PART D PAYMENT SYSTEM

*payment***basics**

Revised: October 2009

In 2006, Medicare began a voluntary outpatient drug benefit known as Part D. A combination of stand-alone prescription drug plans (PDPs) and Medicare Advantage (MA)–Prescription Drug plans (MA–PDs) delivers the benefit. In each of 34 geographic regions, plans compete for enrollees on the basis of annual premiums, benefit structures, specific drug therapies covered, pharmacy networks, and quality of services. Plans bear some risk for their enrollees' drug spending. Overall, Medicare subsidizes premiums by about 75 percent and provides additional subsidies for beneficiaries who have low levels of income and assets. Medicare's payments to plans are determined through a competitive bidding process, and enrollee premiums are also tied to plan bids.

The drug benefit

The standard 2010 benefit will include:

- a $310 deductible;
- coverage for 75 percent of allowable drug expenses up to a benefit limit of $2,830;
- a $4,550 catastrophic limit on true out-of-pocket spending[1] (or $6,440 in total drug expenses for enrollees without supplemental drug coverage); and
- about 5 percent coinsurance for drug spending above the catastrophic limit (Figure 1).

Enrollees with standard benefits pay the full cost of their prescriptions for drug spending greater than $2,830 but less than their catastrophic threshold. However, beneficiaries are able to obtain their plan's discounted price for prescription drugs in this coverage gap.[2]

Plans can and often do offer alternative coverage structures. For example, a plan can offer a deductible lower than $310, or use tiered copayments rather than coinsurance—provided that the alternative benefit meets certain tests of actuarial equivalence. Also, plans may offer additional drug coverage that supplements the standard benefit. Medicare payments to plans do not subsidize such supplemental coverage.

Under Part D, Medicare provides primary drug coverage for individuals who are dually eligible for Medicare and Medicaid. Dually eligible individuals with incomes up to 100 percent of poverty have no deductibles, nominal copays, and no coverage gap. Beneficiaries who do not qualify for full Medicaid benefits, but whose incomes are below 150 percent of poverty and who meet an asset test receive full or partial coverage for premiums and cost-sharing and do not face a coverage gap.

Medicare's subsidy amounts

For each Medicare enrollee in a plan (either stand-alone PDP or MA–PD), Medicare provides plans with a subsidy that averages 74.5 percent of standard coverage for all types of beneficiaries.[3] That average subsidy takes two forms:

- Direct subsidy—a capitated payment to plans calculated as a share of the adjusted national average of plan bids.
- Individual reinsurance—Medicare subsidizes 80 percent of drug spending above an enrollee's catastrophic threshold. Reinsurance acts as a form of risk adjustment by providing greater federal subsidies for the highest cost enrollees.

In addition, Medicare establishes symmetric risk corridors separately for each plan to limit a plan's overall losses or profits. Under risk corridors, Medicare limits a plans' potential losses (or gains) by financing some of the higher-than-expected costs (or recouping excessive profits). These corridors are scheduled

This document does not reflect proposed legislation or regulatory actions.

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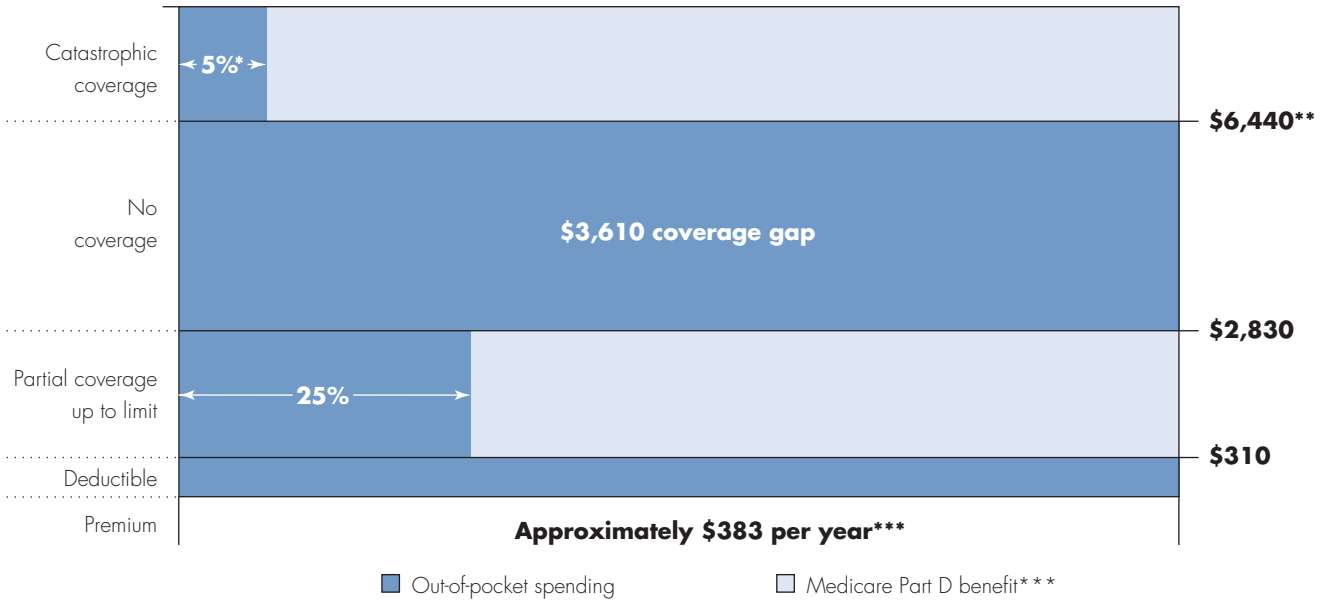
Figure 1 Standard drug benefit in 2010



Note: Benefit structure applies for an enrollee who has no supplementary drug coverage.
* Cost sharing above the catastrophic cap is the greater of either 5 percent coinsurance or a copay of $2.50 for generic drugs, or $6.30 for brand name drugs.
**Equivalent to $4,550 in out-of-pocket spending: $310 (deductible) + $630 (25% cost sharing on $2,520) + $3,610 (100% cost sharing in the "coverage gap").
***There is a base beneficiary premium of $383 per year, which is 25.5% of expected Medicare Part D benefits per person, but the actual premiums that beneficiaries pay vary by plan. Federal subsidies pay for the remainder of covered Part D benefits.

to widen, meaning that plans should bear more insurance risk over time. Also, Medicare pays plans that enroll low-income beneficiaries most of their enrollees' cost sharing and premiums.

Note that although plans get essentially the same level of direct subsidy per enrollee (modified by risk adjusters), the level of subsidies granted through the other three mechanisms differ substantially from plan to plan. Subsidy dollars vary depending on the characteristics of individuals that each plan enrolls (e.g., income and health status), as well as whether a plan's losses or profits trigger provisions of its risk corridors.

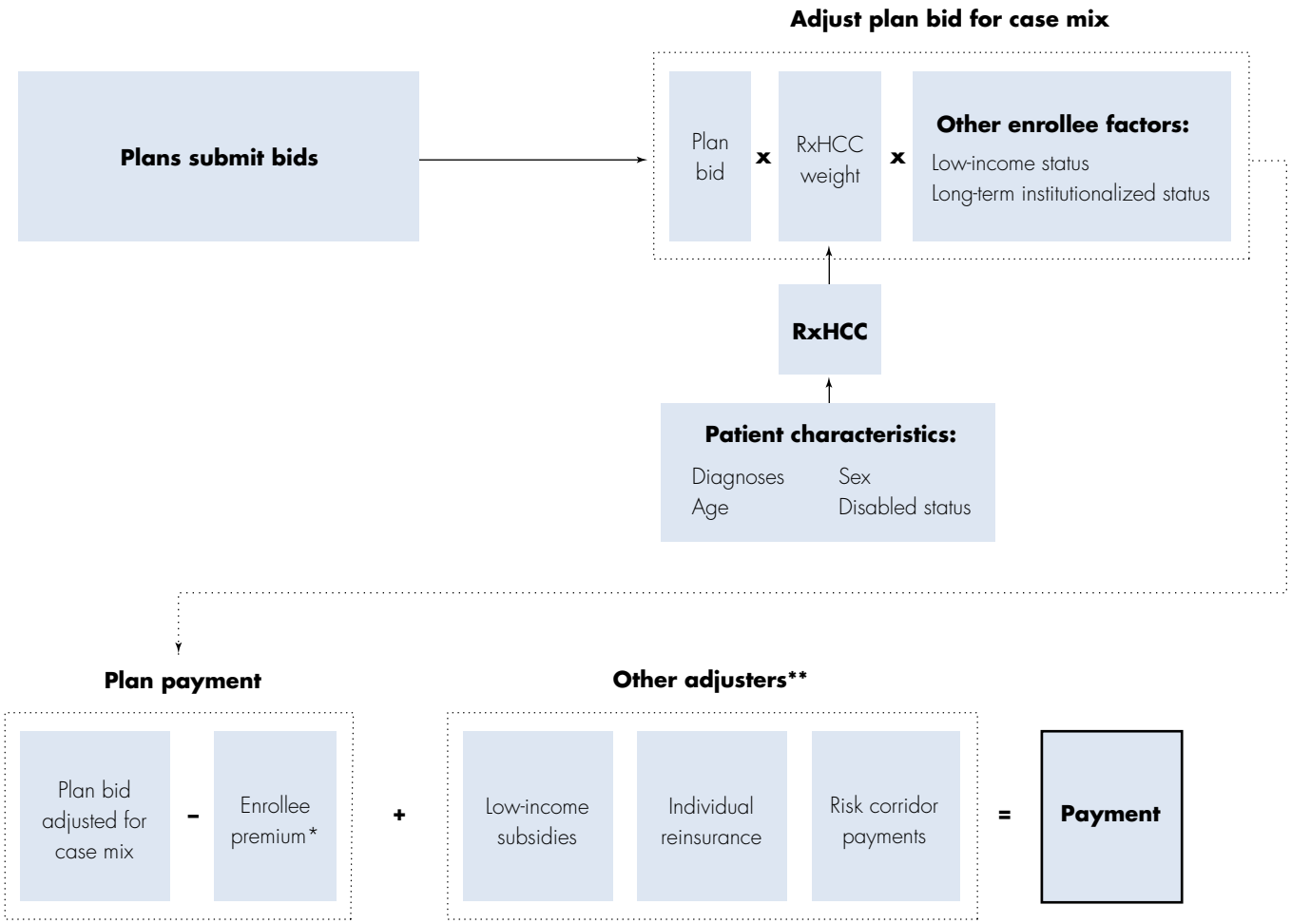
Part D replaced Medicaid as the primary source of prescription drug coverage for individuals who are dually eligible for Medicare and Medicaid. However, states continue to help finance the costs of drug coverage for their dually eligible beneficiaries by making monthly lump sum payments to Medicare.

Medicare's payments to plans

Each plan submits bids annually to the Centers for Medicare & Medicaid Services (CMS) by the first Monday in June. Those bids should reflect the plan's expected benefit payments plus administrative costs after they deduct expected federal reinsurance subsidies. Plans base their bids on expected costs for a Medicare beneficiary of average health; CMS then adjusts payments to plans based on the actual health status of the plans' enrollees.

CMS pays plans a monthly prospective payment for each enrollee (the direct subsidy). This payment is first adjusted by the enrollee's case mix and other subsidy factors, namely low-income status and long-term institutionalized status (Figure 2). A second adjustment to the plan's approved bid is the subtraction of the enrollee's premium. (See the following section on how premiums are calculated.) CMS also provides plans with interim prospective payment adjustments for

Figure 2 Part D payment system



Note: RxHCC (prescription drug hierarchical condition category). The RxHCC is the model that estimates the enrollee risk adjuster.
* Figure 3 outlines the process for calculating enrollee premiums.
**Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.

individual reinsurance and low-income subsidies. The agency reconciles actual levels of enrollment, risk factors, levels of incurred allowable drug costs (after rebates and other discounts), reinsurance amounts, and low-income subsidies after the end of each year.

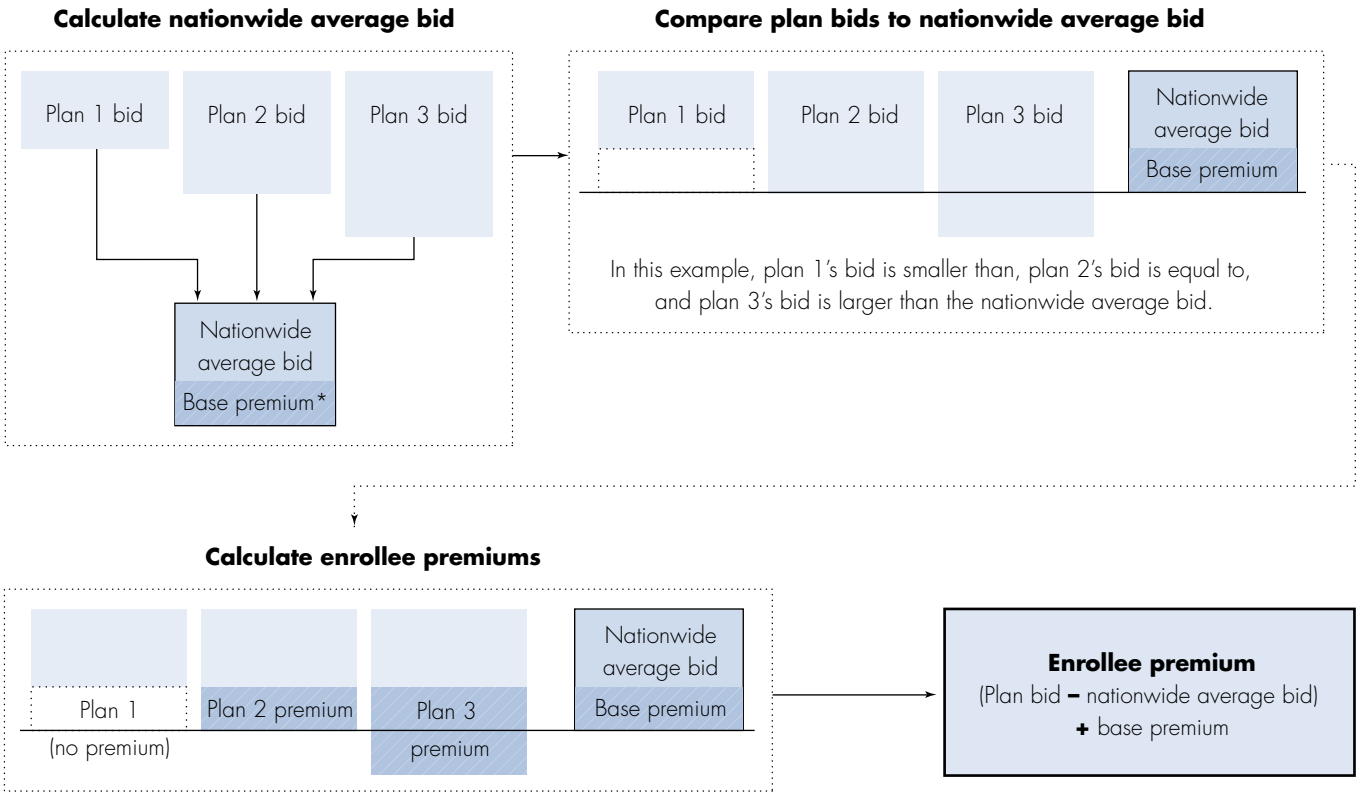
Calculating enrollee premiums

CMS takes plans' standardized bid amounts for basic benefits or the portion of plan bids attributable to basic coverage and calculates the average (Figure 3).[4] From this nationwide average, plan enrollees must pay a base premium ($31.94 in 2010) plus any difference between their plan's bid and the nationwide average bid. Thus, enrollees in costlier plans face higher-than-average premiums for standard Part D coverage; similarly, enrollees in less expensive plans pay lower-than-average premiums.[5]

Benefit and payment updates

Medicare updates the deductible, benefit limit, and catastrophic threshold amounts in the standard Part D benefit each year. Plan payments are a function of plans' updated bids. The benefit's threshold amounts increase by CMS's estimate of

Figure 3 Calculating enrollee premiums



Note: *Base premium is a share of the nationwide average bid. It equals the nationwide average times a factor with a numerator of 25.5% and a denominator of 100% minus CMS's estimate of aggregate plan revenues for Part D benefits that they receive through federal individual reinsurance subsidies.

the annual change in drug spending per person. For example, CMS projects that by 2018, the standard benefit's deductible will be $490, the initial benefit limit will be $4,510 rather than $2,830, and the catastrophic threshold will be $7,250 rather than $4,550 (Boards of Trustees 2009). ■

1 The term "true out of pocket" refers to a feature of Part D that directs fewer federal subsidy dollars toward enrollees who have supplemental coverage. Specifically, only certain types of spending on behalf of the beneficiary count toward the catastrophic threshold: the beneficiary's own out-of-pocket spending; that of a family member or official charity; supplemental drug coverage provided through qualifying state pharmacy assistance programs or Part D's low-income subsidies; and, under CMS's demonstration authority, supplemental drug coverage paid for with MA rebate dollars.

2 Beneficiaries also need to adhere to their plan's formulary, prior authorization, and formulary exceptions processes in order to receive credit for their out-of-pocket spending toward the $4,550 catastrophic limit.

3 For the first few years of Part D, Medicare's subsidy was greater than 74.5 percent. For more information, refer to the section on calculating enrollee premiums.

4 Under current law, CMS is to calculate the nationwide average, weighting each plan's bid by its share of total enrollment in the prior year. Since PDPs had no enrollment information prior to the start of Part D, for 2006 CMS used a simple average of PDP bids and weighted MA–PD bids by prior enrollment. Under CMS's demonstration authority, the agency delayed the move to a weighted average and effectively provided a higher federal subsidy. In 2009, CMS completed phasing in a weighted average in its calculation (i.e., the average is now fully weighted by plan enrollment).

5 Beneficiaries (other than those who receive low-income subsidies) who delay enrolling in Part D until after their initial enrollment period and who do not have creditable coverage must also pay a late enrollment penalty similar to that for Part B. Creditable coverage refers to prescription drug benefits through sources such as a former employer that are at least as generous as the standard Part D benefit.