Medicare Part D: Looking Back and Looking Forward

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Key Characteristics of Medicare Part D (1)

- Provide the first Medicare-sponsored coverage for outpatient prescription drugs
- Keep the coverage voluntary
- Make the coverage available to all beneficiaries, not means-tested
- Offer subsidies for low-income beneficiaries

2

Key Characteristics of Medicare Part D (2)

- Rely on competing private, stand-alone drug plans (but with a federal backup option if no plans participated)
- Provide a managed-care alternative through Medicare Advantage
- Offer plans on a regional basis
- Maintain current employer retiree coverage
- Prohibit any government role in price negotiation

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Key Characteristics of Medicare Part D (3)

- Make the coverage comprehensive
  - Not solely catastrophic coverage
  - Not a capped, limited benefit
- Build cost control into the benefit design
  - Deductible
  - Cost sharing
  - Coverage gap ("doughnut hole")
  - Allow use of prior authorization and other tools
  - Limit total expenditures, originally targeted at $400 billion over 10 years

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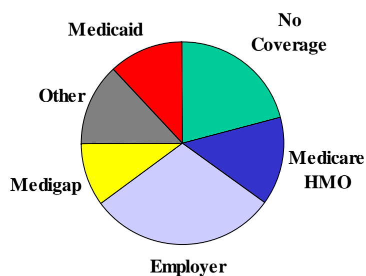
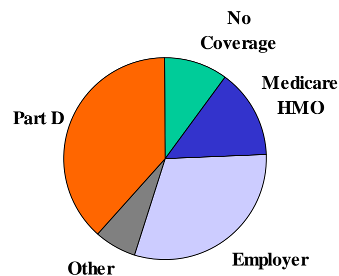
How Close Are We to Universal Coverage in a Voluntary Benefit?

More Medicare Beneficiaries Now Have Drug Coverage

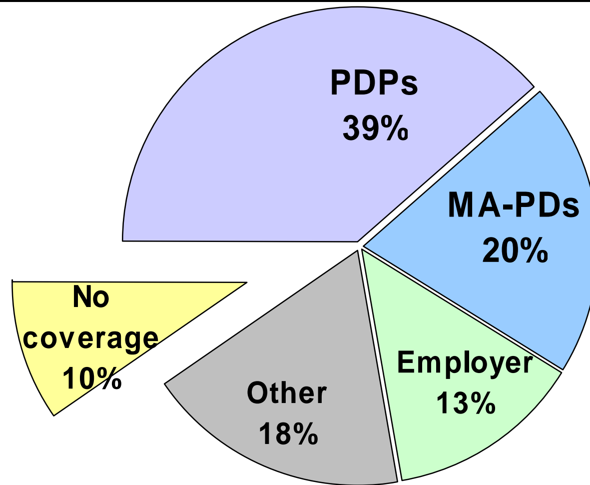
Coverage Before Part D **Coverage After Part D**





Note: "Before" numbers are based on MCBS analysis by Stuart et al. "After" numbers are rough estimates based on CMS numbers. Some beneficiaries may have retained Medigap coverage after Part D, but numbers are not available.

One in Ten Beneficiaries Remains Uncovered in 2009



Source: Analysis of CMS data, February 2009.

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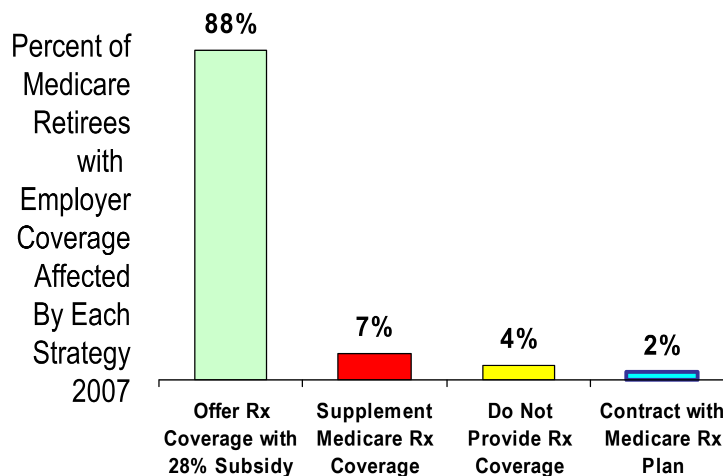
Most Employers Have Used the Government Subsidy to Retain Drug Coverage for Retirees



Source: Hewitt Associates and Kaiser Family Foundation, Retiree Health Benefits Examined: Findings from the Kaiser/Hewitt 2006 Survey on Retiree Health Benefits.

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Beneficiaries Gave a Variety of Reasons for Enrolling in Part D

Note: Respondents could pick more than one response.

Source: NORC/Georgetown survey of beneficiaries conducted for MedPAC, February–March 2006.

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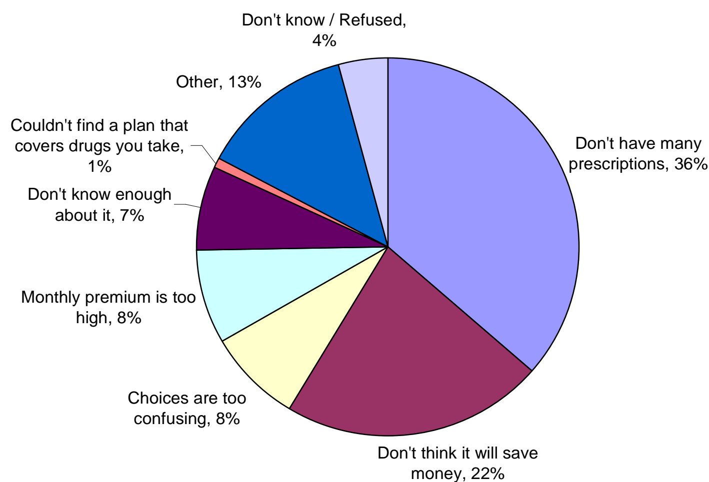
Main Reasons for *Not* Enrolling Were Too Few Prescriptions or No Anticipated Savings



Source: NORC/Georgetown survey of beneficiaries conducted for MedPAC, February–March 2006.

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How Can We Achieve Universal Drug Coverage?

- Make enrollment automatic, unless beneficiaries opt out
- Make the program simpler, less confusing
- Make outreach more aggressive, better targeted

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Is the Low-Income Subsidy Working?

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Low-Income Assistance is Available

- Low-income subsidies (LIS) for beneficiaries with limited income (below $16,245 for an individual) and assets (below $12,510 for an individual)
- LIS generally eliminates premiums and deductibles and restricts copays to no more than $6.00 (2009)
- Beneficiaries qualify as a result of participation in Medicaid or by separate application
- If they do not choose a plan, LIS beneficiaries are automatically enrolled in plans with premiums below a benchmark

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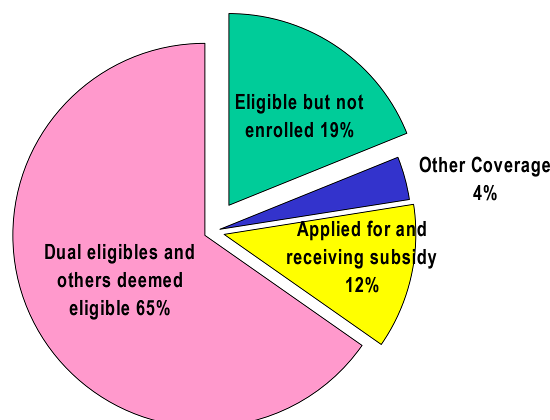
One-Fifth of Those Believed Eligible for the Low-Income Subsidy Are Not Enrolled



Numbers in millions; Total estimated eligible for LIS = 12.5 million

Source: Analysis of CMS data, February 2009.

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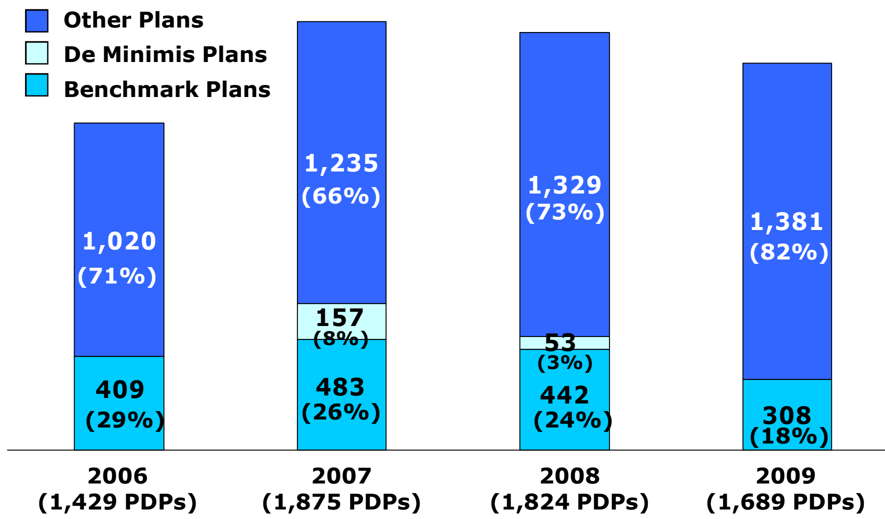
Number of Drug Plans Available for LIS Beneficiaries Without Premium Has Dropped



NOTE: Excludes PDPs in the territories.
SOURCE: Georgetown/NORC analysis of data from CMS for the Kaiser Family Foundation.

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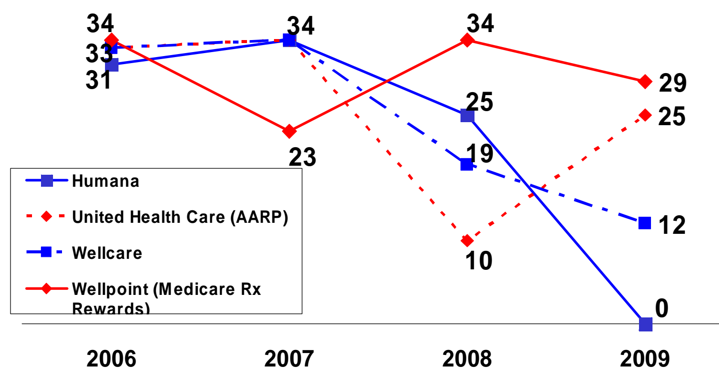
Major Part D Organizations Have Moved In and Out of Offering Benchmark Plans



Source: Georgetown/NORC analysis of CMS PDP Landscape files, 2006-2009, for the Kaiser Family Foundation.

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How Can We Better Help Those with Low Incomes?

- Make LIS enrollment automatic
- Make LIS enrollment permanent, eliminating need for redeterminations
- Eliminate the asset test
- Use beneficiary-centered approach to assign LIS beneficiaries not choosing a plan

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How Have Private Plans Responded to Medicare Part D?

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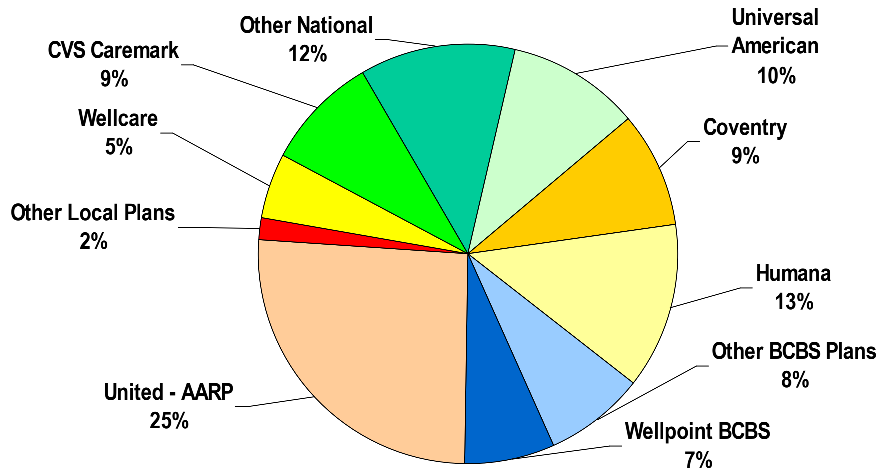
Stand-Alone PDP Enrollment in 2009 is Spread Among Many Plan Sponsors



Source: Analysis of CMS data, February 2009.

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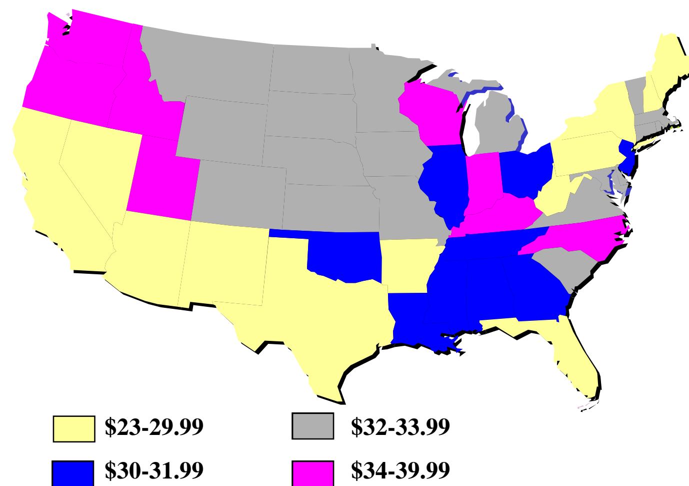
Monthly Premiums for PDPs Vary Substantially by Region, 2009



$23-29.99
$32-33.99
$30-31.99
$34-39.99

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Source: Analysis of CMS data, October 2008.

Should We Modify the Private Market Approach?

- Offer a government-run plan option
- Reduce the number of private plan offerings from the current 45 or more per person
  - Restrict number of plans per sponsor
  - Reject plans based on low enrollment or poor performance
  - Select limited number of plans through competitive bidding
- Increase program oversight of marketing

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What Shape Does Coverage Take, and What Has Been the Impact on Access?

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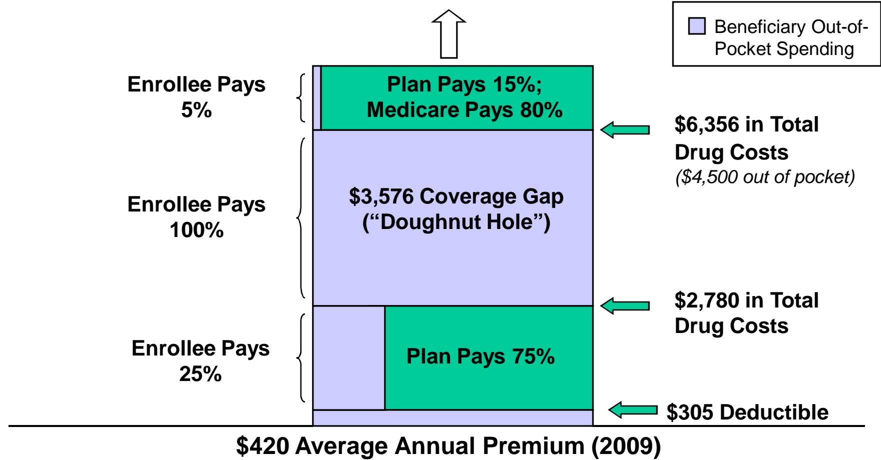
Standard Medicare Prescription Drug Benefit, 2010



Source: CMS data, February 2009.

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Most Part D Plans Modify the Standard Benefit Design

	PDPs	MA-PDs
No Deductible	55%	88%
Tiered Cost Sharing	90%	95%
Separate Tier for Specialty Drugs	85%	94%
Some Type of Gap Coverage	25%	52%
Gap Coverage for Some Brands	<0.5%	17%

SOURCE: Jack Hoadley et al., "Medicare Part D Benefit Designs and Formularies, 2006-2009," presentation to MedPAC, December 5, 2008.

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Median Copayments Charged by Part D Plans Have Been Increasing

Tier	PDPs		MA-PDs	
	2006	2009	2006	2009
Generic	$5	$7	$5	$5
Preferred	$28	$38	$27	$30
Non-Preferred	$55	$75	$55	$60
Specialty	25%	33%	25%	33%

SOURCE: Jack Hoadley et al., "Medicare Part D Benefit Designs and Formularies, 2006-2009," presentation to MedPAC, December 5, 2008.

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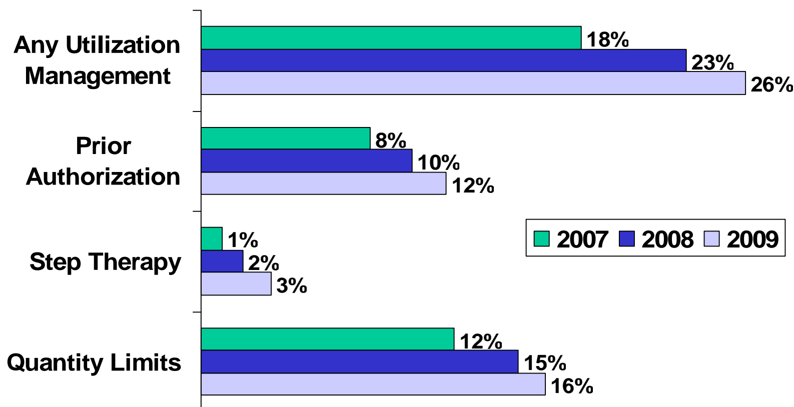
Part D Plans Have Increased the Share of Listed Drugs Subject to Utilization Management



NOTE: Calculations are share of listed chemical entities, weighted by enrollments (2009 bars use 2008 enrollment).
SOURCE: Jack Hoadley et al., "Medicare Part D Benefit Designs and Formularies, 2006-2009," presentation to MedPAC, December 5, 2008.

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Can We Improve Access to Drugs Under Part D?

- Simplify or standardize benefits to improve transparency
- Make it easier to obtain exceptions, get prior authorization, appeal coverage decisions

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How Important is the "Doughnut Hole"?

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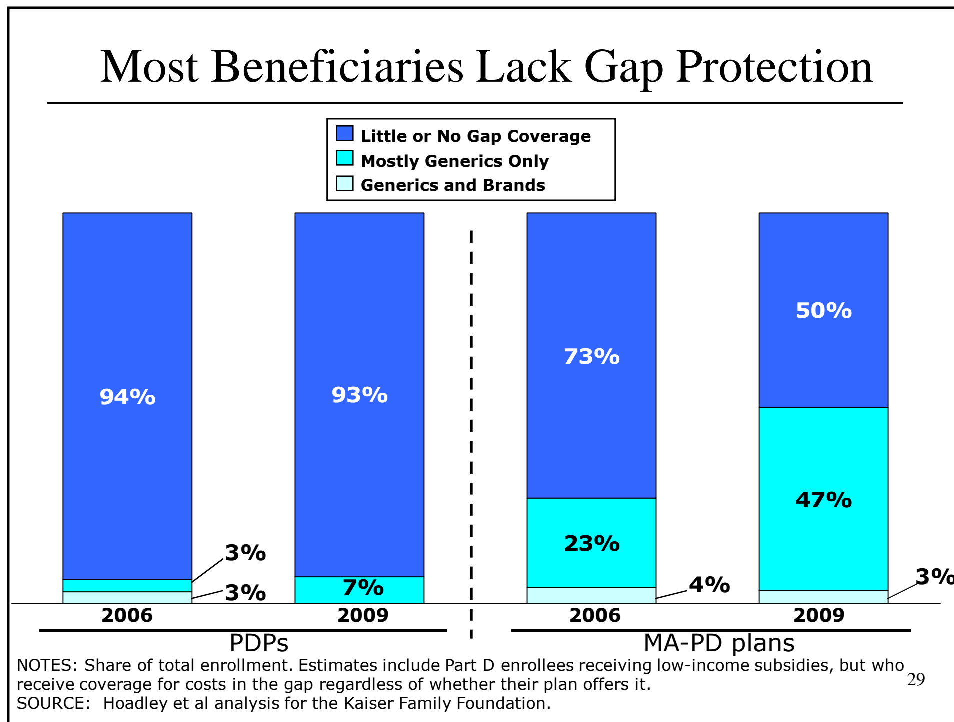
Most Beneficiaries Lack Gap Protection
Little or No Gap Coverage
Mostly Generics Only
Generics and Brands
94%
3%
3%
93%
7%
73%
23%
4%
50%
47%
3%
2006
2009
2006
2009
PDPs
MA-PD plans
NOTES: Share of total enrollment. Estimates include Part D enrollees receiving low-income subsidies, but who receive coverage for costs in the gap regardless of whether their plan offers it.
SOURCE: Hoadley et al analysis for the Kaiser Family Foundation.
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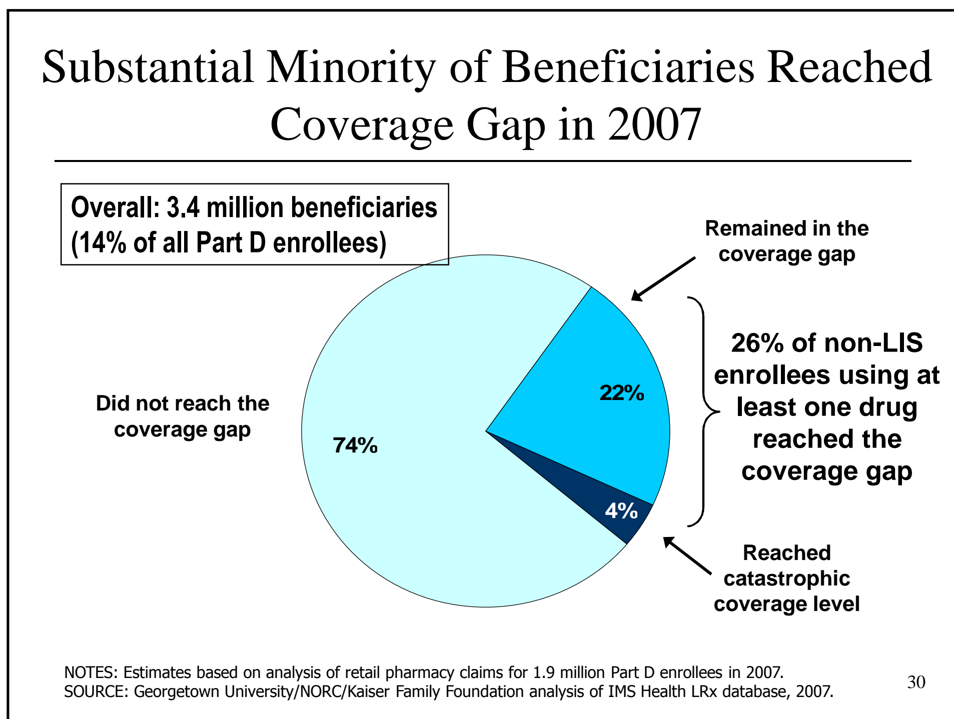
Substantial Minority of Beneficiaries Reached Coverage Gap in 2007
Overall: 3.4 million beneficiaries (14% of all Part D enrollees)
Remained in the coverage gap
26% of non-LIS enrollees using at least one drug reached the coverage gap
Did not reach the coverage gap
74%
22%
4%
Reached catastrophic coverage level
NOTES: Estimates based on analysis of retail pharmacy claims for 1.9 million Part D enrollees in 2007.
SOURCE: Georgetown University/NORC/Kaiser Family Foundation analysis of IMS Health LRx database, 2007.
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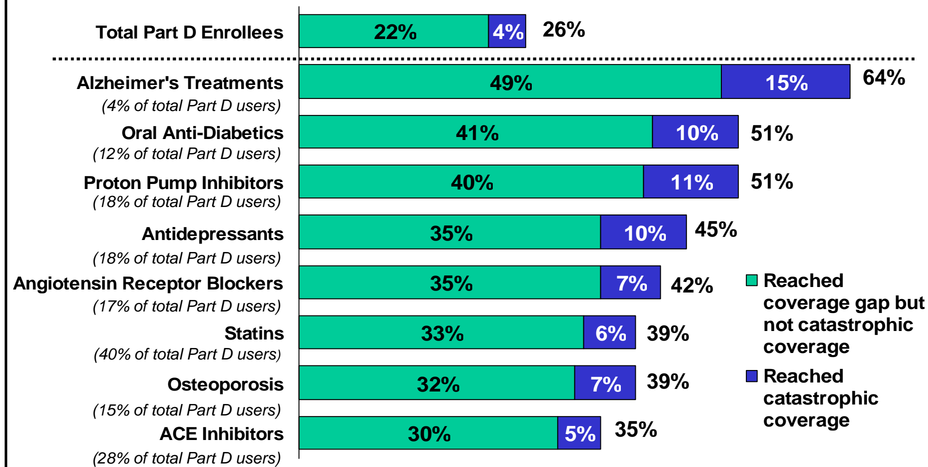
The Gap Disproportionately Affects Those Taking Drugs for Particular Conditions



NOTES: Estimates, based on analysis of retail pharmacy claims for 1.9 million Part D enrollees in 2007, exclude those who receive low-income subsidies or who use no drugs. Enrollees may use drugs in more than one of the eight drug classes.
SOURCE: Georgetown University/NORC/Kaiser Family Foundation analysis of IMS Health LRx database, 2007.

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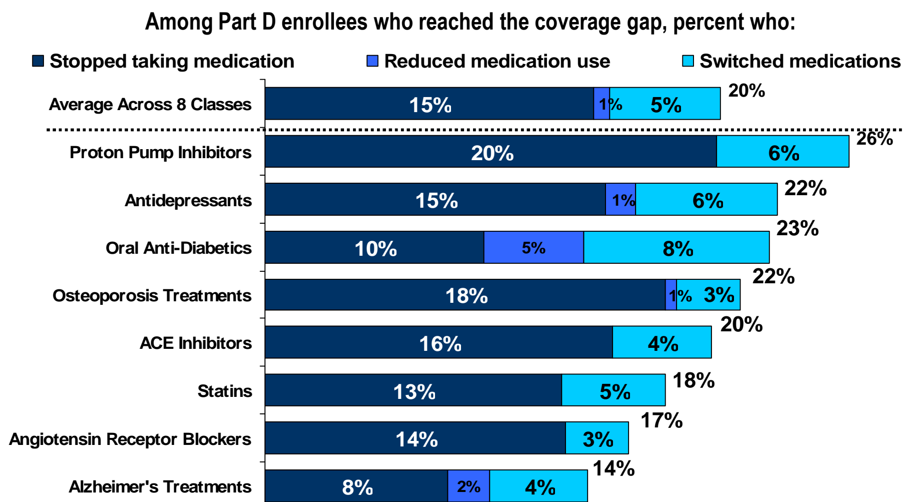
Part D Enrollees Who Reached the Gap in 2007 Often Stopped or Reduced Drug Use

Among Part D enrollees who reached the coverage gap, percent who:



Notes: Estimates based on analysis of retail pharmacy claims for 1.9 million Part D enrollees in 2007.
Source: Georgetown University/NORC/Kaiser Family Foundation analysis of IMS Health LRx database, 2007.

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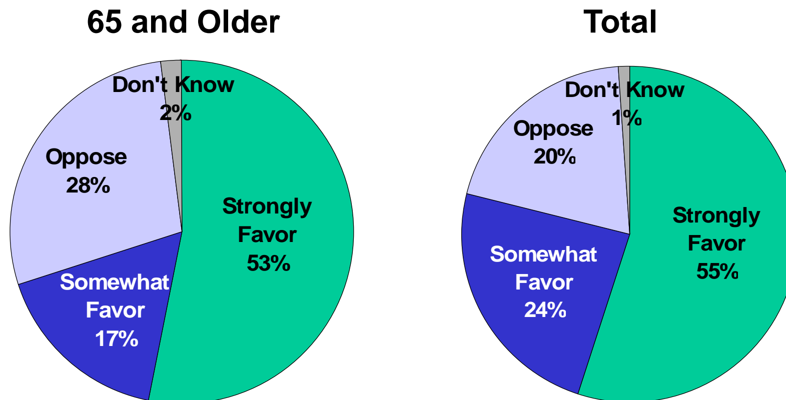
The Public Favors Spending More Federal Money to Get Rid of the Coverage Gap



Source: Kaiser Family Foundation and Harvard School of Public Health, *the Public's Health Care Agenda for the New President and Congress*, Survey conducted December 4-14, 2008.

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How Can We Address the Coverage Gap?

- Fill in the coverage gap
  - Paid for by other program changes
  - Paid for by new federal dollars
- Increase cost sharing in the initial benefit period to eliminate the effect of the gap
- Better information for beneficiaries as they approach the gap
- Easier-to-understand options for gap coverage

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What Has Been the Cost of Medicare Part D Coverage?

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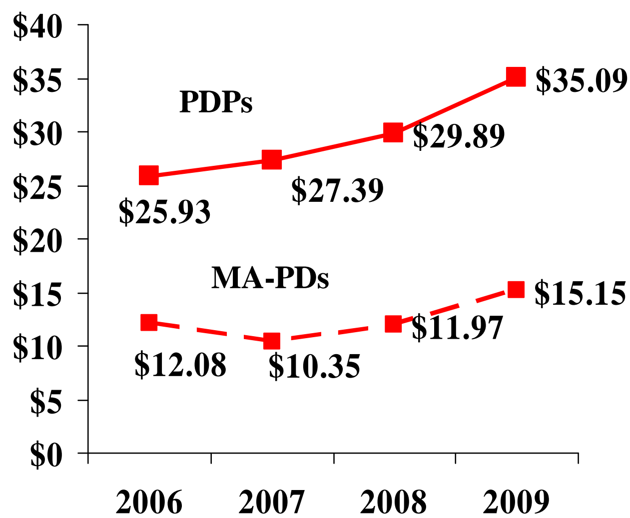
Average Monthly Premiums Have Risen Steadily from 2006 to 2009



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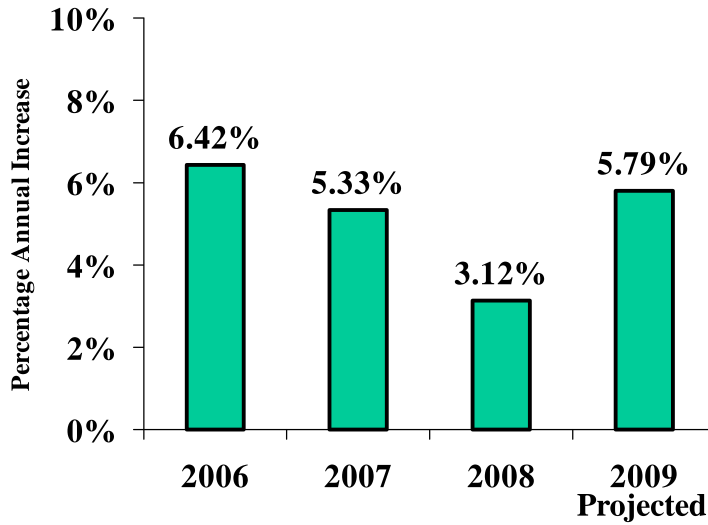
Drug Spending per Eligible Beneficiary Has Increased Each Year



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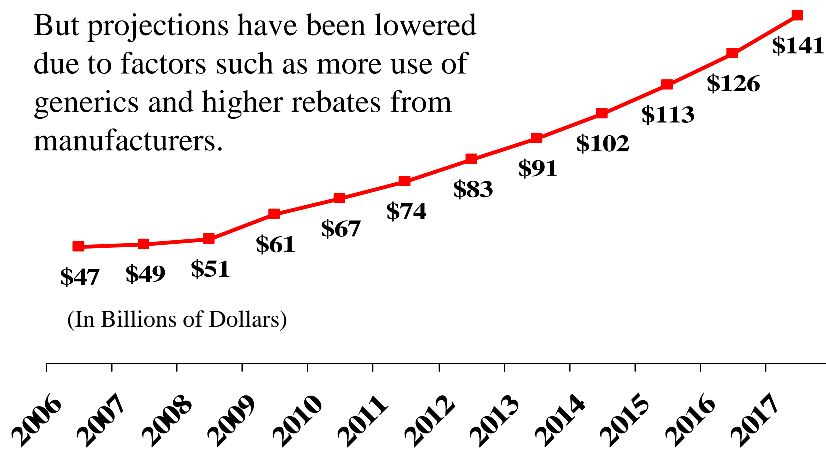
Part D Spending Trend Is Upward

But projections have been lowered due to factors such as more use of generics and higher rebates from manufacturers.



Source: DHHS, Trustees Report, 2008

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What Options Exist for Addressing Rising Costs?

- Address drug prices more vigorously
  - More use of generics
  - Restore rebates, formerly earned for duals
  - Eliminate federal non-interference rule
  - Better manage unnecessary use
- Address growing use of specialty drugs
  - Encourage follow-on biologics
  - Improve management
- Raise revenues – income-related premium

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Has Medicare Part D Succeeded or Failed?

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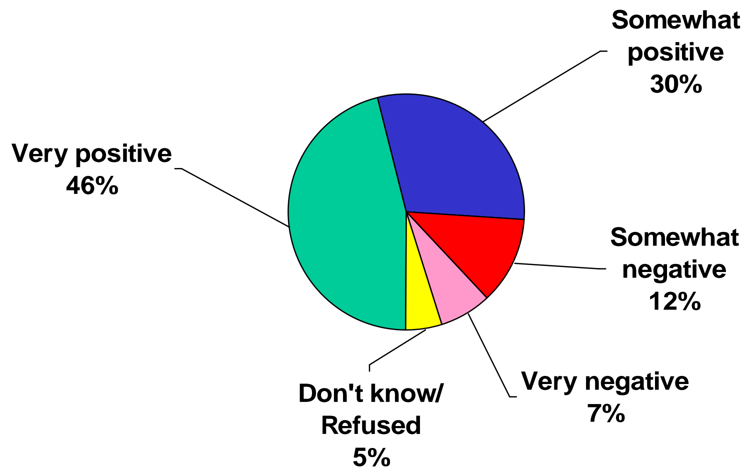
Enrollees' Early Experiences with their Part D Plan Are Mostly Positive



Source: Kaiser Family Foundation, December 2006.

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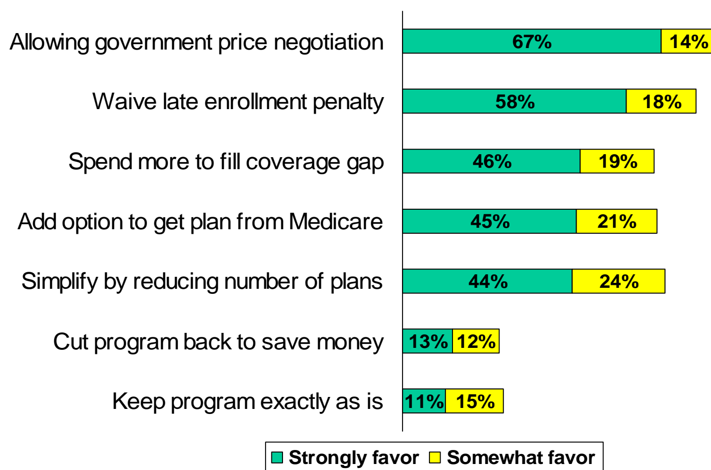
But Beneficiaries Favor Various Changes



Source: Kaiser Family Foundation, November 2006

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Accomplishing Change Will Be Challenged by Political and Economic Realities

- Constraints imposed by the economy and the federal budget
- Competing priorities in the health reform debate
- Long-term Medicare solvency issues
- Potential for disrupting a program already in its 4th year

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