CHAPTER 4

Part D enrollment, benefit offerings, and plan payments

RECOMMENDATION

The Congress should direct the Secretary to make Part D claims data available regularly and in a timely manner to congressional support agencies and selected executive branch agencies for purposes of program evaluation, public health, and safety.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

CHAPTER 4

Part D enrollment, benefit offerings, and plan payments

Chapter summary

This chapter examines Medicare's prescription drug program as it enters its third year. Our analysis of Part D enrollment for 2007 shows:

- Of more than 40 million Medicare beneficiaries, about 90 percent were enrolled in Part D plans or had drug benefits at least as generous as basic Part D coverage. Of the 13 million beneficiaries estimated to be eligible for Part D's "extra help" with premiums and cost sharing, more than 9 million were receiving low-income subsidy (LIS) and nearly another million had other sources of coverage, leaving about 3 million without either.
- Around 17 million individuals (including more than 6 million dually eligible for Medicare and Medicaid) were enrolled in stand-alone prescription drug plans (PDPs). Sixty-one percent of PDP enrollees were in plans with basic coverage that was actuarially equivalent to the defined standard benefit—typically using copays instead of coinsurance and charging no deductible. Nine percent of PDP enrollees were in plans that offered gap coverage. About half

In this chapter

of all PDP enrollees received Part D's extra help, which effectively eliminated their coverage gap.

- Eighty percent of the 7 million individuals enrolled in a Medicare Advantage–Prescription Drug plan (MA–PD) had enhanced benefits—coverage with an average benefit value higher than basic benefits. A much larger share of MA–PD enrollees were in plans that offered some gap coverage: 33 percent compared with 9 percent for PDP enrollees.
- Among enrollees with gap benefits, most had coverage for generic but not brand name drugs.

Our look at Part D formularies shows:

- Most plans use a three-tier structure that includes one generic tier and two other tiers that distinguish between preferred and nonpreferred brand name drugs. The share of enrollees in plans that used a three-tier formulary grew from 59 percent for PDP enrollees in 2006 to 69 percent in 2007, and from 73 percent to 87 percent of MA–PD enrollees.
- In 2006, 63 percent of PDP enrollees and 67 percent of MA–PD enrollees were in plans with specialty tiers for expensive products, unique drugs, and biologicals. In 2007, those percentages rose to 74 percent and 84 percent, respectively. Cost sharing for specialty-tier drugs is typically 25 percent to 30 percent of the plan's negotiated price and enrollees may not appeal cost-sharing amounts as they can for drugs on other tiers.
- For 2007, copays for the median enrollee in either a PDP or MA–PD with a three-tier formulary were $5 per 30-day prescription for a generic drug, $28 or $29 for preferred brand name drugs, and $60 for nonpreferred brands.

Our analysis of benefit offerings, premiums, and plan payments shows:

- For 2008, most beneficiaries again have a choice of 50 to 60 PDPs. There is a slight increase in the share of PDP offerings that include gap coverage.

- Sponsors are offering 19 percent more MA–PDs for 2008 than for 2007. MA–PDs have been much more likely than PDPs to include enhanced benefits, reflecting their use of MA payments to reduce cost-sharing requirements and premiums.
- Average monthly premiums have increased for 2008, and premiums for the most popular PDPs increased more than did those for other plans. For 2008, the average Part D enrollee pays about $27 per month, up 16 percent from the $23 average for 2007. The average PDP enrollee pays about $32 per month, compared with $27 in 2007. For the average enrollee in an MA–PD, plans charge nearly $13 of their monthly MA premium for Part D benefits, compared with about $10 in 2007.
- There are several reasons for the increase in premiums. One is that CMS is phasing down Part D's federal subsidy to 74.5 percent as called for by law. A second reason for increased premiums is that risk scores for Part D enrollees have crept up over time because of changes in how providers code their services under Part A and Part B. A third factor may be Part D's risk corridors that limit plans' profits and losses and are scheduled to widen in 2008. As plans bear more insurance risk, they may bid higher.
- Plans that bid less qualify to enroll LIS beneficiaries without charging those enrollees a premium. Medicare law set up this process to provide an incentive for plans to control growth in drug spending and keep premiums low.
    - For 2007, CMS chose not to follow the law in setting regional thresholds and did not weight plan premiums by enrollment. As a result, fewer beneficiaries were reassigned to a new plan relative to what would have happened under the law, and Medicare spending was higher.
    - For 2008, about 2.6 million individuals needed to switch to a different plan if they did not want to pay a premium. CMS reassigned 2.1 million of those beneficiaries. This number is considerably more than last year because the agency began phasing in enrollment

weighting to set the thresholds, which led to lower thresholds in many regions. More plans had higher bids and premiums, and so more LIS enrollees needed to change plans.

- As Part D moves into its third year, the Commission is concerned that CMS has not made drug claims data available to congressional support agencies and selected executive branch agencies. CMS released a proposed rule on this topic in 2006, but the agency has not finalized the rule and stakeholders could challenge a final version in court. Stakeholder concerns about release of the data could be mitigated. The Commission needs claims data to monitor and evaluate Part D and make recommendations to improve the program. Other agencies need drug claims to monitor drug safety and health trends and to evaluate the program. ■

Recommendation 4-1

COMMISSIONER VOTES:
YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

The Congress should direct the Secretary to make Part D claims data available regularly and in a timely manner to congressional support agencies and selected executive branch agencies for purposes of program evaluation, public health, and safety.

TABLE 4–1 **Parameters of the defined standard benefit increase over time**

	2006	2007	2008
Deductible	$250.00	$265.00	$275.00
Initial coverage limit	2,250.00	2,400.00	2,510.00
True out-of-pocket spending limit	3,600.00	3,850.00	4,050.00
Total covered drug spending at true out-of-pocket limit	5,100.00	5,451.25	5,726.25
Minimum cost sharing above the true out-of-pocket limit:			
Copay for generic/preferred multisource drug prescription	2.00	2.15	2.25
Copay for other prescription drugs	5.00	5.35	5.60

Note: Under Part D's defined standard benefit, the enrollee pays the deductible and then 25 percent of covered drug spending (75 percent paid by the plan) until total covered drug spending reaches the initial coverage limit. The enrollee then reaches the coverage gap where she must pay 100 percent of covered drug spending until she reaches the true out-of-pocket limit. "True out of pocket" refers to the fact that cost sharing paid by most sources of supplemental coverage does not count toward this limit. The enrollee pays nominal cost sharing above this limit.

Source: CMS 2007g, CMS 2006a.

Under Medicare Part D, private plans compete to deliver prescription drug benefits and try to attract enrollees on the basis of premiums, benefit design, drug formularies, pharmacy networks, and quality of services. Organizations that offer Part D plans bear insurance risk for some of their enrollees' benefit spending. Plan sponsors may offer Part D benefits either as a drug-only package (as a stand-alone prescription drug plan (PDP)) or as part of the broader package of medical benefits offered by Medicare Advantage–Prescription Drug plans (MA–PDs). PDPs must offer their plan throughout their PDP region; CMS created 34 such regions throughout the United States. Most MA–PDs are local plans that select individual counties where they offer their benefits. Regional MA–PDs are an exception; they must offer their plan throughout 1 of the 26 MA regions across the country. For more about the Part D and Medicare Advantage payment systems, see www.medpac.gov/documents/MedPAC_Payment_Basics_07_PartD.pdf and www.medpac.gov/documents/MedPAC_Payment_Basics_07_MA.pdf.

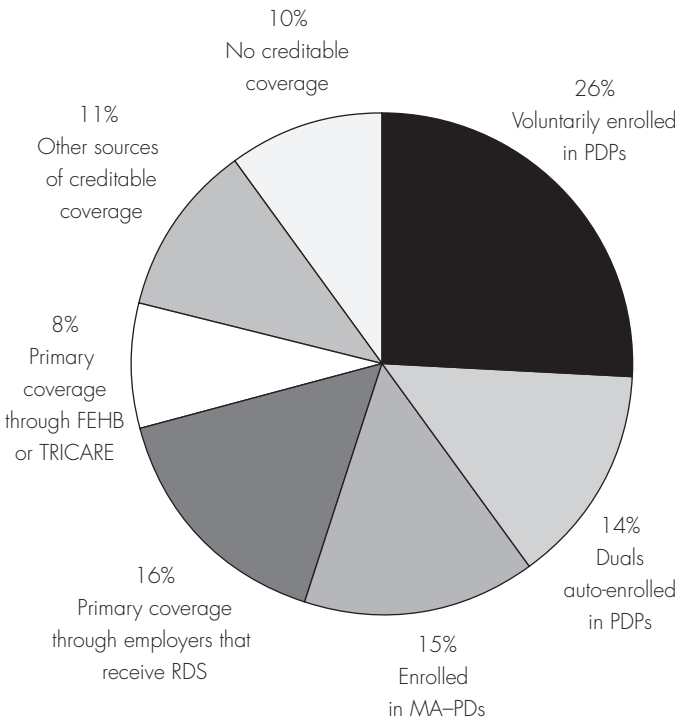
Medicare trustees report that, during calendar year 2006, the Medicare program and enrollees spent $47 billion on Part D benefits and premiums (Boards of Trustees 2007). (Medicare program spending made up $44 billion of the total.) In 2007, updated 10-year projections of spending for the program were about 30 percent lower than projections prepared when the law that created Part D was enacted. Analysts attribute lower projections to competitive bids from plan sponsors that were lower than expected, as well as to levels of enrollment that were lower than anticipated originally (CBO 2007).

According to CMS, five separate surveys suggest that more than 75 percent of Part D enrollees are satisfied with the program (CMS 2007j). (Some individual surveys report higher percentages.) An important reason is that the Part D program subsidizes enrollees' drug spending, thereby saving most beneficiaries money. CMS estimates that in 2007, enrollees saved an average of $1,200 compared with individuals without prescription drug coverage. Enrollees who receive extra help with premiums and cost sharing through Part D's low-income subsidy (LIS) saved an average of $3,350, according to CMS (CMS 2007j).

The law that created Part D set out a defined standard benefit structure for the program's initial year, but the deductible, initial coverage limit, and out-of-pocket spending limit increase over time at the same rate as the annual increase in average total Part D drug expenses of Medicare beneficiaries (Table 4-1). For 2008, the defined standard benefit includes a $275 deductible, 25 percent coinsurance until the enrollee reaches $2,510 in total covered drug spending, and then a coverage gap in which enrollees are responsible for the full discounted price of covered drugs until their true out-of-pocket spending reaches $4,050. ("True out of pocket" refers to the fact that cost sharing paid by sources of supplemental coverage such as employer-sponsored policies does not count toward this $4,050 limit.) An individual with basic Part D benefits with no other source of drug coverage reaches the true out-of-pocket limit at $5,726.25 in total drug spending (the combination of the enrollee's spending plus spending that the Part D plan covers). Enrollees with drug spending exceeding $5,726.25 pay $2.25 to $5.60 per prescription or 5 percent of the plan's negotiated price for the drug, whichever is higher.

FIGURE 4–1

In 2007, about 90 percent of Medicare beneficiaries were enrolled in Part D plans or had other sources of creditable coverage



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), RDS (retiree drug subsidy), FEHB (Federal Employees Health Benefits program). TRICARE is the health program for military retirees and their dependents. Total Medicare enrollment was 43.5 million. Creditable drug coverage means benefits of value equal to or greater than Part D. Other sources of creditable coverage include the Department of Veterans Affairs, Indian Health Service, former employers that do not receive Medicare's RDS, current employers, and certain state pharmaceutical assistance programs.

Source: CMS 2007h.

Part D enrollment and recipients of "extra help"

As of January 2007, about 90 percent of Medicare beneficiaries were either enrolled in Part D plans or had creditable coverage—which means they have credit for having prescription drug benefits through non-Medicare sources at least as generous as basic Part D coverage (Figure 4-1). Medicare subsidized drug spending for 71 percent of all Medicare beneficiaries. They fell into the following four categories: One group is the nearly 11 million individuals, or 26 percent of all beneficiaries, who enrolled voluntarily in stand-alone PDPs. A second group is made up of more than 6 million beneficiaries (14 percent) who are dually eligible for both Medicare and Medicaid that CMS automatically enrolled in stand-alone Part D plans. (Those individuals may switch to a different plan if they prefer to do so.) Third, another 6.7 million (15 percent) were enrolled in MA–PDs (including about 0.5 million dual eligibles). And fourth, 7 million beneficiaries (16 percent) received primary prescription drug coverage through their past employers. In return, Medicare provided those employers with a tax-free subsidy for some of each eligible individual's drug costs.

Another 19 percent of Medicare beneficiaries have other sources of creditable coverage that Medicare does not subsidize. About 8 percent of individuals had primary drug coverage through the Federal Employees Health Benefits Program or TRICARE, the health care systems for government and military retirees, respectively. CMS estimates that 11 percent of Medicare beneficiaries have creditable coverage through the Department of Veterans Affairs, Indian Health Service, former employers that do not participate in Medicare's retiree drug subsidy, current employers (in the case of individuals who are still active workers), or qualified state pharmaceutical assistance programs. That leaves 10 percent (about 4.5 million beneficiaries) without prescription drug coverage or with coverage of lesser value than Part D.

Part D includes an LIS that provides assistance with premiums and cost sharing for individuals with low incomes and assets. In the agency's public outreach campaign to beneficiaries, CMS refers to this as "extra help." As of January 2007, an estimated 13.2 million Medicare beneficiaries (more than 30 percent) were eligible for extra help (Kaiser Family Foundation 2007). Of those 13.2 million, about 9.3 million were receiving the subsidy, and another 0.7 million had other sources of creditable coverage. CMS estimated that an additional 3.3 million Medicare beneficiaries were eligible for extra help but had not yet signed up. (For a more in-depth discussion of LIS outreach efforts, see Chapter 5.)

Patterns of enrollment in 2007

In 2006 and 2007, the typical Medicare beneficiary had 50 to 60 PDPs available, in addition to MA–PDs. However, Part D enrollment was concentrated in plans offered by relatively few sponsors. For 2008, only a

handful of sponsors have exited the market and Medicare beneficiaries continue to have a broad number of choices of PDPs and MA–PDs.

Thus far, the market shares of Part D plan sponsors have not changed much. Even though premium competition was a central component of Part D's design (to provide an incentive to manage growth in drug spending), stable market shares might suggest that, to date, Part D enrollees have not been willing to switch among plans. In a survey of seniors that CMS conducted after Part D's open enrollment period for the 2007 benefit year, only about 6 percent reported switching plans (CMS 2007j). However, as we show later in the chapter, premiums for many of the most popular plans increased for 2008, and so greater numbers of enrollees may have decided to switch to plans with lower premiums. (Enrollment data by plan were not available for 2008 at publication.)

Part D's annual process for setting LIS premium subsidy thresholds is another source of competitive pressure because plans may compete to remain premium-free to LIS enrollees and thereby hold on to this group of members for the upcoming year. In 2006, dual eligibles and other LIS enrollees were randomly assigned to qualifying plans through an auto-assignment process. This process helped to ensure that dual eligibles would have continuous drug coverage as Medicaid's responsibility for that coverage ended and Medicare's status as primary payer began. Auto-assignment also allowed plans to save on marketing costs and meant that qualifying plans could count on Medicare to pay for all or much of those enrollees' premiums and cost sharing. CMS pays plans more for LIS enrollees by applying a multiplier to the risk factor that is based on a beneficiary's health status to compensate for higher average drug spending. In 2007 and subsequent years, CMS randomly assigns new Part D enrollees who receive extra help to a qualifying plan. The agency reassigns some individuals to a new qualifying plan if their previous year's plan bids in such a way that its premium is above the threshold. For some PDP sponsors, the stakes in this annual threshold competition are high because a very large proportion of plan members are LIS enrollees. However, other sponsors rely much less on LIS enrollees and may believe that CMS's risk adjusters do not provide sufficient compensation.

After Part D's initial open enrollment period in 2006, plan membership was highly concentrated in plans offered by relatively few sponsors. That pattern remained unchanged in 2007. As of July 2007, the top two sponsors accounted for nearly half of enrollment in all stand-alone PDPs and about one-third of MA–PD enrollment. UnitedHealthcare and PacifiCare (which merged in 2006) accounted for 27 percent of the 16.8 million PDP enrollees and 17 percent of the 7.4 million MA–PD enrollees (Figure 4-2, p. 284). Similarly, Humana had 21 percent of all PDP enrollees and 15 percent of MA–PD enrollees.

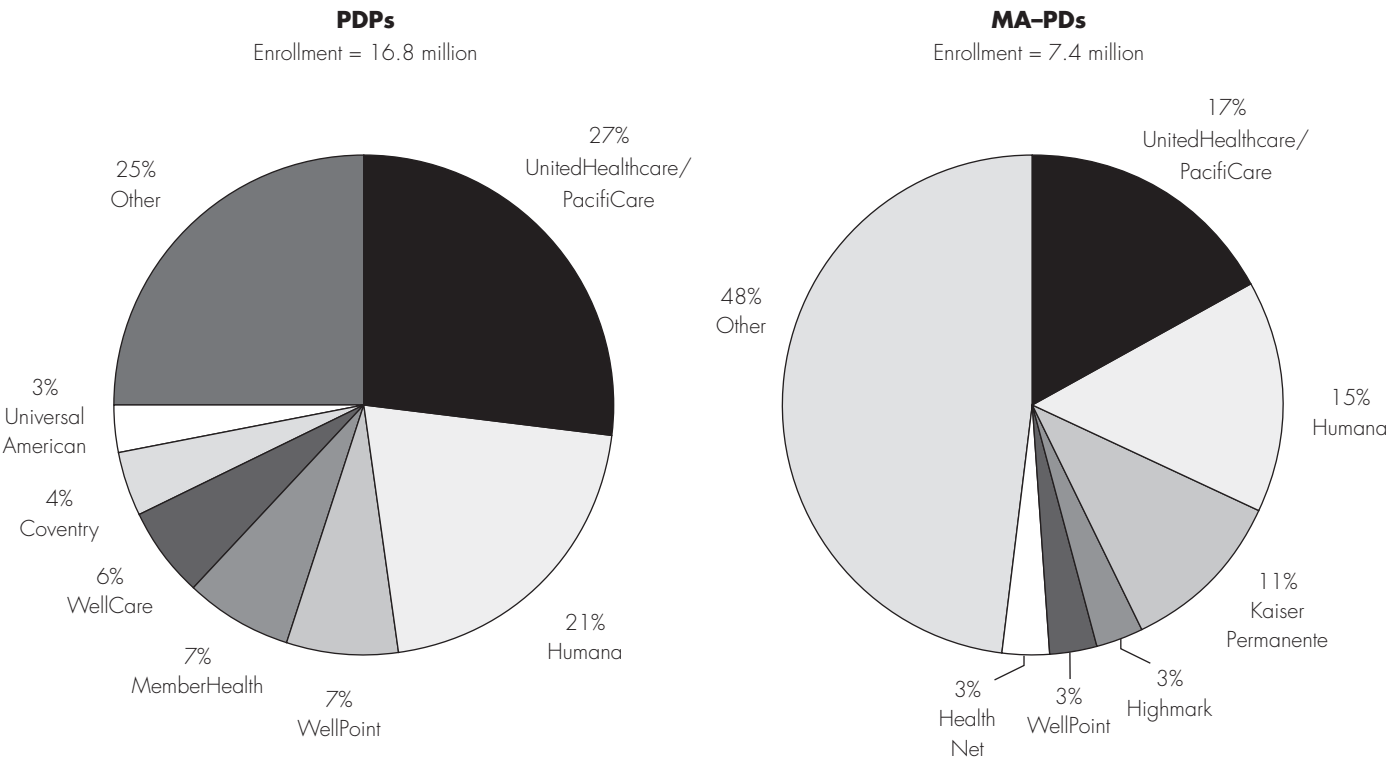
For 2008, changes in whether specific sponsors bid low enough so that their plans qualify to remain premium-free to LIS enrollees could affect the market shares shown in Figure 4-2. As one example, consider the case of UnitedHealthcare. For 2008, that sponsor's bids led to relatively higher plan premiums, and the company no longer offers a premium-free product to 650,000 LIS enrollees who live in 18 of the 34 PDP regions where the insurer's plans qualified for 2007 (UnitedHealth Group 2007). If all 650,000 were in PDPs and allowed themselves to be reassigned to other plans, the loss of enrollees would equate to about 4 percentage points of United's 27 percent PDP market share for 2007. (Note, however, that some LIS enrollees may have chosen to stay in United's plans and pay some of the premium.) Relatively higher bids for some plans offered by Humana, CIGNA, WellCare, and other sponsors also led them to lose qualifying status as premium-free plans in several regions. Other sponsors stand to gain LIS enrollees as beneficiaries are reassigned to qualifying plans.

Part D formularies

The Medicare drug benefit allows plans to develop formularies to manage the cost and use of prescription drugs by covering different drugs and tiering their cost sharing. A formulary is a list of drugs that plans agree to cover and the terms under which they will cover them. In non-Medicare markets, most formularies are variations of two basic models: open or closed. In an open formulary, a payer provides coverage for all drugs in most, if not all, therapeutic classes and may encourage enrollees to use preferred drugs through tiered cost sharing. In a closed formulary, the payer does not reimburse for drugs unless they are listed on the formulary or are covered through an exceptions process. Many payers have moved to a hybrid of open and closed formularies that uses three cost-sharing tiers: low copays for generic drugs, higher but still relatively low copays for preferred brand name drugs, and significantly higher copays for nonpreferred brands. (See MedPAC 2004 for a broader discussion of formularies.)

FIGURE 4–2

Part D enrollees are concentrated among few plan sponsors



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Enrollment numbers are as of July 2007.

Source: CMS 2007c.

When designing formulary systems, plans must strike a balance between providing enrollees with access to medications and controlling growth in drug spending by negotiating drug prices and managing utilization. Part D plans must rely on clinicians when developing and reviewing their formularies through a pharmacy and therapeutics committee made up primarily of practicing physicians and pharmacists. However, plans also consider how to control costs when developing formularies. Making all medications readily accessible at preferred levels of cost sharing can lead to Part D premiums that are high relative to a plan's competitors. On the other hand, an overly restrictive formulary may keep a plan's premium competitive but also may be less likely to attract Part D enrollees because of the limited number of drugs it covers.

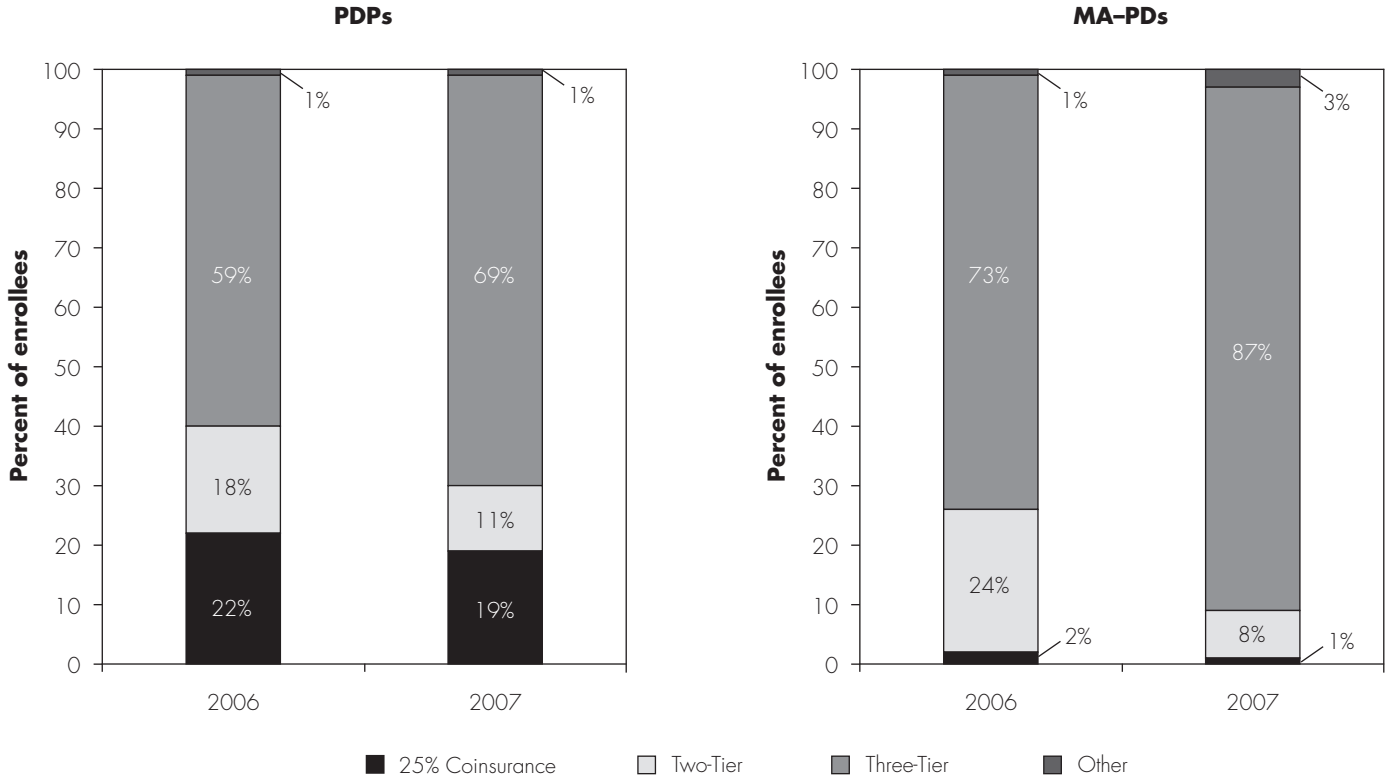
The Commission asked researchers at NORC at the University of Chicago and Georgetown University to describe features of and changes in Part D formularies. Since medication therapies come in a variety of forms and dosages, a critical task of this work was to analyze how to define a drug (see text box, pp. 286–287). Each month, Part D plans submit data to CMS on the list of drugs they cover, cost-sharing tiers on which drugs are placed, and whether each drug is subject to utilization management tools such as requirements for prior authorization. The NORC/Georgetown team analyzed CMS data for 2006 and 2007 to compare tier structures, the numbers of drugs listed, and the degree to which plans managed utilization.

Plan tier structures

CMS data show that most plans' formularies fall into three categories: 25 percent cost sharing for all listed drugs (as in the defined standard benefit), one generic and one brand name tier, and three-tier designs that distinguish

FIGURE 4–3

More enrollees were in Part D plans that used three-tier formularies in 2007



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Percentages are weighted by enrollment. PDPs exclude employer-only groups and plans offered in U.S. territories. MA–PDs exclude demonstration programs, 1876 cost plans, employer-only groups, and plans offered in U.S. territories. Two-tier plans have one lower tier of cost sharing for generic drugs and one higher tier for brand name drugs. Three-tier plans have a generic tier and distinguish between preferred and nonpreferred brands—the latter have higher levels of cost sharing. Many plans also include a fourth specialty tier that applies to expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing. Totals may not sum to 100 percent due to rounding.

Source: NORC/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 2006 and January 2007.

between preferred and nonpreferred brands.[1] Among these categories, most plans use the latter. In addition, CMS permits Part D plans to use a specialty tier for expensive products, unique drugs, and biologicals, and most plan formularies also include a specialty tier.

By setting differential copays between preferred and nonpreferred brands, three-tier formularies may give plans a stronger tool than two tiers for encouraging substitution among drugs within the same therapeutic class. Use of three-tier designs in Part D has increased: The share of beneficiaries enrolled in a three-tier formulary grew from 59 percent of PDP enrollees in 2006 to 69 percent in 2007, and from 73 percent of MA–PD enrollees in 2006 to 87 percent in 2007 (Figure 4-3).[2] (Here the term "three-tier formulary" refers to plans that distinguish between preferred and nonpreferred brand name drugs even if the plan includes a fourth tier for specialty drugs.)

The use of specialty tiers has also increased significantly. In 2006, 63 percent of PDP enrollees and 67 percent of MA–PD enrollees were in plans that used such a tier. In 2007, those shares rose to 74 percent of PDP enrollees and 84 percent of MA–PD enrollees (Figure 4-4, p. 288).[3] Most of the remaining enrollees were either in plans that had the defined standard benefit structure (which uses flat 25 percent coinsurance) or in plans with cost-sharing requirements comparable to those of specialty tiers. For 2006, CMS did not establish specific criteria for placing drugs on a specialty tier. However, for 2007, CMS defined specialty tiers more clearly: Only Part D drugs with negotiated prices that exceeded $500 per month could be

What is a drug?

How drugs are defined can have a significant impact on formulary rules and standards. CMS generally requires that plan formularies include at least two drugs in each of its therapeutic categories and classes (unless only one drug is available). Yet, two products may be considered the same drug by one measure, while they are treated as separate entities by another.

The Food and Drug Administration's national drug codes (NDCs) are very detailed, with separate codes for every combination of chemical ingredients, strength, form, package size (how many doses included in one container used by the pharmacy), and the firm that manufactures or distributes the drug. Meanwhile, the model therapeutic coding system that many Part D plans use was designed by the U.S. Pharmacopeia

TABLE 4–2

Example of how formulary listings of one chemical entity can vary

					Percent of 2007 Part D plans listing:		
Generic name	**Trade name**	**Form**	**Strength**	**NDC**	**NDC**	**Trade name**	**Chemical entity**
Paroxetine HCl	Paroxetine HCl	Oral solid	40 mg	00093712156	100.0%	100.0%	100.0%
			30 mg	00093711656	100.0		
			20 mg	49884087701	99.7		
			10 mg	00093711456	99.6		
	Paxil®	Oral solid	10 mg	00029321013	36.1	100.0	
			40 mg	00029321313	35.9		
			20 mg	00029321113	36.1		
			30 mg	00029321213	35.7		
		Suspension	10 mg/5 ml	00029321548	100.0		
	Paxil CR®	Oral solid	25 mg	00029320713	71.4	71.4	
			12.5 mg	00029320613	71.4		
			37.5 mg	00029320813	71.4		
Paroxetine mesylate	Pexeva®	Oral solid	10 mg	63672201001	55.0	55.0	

Note: NDC (national drug code), HCl (hydrochloride), CR (continuous release), mg (milligrams), ml (milliliters). Oral solids are in pill form and suspensions are in liquid form. Percent of plan values are for stand-alone prescription drug plans and Medicare Advantage–Prescription Drug plans combined. Other NDCs for paroxetine exist, but these are the 13 reference codes for which CMS required plans to report whether they listed the codes in their formularies for 2007.

Source: NORC/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 2007.

on a specialty tier. In 2008, only drugs with prices that exceed $600 per month may be on a specialty tier.

Broader use of specialty tiers has important implications for beneficiaries and plans. From an enrollee's perspective, cost-sharing requirements for specialty-tier drugs can be high (at least 25 percent of the plan's negotiated price) until the beneficiary reaches the catastrophic levels of spending in Part D's benefit that limit out-of-pocket spending. In addition, under CMS's regulations, enrollees may not appeal cost sharing as they can for other drugs such as those on nonpreferred brand tiers. Since the drugs

What is a drug? (continued)

(USP) and is more general and lists only chemical ingredients. Considerations such as brand name versus generic, strength, and (in most cases) form are absent from the USP scheme.

After considering several analytical approaches, researchers at NORC and Georgetown University conducted the research for this chapter by defining drugs at the level of chemical entities—a broader grouping that encompasses all of a chemical's forms, strengths, and package sizes. This definition combines brand name and generic versions of the same chemical entity. Consider, for example, the case of paroxetine, an antidepressant also known under the brand name Paxil® (Table 4-2). Under CMS regulations, antidepressants are one of six protected therapeutic classes in which plans must cover all or substantially all drugs. By conducting the analysis at the level of chemical entities, plans are credited with including paroxetine on their formulary when they list the generic version (paroxetine hydrochloride) even if they do not list Paxil®, its continuous release version Paxil CR®, or the brand name drug Pexeva® (paroxetine mesylate) manufactured by a different company. In 2007, 100 percent of Part D plans listed some form of the chemical entity paroxetine on their formularies. Smaller percentages of plans listed certain individual NDCs for paroxetine or the trade names for it: For example, 36 percent listed the 10 milligram dosage of Paxil®, 71 percent listed Paxil CR®, and 55 percent listed Pexeva®.

Conducting this analysis at the level of chemical entities recognizes that formulary listings are a key tool for encouraging the use of generic equivalents and therapeutically similar drugs. This level of analysis is also generally consistent with how CMS reviews plan formularies. The agency does not require plans to list all dosages of a drug or all manufacturers' versions of a multisource product. Nor does CMS require plans to cover extended-release or continuous-release versions of drugs.

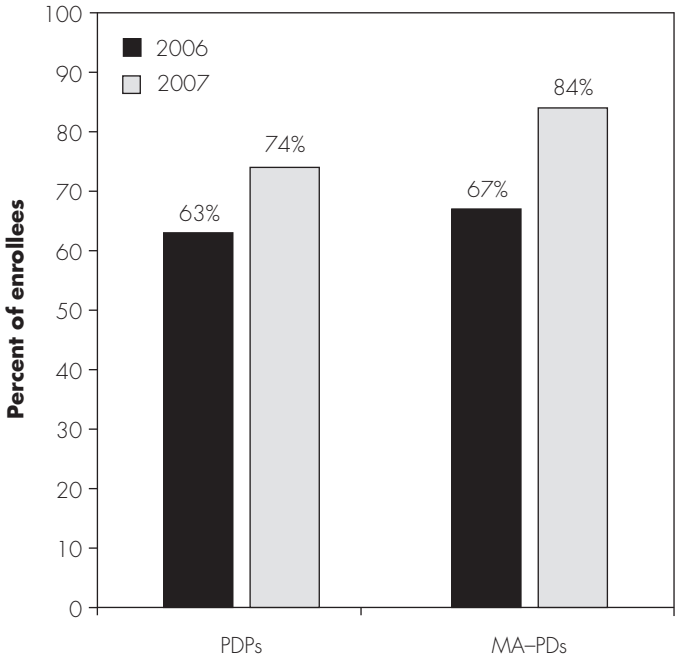
Alternatively, some analysts believe there are clinical reasons to encourage plans to list more varieties of a chemical entity. For example, beneficiaries in fragile health may find it easier to take drugs in liquid (suspension) form than in pill (oral solid) form. (In the case of paroxetine, Table 4-2 shows that all Part D plans covered the liquid form of Paxil® for 2007, which is not available as a generic. Note, however, that plans do not necessarily place liquid and solid forms of the drug on the same cost-sharing tier.) Other analysts believe that patients adhere more closely to treatment regimens when drugs are prescribed in extended- or continuous-release form rather than asking the patient to take several pills each day. (For 2007, 29 percent of Part D plans do not list Paxil CR® on their formulary.) CMS requires all Part D plans to have exceptions policies in place so that enrollees can seek coverage of specific drugs when medical conditions warrant it. At the same time, proponents of broader formularies contend that seeking exceptions takes time and can impede treatment. ■

on specialty tiers are often used to treat very serious illnesses such as rheumatoid arthritis, multiple sclerosis, some cancers, and hepatitis C, these patients could be facing relatively high cost sharing for medications on top of significant out-of-pocket costs for the rest of their medical care. From a plan's perspective, if most of its competitors are using specialty tiers, it may be important to add a specialty tier to limit the risk of attracting sicker enrollees who use very expensive drugs. Otherwise, those expensive drugs would be available for a much lower copay.

For 2007, copay levels for the median enrollee in either a PDP or MA–PD with a three-tier formulary were similar: $5 per 30-day prescription for a generic drug, $28 or $29 for preferred brand name drugs, and $60 for nonpreferred brands (Table 4-3, p. 289). Plans charged the median PDP enrollee 30 percent for specialty-tier drugs, while the median MA–PD enrollee paid 25 percent. There is wide variation in what enrollees pay across Part D plans. Among PDPs, for example, copays for generic drugs ranged from zero to $25 dollars, while copays for preferred brand name drugs ranged from $15 to $59 and

FIGURE 4–4

More enrollees were in Part D plans that used specialty tiers in 2007



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Calculations are weighted by enrollment. PDPs exclude employer-only groups and plans offered in U.S. territories. MA–PDs exclude demonstration programs, 1876 cost plans, employer-only groups, and plans offered in U.S. territories. Specialty tiers apply to expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

Source: NORC/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 2006 and January 2007.

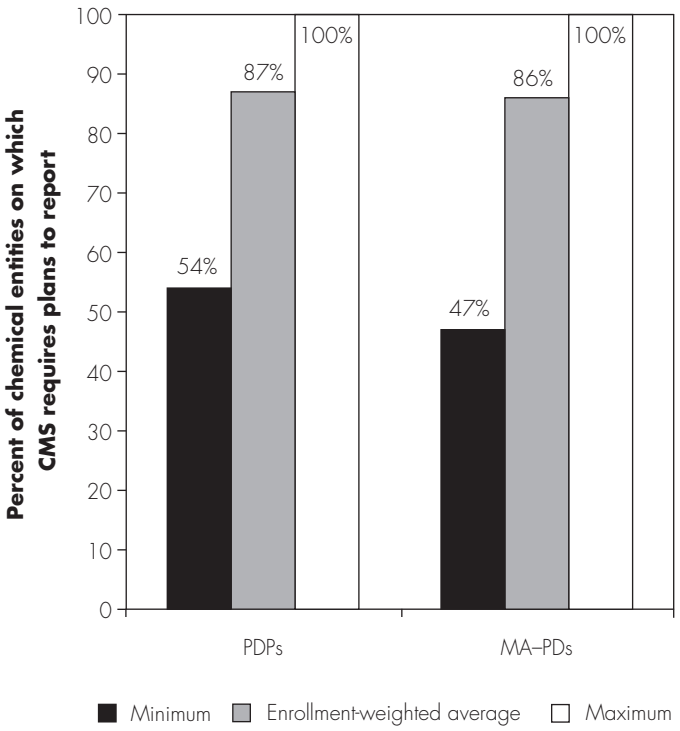
those for nonpreferred drugs ranged from $35 to $93. Among MA–PDs, the variation in copays for preferred and nonpreferred brand name drugs and specialty drugs was greater than the variation in copays for equivalent formulary tiers in PDPs. This likely reflects that enrollment in PDPs is more highly concentrated among a limited number of national plans.

Although copays for the median enrollee were fairly stable between 2006 and 2007 for generic drugs, those for nonpreferred brand name drugs increased from $55 to $60. For the median MA–PD enrollee, copays for prescriptions of preferred brands increased from $27 to $29. Meanwhile, the median enrollee in a PDP saw coinsurance rates for drugs on the specialty tier rise from 25 percent in 2006 to 30 percent in 2007. Copays across Part D plans varied widely in both 2006 and 2007.

Under CMS regulations, plans are to limit cost sharing for specialty-tier drugs to no more than 25 percent of the negotiated price within the benefit's initial coverage limit. However, plans may use higher coinsurance to maintain actuarial equivalence in a basic benefit with no deductible or one that is lower than the defined standard benefit's deductible (CMS 2007f). For 2007, the median enrollee in a PDP that uses a specialty tier faced 30 percent cost sharing for those drugs. This shows that plans are making extensive use of the flexibility that Part D allows for actuarial equivalence in benefit designs, trading off a lower or no deductible for all plan members with higher cost sharing on specialty drugs used by a few enrollees (Hargrave et al. 2007). At the same time, this form of actuarial equivalence may raise out-of-pocket spending

FIGURE 4–5

PDPs and MA–PDs listed similar numbers of drugs on their formularies in 2007



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). PDPs exclude employer-only groups and plans offered in U.S. territories. MA–PDs exclude demonstration programs, 1876 cost plans, employer-only groups, and plans offered in U.S. territories. Values reflect the percent of distinct chemical entities listed within CMS's file of reference national drug codes. The text box (pp. 286–287) provides a discussion of alternative definitions of drugs.

Source: NORC/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 2007.

TABLE 4–3 **Cost sharing for Part D plans in 2007**

	PDP			MA–PD		
Tier	**Median**	**Minimum**	**Maximum**	**Median**	**Minimum**	**Maximum**
Copay						
Generic	$5	$0	$25	$5	$0	$15
Preferred brand name drug	28	15	59	29	0	54
Nonpreferred brand name drug	60	35	93	60	20	120
Specialty-tier coinsurance	30%	25%	33%	25%	10%	33%

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Calculations are weighted by enrollment. Generic copay values are for all plans that use dollar copays. Copay values for preferred and nonpreferred brand name drugs are only for plans that use three tiers. PDPs exclude employer-only groups and plans offered in U.S. territories. MA–PDs exclude demonstration programs, 1876 cost plans, employer-only groups, and plans offered in U.S. territories. Specialty tiers apply to expensive products and unique drugs and biologicals for which enrollees may not appeal for lower cost sharing.

Source: NORC/Georgetown University analysis for MedPAC of formularies submitted to CMS for January 2006 and January 2007.

and disproportionately affect access for beneficiaries who use these high-cost drugs.

Currently, the Commission does not have access to Part D claims information that might allow us to examine trends among beneficiaries who use drugs on specialty tiers. (See discussion at the end of this chapter on Part D claims data.) When linked with claims for Part A and Part B services, drug claims would allow us to look at patients' current levels of utilization, as well as whether greater adherence to those medication therapies is associated with lower use of other health care services.

Formulary sizes, stability, and utilization management

The number of drugs that plans list on their formulary can be another way to analyze Part D plans. Note, however, that the number of drugs on a plan's formulary does not necessarily represent beneficiary access to medications. Plans' processes for nonformulary exceptions, prior authorization (preapproval from a plan before coverage), quantity limits (plans limit the number of doses of a particular drug covered in a given time period), and step therapy requirements (enrollees must try specified drugs before moving to other drugs) can have a strong influence on access to certain drugs. For example, unlisted drugs may be covered through the nonformulary exceptions process, which may be relatively easy for some plans and more burdensome for others. Alternatively, on-formulary drugs may not be covered in cases in which a plan does not approve a prior authorization request. Also, a formulary's size can be deceptively large if it includes drugs that are no longer used in common practice.

During 2007, enrollees in stand-alone PDPs and MA–PDs had similar numbers of drugs listed on their plans' formularies. The average PDP enrollee was in a plan that listed 87 percent of all distinct chemical entities on which CMS requires plans to report, while the average MA–PD enrollee was in a plan listing 86 percent (Figure 4-5). However, the number of drugs listed on any given plan's formulary can vary considerably, from around 50 percent for plans with the tightest formularies to 100 percent for some of the most popular plans.

Plans may remove a drug from their formularies, move a drug to a higher cost-sharing tier, or impose new restrictions at any point during the year, as long as they notify affected enrollees, pharmacists, and physicians at least 60 days before the change. Beginning in 2007, CMS began requiring plans to provide continued coverage of an enrollee's medications for those who were already on medications affected by formulary changes during the year. (Some exceptions apply, such as removing formulary drugs that the Food and Drug Administration or a product manufacturer has withdrawn from the market.)

During 2007, the average Part D enrollee was relatively unaffected by formulary changes. In their analysis, NORC/Georgetown researchers found that the average PDP enrollee was in a plan that listed 1,116 chemical entities in January 2007. During the year, average enrollees saw slightly more drugs deleted than added to their plan's formulary, but those changes amounted to just 2

TABLE 4–4

Characteristics of PDPs

	2007				2008		
	Plans		Enrollees (as of July 2007)		Plans		
	Number	Percent	Number (in millions)	Percent	Number	Percent	Percent of estimated enrollment[a]
Total	1,866	100%	16.1	100%	1,824	100%	100%
Type of organization							
National[b]	1,507	80	13.9	86	1,589	87	86
Near-national[c]	149	8	0.6	4	32	2	1
Other	210	11	1.7	10	203	11	13
Type of benefit							
Defined standard	219	12	2.9	18	217	12	17
Actuarially equivalent[d]	760	41	9.9	61	682	37	61
Enhanced	877	48	3.3	20	925	51	21
Type of deductible							
Zero	1,127	60	8.6	54	1,065	58	58
Reduced	157	8	0.5	3	150	8	1
Defined standard[e]	582	31	7.0	43	609	33	41
Drugs covered in the gap							
Some generics but no brand name drugs	511	27	1.3	8	528	29	8
Some generics and some brand name drugs	27	1	0.1	1	1	<0.5	<0.5
None	1,328	71	14.7	91	1,295	71	92

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. Sums of percentages may not add to totals due to rounding.

a. Assumes that enrollees will remain in the same plan in which they were enrolled in 2007. Note, however, that some beneficiaries will enroll in or (in the case of beneficiaries who receive extra help) be reassigned to a different plan for 2008. About 99 percent of July 2007 PDP enrollees who were within the scope of our analysis were in 2007 plans that could be matched to 2008 plans

b. Reflects total numbers of plans for the 17 organizations with at least one PDP in all 34 PDP regions.

c. Totals for organizations offering 30 or more PDPs across the country, but without 1 in each PDP region.

d. Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.

e. $265 in 2007 and $275 in 2008.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

percent of the drugs listed. Most of the drugs that were dropped reflect adjustments to CMS's requirements for reporting formulary information to the agency rather than meaningful changes to coverage. Most of the drugs added were newly approved by the Food and Drug Administration.

NORC/Georgetown analysts also examined the degree to which plans changed their formularies between 2006 and 2007. For 2007, CMS changed its process for submitting formulary information and introduced a standard set of reference drugs that permitted better comparisons across plans. At the same time, the change in reporting requirements made the task of comparing the same plan's formulary for the two years more difficult. Nevertheless, NORC/Georgetown researchers saw evidence suggesting that plans dropped only a small share of drugs from the

average enrollee's plan formulary—affecting about 1 percent of total drugs listed.

Part D plans apply utilization management tools—including prior authorization, step therapy, and quantity limits—to selected drugs. Plans use tools for drugs that are expensive; potentially risky; subject to abuse, misuse, or experimental use; or to encourage use of lower cost therapies. Some tools are more common than others. For example, all PDPs and almost all MA–PDs use prior authorization for at least one drug on their formularies. For 2007, average enrollees in either a PDP or MA–PD faced some sort of utilization management for 18 percent of the drugs listed on their formulary. Prior authorization was used for 8 percent of drugs, step therapy for 1 percent, and quantity limits for 12 percent. The use of specific tools varies by drug class. For example, in 2006 Part D formularies, 70 percent or more of drugs listed in the therapeutic class of immune suppressants (rheumatoid arthritis agents) required prior authorization, while fewer than 5 percent of renin angiotensins (selected hypertension drugs) had similar requirements (MedPAC 2006).

Plan offerings for 2008

The total number of PDPs available for 2008 is relatively stable. Organizations are offering just 2 percent fewer stand-alone plans than for 2007: 1,824 compared with 1,866 (Table 4-4). In most states, Medicare beneficiaries can choose from 50 to 60 PDPs in addition to MA–PDs available in their county (data not shown).

In the near term, industry consolidation will reduce the number of plans to a limited degree. A few major plan sponsors are acquiring one another. For example, UnitedHealthcare acquired PacifiCare in 2006 and Sierra in late 2007. Universal American Financial Corp. acquired MemberHealth in 2007. Most of these component companies currently offer several PDPs in each region. We expect their combined numbers of plans to decline. Other sponsors may decide to exit the Part D market if they are unable to attract sufficient enrollment or if Part D's widening risk corridors (which cause plans to bear more insurance risk for their enrollees' drug spending) leave them with the risk of unacceptable losses. Under CMS's guidelines, sponsoring organizations may usually offer no more than two PDPs in each region but may offer up to four if additional plans have meaningful differences in benefit design, such as coverage in the gap (CMS 2007a). If one sponsor acquires another, the parent organization has three years to consolidate its plan offerings, and generally sponsors should offer no more than two plans with basic benefits among subsidiaries.

In 2008, 17 national organizations offer at least one PDP in each region, and those sponsors account for 87 percent of all stand-alone plans and 86 percent of total enrollment in PDPs (Table 4-4). In 2007, there were also 17 organizations participating nationwide, but some of the sponsors have changed. Express Scripts and National Medical Health Card Systems no longer offer PDPs to all Medicare beneficiaries. Instead, both companies will concentrate on PDPs offered to individuals within employer-only group arrangements.[4] In their place, Sterling Insurance Company and Universal American Financial Corporation expanded their 2008 offerings in all 34 regions to include PDPs open to any Medicare beneficiary. SierraRx is nearly national, offering 32 PDPs in 24 regions, but without a plan in each region.

Little change in PDP benefit designs for 2008

Within certain limits, sponsoring organizations may offer Part D plans that have the same actuarial (average benefit) value as the defined standard benefit but a different benefit structure. For example, a plan may use tiered copayments rather than 25 percent coinsurance. Or a plan may have no deductible but use cost-sharing requirements that are equivalent to a rate higher than 25 percent. Both defined standard benefit plans and plans that are actuarially equivalent to the defined standard benefit are known as "basic benefits." Once an organization offers at least one PDP with basic benefits within a PDP region, it may also offer a plan with "enhanced benefits"—basic and supplemental coverage combined, with a higher average benefit value.

In 2007, many beneficiaries—61 percent of all PDP enrollees—enrolled in plans with basic coverage that was actuarially equivalent to the defined standard benefit. Typically, actuarially equivalent basic benefits use copays rather than the 25 percent coinsurance charged in Part D's defined standard benefit. More than half (54 percent) of PDP enrollees enrolled in plans that charged no deductible (Table 4-4). Nine percent of PDP enrollees were in plans that offered gap coverage, typically only for generic rather than brand name drugs. However, just over half of all PDP enrollees received Part D's extra help, which effectively eliminated their coverage gap.

TABLE 4–5

Characteristics of MA–PDs

	2007				2008		
	Plans		Enrollees (as of July 2007)		Plans		
	Number	Percent	Number (in millions)	Percent	Number	Percent	Percent of estimated enrollment[a]
Total	1,622	100%	5.0	100%	1,932	100%	100%
Type of organization							
Local HMO	947	58	3.7	75	1,025	53	78
Local PPO	247	17	0.3	7	353	18	6
PFFS	367	23	0.8	16	520	27	14
Regional PPO	34	2	0.1	2	34	2	2
Type of benefit							
Defined standard	84	5	0.1	1	79	4	1
Actuarially equivalent[b]	321	20	1.0	19	132	7	5
Enhanced	1,217	75	4.0	80	1,721	89	94
Type of deductible							
Zero	1,461	90	4.7	95	1,665	86	95
Reduced	38	2	0.1	1	45	2	2
Defined standard[c]	123	8	0.2	3	222	11	3
Drugs covered in the gap							
Some generics but no brand name drugs	450	28	1.2	25	661	34	37
Some generics and some brand name drugs	76	5	0.4	8	327	17	25
None	1,096	68	3.3	67	944	49	38

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), PPO (preferred provider organization), PFFS (private fee-for-service). The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans. Sums of percentages may not add to totals due to rounding.
a. Assumes that enrollees will remain in the same plan in which they were enrolled in 2007. Note, however, that some beneficiaries will enroll in a different plan for 2008 and the distribution of types of organizations could look considerably different (e.g., a larger share of enrollees are likely to be in PFFS plans). About 96 percent of July 2007 MA–PD enrollees that were within the scope of our analysis were in 2007 plans that could be matched to 2008 plans. New plan entrants are credited with no enrollment.
b. Benefits labeled actuarially equivalent to Part D's standard benefit include what CMS calls "actuarially equivalent standard" and "basic alternative" benefits.
c. $265 in 2007 and $275 in 2008.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

For 2008, plan sponsors have kept benefit designs similar to those in 2007. Sponsors are offering somewhat fewer actuarially equivalent basic plans and somewhat more enhanced plans (Table 4-4, p. 290). Just over half of all PDPs (51 percent) are enhanced packages with a higher average benefit value than basic benefits. However, a plan's enhancement need not include coverage within the defined standard benefit's coverage gap. A common form of supplemental benefits offered in enhanced plans is coverage of the defined standard benefit's deductible. Fifty-eight percent of all PDPs charge no deductible for 2008, and another 8 percent of plans use a lower deductible than the $275 that is part of the defined standard benefit. For 2008, only about 30 percent of PDPs include gap coverage, and nearly all of those plans cover only generic drugs. Among those that offer generic drugs

in the coverage gap, about half limit that coverage to preferred generics.

Differences between MA–PDs and PDPs

Sponsors are offering 19 percent more MA–PDs for 2008: 1,932 compared with 1,622 in 2007 (Table 4-5). (Note that our analysis focuses primarily on plans open to any enrollee in the region and thereby excludes employer-only group plans, special needs plans, and plans for beneficiaries who do not have Part A coverage. We also exclude cost plans.) Although HMOs still dominate the ranks, in 2008 private fee-for-service (PFFS) plans make up a larger share of all MA–PDs: 27 percent compared with 23 percent in 2007. This is consistent with the rapid growth in enrollment among PFFS plans that the Commission documented in several recent reports and in Chapter 3 of this report (MedPAC 2007a, MedPAC 2007b).

Offerings through MA–PDs differ systematically from PDPs. The law allows MA–PDs to use 75 percent of the difference between an MA plan's benchmark payment and its bid (called rebate dollars) for providing Part A and Part B services to supplement its package of benefits or lower its premium. Many MA–PDs use some of their rebate dollars to enhance their Part D benefits or to reduce the portion of their plan premium associated with drug coverage.

Over the past two years, MA–PDs have been much more likely than PDPs to include enhanced benefits. However, this difference is more striking for 2008: 89 percent of MA–PD offerings were enhanced, up from 75 percent in 2007. By comparison, enhanced plans comprised 51 percent of all PDP offerings in 2008, up from 48 percent in 2007.

Another key difference between PDPs and MA–PDs is the relative importance of LIS recipients. Among PDPs, LIS enrollees made up more than half of total enrollment. By comparison, LIS enrollees made up less than 10 percent of the 7 million MA–PD enrollees. (Note that special needs plans are omitted from our analysis.[5]) This difference is not surprising, since dual-eligible beneficiaries made up most of the population of LIS recipients, and most duals are in traditional Medicare rather than in MA plans. For that reason, CMS automatically assigned most duals and other low-income beneficiaries to PDPs rather than to MA–PDs.

Beneficiary premiums, thresholds for low-income premium subsidies, and plan payments

In the Commission's March 2007 report, we drew attention to the fact that, when setting Part D premiums and LIS thresholds for 2007, CMS chose to depart from current law (MedPAC 2007a). The Medicare law called for weighting Part D plan bids for 2007 with their 2006 enrollment when calculating the national average bid (called enrollment weighting). In 2006, Medicare's Part D subsidy was 80 percent or more rather than the 74.5 percent called for by law, because in the first year of the program CMS lacked information about which plans would draw the most enrollees. However, for 2007, CMS had enrollment data that it could have used to set premiums consistent with the law. Since enrollees tended to select or were auto-enrolled in plans with lower premiums, fully weighting plan bids by enrollment would have led to a lower government subsidy, lower Medicare payments to plans, and higher enrollee premiums. Instead, CMS chose not to use enrollment weighting fully in 2007, which raised Medicare's subsidy, increased the government's payments to plans, and lowered enrollee premiums relative to the statutory requirement.

The Medicare law also calls for enrollment weighting in the formula for calculating each region's LIS premium threshold. CMS also chose not to do this in 2007. Enrollment weighting would have led to fewer premium-free plans available for LIS enrollees, which meant that more individuals would have had to change plans or pay more to stay in the same plan. Using unweighted premiums avoided disruption for 2007 but increased payments to plans from the program and postponed but did not avoid the need for some LIS enrollees to switch plans.

For both actions, CMS used its general demonstration authority to transition to enrollment weighting over time. In its report, the Commission reiterated a past recommendation that CMS should not use its general demonstration authority as a mechanism to increase payments (MedPAC 2007a). According to CMS's Office of the Actuary, the demonstrations raised Medicare spending in 2007 by $1 billion relative to current law—$0.6 billion for higher program payments that limited the increase in enrollee premiums and $0.4 billion for the transition in setting LIS premium thresholds. The phase-in of enrollment weighting will also lead to higher spending—albeit in decreasing amounts over time—in

TABLE 4–6

Comparison of Part D monthly premiums in 2007 and 2008

	2007 enrollment (in millions)	Premium*		Percentage change in premium
		2007	2008	
PDPs				
Basic coverage	12.8	$24.05	$28.32	18%
Enhanced coverage	3.3	40.42	45.43	12
Any coverage	16.1	27.39	31.81	16
MA–PDs**				
Basic coverage	1.0	16.86	20.72	23
Enhanced coverage	4.0	8.68	10.51	21
Any coverage	5.0	10.35	12.59	22
All plans				
Basic coverage	13.8	23.52	28.15	20
Enhanced coverage	7.3	23.09	25.61	11
Any coverage	21.1	23.37	27.28	17

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans.
*Premiums are the weighted average using July 2007 enrollment. New plan entrants are credited with no enrollment. Almost 99 percent of July 2007 PDP enrollees and about 96 percent of MA–PD enrollees that were within the scope of our analysis were in 2007 plans that could be matched to 2008 plans. Note that some beneficiaries will choose to enroll in or be automatically reassigned to a different plan for 2008.
**Reflects the portion of MA plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage. MA–PD premiums reflect rebate dollars (75 percent of the difference between a plan's payment benchmark and its bid for providing Part A and Part B services) that were used to offset Part D premium costs. Note that lower average premiums for enhanced MA–PD premiums reflect a different mix of sponsoring organizations and counties of operation than the MA–PDs with basic coverage.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

future years. CMS has not specified whether the two demonstrations will continue and for how long. In the President's budget proposal for fiscal year (FY) 2008, documents suggested that the demonstration to limit increases in premiums could last through FY2009 and the demonstration for setting LIS thresholds could last through FY 2011 (OMB 2007). Actual timing could differ.

For 2008, the agency still is not using full enrollment weighting but does weigh enrollment to a greater degree. Last year, 20 percent of the national average bid to provide basic benefits was based on an enrollment-weighted average of PDP bids. For 2008, 60 percent of the national bid is enrollment weighted (CMS 2007i). Once plans have submitted their bids, enrollment weighting lowers federal expenditures for plan payments and raises enrollee premiums relative to the agency's approach to setting payments for 2007. CMS is also placing more emphasis on enrollment weighting in setting LIS regional thresholds. For 2007, 0 percent of premium thresholds were based on enrollment-weighted average premiums while, for 2008, 50 percent are enrollment weighted. This means that substantially more LIS-eligible beneficiaries needed to switch Part D plans or begin paying some of the premium. CMS switched most of those beneficiaries through the agency's auto-assignment process.

The delay in moving to statutory requirements for enrollment weighting runs counter to an underlying philosophy of Part D: Beneficiaries' enrollment choices should drive the competitive outcome among plans. CMS's decision to delay setting the national average bid and LIS premium thresholds based on enrollment means that plans with higher premiums or premiums above the LIS thresholds probably will retain many of their enrollees. This could mean that some sponsors with higher premium plans remain in the market longer than they would in the absence of those decisions and prevent enrollment from moving to more competitive plans. At the same time, switching plans can be difficult for some beneficiaries, as we discuss later.

TABLE 4–7 **Distribution of Part D monthly premiums in 2007 and 2008**

	2007				2008				
	Mean	Median	25th percentile	75th percentile	Mean	Median	25th percentile	75th percentile	Percentage change in mean
PDPs									
Basic coverage	$28.79	$28.20	$24.50	$32.50	$30.14	$27.80	$24.10	$34.00	5%
Enhanced coverage	45.66	42.90	37.50	49.50	49.63	44.50	31.40	64.70	9
Any coverage	36.81	33.40	26.70	43.10	40.02	33.55	25.80	46.90	9
MA–PDs*									
Basic coverage	18.57	21.00	10.20	24.80	20.47	23.70	15.60	24.30	10
Enhanced coverage	16.81	17.60	0.00	27.30	18.04	18.20	0.00	30.30	7
Any coverage	17.26	18.80	0.00	26.70	18.30	19.00	0.00	29.90	6

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). These data are unweighted by enrollment. The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special needs plans, demonstrations, and Part B-only plans.
*Reflects the portion of MA plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage. MA–PD premiums reflect rebate dollars (75 percent of the difference between a plan's payment benchmark and its bid for providing Part A and Part B services) that were used to offset Part D premium costs. Note that lower average premiums for enhanced MA–PD premiums reflect a different mix of sponsoring organizations and counties of operation than the MA–PDs with basic coverage.

Source: MedPAC analysis of CMS landscape, bid, and enrollment data.

Average Part D premiums

On average, Part D enrollees will pay $27 per month in 2008, up about $4 or 17 percent from the $23 average for 2007. The average PDP enrollee will pay about $32 per month, compared with $27 in 2007—a 16 percent increase (Table 4-6). Similarly, the portion of MA premiums attributable to prescription drug benefits will increase for 2008, with the average MA–PD enrollee paying nearly $13 per month compared with $10 in 2007 (22 percent higher). (These amounts reflect MA–PDs' rebate dollars, which come from the MA payment system.) According to CMS, in 2008 the average portion of an MA–PD premium for Part D benefits was $11 below the average PDP premium before rebates (CMS 2007j). Since bids for both PDPs and MA–PDs make up the overall national average bid and affect Medicare's payments to plans, lower average bids by MA–PDs somewhat reduce federal program spending for Part D.

Although most plans have higher premiums for 2008, plans with greater shares of total enrollment had larger increases in their premiums than other plans. For this reason, unweighted averages for plan premiums increased more slowly than did averages weighted by plan enrollment. For example, the unweighted average premium for basic coverage in a PDP rose from $28.79 per month in 2007 to $30.14 in 2008—an increase of 5 percent (Table 4-7). However, if PDP enrollees remained in the same plans, premiums for basic coverage would rise from $24.05 in 2007 to approximately $28.32 in 2008—an increase of 18 percent (Table 4-6).

There are several reasons for the increase in premiums for 2008. One is CMS's continued transition to enrollment weighting described earlier. A second reason is that average risk scores for Part D enrollees have increased over time because of changes in how providers code their services under Part A and Part B. For Medicare to avoid paying too much for a beneficiary of average health, CMS adjusted Part D payments downward. Since enrollee premiums are tied to plan bids, lower risk-adjusted payments from Medicare mean enrollee premiums must increase. A third factor may be the widening of risk corridors that limit plans' profits and losses under Part D in 2008. This means that plans will bear more insurance risk in 2008 and may have led to higher bidding.

Regional thresholds for low-income premium subsidies

For 2008, 495 PDPs (27 percent) qualified as premium-free for enrollees who receive the full LIS. All PDP regions have at least five qualifying PDPs, most regions have 15 or more, and some have as many as 20. Eleven of the 34 PDP regions had fewer qualifying PDPs for 2008, while 15 regions had more qualifying plans. CMS will randomly assign new Part D enrollees who receive

extra help as well as those individuals who need to be reassigned to plans with premiums below their regional threshold. Under the agency's 2008 "de minimis" policy, plans with premiums within $1 of their regional threshold remain premium-free to LIS recipients, but those plans will not receive new randomly assigned enrollees. CMS used a $2 de minimis policy in 2007.

CMS estimates that for 2008, 2.6 million individuals (more than 25 percent of all who received extra help during 2007) were affected by turnover among qualifying plans (CMS 2007k). Of those individuals, 1 million are beneficiaries who were reassigned to a qualifying plan offered by the same sponsor. Since many plan sponsors use the same formulary for all their plans, these reassigned beneficiaries are less likely to face significant changes due to their reassignment. However, CMS reassigned another 1.2 million individuals to qualifying plans offered by a different plan sponsor, and those beneficiaries and the physicians and pharmacies who serve them could face transition issues as they change formularies. Among the individuals that CMS reassigned to a new plan, 0.2 million are dual-eligible beneficiaries who reside in long-term care facilities. CMS estimates that the agency reassigned just under half of the 0.2 million individuals to plans offered by a different sponsor (CMS 2007d). Another 0.4 million LIS enrollees picked a plan on their own for 2007. CMS notified those individuals that their 2007 plan no longer qualified for 2008, and it was up to them to enroll in a new qualifying plan on their own or they must pay some of the premium to stay in the same plan. The amount LIS enrollees would need to pay to remain in the same plan differs across plans, ranging between $1 and $22 per month. The most common amount would be $4 to $5 per month.

By comparison, for 2007, about 1.2 million LIS enrollees were in plans that had premiums above the regional thresholds (CMS 2007e). Ultimately, only about 0.2 million individuals were reassigned to a qualifying plan offered by a different sponsor; the remaining beneficiaries were reassigned to qualifying plans under the same sponsor (CMS 2006c). The increase in the number of individuals reassigned to a new plan for 2008 reflects CMS's transition to enrollment-weighted thresholds. In 2007, CMS did not use enrollment weighting at all when setting regional LIS thresholds. For 2008, 50 percent of threshold amounts were based on enrollment-weighted averages, which led to lower thresholds in many regions. In turn, more plans had higher bids with premiums above those thresholds; therefore, more LIS enrollees needed to change plans.

Before the start of Part D, the Commission studied issues that arise when individuals switch drug plans (MedPAC 2004). Transitioning enrollment from one plan to another can affect which pharmacies beneficiaries may use, the number of drugs available to them, and the degree to which they must navigate management tools such as plans' requirements for prior authorization and quantity limits. It may also affect costs for providers. For example, pharmacists often must call physicians to make therapeutic substitutions consistent with a new plan's formulary, and physicians or their staff often must provide more information to plans to obtain prior authorization on behalf of a patient. Some implications that we drew from our research were that it is critically important to coordinate quick exchange of enrollment and other data between old and new plans, and Medicare and plans need detailed strategies to communicate with beneficiaries about how their new plan could affect their coverage.

CMS requires Part D plans to have formal transition policies in place for any newly enrolled beneficiary. Specifically, during the first 90 days of a beneficiary's enrollment, plans must provide a temporary 30-day supply of the enrollee's current drug if the beneficiary appears at the pharmacy and requests a refill for a nonformulary drug (CMS 2006d). (Residents of long-term care facilities may receive a 90-day supply.) CMS allows plans to use prior authorization and other management tools during this transition period but only if such requirements can be resolved at the point of sale. Plans must also send written notice to the enrollee within three days of the transition refill about the temporary nature of the supply and the plan's transition policy. Plans may charge cost sharing for transition refills, but LIS enrollees pay no more than the statutory amount: $2.25 or $5.60 copays in 2008, or 15 percent coinsurance, depending on the extra help a beneficiary is eligible to receive.

When CMS departed from law in 2007 and 2008 and delayed enrollment weighting, the agency set LIS premium thresholds in a way that meant less disruption of coverage for LIS enrollees, since fewer needed to switch plans. However, CMS's approach also increased Medicare program spending relative to current law at a time when the program faces considerable problems with financial sustainability, as we discuss in depth in Chapter 1.

Should policymakers take further steps to reduce the number of LIS enrollees who must switch plans? On the one hand, transitions may be particularly challenging for dual-eligible beneficiaries, who tend to have more chronic conditions and use more prescription drugs. Some of these individuals have cognitive impairments and lack family support to help them navigate the transition to a new plan's formulary. On the other hand, year-to-year changes in enrollment are part of the fundamental design of Part D: Plans that are able to manage drug spending and bid more competitively are rewarded with more enrollment than plans that are not. Moreover, other Part D enrollees who do not receive extra help face transition issues. For example, one estimate suggests that nearly 20 percent of PDP enrollees would face a premium increase of $10 per month or more in 2008 if they did not change plans (Hoadley et al. 2007a). Some of those individuals may have found such an increase unaffordable, needed to switch plans, and may need to change some medications or seek formulary exceptions.

Some stakeholders suggest that one way to reduce the number of beneficiaries who must be reassigned from year to year is to require CMS to exclude rebate dollars from MA–PD premiums when setting regional thresholds. MA–PDs may use rebate dollars to lower plan premiums and provide additional benefits. (Rebate dollars are made up of 75 percent of the difference between a plan's county payment benchmark for providing Part A and Part B services and its bid.) Most MA–PDs use a portion of their rebate dollars to lower the premium they charge enrollees for Part D benefits. When setting LIS thresholds for each region, CMS averages PDP premiums with these lower premiums from MA–PDs.[6] In regions where MA–PDs hold sizable shares of Part D enrollment, reducing MA–PD premiums with rebate dollars leads to lower regional thresholds and fewer PDPs with qualifying premiums. For example, Arizona and Nevada have many Medicare beneficiaries enrolled in MA–PDs and the lowest LIS premium thresholds in the country: $16 and $17 per month, respectively. Those states also have the fewest number of PDPs available at no premium to LIS enrollees: seven and five, respectively.

The Commission supports the participation of private health plans in Medicare. We also note that MA benchmarks and payments significantly exceed average expenditures in fee-for-service (FFS) Medicare (see Chapter 3.) To the extent that Medicare paid MA-PDs no more than FFS spending, plan rebate dollars could reflect more efficient provision of care. Under those circumstances, policymakers may want CMS to continue setting regional thresholds using MA–PD premiums net of rebate dollars. However, if MA–PD rebate dollars largely reflect payments in the MA program that are higher than FFS, policymakers might want to exclude rebate dollars when setting the thresholds.

In today's context where benchmarks exceed FFS spending, it would be difficult to tease out how many of a plan's rebate dollars are due to efficiency versus higher payments. Just removing rebate dollars from the threshold calculations would also increase program spending, since the thresholds would rise and Medicare would pay somewhat more each month for the premiums of plans that would then qualify at the margin. However, if the Congress followed the Commission's recommendation for payment equity between MA and FFS Medicare and reduced benchmarks, any bids below average FFS spending would result only from efficiency gains.

There may be other ways to lower the number of LIS enrollees who must switch plans from year to year or to limit burdensome effects that can result from switching plans. Most of these alternatives involve a trade-off between lower transition effects on LIS beneficiaries and higher Medicare program spending. For example, CMS could have used a $2 de minimis policy in 2008 as the agency did in 2007. Under such a policy, more plans would have qualified as premium-free and CMS estimates that it would have needed to reassign 0.5 million fewer LIS enrollees. However, the higher de minimis amount could have increased program spending somewhat if the added costs of that policy for plans led sponsors to raise their bids in subsequent years.[7] Plans with premiums below regional thresholds might also perceive a higher de minimis policy as unfair. Another approach could be to lengthen the period under which a newly reassigned LIS enrollee may receive a temporary transitional prescription refill from 30 days (current policy) to 90 days. This would give beneficiaries more time to seek help in obtaining prescriptions for drugs on their new plan's formulary or to seek formulary exceptions. However, program spending and all Part D premiums would also increase somewhat, since plans would need to include the added costs of these transitional refills within their bids.

The Commission is evaluating beneficiary-centered assignment—an alternative method to reduce the burden on beneficiaries who must switch plans. Instead of reassigning beneficiaries randomly among qualifying plans, CMS could reassign them based on the degree to

TABLE 4–8 **Largest estimated reconciliation amounts by sponsoring organization**

	2006 reconciliation amounts (in millions)			
	Risk corridors	Individual reinsurance	Low-income cost sharing	Total (in millions)
Total for all organizations	–$2,700	–$1,600	–$37	–$4,300
Top organizations that owe Medicare:				
UnitedHealthcare/PacifiCare	–680	–780	–550	–2,000
Humana	–720	–180	446	–460
Coventry	–81	–270	–34	–390
Independence Blue Cross	–50	–96	–89	–230
WellPoint	–140	2	–73	–210
Top organizations that Medicare owes:				
MemberHealth	–41	146	216	321
Longs Drug Stores	–8	101	63	157
CIGNA	–9	64	55	109
Sierra Health Services	–23	45	27	48
Health Net	–42	76	8	41

Note: Amounts are for both stand-alone and Medicare Advantage prescription drug plans. The low-income cost-sharing, reinsurance, and risk-sharing amounts may not equal the total reconciliation amount because of rounding and an adjustment made for the Part D Payment Demonstration program.

Source: CMS 2007b.

which an individual's past use of medications matches a plan's formulary. Some Medicaid and state pharmacy assistance programs have used this approach to help their enrollees select among Part D plans (Hoadley et al. 2007b). State officials believe beneficiaries have better access to the drugs they are used to taking under this approach. The Commission is continuing to look at the effects of beneficiary-centered assignment on individuals' access to drug therapies, as well as whether the approach could potentially lead to Medicare program savings.

Plan payments and reconciliations

For each Medicare enrollee in a plan (either stand-alone PDP or MA–PD), current law calls for Medicare to provide plans with a subsidy that averages 74.5 percent of basic coverage for beneficiaries. That average subsidy takes two forms:

- Direct subsidy—a monthly payment to plans set as a share of the national average bid, adjusted for the risk of the individual enrollee.
- Individual reinsurance—Medicare subsidizes 80 percent of drug spending above an enrollee's catastrophic threshold. Reinsurance reduces risk for Part D sponsors 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 plans' potential losses or gains by financing some of the higher-than-expected costs or recouping excessive profits. Also, Medicare pays expected cost sharing and premiums for plan enrollees who receive LIS.

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

CMS makes prospective payments to plans for direct subsidies, expected reinsurance, and LIS cost-sharing amounts based on plans' estimates of their costs as reflected in their bids. The agency announced that for 2006, it expects to collect $4.3 billion from plan sponsors because plans' actual costs were lower than expected. CMS reconciles prospective payments with plans after the end of each year by comparing data on actual levels of enrollment, enrollee risk factors, levels of incurred allowable drug costs (after rebates and other discounts), individual reinsurance amounts, LIS, and risk corridors. Of the $4.3 billion, $1.6 billion stems from prospective payments that were too high for individual reinsurance and $2.7 billion is from risk corridors that limit plans' profits and losses. CMS estimates that one sponsoring organization owes nearly half of the total (Table 4-8). Eighty percent of plan sponsors owed Medicare, while the remaining 20 percent of sponsors received money (OIG 2007).

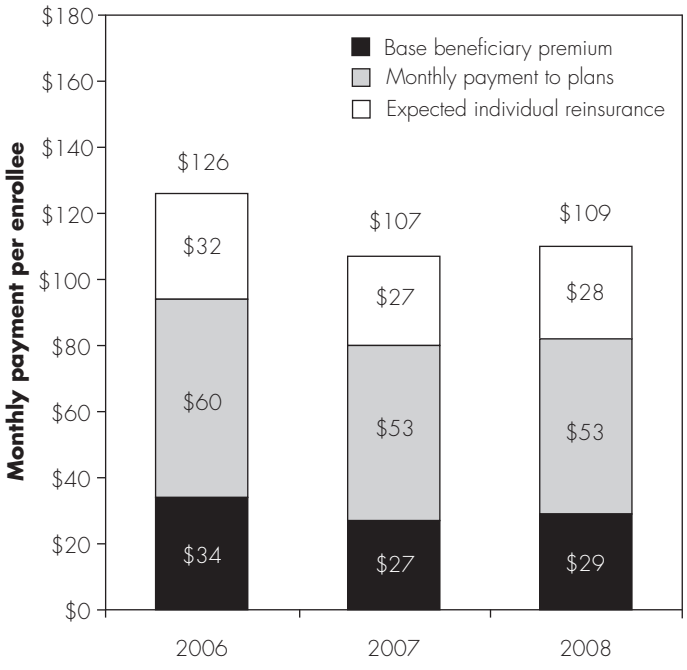
These reconciliation payments stem from the fact that, for many plans, the ultimate cost of providing Part D benefits in 2006 was considerably lower than what they bid. When sponsors prepared bids for 2006, few had reliable information from which to estimate the drug spending of future enrollees. As a result, sponsors submitted a wide range of bids and the distribution of plan premiums was broad. For 2007 bids, sponsors had actual claims experience to draw upon. Plans whose 2006 premiums were relatively high tended to lower their bids for 2007.

Since CMS completed the reconciliation process about nine months after the 2006 plan year ended, plan sponsors had use of these reconciliation funds for a considerable time. The Department of Health and Human Services' Office of Inspector General recommends that CMS consider an interim reconciliation process so that sponsors will not owe Medicare such large amounts in the future (OIG 2007). However, CMS believes that the accuracy of plan bids is improving as plans have gained experience in providing Part D benefits, which should also lower the magnitude of reconciliation amounts.

One can observe the effects of lower bids for basic coverage in the average prospective payments to plans, which fell from $126 per enrollee in 2006 to $107 in 2007 (Figure 4-6). When one divides the $4.3 billion that CMS expects in net reconciliation amounts by total enrollment for 2006, plans owed Medicare about $16 per enrollee per month. Net of this average reconciliation amount, average costs per enrollee for basic coverage in 2006 were about

FIGURE 4–6

Average prospective monthly payments per enrollee for basic coverage



Note: These amounts reflect averages based on bids to provide basic Part D benefits. These averages include plans that offer the defined standard benefit, actuarially equivalent basic benefits, and the portion of enhanced Part D coverage attributable to basic coverage. Enrollees in plans with enhanced coverage must pay the full price of benefits that supplement basic coverage. The combination of monthly payments to plans and expected payments for individual reinsurance make up 74.5 percent of total average monthly benefit costs.

Source: MedPAC based on CMS releases of Part D national average monthly bid amounts and base beneficiary premiums for 2006, 2007, and 2008.

$110 per month—12.5 percent lower than the average $126 per month that plans received prospectively.

For 2008, a larger proportion of PDPs raised their bids. Nearly two-thirds of all PDPs have higher premiums for 2008 than they had in 2007. However, average prospective payments for basic coverage rose only 2 percent, from $107 per month in 2007 to $109 in 2008 (Figure 4-6). Of that amount, the base beneficiary premium makes up $28, while Medicare pays the remainder through direct subsidies ($53) and plans' expected individual reinsurance ($29). Combined, the direct subsidy and the base beneficiary premium make up the national average bid ($80.52). These average amounts reflect the continued phase-in of enrollment weighting. Specific premiums for plans are higher or lower than the base beneficiary premium, depending on how each plan's bid compares

with the national average bid. (In plans with bids above the national average, enrollees must pay the full difference between their plan's bid and the national average.)

Part D data still unavailable for purposes other than payment

In calendar year 2006, the Medicare program and Part D enrollees spent nearly $50 billion on benefits and premiums. Yet, because of gaps in available data, there are fundamental questions that the Commission and other organizations cannot answer about how Part D is operating. These include questions such as:

- which prescription drugs enrollees are using most widely;
- how much, on average, enrollees are paying out of pocket for their medicine; and
- how many beneficiaries are entering Part D's coverage gap.

In its March 2007 report, the Commission reiterated a past recommendation that the Secretary establish a process so that congressional support agencies such as MedPAC would have timely access to Part D data (MedPAC 2007a). Congressional support agencies must report to the Congress about the effects of Medicare payment policies on cost, quality, and access. Data on Part D are necessary for analyzing program performance and making policy recommendations. Detailed data on quality measures would help evaluate the performance of individual plans and providers, which could help Part D beneficiaries make more informed choices. Other federal agencies need Part D data to carry out postmarketing surveillance of drug safety and efficacy, to help monitor the prevalence and treatment of specific conditions, and to support research on clinical outcomes and the effectiveness of covered drugs. Federal and private researchers could make significant contributions to public health and health services research by analyzing linked files of Part A, Part B, and Part D claims. (For an overview of the different types of data CMS collects to administer Part D, see Greenwald 2007.)

Last year, CMS proposed a regulation to resolve statutory ambiguity and explain how the agency would use Part D claims data for purposes other than payment (CMS 2006b). The proposed rule is similar but not identical to language introduced in the Senate during 2006 and 2007 and in the House in 2007 that would explicitly assign responsibility to CMS for sharing prescription drug data with other government agencies, congressional support agencies, and private researchers.

In its proposed rule, CMS would rely on its authority to add terms to its contracts with plans to make claims data available to other parts of CMS, to executive branch and congressional support agencies, and to private researchers so long as they sign data use agreements. CMS has not published a final version of the rule, and as a result the Commission still does not have access to claims information and thus cannot use these data to tell what drugs people use. This information is critical to evaluating Part D and reporting to the Congress about this program. While many private researchers and other government agencies support the rule, some stakeholders have opposed it because of concerns about patient and provider privacy. Some plan sponsors are also concerned that if data showing utilization patterns for their enrollees become public, that information could affect plans' negotiations with manufacturers over drug prices and rebates. The Commission believes it is possible for CMS to protect privacy issues by, for example, not allowing agencies to reveal patient identification. Similarly, plans' concerns about proprietary information could be mitigated by requiring appropriate data use agreements with CMS and limiting access to congressional support agencies and selected federal agencies. However, even if the proposed rule moves forward, stakeholders could challenge it in court.

Three years ago, the Commission recommended the following (MedPAC 2005):

> The Secretary should have a process in place for timely delivery of Part D data to congressional support agencies to enable them to report to the Congress on the drug benefit's impact on cost, quality, and access.

Given that the proposed rule has not moved forward and that stakeholders could potentially challenge such a rule in court, the Commission recommends the following:

RECOMMENDATION 4-1

The Congress should direct the Secretary to make Part D claims data available regularly and in a timely manner to congressional support agencies and selected executive branch agencies for purposes of program evaluation, public health, and safety.

RATIONALE 4-1

Congressional support agencies such as the Commission need these data to monitor and evaluate the performance of Part D and to make recommendations to improve the program. Other executive branch agencies such as the Food and Drug Administration and offices within CMS that do not pay plans need Part D data to monitor adverse drug events and other health trends associated with the use of drugs, to look at whether the use of appropriate medication therapy reduces the use of other Medicare services, and to evaluate the program.

IMPLICATIONS 4-1

Spending

- This recommendation would not increase federal program spending.

Beneficiary and provider

- Beneficiaries could benefit from this recommendation to the extent that CMS and congressional agencies are able to improve the Part D program. Research conducted by executive branch and congressional agencies using Part D claims could also benefit public health and better ensure drug safety.
- Stakeholders will likely object to the extent that they have concerns about protecting patient and provider privacy and protecting proprietary information. The Commission believes that CMS could provide claims data in a way that addresses these concerns. ■

Endnotes

1 Plans submitted formularies to CMS with a variety of tier structures, ranging from one to eight tiers. However, not all tiers reflect cost-sharing differences for enrollees; some plan formularies include several tiers that have the same cost sharing. For our formulary analysis, we delineate tiers only when they mark differences in cost sharing.

2 The fact that a much larger percentage of PDP enrollees are in plans that use 25 percent coinsurance rather than tiered copays reflects that recipients of Part D's LIS make up a much higher percentage of total PDP enrollment than MA–PD enrollment. For 2006, CMS auto-assigned LIS enrollees randomly among PDPs that had premiums below regional threshold values. Plans with the defined standard benefit (which uses 25 percent coinsurance) tend to have lower premiums than plans with tiered copays.

3 On the plan formulary data, CMS does not indicate which tiers were specialty tiers. Therefore, there may be some tiers that offer specialty-type drugs but do not claim this appeal exemption. Tiers for nonspecialty injectable drugs in some plan formularies are an example.

4 2008 is the first year when CMS allows sponsoring organizations to offer only employer-group PDPs without also offering PDPs open to any Medicare beneficiary.

5 In previous years, CMS did not include data on special needs plans (SNPs) in the landscape files that MedPAC uses for its analysis. However, the agency did provide landscape data on SNPs for 2008. To allow comparisons between 2008 data and our analysis of 2007 plans, we excluded SNPs.

6 CMS excludes certain types of MA–PDs when setting the thresholds: Program of All-Inclusive Care for the Elderly, PFFS, medical savings accounts, and Section 1876 cost plans.

7 Under the de minimis policy, plans with premiums that are within $1 of their regional threshold may charge enrollees who are eligible for full LIS benefits no more than the applicable low-income premium subsidy amount.

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