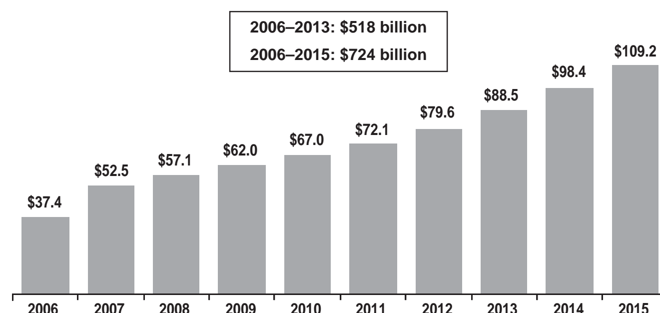
Expenditures and Financing

The net federal cost of the new Medicare drug benefit is estimated to be $724 billion between 2006 and 2015 (Figure 5). Financing for the Medicare drug benefit will come from several sources, including premiums paid by beneficiaries, receipts from states (known as the "clawback"), Medicaid savings, and general revenues.

Future Challenges

Figure 5

Net Federal Cost of the Medicare Prescription Drug Benefit (HHS 2005 Projections)
(in billions)



SOURCE: Administration's FY 2006 Budget.

The Medicare drug benefit offers help to beneficiaries with rising out-of-pocket drug costs, especially those with low incomes, but implementation poses significant challenges for CMS, drug plans, and beneficiaries. Successful implementation will depend on whether new drug plans emerge throughout the country and provide beneficiaries with access to needed medications and a stable, affordable source of drug coverage over time, while controlling rising drug costs. Beneficiary education and counseling will be critical to promote informed decision-making and a smooth transition as the new drug benefit is implemented.

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