THE HENRY J. KAISER FAMILY FOUNDATION

THE MEDICARE Rx DRUG LAW

ESTIMATES OF MEDICARE BENEFICIARIES' OUT-OF-POCKET DRUG SPENDING IN 2006

Modeling the Impact of the MMA

Prepared by

Actuarial Research Corporation
Jim Mays and Monica Brenner

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EXECUTIVE SUMMARY

Introduction

The Medicare Modernization Act of 2003 (MMA) was enacted to extend coverage for prescription drugs to the Medicare population and to ease the financial burden of prescription drug spending for beneficiaries, especially those with low incomes or extraordinarily high out-of-pocket drug expenses. With the new Medicare Part D prescription drug benefit scheduled to begin on January 1, 2006, and enrollment starting in November 2005, there is considerable interest in understanding how the new benefit could affect beneficiaries' out-of-pocket drug spending. In 2006, the first year of implementation, the Congressional Budget Office (CBO) estimates that Part D participants will spend, on average, $792 out of pocket for prescription drugs (excluding premiums), which is 37% less than the $1,257 they would have spent in the absence of the law.[1]

This report delves beneath these average estimates to show how out-of-pocket spending on prescription drugs is likely to vary among Medicare beneficiaries who are expected to enroll in Part D plans in 2006. It examines how the MMA is expected to affect spending by Part D participants at different income and subsidy levels, and projects the effects for beneficiaries with very high out-of-pocket drug expenditures. The report also provides new estimates for the number and characteristics of Part D participants who are expected to have drug spending in excess of the initial coverage limit (in the "doughnut hole") and spending above the catastrophic threshold.

Background on the Medicare Drug Benefit

Under the new Medicare drug benefit (Part D), Medicare will begin to pay for outpatient prescription drug coverage through private drug plans, giving beneficiaries access to a standard prescription drug benefit, or its actuarial equivalent. Under the standard benefit in 2006, after the first $250 in total drug costs (the deductible), Medicare will pay 75% of costs between $250 and an initial coverage limit of $2,250; 0% of costs between $2,250 and $5,100 (with beneficiaries paying 100% of costs in the "doughnut hole"); and 95% after total costs exceed $5,100 ($3,600 out-of-pocket).

The MMA devotes substantial resources to provide premium and cost-sharing assistance to beneficiaries with incomes below 150% of the federal poverty level ($13,965 for an individual in 2004) and modest assets.[2] For example, Part D participants with incomes below 135% of poverty ($12,569 for an individual in 2004) and assets no greater than $6,000 individual/$9,000 couple will receive a premium subsidy for basic coverage in their region, and will be required to pay $2 and $5 copayments for generic and brand-name drugs (respectively) up to the catastrophic limit. The law also replaces state Medicaid programs with new Part D private drug

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[1] Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, July 21, 2004.
[2] See Exhibit 2 in the main text of this report for a detailed overview of Part D benefits for low-income beneficiaries.

plans as the source of prescription drug coverage for beneficiaries who are dually eligible for Medicare and Medicaid.

Methodology

The analysis presented in this report is based on a model developed by Actuarial Research Corporation (ARC). The model was designed to forecast the effects of a major change in public policy, and like any analysis of this type, the reliability of the projections depends on the accuracy of the underlying assumptions. The ARC model generally conforms to CBO assumptions and projections about average per capita drug spending by Medicare beneficiaries, drug utilization[3], Part D participation, and low-income subsidy recipients. The model controls to CBO projections, rather than those prepared by the Office of the Actuary (OACT) at the Department of Health and Human Services (HHS), to be consistent with spending estimates that were used by the Congress when enacting the MMA.[4] In addition, the model developed by ARC incorporates information about beneficiary characteristics, including demographics and insurance coverage, which allows for analysis of projected variations in average per capita spending and distributions of total and out-of-pocket spending by characteristic. A detailed description of the methodology is included in the appendix of this report.

This analysis focuses on beneficiaries who are expected to enroll in Part D plans in 2006 – 29 million of 42.6 million Medicare beneficiaries, according to CBO, including the 8.7 million Part D participants who are projected to receive low-income subsidies that year. CBO assumes that 13.6 million Medicare beneficiaries will not participate in Part D, including 8.2 million beneficiaries who are expected to receive drug coverage through qualified employer-sponsored plans, 5.4 million who receive drug coverage from the Federal Employees Health Benefits Program or TRICARE, or are assumed to go without any drug coverage in that year, and others with Medicare Part A only and not Medicare Part B.[5]

The model takes into account out-of-pocket spending associated with the Part D standard benefit, or its actuarial equivalent, but does not take into account any form of supplemental coverage that beneficiaries might obtain. This feature of the model has the potential to overstate our projections of out-of-pocket spending if beneficiaries receive coverage under Part D plans that is more generous than the standard benefit, or if they receive additional coverage from other sources. The model also excludes out-of-pocket spending for drugs not covered by Part D plans, such as non-formulary drugs or prescriptions filled at out-of-network pharmacies. Excluding these potential costs could have the effect of understating our out-of-pocket spending projections under the new drug benefit.

The out-of-pocket spending estimates presented in this report also exclude premiums paid by beneficiaries for existing prescription drug coverage such as Medigap or retiree health plans in the absence of the MMA, as well as annual premiums for Part D coverage (estimated by CBO to

[3] Similar to CBO and OACT, we assume that drug utilization would change as a result of insurance coverage.
[4] For a comparison of CBO and OACT assumptions and projections, see Appendix Table 1.
[5] CBO assumes that only Part B enrollees, a majority of all Medicare beneficiaries, will join Part D.

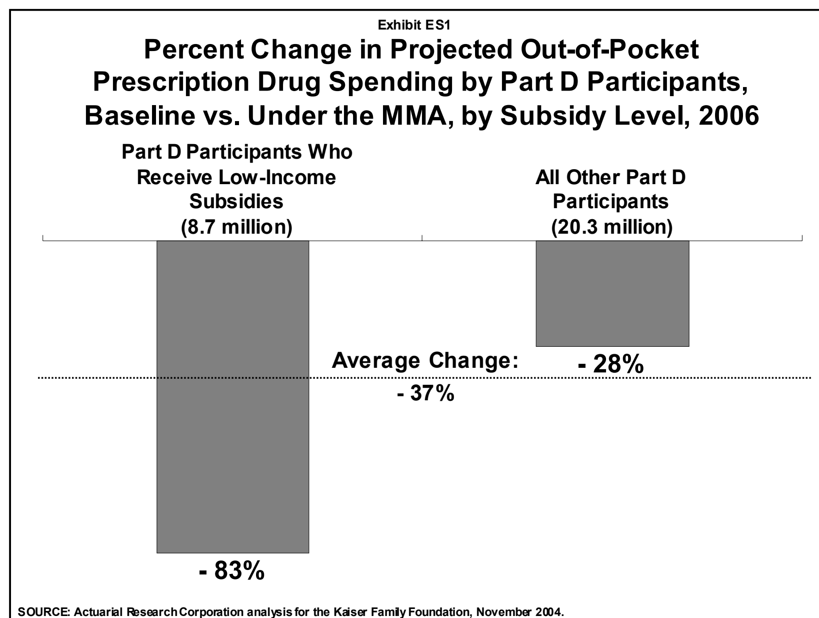
average $420 for 2006[6]). Premiums are excluded from baseline spending estimates because existing data sources do not provide sufficient information to measure the drug-related portion of premiums that beneficiaries pay out of pocket for different sources of supplemental coverage nor how premiums vary by beneficiary characteristics. Therefore, the only beneficiaries for whom we consider the effects of estimated Part D premiums are those beneficiaries who are assumed to lack drug coverage in the absence of the MMA, and therefore face no existing premiums, but who are expected to enroll in Part D plans in 2006.

Key Findings

Part D Participants Receiving Low-Income Subsidies Projected to Spend 83% Less, on Average, on Prescription Drugs Under the MMA; 28% Less for All Others

The 29 million beneficiaries who CBO assumes will participate in Part D in 2006 are projected to spend, on average, 37% less out-of-pocket for drugs under the MMA than they would have spent in the absence of the law. The MMA is projected to have a large impact on out-of-pocket drug spending by Part D participants who *do* receive low-income subsidies, but a noticeably smaller effect on out-of-pocket spending by beneficiaries *not* receiving these subsidies, who comprise the majority of those expected to enroll in Part D plans in 2006.

- The 8.7 million Part D participants who receive low-income subsidies are projected to spend, on average, 83% ($584) less under the MMA than they would have spent in the absence of the law in 2006 **(Exhibit ES1)**.



  - In dollar terms, the most significant reductions are projected to occur for an estimated 2.3 million low-income beneficiaries who did *not* have Medicaid drug coverage prior to 2006. These low-income subsidy recipients are projected to spending approximately $1,400 less out of pocket under the MMA than they would have spent in the absence of the law.

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[6] $420 is CBO's estimate of the average annual premium for Part D plans, however some Part D participants will pay more and others will pay less depending on geography, demographics, and the particular plan they join.

- The estimated 6.4 million Medicare beneficiaries with Medicaid prior to 2006 (dual eligibles) are projected to see a substantially smaller reduction in average out-of-pocket spending, in dollar terms, under the MMA, because of their relatively low out-of-pocket spending for drugs under Medicaid. On average, dual eligibles are projected to spend $263 less under the MMA than their baseline spending in 2006.

- The 20.3 million Part D participants who do *not* receive low-income subsidies are projected to spend, on average, 28% ($414) less under the MMA than they would have spent without the new drug benefit in 2006. Their out-of-pocket spending is projected to fall from $1,495 to $1,081 under the MMA.

- For the 8.5 million beneficiaries currently lacking drug coverage who are expected to enroll in Part D plans in 2006 but not receive low-income subsidies, average out-of-pocket drug spending is projected to be 50% lower under the MMA than it would be in the absence of the new law, but only 23% lower when Part D premiums are taken into account.

- The 5.7 million Part D participants with incomes less than 150% of poverty who are *not* projected to get low-income subsidies in 2006 – either because their assets are too high or because they do not apply for subsidy assistance – are projected to pay substantially more out-of-pocket on prescriptions than beneficiaries at the same income level who *do* receive Part D low-income subsidies.[7]

  - For example, the 2 million beneficiaries with incomes below 100% of poverty ($9,310 for an individual in 2004) who are *not* expected to receive low-income subsidies in 2006 are projected to spend, on average, 10 times more than the 5.2 million beneficiaries at the same income level who *do* receive subsidies ($943 vs. $90, respectively)

6.9 Million Beneficiaries Projected to Have Spending in the "Doughnut Hole"

Under the MMA, Part D participants could face significant out-of-pocket costs if they have spending that falls in the gap in the standard Part D benefit – known as the "doughnut hole." By definition, beneficiaries with spending in the doughnut hole will have out-of-pocket spending that exceeds $750 (equivalent to the initial coverage limit of $2,250 in total drug costs), and will be required to pay 100% of their total costs between $2,250 and $5,100 ($3,600 out-of-pocket) before receiving catastrophic benefits.

- One in four Part D participants, or 6.9 million beneficiaries, are projected to have spending in the "doughnut hole" in 2006 **(Exhibit ES2)**.

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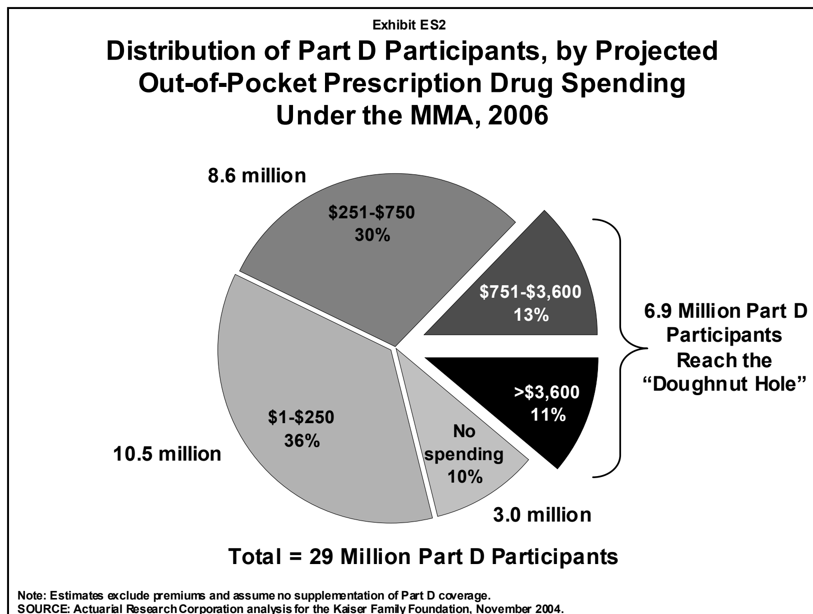
[7] CBO estimates that 1.8 million Medicare beneficiaries with incomes below 150% of poverty will not receive low-income subsidies in 2006 because they have assets above the threshold defined in the law. There are various reasons why eligible beneficiaries might not enroll in the low-income subsidy programs, including lack of knowledge about the subsidies or their eligibility, administrative burden, or stigma associated with receiving the extra help.

In general, low-income subsidy recipients with high total drug costs are not likely to have spending that exceeds the initial coverage limit, because they pay only nominal copayments under Part D (up to $5 per prescription in 2006). However, those with low-incomes who do *not* receive the additional subsidies would pay the standard Part D benefit cost-sharing obligations, and thus could face significant out-of-pocket drug costs.



- Of the 6.9 million beneficiaries who are projected to have out-of-pocket spending in the doughnut hole in 2006:
  - 1.9 million people (28%) have incomes less than 150% of poverty;
  - 2.9 million (42%) are in fair or poor health;
  - 3.8 million (55%) are women.

More than half (55% or 3.8 million) of the 6.9 million Part D participants projected to have spending in the doughnut hole are *not* expected to receive catastrophic benefits in 2006 because their out-of-pocket drug spending is projected to be less than $3,600.

Catastrophic Benefits Projected for 3.1 Million Part D Participants

For Part D participants with extraordinarily high out-of-pocket drug expenditures, the law provides additional assistance, because Medicare will pay 95% of costs above the catastrophic threshold ($3,600 in out-of-pocket spending in 2006). Nevertheless, beneficiaries with catastrophic expenses in 2006 are projected to continue to face high average out-of-pocket spending under the MMA, due to the doughnut hole in the benefit design.

- Nearly half (44% or 3.1 million) of those with spending in the doughnut hole are projected to receive catastrophic benefits because they incur at least $3,600 in out-of-pocket drug costs in 2006.

- The roughly one in 10 Part D participants who are projected to have out-of-pocket drug expenses above the catastrophic threshold are estimated to experience a 37% reduction in average out-of-pocket spending – from $5,980 in the absence of the MMA to $3,784 under the MMA in 2006.

One in Four Part D Participants Projected to Spend More

Although on average, Part D participants are projected to have lower out-of-pocket drug spending in 2006 than they would in the absence of the law, some beneficiaries are projected to spend more.

- In 2006, 18.6 million Part D participants (64% of total) are expected to have lower out-of-pocket spending than they would have had in the absence of the new drug benefit, with an average reduction of $919 (excluding premiums).

  - The greatest reductions are expected to occur for low-income subsidy recipients who did not have Medicaid drug coverage, and for beneficiaries who receive catastrophic benefits under Part D in 2006.

- One in four Part D participants – 7.4 million – are projected to have higher out-of-pocket spending under the MMA than they would have had without the drug benefit in 2006, with an average increase of $492.

  - Two-thirds of these beneficiaries are projected to face modest increases of $250 or less. This group would likely include beneficiaries with low drug spending who currently have prescription drug coverage with a low or no deductible (e.g., Medicare Advantage enrollees), but who would pay a $250 deductible before coverage begins under Part D. It also includes an estimated 2 million low-income Medicare beneficiaries with Medicaid, who generally face low or no cost-sharing for prescription drugs under state Medicaid programs (prior to the MMA).

  - The remaining one-third are projected to pay significantly higher amounts in 2006 under the MMA than their spending in the absence of the law, including people with relatively high drug costs who are projected to lose access to more comprehensive drug coverage such as an employer-sponsored retiree plan, after the new Medicare drug benefit goes into effect.[8]

- Three million Part D participants (10%) are projected to have no prescription drug spending in 2006 and thus no change in out-of-pocket spending for drugs.

Conclusion

The MMA commits substantial resources to achieve the goals of expanding access to drug coverage among Medicare beneficiaries and providing additional help to those with low incomes or catastrophic drug expenses. As a result, the 29 million beneficiaries CBO expects to enroll in a Part D plan in 2006 are projected to spend, on average, 37% ($465) less out of pocket for drugs

[8] Our model incorporates CBO's projection that 2.7 million beneficiaries with employer-sponsored drug coverage will lose it and shift into Part D plans once the new drug benefit takes effect. For purposes of this analysis, we assume this shift will occur in 2006.

under the MMA than they would have spent in the absence of the law. And, as designed, those with low incomes who take advantage of the low-income subsdies under the MMA receive substantial additional projection. Thus, as this analysis shows, the expected change in out-of-pocket spending varies substantially by income (which determines whether or not beneficiaries will be eligible for low-income subsidies) and by total drug costs.

Low-income beneficiaries receiving additional help with premiums and cost-sharing under the new law, particularly those without Medicaid drug coverage prior to the MMA, are projected to see a significant reduction in out-of-pocket drug spending in 2006. Overall, those who receive low-income subsidies are projected to spend 83% less under the MMA than they would have spent in the absence of the law. However, all other Part D participants (20.3 million in 2006), who are *not* expected to receive low-income subsidies, are projected to realize a more modest 28% reduction in their average out-of-pocket drug spending.

Although average out-of-pocket spending in 2006 is projected to be lower under the MMA than it would have been had the MMA not been enacted, many beneficiaries will continue to face high out-of-pocket costs when the new law goes into effect, especially the 6.9 million Part D participants who are projected to have spending in the doughnut hole. Our analysis projects that the majority of Part D participants will spend less under the MMA in 2006 than they would have spent in the absence of the law, but one in four will pay somewhat more. For low-income beneficiaries not receiving subsidy assistance, even modest increases in out-of-pocket spending could represent a financial burden and a barrier to getting needed medications.

Amid uncertainty about the actual response of Medicare beneficiaries to the new drug benefit, the design of Part D plans, and ongoing concern about prescription drug prices, the impact of the MMA on beneficiaries' out-of-pocket drug spending is a measure of the program's success and should be carefully monitored as the law is implemented.

INTRODUCTION

The Medicare Modernization Act of 2003 (MMA) was enacted to extend coverage for prescription drugs to the Medicare population and to ease the financial burden of prescription drug spending for beneficiaries, especially those with low incomes or extraordinarily high out-of-pocket drug expenses. The law is estimated to cost between $400 billion[1] and $553 billion[2] over the 2004-2013 period, which includes $192 billion in subsidies targeted to beneficiaries with low incomes, according to CBO. With the new Medicare Part D prescription drug benefit scheduled to begin on January 1, 2006, and enrollment in drug plans starting in November 2005, there is considerable interest in understanding how the new benefit could affect beneficiaries' out-of-pocket drug spending. In 2006, the Congressional Budget Office (CBO) estimates that beneficiaries who enroll in Part D plans will spend, on average, $792 out-of-pocket for prescription drugs (excluding premiums), which is 37% ($465) less than their estimated baseline spending of $1,257 in the absence of the law.

This report delves beneath these average estimates by examining how out-of-pocket spending in 2006 could vary among Part D participants with the standard benefit.[3] The analysis explores the following questions:

- How is the MMA projected to affect out-of-pocket prescription drug spending among beneficiaries who are expected to enroll in Part D plans in 2006?
- What is the projected change in out-of-pocket drug spending for Part D participants at different income and low-income subsidy levels?
- How many Part D participants are projected to have drug spending in excess of the initial coverage limit (in the "doughnut hole") and have spending above the catastrophic benefit level, and what are their characteristics?
- How is the MMA projected to affect out-of-pocket spending among beneficiaries who reach the catastrophic threshold in 2006?
- How is the MMA projected to affect out-of-pocket spending among beneficiaries who lack drug coverage prior to enrolling in Part D plans in 2006?

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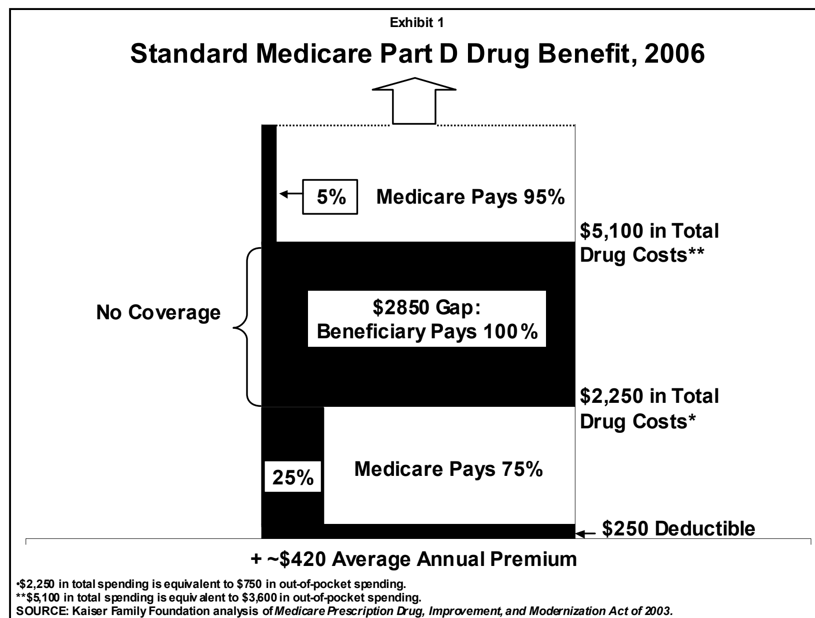
[1] Congressional Budget Office, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*; July 21, 2004.

[2] The Office of the Actuary at the Department of Health and Human Services initially estimated $534 billion over the 2004-2013 period. According to the Bush Administration's 2005 Mid-Session review, this estimate increased by $19 billion to $553 billion (Office of Management and Budget, *FY 2005 Mid-Session Review, Budget of the U.S. Government;* July 2004).

[3] The analysis of average out-of-pocket spending does not incorporate the added value of the risk reduction that is associated with having insurance coverage for catastrophic drug spending. Having insurance provides some peace of mind to everyone who is insured, regardless of whether an insured individual gets sick and receives benefits. The value of risk reduction is this reduced uncertainty.

Background on the Medicare Drug Benefit

Under the new Medicare drug benefit (Part D), all beneficiaries who sign up for coverage will have access to a standard prescription drug benefit, or its actuarial equivalent. In 2006, beneficiaries with the standard benefit will pay a $250 deductible; 25% of total drug costs between $250 and $2,250; 100% of costs between $2,250 and $5,100; and 5% of costs that exceed $5,100 (equivalent to $3,600 in out-of-pocket spending) **(Exhibit 1)**. The difference between the initial coverage limit of $2,250 in total spending and the $5,100 catastrophic threshold is often referred to as the "doughnut hole." The size of the doughnut hole in 2006 is $2,850, and increases to $5,066 in 2013.



The MMA also devotes substantial resources to provide additional assistance to beneficiaries with incomes below 150% of the federal poverty level ($13,965 for an individual in 2004) and with modest assets, and replaces state Medicaid programs with new private drug plans as the source of prescription drug coverage for beneficiaries who are dually eligible for Medicare and Medicaid **(Exhibit 2)**. These low-income beneficiaries will be eligible to receive various levels of premium and cost-sharing assistance covering

Exhibit 2

Overview of Low-Income Part D Benefits Under the MMA, 2006

Low-Income Subsidy Levels	Premium	Deductible	Copayments
Full-benefit dual eligible Income up to 100% FPL ($9,310 for individual in 2004)	$0	$0	$1/generic $3/brand-name; no copays after total drug costs reach $5,100
Full-benefit dual eligible Income greater than 100% FPL	$0	$0	$2/generic $5/brand-name; no copays after total drug costs reach $5,100
Income less than 135% FPL ($12,569 for individual in 2004) and assets <$6,000/indiv; $9,000/couple	$0	$0	$2/generic $5/brand-name; no copays after total drug costs reach $5,100
Income 135%-150% FPL ($12,569-$13,965 for individual in 2004) and assets <$10,000/indiv; $20,000/couple	sliding scale from $0-$35/ month	$50	15% of total costs up to $5,100 catastrophic limit; $2/generic $5/brand-name thereafter

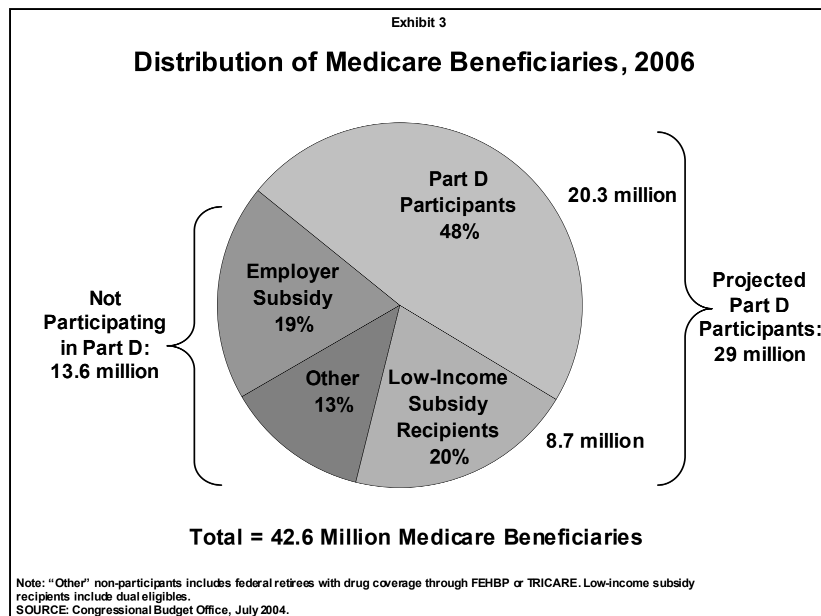
all or a portion of their out-of-pocket drug costs: beneficiaries who are dually eligible for Medicaid, regardless of assets or income; beneficiaries with income below 135% of poverty and low assets; and beneficiaries with income under 150% of poverty and slightly higher assets.[4]

Methodology

The analysis presented in this report is based on a model developed by Actuarial Research Corporation (ARC). In general, the ARC model conforms to CBO assumptions and projections of Medicare enrollment, per capita total and out-of-pocket prescription drug spending for Medicare beneficiaries, rates of participation in Part D plans and the low-income subsidy programs, and coverage under employer/union plans. The model controls to CBO projections, rather than those prepared by the Office of the Actuary (OACT) at the Department of Health and Human Services (HHS), to be consistent with spending estimates that were used by the Congress when enacting the MMA.[5]

The model developed by ARC incorporates information about beneficiary characteristics, including demographics and source of insurance coverage, which allows for analysis of variation in projected average per capita spending and distributions of total and out-of-pocket spending by characteristic. The analytic model draws on multiple sources of data and information, including the 2000 Medical Expenditure Panel Survey (MEPS) and the Medicare Current Beneficiary Survey (MCBS) Cost and Use Files (1995-2000), and a report from CBO explaining its cost estimate of the Medicare prescription drug benefit.[6]

This analysis focuses on Medicare beneficiaries who are expected to enroll in Part D in 2006, based upon CBO's participation assumptions. CBO projects that 29 million of Medicare's 42.6 million beneficiaries (or 68% of the total) will enroll in Part D plans in 2006 **(Exhibit 3)**. Part D participants include those who stay in fee-for-service Medicare and enroll in stand-alone prescription drug plans (PDPs) and those who enroll in Medicare Advantage (MA) managed care plans,



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[4] Kaiser Commission on Medicaid and the Uninsured, "Implications of the New Medicare Law for Dual Eligibles: 10 Key Questions and Answers," January 2004; Kaiser Family Foundation, "Additional Help with Prescription Drug Costs for Low-Income People on Medicare," http://www.kff.org/medicare/med062804oth.cfm.

[5] For a comparison of CBO and OACT assumptions and projections, see Appendix Table 1.

[6] CBO, July 2004.

such as HMOs or PPOs, that cover prescription drugs (MA-PDs). CBO assumes 13.6 million beneficiaries will not participate in Part D in 2006. Non-Part D participants include 8.2 million beneficiaries who are expected to receive drug coverage through qualified employer-sponsored plans, and 5.4 million who are either federal retirees retaining coverage through the Federal Employees Health Benefits Program (FEHBP) or TRICARE for Life (TFL), or are assumed to choose to go without any drug coverage in that year, and others with Medicare Part A only and not Medicare Part B.[7]

Our model also incorporates CBO's assumptions about take-up rates for low-income subsidies. CBO assumes that 8.7 million Medicare beneficiaries (30% of all Part D participants) will receive low-income subsidies in 2006, which represents 61% of the 14.2 million Part B enrollees who are projected to be eligible to receive low-income assistance in 2006.[8] The majority of those projected to receive low-income subsidies – 6.4 million – are dually eligible for Medicare and Medicaid. CBO estimates that 1.8 million Medicare beneficiaries with incomes below 150% FPL will not receive low-income subsidies in 2006 because they have assets above the thresholds defined in the law. Millions more – almost 4 million according to our analysis – are projected to be eligible but not sign up for the low-income subsidies.[9]

With respect to coverage, the ARC model assumes that all Part D participants receive the standard benefit defined in the MMA, as shown in Exhibit 1, or its actuarial equivalent. The analysis assumes no supplementation of Part D coverage; that is, Part D participants are assumed to be fully responsible for any cost-sharing that is required under the standard benefit, unless they receive low-income subsidies. Making this assumption could result in inflated projections of out-of-pocket spending if, in fact, beneficiaries sign up for a Part D plan that provides more generous coverage than the standard benefit requires, or if they receive additional or wraparound coverage from other sources, such as a state pharmacy assistance program (SPAP).

Our spending estimates exclude certain drug-related out-of-pocket costs that beneficiaries may face:

- **Premiums.** Our out-of-pocket spending projections do not incorporate costs associated with premiums for drug coverage – either the premiums beneficiaries might have paid for prescription drug coverage if the MMA had not been enacted (for example, Medigap premiums), or the premiums that Part D participants are expected to pay for standard Part D coverage (an estimated average annual premium of $420 in 2006, according to CBO[10]). The model does not include premiums in the baseline estimates because existing data sources do

[7] CBO assumes that only Part B enrollees, a majority of all Medicare beneficiaries, will join Part D.
[8] CBO assumes that by 2013, 75% of beneficiaries with incomes below 135% of poverty receive low-income subsidies and 35% of those with incomes between 135%-150% of poverty receive low-incomes subsidies, including dual eligibles (CBO, July 2004). CBO assumes that the percent of low-income subsidy-eligible beneficiaries who are not enrolled in subsidy programs will decrease over time as more of them take advantage of the new low-income subsidies.
[9] There are various reasons why eligible beneficiaries might not enroll in the low-income subsidy programs, including lack of knowledge about the subsidies or their eligibility, administrative burden, or stigma associated with receiving the extra help.
[10] $420 is CBO's estimated average annual premium amount for Part D plans, however some Part D participants will pay more and some will pay less depending on geography, demographics, and the particular plan they join.

not provide sufficient information to measure the drug-related portion of premiums beneficiaries pay out of pocket for different sources of supplemental coverage, such as Medigap and retiree health benefits. Therefore, the only beneficiaries for whom we consider the effects of estimated Part D premiums are those beneficiaries who are assumed to lack drug coverage in the absence of MMA, and therefore face no existing premiums, but are expected to enroll in a Part D plan in 2006.

- **Costs for prescriptions not covered by Part D plans.** Because the analysis focuses on projected out-of-pocket spending for drugs covered through the standard Part D benefit, it does not reflect spending that beneficiaries could incur for drugs that are not covered by Part D plans. This could include costs paid by beneficiaries for drugs that are not on a Part D plan formulary (the list of approved drugs) or costs for prescriptions filled at non-network pharmacies.[11]

Finally, a caveat. Because this analysis was designed to forecast the effect of a major change in public policy – an exercise involving some degree of uncertainty – the projections are based upon a number of assumptions. Like any analysis of this type, the reliability of the projections depends on the accuracy of the underlying assumptions. Our projections are sensitive to assumptions about the number and characteristics of people who might enroll in Part D prescription drug plans, the number of beneficiaries who might receive low-income subsidies, the extent to which Part D plans could manage drug costs, and the extent to which the availability of prescription drug coverage could result in higher drug use. As noted earlier, our model generally conforms to CBO assumptions and projections for consistency, but there are a number of factors that could result in actual per capita spending under the MMA that differs from CBO's 2006 estimates, as well as from those presented in this report.

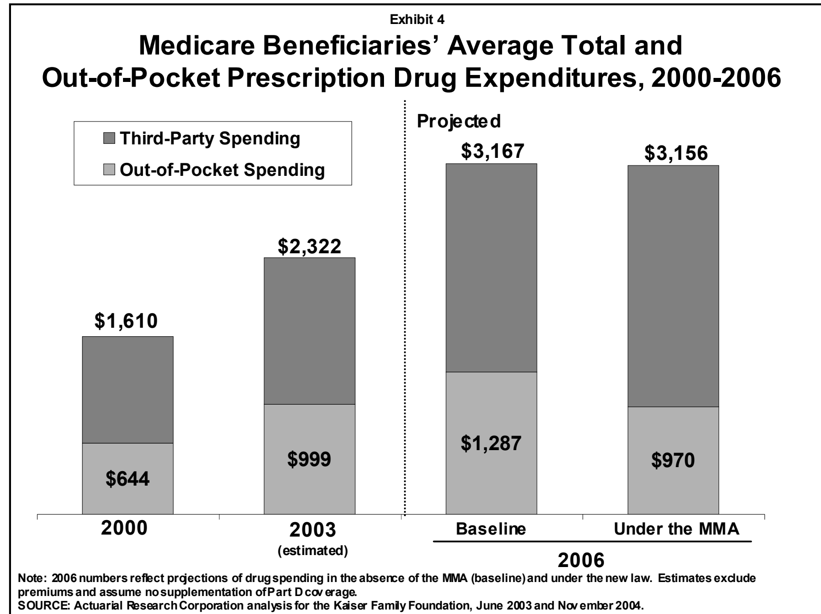
A detailed description of the methodology and the assumptions used to develop the model is included in the appendix that accompanies this report.

[11] To the extent that formularies do not cover all drugs, beneficiaries may be able to appeal adverse coverage decisions by their Part D plan.

FINDINGS

Trends in Total and Out-of-Pocket per Capita Prescription Drug Spending, 2000-2006

Total and out-of-pocket prescription drug spending by or on behalf of Medicare beneficiaries has been climbing steadily since 2000. Per capita drug spending by all Medicare beneficiaries between 2000 (actual) and 2003 (estimated) and projections of spending in 2006 both under the MMA and in the absence of the law are shown in **Exhibit 4**. CBO's baseline average spending projections for 2006 are used throughout this analysis as the basis for projecting the impact of the MMA on beneficiaries' average per capita spending and to show variation in projected total and out-of-pocket spending among those who are expected to enroll in Part D plans in 2006.

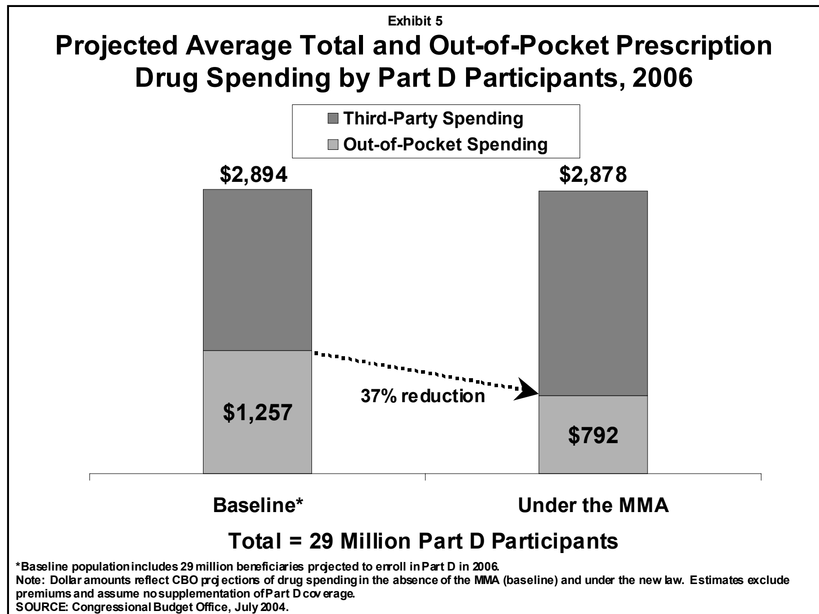


Between 2000 and 2006, total per capita Medicare drug spending is projected to double. The MMA is projected to have virtually no effect on average total drug spending in 2006, compared with baseline spending projections in the absence of the law ($3,156 under the MMA; $3,167 in the absence of the law). The 2006 total per capita spending estimate under the MMA is the net result of increased utilization and spending, including higher administrative costs, offset by the effect of cost management tools expected to be used by Part D drug plan sponsors, particularly among those who previously lacked drug coverage and paid full retail prices.

From 2000 to 2003, out-of-pocket spending on prescription drugs by Medicare beneficiaries increased by more than 50%, from an average of $644 in 2000 to an estimated average of $999 in 2003. Between 2003 and 2006, average out-of-pocket drug costs are projected to increase by roughly one-third, to $1,287. Under the MMA, however, average out-of-pocket drug spending by Medicare beneficiaries is projected to be $970 in 2006 – which is 25% ($317) less than the baseline per capita out-of-pocket spending projection.

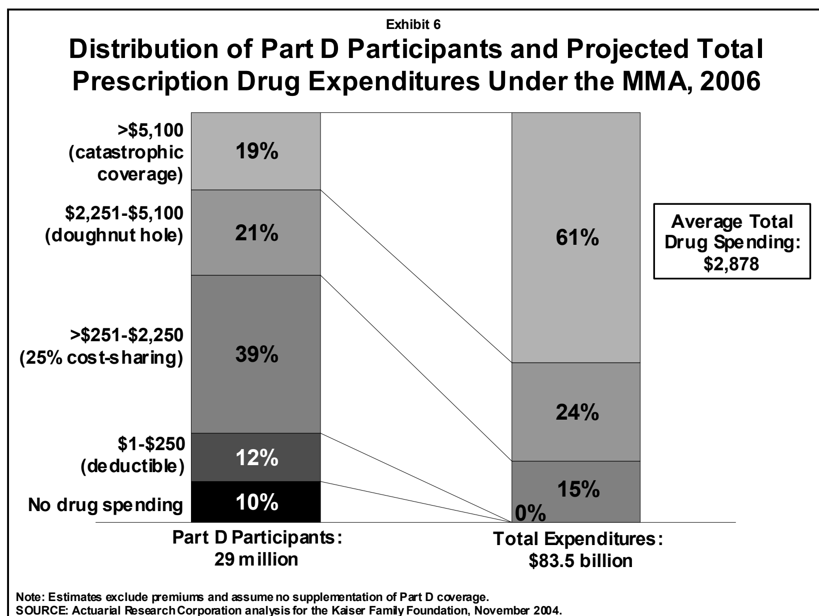
Projections of total and out-of-pocket drug spending under the MMA vary by a number of factors, including whether beneficiaries are expected to participate in Part D, and if so, whether they receive low-income subsidies. **Exhibit 5** shows estimates of total and out-of-pocket spending for Part D participants in 2006 (consistent with CBO projections). Although the MMA

is projected to have little impact on Part D participants' total drug spending in 2006, average out-of-pocket spending on prescription drugs under the MMA – excluding premiums – is estimated to be $792 for Part D participants in 2006. This amount is 37% ($465) less than estimated baseline spending of $1,257 in the absence of the MMA.



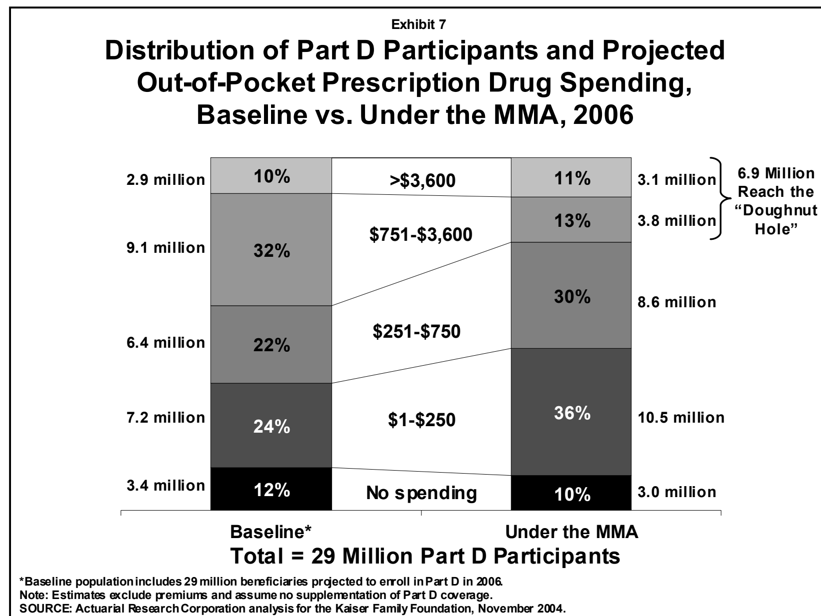
The Distribution of Prescription Drug Spending in 2006

The amount of beneficiaries' total spending on prescription drugs is highly skewed, with a minority of all beneficiaries accounting for a majority of total spending. In 2006, 61% of total drug spending by or on behalf of Part D participants ($83.5 billion) is projected to be concentrated among the 19% of beneficiaries with at least $5,100 in total spending (corresponding to the level at which coverage for catastrophic costs begins under the standard Part D benefit) **(Exhibit 6)**.[12] Yet because most Medicare beneficiaries use prescription drugs in any single year, the majority (90%) of Part D participants are projected to incur some amount of drug expenses in 2006.



[12] Total drug spending includes expenditures from all sources, including out-of-pocket payments and payments from other sources, such as employer plans, Medicare Advantage and PDPs.

As described earlier, the MMA defines standard Part D drug benefit levels in terms of out-of-pocket costs, including a gap in coverage that begins after beneficiaries spend more than $750 out of pocket. Part D participants will be responsible for 100% of their drug costs between this initial coverage limit and the catastrophic threshold of $3,600 in out-of-pocket drug costs. To understand how many Part D participants could be affected by the coverage gap and how many might receive catastrophic benefits, we projected the number who are estimated to incur out-of-pocket drug spending at each level of standard Part D coverage in 2006 **(Exhibit 7)**.



According to our analysis, the MMA is projected to have a measurable but relatively small impact on the number of people who have either no or very high out-of-pocket drug spending. However, coverage under the standard Part D benefit is expected to result in a shift of Part D participants into lower out-of-pocket spending categories in 2006, by covering a portion of their drug costs up to the initial coverage limit (after the $250 deductible). This results in an increase in the number of beneficiaries projected to spend between $1 and $750 out of pocket under the MMA (66%), compared to the share with spending at this level at baseline (46%).

- 10% (3 million) of those who enroll in a Part D plan are projected to have no drug spending (either total or out-of-pocket) under the MMA, compared with 12% (3.4 million) with no out-of-pocket spending in the absence of the law.

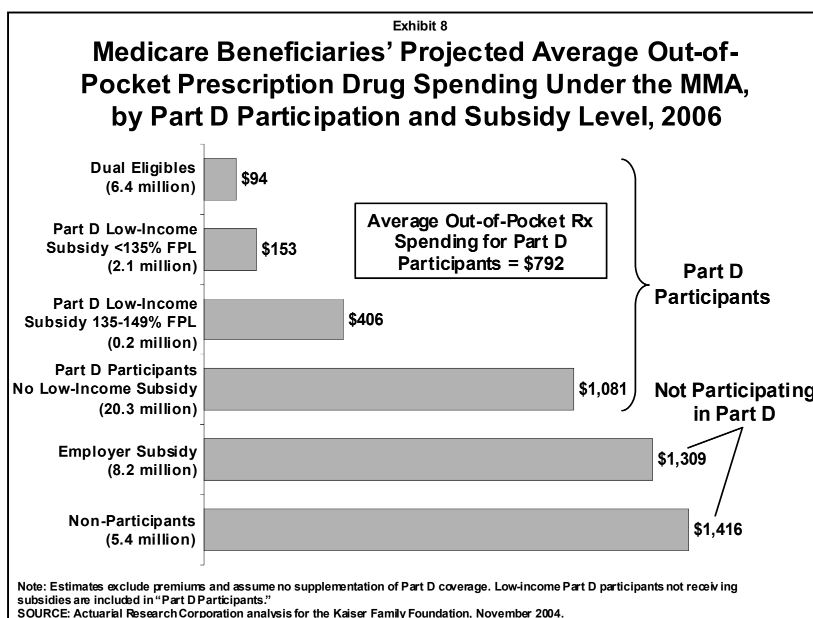
- 36% (10.5 million) are projected to spend less than $250 out of pocket under the MMA (an amount which corresponds to the deductible for standard coverage), compared with 24% (7.2 million) at baseline. The increase in the share of beneficiaries with spending at this level can be explained by the financial assistance provided by low-income subsidies. More than two-thirds of this group (71% or 7.5 million) are low-income beneficiaries likely to receive assistance with premiums and cost-sharing amounts and face relatively low copayments for their prescriptions. The remainder are those projected not to receive low-income subsidies who have total drug costs of less than $250.

- 30% (8.6 million) are projected to have out-of-pocket spending greater than $250 but no more than $750 under the MMA, compared with 22% (6.4 million) at baseline.

- 24% of expected Part D participants (6.9 million) are projected to have out-of-pocket spending that exceeds $750, down from 42% (12 million) at baseline – meaning that these beneficiaries will have spending in the "doughnut hole."
  - Of Part D participants with spending in the doughnut hole, more than half – 55% or 3.8 million (13% of all Part D participants) – are projected to have prescription drug expenses that do not exceed the catastrophic threshold of $3,600 in out-of-pocket costs. These beneficiaries will face, on average, $1,724 in out-of-pocket drug spending under the MMA in 2006.
  - The remainder – 3.1 million or 11% of all Part D participants – are projected to have out-of-pocket costs that exceed $3,600 in 2006, and therefore receive catastrophic benefits for drug expenses. Average out-of-pocket spending by Part D participants who receive catastrophic benefits is projected to be $3,784 in 2006.

Impact of the MMA on Out-of-Pocket Prescription Drug Spending

As mentioned earlier, CBO projects that, on average, Part D participants will incur $792 in out-of-pocket drug expenses under the MMA in 2006. This projection averages per capita spending across Part D participants who do and do not receive low-income subsidies. Our model incorporates data about Part D participants' income and other demographic characteristics to present a more complete picture of how the new drug benefit could affect their out-of-pocket drug spending.



Our analysis shows that the 29 million Medicare beneficiaries expected to participate in Part D are projected to have substantially lower per capita out-of-pocket costs in 2006 than beneficiaries who do not participate in Part D **(Exhibit 8)**.[13] Per capita out-of-pocket spending under the MMA also is projected to vary among Part D participants.

[13] Higher projected per capita out-of-pocket drug spending under the MMA for beneficiaries who remain in employer subsidy plans ($1,309 on average) compared with those in Part D plans is based on the ARC assumption that their out-of-pocket drug spending in 2006 will account for the same share of total spending under the MMA as in the absence of the law. The higher projection is also consistent with higher average total drug spending among beneficiaries in employer plans. Non-Part D participants primarily consist of active workers and federal retirees who have coverage through FEHBP or TFL, and these beneficiaries also have higher average total drug costs.

The 20.3 million beneficiaries who have standard Part D coverage but do *not* receive low-income subsidies – the majority (70%) of Part D participants – are projected to spend $1,081 out of pocket on prescription drugs in 2006. Their average per capita spending is over $200 less than beneficiaries who remain in employer plans and over $300 less than other beneficiaries who do not participate in Part D. However, these beneficiaries are projected to spend far more than the 8.7 million beneficiaries who receive low-income subsidies under Part D.

- In dollar terms, the most significant reductions are projected to occur for an estimated 2.3 million low-income beneficiaries without Medicaid drug coverage prior to 2006. These low-income subsidy recipients are projected to spending approximately $1,400 less out of pocket under the MMA than they would have spent in the absence of the law.

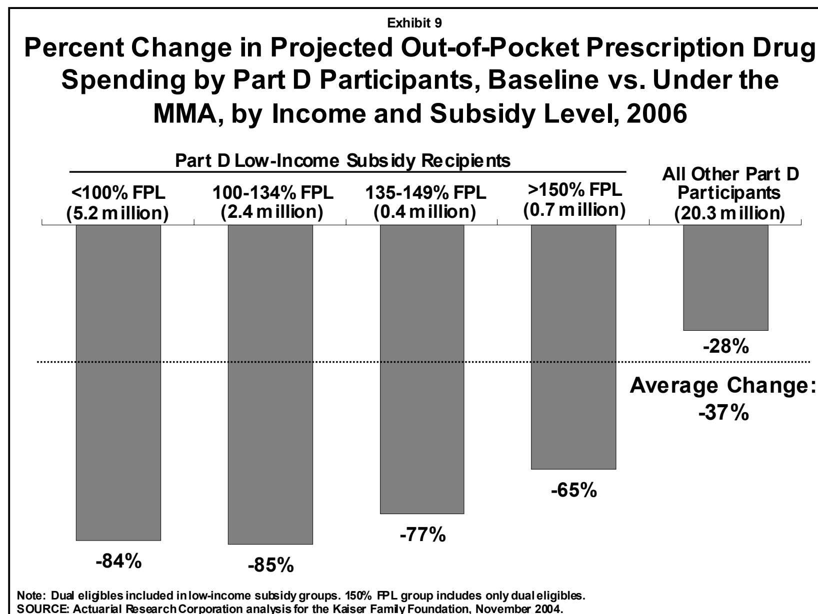
- The estimated 6.4 million Medicare beneficiaries with Medicaid prior to 2006 (dual eligibles) are projected to see a substantially smaller reduction in average out-of-pocket spending, in dollar terms, than other low-income subsidy recipients. This is because dual eligibles face relatively low cost-sharing requirements for Medicaid drug coverage. On average, dual eligibles are projected to spend $263 less under the MMA than their baseline spending in 2006.

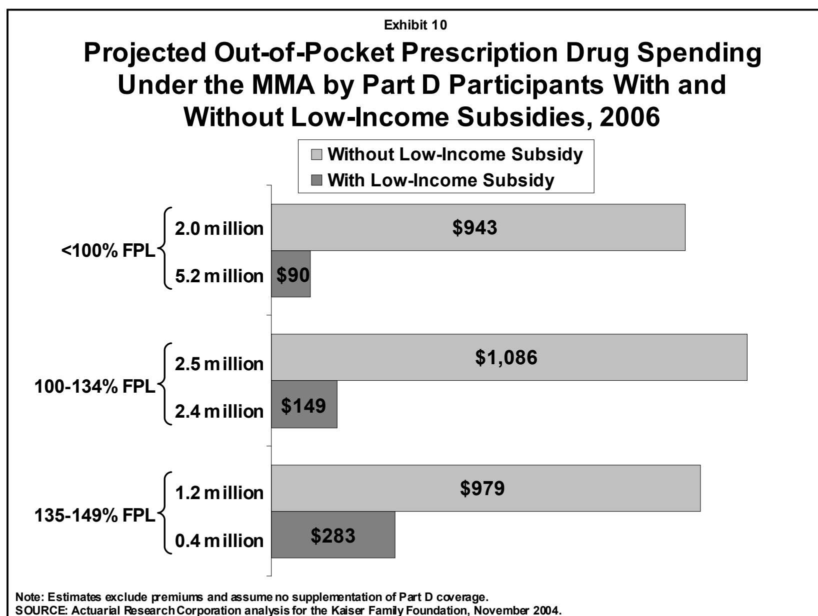
Impact of the MMA by Income and Low-Income Subsidy Levels

Our analysis shows that projected per capita out-of-pocket spending in 2006 is lower under the MMA for Part D participants at all income levels than these beneficiaries' baseline per capita spending in the absence of the law (see Appendix Table 3 for detailed results). However, the change in projected out-of-pocket spending from baseline to under the MMA (measured in absolute dollars and in percent) is greater for low-income beneficiaries than for people with higher incomes. This result is not surprising, since the MMA provides $192 billion in low-income subsidies for Part D participants, according to CBO. This finding illustrates the progressive nature of the new drug benefit.

The value of the low-income subsidies provided by the MMA can be shown by comparing the percent change in projected out-of-pocket spending from the 2006 baseline to spending under the MMA by beneficiaries who are expected to participate in Part D, according to their income and subsidy level **(Exhibit 9)**. As stated earlier, the average percent change for all part D participants is projected to be -37%. Exhibit 9 shows that, on average, the 20.3 million Part D participants who are not expected to receive low-income subsidies are projected to spend 28% less under the MMA than they would have spent in the absence of the law. However, for the 8.7 million Part D participants who are expected to receive low-income subsidies under the MMA, the reduction in projected out-of-pocket spending averages 83%.

Although the MMA provides substantial financial assistance to beneficiaries with limited incomes and few assets who enroll in Part D plans, not all low-income beneficiaries will receive this additional help, either because their assets are higher than allowed under the law or because they do not enroll in the low-income subsidy program for which they are eligible.[14] As a result, many low-income beneficiaries are likely to continue to bear a significant out-of-pocket spending burden under the MMA. **Exhibit 10** shows our projections of average per capita out-of-pocket spending for low-income Part D participants according to whether or not they are projected to receive low-income subsidies.





- For example, Part D participants with incomes below 100% of poverty who receive low-income subsidies (5.2 million) are projected to spend, on average, $90 out of pocket for drugs in 2006. The 2 million beneficiaries in the same income group who do not receive additional subsidies are projected to spend, on average, 10 times this amount ($943).

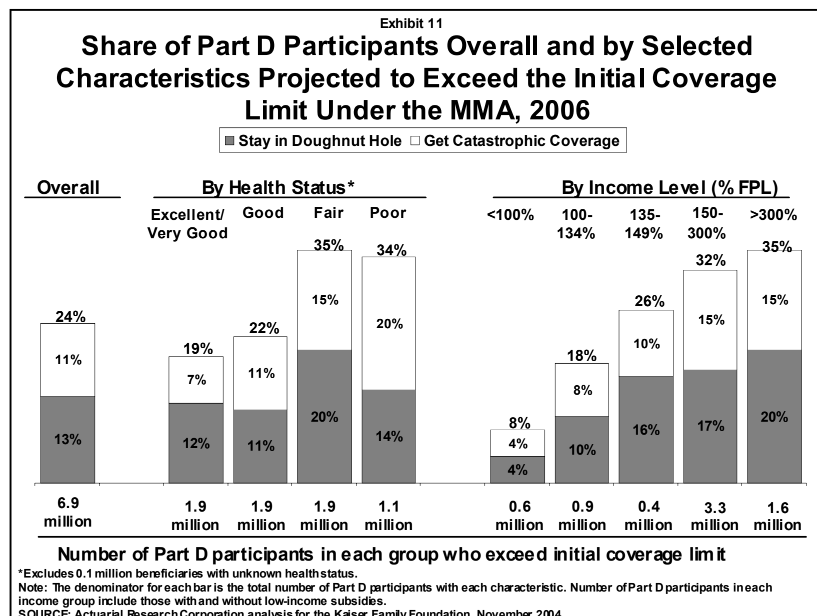
These findings underscore the importance of maximizing enrollment of low-income beneficiaries in Part D plans and in the low-income subsidy program. They also illustrate the financial implications for low-income beneficiaries of the asset test in disqualifying those who would otherwise be eligible from receiving additional subsidies.

[14] Except for "full benefit" dual eligible individuals, enrollment in low-income subsidy programs is a separate application process from enrollment in Part D plans.

Spending in the Doughnut Hole and Beyond

As noted above, 24% of all Part D participants (6.9 million beneficiaries) are projected to have out-of-pocket drug costs that exceed the initial coverage limit and less than half of this group (or 11% of Part D participants) qualify for catastrophic benefits.[15] Whether Part D participants will actually incur out-of-pocket spending in the doughnut hole and ultimately receive catastrophic benefits is a function of both their total drug spending (driven by utilization, among other factors) and whether they receive low-income subsidies designed to reduce the out-of-pocket drug spending burden.

According to our analysis (and as might be expected), a greater share of beneficiaries in poor health (34%) are projected to exceed the initial coverage limit than beneficiaries in excellent or very good health (19%), likely due to higher total drug costs among those in poor health. We also estimate that a larger share of high-income Part D Participants (35% of those with incomes greater than 300% of poverty) will exceed the initial coverage limit than those with lower incomes (8% of those with incomes less than 100% of poverty), mainly because low-income subsidies will limit cost-sharing obligations **(Exhibit 11)**.[16]



Characteristics of Beneficiaries with Spending in the Doughnut Hole

Our analysis shows that roughly three-fourths of Part D participants with drug spending that is projected to exceed the initial coverage limit have incomes below 300% of poverty (less than $27,930 in 2004) and are disproportionately in fair or poor health **(Exhibit 12)**. They also are predominantly female and residents of urban areas.

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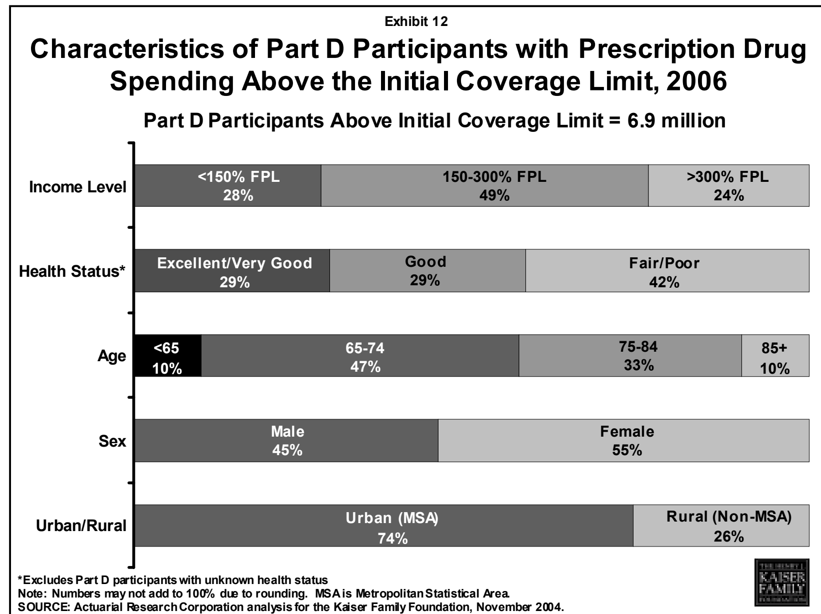
[15] Again, these estimates assume beneficiaries do not receive supplemental coverage for required cost-sharing amounts under Part D.

[16] Appendix Tables 4 and 5 present more detailed information on the share of beneficiaries who are projected to reach the initial coverage limit by other characteristics, including race/ethnicity, age, sex, and urban/rural status.

- *Income.* More than one-quarter (28% or 1.9 million) of Part D participants projected to have spending in the doughnut hole have incomes below 150% of poverty, nearly half (49%) have incomes between 150% and 300% of poverty (3.3 million), and 24% (1.6 million) have incomes above 300% of poverty. As noted earlier, low-income subsidies generally shield subsidy recipients from having out-of-pocket spending that exceeds the initial coverage limit. Thus, low-income beneficiaries with spending in the "doughnut hole" are likely to be those who do not receive this additional financial assistance.



- *Health status.* Part D participants in fair or poor health are projected to account for 42% of those with spending above the initial coverage limit, but only 29% of Part D participants overall.

- *Age.* Beneficiaries between the ages of 65 and 74 are projected to comprise the largest share of those in the doughnut hole (47%), slightly more than their share of total Part D participants (42%). Only 10% are projected to be younger than 65 years of age, despite being 15% of the total Part D population. Disabled beneficiaries under age 65 years are disproportionately low income, and therefore less likely to reach the initial coverage limit because they would be more likely to qualify for low-income subsidies than older beneficiaries who are not disabled.

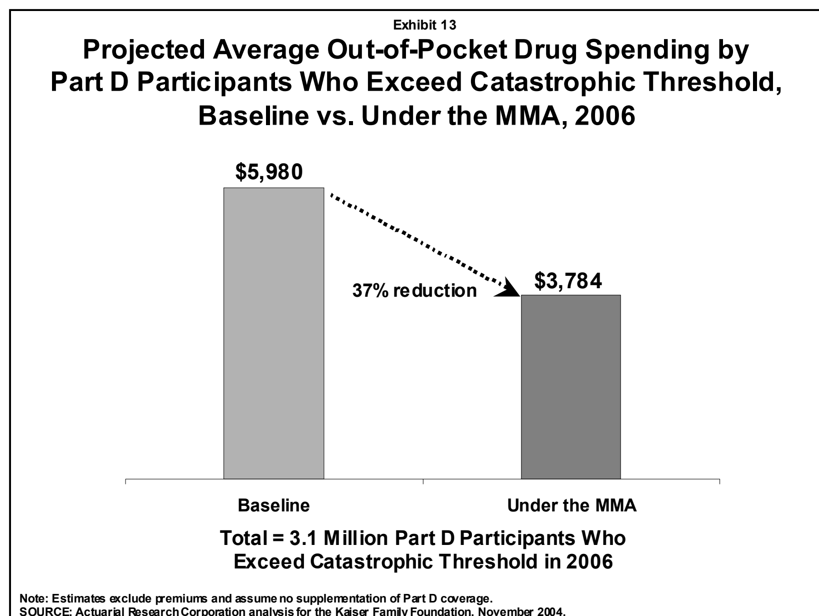
- *Sex.* A greater number of women than men are projected to spend more than the initial coverage limit: 55% (3.8 million) are women and 45% (3.1 million) are men, which is roughly equal to their share of Part D participants overall.

- *Rural/urban status.* 74% of beneficiaries with projected out-of-pocket spending in the doughnut hole and higher are residents of urban areas, also in proportion to their share of Part D participants.

Impact of the MMA on Beneficiaries with High Out-of-Pocket Costs

The MMA was designed to assist the relatively small share of beneficiaries who have catastrophic out-of-pocket drug expenses, which is defined in the MMA to be $3,600 or more in 2006. Overall, 10% of Part D participants are projected to have out-of-pocket spending high enough to qualify for catastrophic benefits under the MMA in 2006. Our analysis indicates that for beneficiaries who do not receive low-income subsidies, the greatest value of the MMA may be in getting help reducing the out-of-pocket spending burden of catastrophic drug expenses.

The MMA is projected to have a very small effect on the share of beneficiaries expected to enroll in a Part D plan who incur out-of-pocket spending of at least $3,600 in 2006: 10% (2.9 million) are projected to have spending above this threshold in the absence of the MMA in 2006, whereas 11% (3.1 million) are projected to have spending above this level after the MMA is implemented **(Exhibit 13)**. We estimate, however, that the MMA will substantially reduce projected average per capita out-of-pocket spending among Part D participants who exceed the $3,600 out-of-pocket catastrophic threshold. Average out-of-pocket spending among beneficiaries in this group is projected to be $5,980 in the absence of the new drug benefit in 2006, but $3,784, on average, after the MMA is implemented – a reduction of 37% ($2,196). This projected reduction results from the low (5%) cost-sharing requirement for beneficiaries with standard Part D coverage once their out-of-pocket drug spending exceeds the catastrophic threshold.

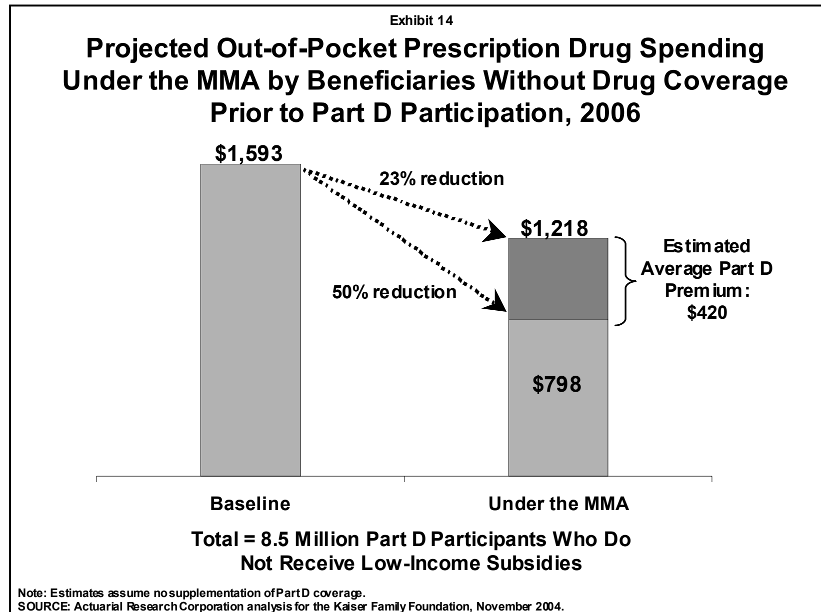


Impact of the MMA on Beneficiaries Who Lacked Drug Coverage

Providing drug coverage to the millions of Medicare beneficiaries who currently lack coverage was a primary objective of the MMA. According to our analysis, 9.6 million beneficiaries who currently lack drug coverage (and therefore face no existing premiums for drug coverage) are expected to enroll in Part D plans in 2006. The majority of these beneficiaries (89% or 8.5 million) are projected to enroll in Part D but not receive low-income subsidies, while 11% (1.1 million) are projected to be low-income subsidy recipients. We estimated out-of-pocket

spending for these beneficiaries under the MMA, and also consider the effects of the estimated average annual premium for Part D coverage for those who do not receive low-income subsidies.

Average out-of-pocket drug spending by the 8.5 million beneficiaries who enroll in Part D but do not receive low-income subsidies is projected to be 50% lower under the MMA than their baseline spending, from $1,593 in the absence of the law to $798 under the MMA in 2006 – a difference of almost $800 **(Exhibit 14)**. However, the annual premium for standard Part D coverage – estimated by CBO to average $420 in 2006 – would erase over half of the difference between projected baseline spending and spending under the MMA for these beneficiaries. After premium payments are taken into account, these beneficiaries are projected to face average per capita out-of-pocket costs of $1,218, which is 23% less than they would have spent in the absence of the law.



The 1.1 million beneficiaries previously lacking drug coverage who receive Part D low-income subsidies are projected to see a significant reduction in out-of-pocket drug spending under the MMA. They are projected to pay, on average, $195 out of pocket for their prescriptions under the MMA in 2006, which is only one-ninth of their projected spending in the absence of the law ($1,746).

Impact of the MMA by Beneficiary Characteristics

Although average per capita out-of-pocket spending is projected to be lower for Part D participants under the MMA compared to their projected spending in the absence of the law, Estimates of average out-of-pocket drug spending continue to vary substantially by beneficiary characteristic under the MMA in 2006 **(Exhibit 15)**. Moreover, depending on their baseline per capita spending projections, the MMA will provide varying degrees of relief when measured in terms of the percent change in out-of-pocket spending.

- *Health status.* Part D participants in poor health are estimated to have average out-of-pocket costs under the MMA that are nearly twice as high as spending by beneficiaries in excellent or very good health ($1,154 vs. $611, respectively). This difference is not surprising, given the higher level of drug use and total spending among those in relatively poor health. However, Part D participants in poor health are projected to spend 41% ($802) less under the MMA than they would have in the absence of the law, while those in better health are projected to spend 34% ($322) less.

Exhibit 15

Projected Out-of-Pocket Prescription Drug Spending by Part D Participants, Baseline vs. Under the MMA, by Selected Characteristics, 2006

	Out-of-Pocket Spending		Percent Change
	Baseline	Under the MMA	
Health Status			
Excellent/Very good	$933	$611	-34%
Good	$1,297	$808	-38%
Fair	$1,590	$1,080	-32%
Poor	$1,956	$1,154	-41%
Sex			
Male	$1,070	$786	-27%
Female	$1,406	$796	-43%
Race			
White	$1,364	$868	-36%
Black	$874	$545	-38%
Hispanic	$735	$383	-48%
Age/Disability			
Disabled <65	$1,035	$516	-50%
65+	$1,298	$842	-35%

Note: Estimates exclude premiums and assume no supplementation of Part D coverage.
SOURCE: Actuarial Research Corporation analysis for the Kaiser Family Foundation, November 2004.

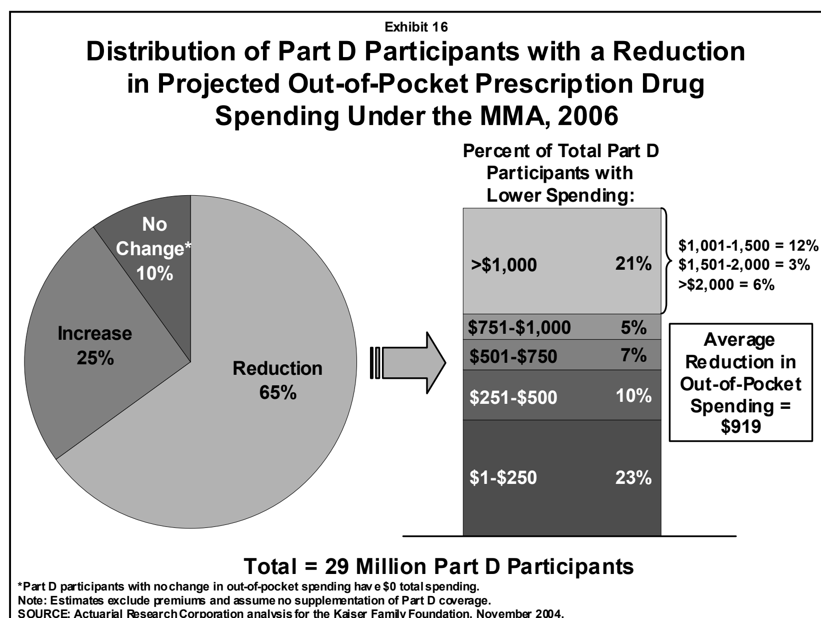
- *Sex.* Projected average out-of-pocket drug spending under the MMA for women and men who participate in Part D shows little variation in dollar terms ($796 vs. $786, respectively), despite substantially higher projected per capita drug spending among women compared with men in the absence of the law ($1,406 vs. $1,070, respectively). The greater projected reduction in out-of-pocket spending for women is because they are disproportionately low income and thus would be more likely to receive low-income subsidies under Part D than men. In addition, higher projected out-of-pocket spending in the absence of the law among women means that the MMA would likely have a greater impact on their out-of-pocket costs than those of men in 2006.

- *Race.* The change in out-of-pocket spending from projections at baseline to under the MMA is greater for Hispanic Part D participants (-48% or $352 less) than for whites (-36% or $496 less) or blacks (-38% or $329 less). Again, income differences and receipt of low-income subsidies are likely to explain these projected differences in out-of-pocket spending.

- *Age/disability.* Disabled beneficiaries under age 65 who are expected to participate in Part D are projected to have lower average out-of-pocket drug costs than the elderly under the MMA in 2006, despite their substantially higher total per capita drug costs, and also are projected to see a greater change in their out-of-pocket costs. Lower out-of-pocket spending under the MMA by the under-65 disabled could be explained by the fact that they are disproportionately low income and thus more likely than the elderly to receive low-income subsidies.

Projected Changes in Out-of-Pocket Spending By Part D Participants

Although our estimates show that, on average, Part D participants will spend less out of pocket under the MMA than they would have if the law had not gone into effect, the average includes many who are projected to spend less and some who are projected to spend more. Exhibits 16 and 17 show the distributions of Part D participants according to whether they are projected to spend more or less under the MMA in 2006 than they would have spent in the absence of the law. These projections reflect Part D participants' out-of-pocket spending on prescription drugs only. As mentioned earlier, they do not take into account premiums for existing coverage or the Part D benefit (which would have an unknown impact on our out-of-pocket estimates, depending on whether and how much they paid), or amounts spent under the MMA for non-covered drug-related costs or for coverage to supplement Part D.



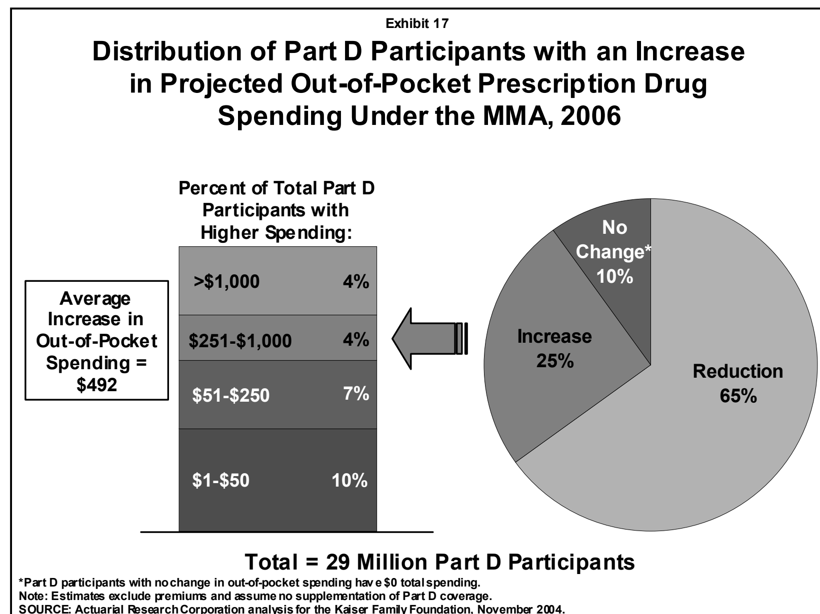
Our analysis shows that almost two-thirds of all Part D participants (65% or 18.6 million) are projected to spend less out of pocket in a single year (for this analysis, in 2006) than they would have spent had the law not been enacted – on average, $919 less **(Exhibit 16)**. A minority of Part D participants (10% or 3 million) are projected to have no drug spending at all in 2006 and thus would experience no change in spending, although they could experience changes in spending on premiums for drug coverage. Among all Part D participants:

- 23% (6.5 million) are projected to spend up to $250 less in 2006 under the MMA than they otherwise would have spent;
- 22% (6.1 million) are projected to spend between $251 and $1,000 less out of pocket than they would have spent in the absence of the MMA;
- 21% (5.9 million) are projected to have a reduction of $1,000 or more in their out-of-pocket drug spending under the MMA.

At the same time, our model projects that, in the absence of supplementation of Part D coverage, one-fourth of Part D participants (25% or 7.4 million) will have higher out-of-pocket drug

spending in 2006 under the MMA than they would have spent in the absence of the law, averaging $492 more **(Exhibit 17)**. Among those who are expected to enroll in a Part D plan:

- 17% (5 million) are projected to spend between $1 and $250 more under the MMA than they would have in the absence of the law;
- 4% (1.1 million) are projected to spend between $250 and $1,000 more out of pocket;
- 4% (1.3 million) are projected to spend more than $1,000 under the MMA than they would have spent in the absence of the law.



Our model shows that two-thirds of those projected to spend more under the MMA (5 million of the 7.4 million Part D participants with a projected increase) will experience relatively modest out-of-pocket spending increases of $250 or less. This group includes beneficiaries with low drug spending who currently have coverage for prescription drugs with low or no deductibles and cost-sharing, who would have to pay a $250 deductible before coverage begins under the standard Part D benefit. It also includes roughly 2 million low-income Medicare beneficiaries with Medicaid (dual eligibles) – many of whom currently face low or no cost-sharing for prescription drugs under state Medicaid programs – who are expected to shift to Part D plans in 2006 and face higher cost-sharing requirements.

The remaining one-third of beneficiaries projected to pay more out of pocket include those with relatively high out-of-pocket spending who could pay more under the MMA because they are projected to shift from relatively generous coverage, such as employer-sponsored retiree health plans, to the Part D standard benefit (again, assuming no supplementation of Part D coverage). For example, our model follows CBO projections that 2.7 million beneficiaries will shift from employer-sponsored drug coverage to enrollment in Part D plans, and employer-sponsored benefits are typically more generous than the standard Part D benefit. To the extent that beneficiaries receive supplemental coverage from other sources, such as state pharmacy assistance programs, the number of beneficiaries who actually experience an increase in out-of-pocket spending under the MMA could be lower than our estimates suggest.

SUMMARY AND DISCUSSION

The new Medicare drug benefit was designed to extend prescription drug coverage to the Medicare population, reduce the share of total drug spending paid out of pocket by beneficiaries, provide additional relief to those with low incomes, and help those with extraordinarily high out-of-pocket drug spending. The law commits substantial resources to achieve these goals, resulting in a projected reduction in spending among the majority of beneficiaries who are expected to enroll in Part D plans.

Based upon CBO participation assumptions, our analysis shows that the 29 million projected Part D participants are expected to spend, on average, 37% less out of pocket for drugs under the MMA than they would otherwise have spent in the absence of the law. Many low-income beneficiaries who participate in Part D are projected to receive substantial assistance under the new Medicare drug benefit as a result of the low-income subsidies provided by the law. These subsidies account for almost 25% of direct federal spending related to Medicare drug benefit provisions over the 2006-2013 budget period (in addition to payments made by Medicare to plans on behalf of low-income beneficiaries for the standard Part D benefit).[17] The 8.7 million low-income subsidy recipients are projected to have out-of-pocket spending under the MMA that is 83% less, on average, than their projected spending in the absence of the new law in 2006.

Overall, the majority of beneficiaries expected to enroll in Part D plans but *not* receive low-income subsidies (20.3 million beneficiaries in 2006) are projected to have out-of-pocket spending that is 28% less, on average, than what they would have spent in the absence of the MMA (excluding costs associated with premiums for drug coverage). The 8.5 million beneficiaries in this group who currently lack drug coverage but enroll in a Part D plan in 2006 are projected to have average out-of-pocket spending that is 50% lower under the MMA than their projected spending in the absence of the law, excluding premiums – but only 23% less than their baseline spending when Part D premiums are taken into account. For this group of beneficiaries, the reduction in projected spending on prescription drugs is roughly comparable to estimated average savings under Medicare-approved prescription drug discount cards.[18]

Our analysis underscores the substantial value of the additional subsidies for low-income beneficiaries. Low-income Part D participants who do *not* receive low-incomes subsidies are projected to face out-of-pocket spending that is significantly higher than low-income subsidy recipients – as much as 10 times more for the 2 million Part D participants with incomes below 100% of poverty. We estimate that out of 8 million Part D participants with incomes below the low-income subsidy threshold level (150% of poverty) – excluding dual eligibles – 5.7 million will not receive these subsidies because they are ineligible based on their assets or they do not enroll in subsidy programs. Our findings confirm the importance of maximizing

[17] According to CBO, spending on low-income subsidies is projected to be $192 billion over the 10-year period from 2004-2014, out of $770 billion in total federal spending on the MMA over the same period.
[18] Centers for Medicare and Medicaid Services, “Studies Confirm Significant Savings Through Medicare-Approved Drug Discount Cards,” Updated September 23, 2004, http://www.cms.hhs.gov/media/press/files/studies_confirm_savings.pdf; Kaiser Family Foundation, “Medicare Drug Discount Cards: A Work in Progress,” July 2004.

participation in the low-income subsidy program, as well as illustrating the impact of the asset test used to determine eligibility, which could preclude nearly two million low-income beneficiaries from receiving these subsidies, according to CBO.

Our analysis suggests that many Medicare beneficiaries will continue to face high out-of-pocket drug costs under the MMA. Of the 6.9 million Part D participants who are projected to have spending in the doughnut hole (assuming no supplementation of Part D coverage), nearly half are projected to spend more than $3,600 out of pocket after the MMA goes into effect in 2006. Roughly three-quarters of those projected to have spending in the doughnut hole have incomes below 300% of poverty ($27,930 for an individual in 2004) and a disproportionate share are in fair or poor health. Moreover, even though the MMA provides additional subsidies to protect the low-income from catastrophic out-of-pocket drug costs, many low-income beneficiaries are likely to have spending in the doughnut hole. Almost 2 million of those projected to have spending in the doughnut hole have incomes less than 150% of poverty ($13,965 for an individual in 2004).

For Part D participants who do not receive low-income subsidies, the greatest value of the MMA may be in reducing the out-of-pocket burden of catastrophic expenses. The roughly one in 10 beneficiaries in this group who are projected to have extraordinarily high out-of-pocket drug expenses (more than $3,600 out of pocket in 2006) can expect to see a reduction of more than one-third (37%) in their out-of-pocket drug spending under the MMA. Nevertheless, these beneficiaries are projected to continue to face very high out-of-pocket spending under the MMA in dollar terms (on average, $3,784 in 2006) because of the doughnut hole in the design of the Part D benefit.

On average, Part D participants are projected to have lower out-of-pocket spending under the MMA than they would have in the absence of the law (again, excluding premiums and supplemental coverage from the analysis); however, one in four are projected to spend more. In 2006, 18.6 million Part D participants (64% of total) are expected to have lower out-of-pocket drug spending than they would have had in the absence of Part D, with an average reduction of $919 in 2006. Another 3 million participants (10%) are expected to have no prescription drug spending in that year and thus have no change in spending. The remaining 7.4 million Part D participants are projected to spend more out of pocket in 2006 under the MMA than they would have spent in the absence of the law, with an average increase of $492. For low-income beneficiaries not receiving subsidy assistance, even modest increases in out-of-pocket spending could represent a financial burden and a barrier to getting needed medications.

With just over one year before the Part D program takes effect, there is a great deal of uncertainty about the impact of the new drug benefit. Determining how well any given Medicare beneficiary could fare depends on a number of factors, including their decision to participate in Part D and sign up for low-income subsidies (if eligible) and their total drug costs in a single year. The financial burden on beneficiaries will also be driven by factors that are beyond the scope of this analysis, including Part D premiums, cost-sharing structures under Part D drug plans that do not follow the standard benefit design, payments for drugs that are not covered by their Part D plan, and access to supplemental coverage. Amid uncertainty about the actual response of Medicare beneficiaries to the new drug benefit, the design of Part D plans, and

ongoing concern about prescription drug prices, the impact of the MMA on beneficiaries' out-of-pocket drug spending is a measure of the program's success and should be carefully monitored as the law is implemented.

APPENDIX: METHODOLOGY AND KEY ASSUMPTIONS

Overview of the Model

The estimates presented here are based on a model developed for this analysis by Actuarial Research Corporation (ARC). The model developed by ARC incorporates information about beneficiary characteristics, including demographics and insurance coverage, which allows for analysis of variations in projected average spending and distributions of total and out-of-pocket spending by characteristic. The model incorporates detailed demographic information about Medicare beneficiaries, including their age, gender, race/ethnicity, health status, and source of prescription drug coverage.

In general, the ARC model conforms to CBO projections of total Medicare enrollment, per capita total and out-of-pocket prescription drug spending for Medicare beneficiaries, rates of participation in Part D plans and the low-income subsidy programs, and coverage under employer/union plans.[19] CBO projections differ somewhat from those produced by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary (OACT) at HHS (see Table 1 for a comparison). The ARC model controls to CBO projections, rather than those prepared by OACT, to be consistent with spending estimates that are used by the Congress.

Data Sources and Methods

The analytic model draws on multiple sources of data and information, including the 2000 Medical Expenditure Panel Survey (MEPS), the Medicare Current Beneficiary Survey (MCBS) Cost and Use Files (1995-2000), a report from CBO explaining its methods and assumptions in estimating the cost of the Medicare prescription drug benefit,[20] and the 2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.[21]

Baseline Population and Spending Projections

The ARC model begins with data from MEPS 2000 of Medicare beneficiaries' per capita out-of-pocket and total drug spending. Medicare+Choice enrollment for 2000 was imputed using probabilities derived from the MCBS. The MEPS spending data were then controlled to ARC's in-house baseline of Medicare drug spending by supplemental insurance type and Medicare status (aged/disabled) in the absence of the MMA. The ARC baseline uses MCBS 2000 as a starting point, corrects for underreporting of prescription drugs in the survey, and derives trends

[19] For a comparison of CBO and OACT assumptions and projections, see Table 1.
[20] CBO, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit* (July 21, 2004).
[21] http://www.cms.hhs.gov/publications/trusteesreport/

in enrollment and spending based on data from MCBS 1995-2000, CBO Fact Sheets,[22] an analysis by ARC for the Kaiser Family Foundation in June 2003,[23] and the Boards of Trustees' 2004 Annual Report to estimate enrollment and total and out-of-pocket prescription drug spending in 2000-2013 in the absence of the Medicare drug law. Spending projections were performed separately by source of prescription drug coverage prior to the MMA. The baseline distributions were then modified slightly to match CBO assumptions.

The model controls to CBO's 2006 enrollment projection of 42.6 million Medicare beneficiaries. It then incorporates CBO poverty distributions for the Medicaid and non-Medicaid Part B populations, and CBO assumptions about rates of low-income participation in Part D. Once populations were distributed based on income, we controlled baseline total and out-of pocket prescription drug spending to the CBO projections for Part D participants. Total baseline spending in the absence of the MMA for beneficiaries with employer subsidy plans was also controlled to the CBO projection. CBO did not project baseline out-of-pocket drug spending for those with employer subsidy plans, so the ARC model assumes that the share of total drug spending paid out-of-pocket by Medicare beneficiaries with employer subsidy plans, as well as those who switch from employer-sponsored plans to Part D, is the same as it would have been in the absence of the MMA, according to the ARC baseline. Total drug spending in the absence of the MMA for all Medicare beneficiaries, including non-Part D participants, is assumed to be consistent with CBO's January 2003 baseline projection for 2006 ($3,167). Total out-of-pocket drug spending by non-Part D beneficiaries was projected to 2006 using ARC's MCBS-based modeling, resulting in an overall out-of-pocket share of total drug spending of 41% for all Medicare beneficiaries.

Enrollment and Spending Projections Under the MMA

Once populations and baseline per capita spending amounts were established, we then modeled spending under the MMA. The model assumes an induction factor of 0.7, meaning that for every $1 saved by a beneficiary in out-of-pocket expenses for prescription drugs, spending on such drugs increases by $0.70. This results in an overall increase in covered charges for Part D participants of 9%, due to increased utilization, which is consistent with CBO's "use effect." This induction formula is somewhat simpler than that used by both CBO and OACT, but results in the same increase in covered charges due to induction.

We also assume an average net discount on gross drug costs of 7.6% for Part D participants. This net discount was based on CBO's assumptions, in the absence of the MMA and under the MMA, used to derive gross drug costs per Part D participant, including gross drug savings (the "cost management factor"). The model assumes a net discount based on the assumption that the plans in which beneficiaries were enrolled prior to Part D participation had some degree of cost management. For all other beneficiaries (such as those who are projected not to participate in

[22] CBO Fact Sheets are available as "Supplemental Data on Major Entitlement Programs" from "An Analysis of the President's Budgetary Proposals for Fiscal Year 2005," accessible at http://www.cbo.gov/showdoc.cfm?index=5151&sequence=0; CBO 2004 Medicare and Medicaid Fact Sheets: http://www.cbo.gov/factsheets/2004b/Medicare.pdf; http://www.cbo.gov/factsheets/2004b/Medicaid.pdf

[23] Kaiser Family Foundation, "Medicare and Prescription Drug Spending Chartpack," June 2003.

Part D and those with employer-subsidy plans), total and out-of-pocket spending under the MMA is assumed to be the same as their baseline spending in the absence of the MMA. Additional factors affecting costs incorporated in CBO's model are assumed to be embedded in the adjustment factors we use to match the CBO projections.

After applying the induction formula and net discounts described above, our raw total and out-of-pocket per capita spending amounts under the MMA for Part D participants were $2,962 and $847, respectively, for 2006 (29% out-of-pocket share of total). We then controlled these amounts with multiplicative adjustment factors (0.972 for total spending and 0.935 for out-of-pocket spending) to match CBO's total and out-of-pocket spending projections of $2,878 and $792, respectively, for 2006 (28% out-of-pocket share of total).

After constructing complete data files, we generated tables showing distributions of projected average total and out-of-pocket drug spending, per capita, in the absence of and under the MMA, by selected beneficiary characteristics, for 2006 and 2013.

Assumptions about Sources of Prescription Drug Coverage and Part D Participation

The model is based on certain assumptions about Part D participation and projected total and out-of-pocket prescription drug spending by Medicare beneficiaries in the absence of the law and under the MMA, based on a beneficiary's prior source of prescription drug coverage. Unless 2006 benchmarks were available from CBO or other sources, as noted below or in Table 1, assumptions about enrollment and total and out-of-pocket prescription drug spending were based on projections derived from the 2000 MCBS.

- **Participation in Part D and low-income subsidy programs.** Our analysis is based on CBO's assumptions about Part D participation. CBO projects that 29 million of Medicare's 42.6 million beneficiaries (or 68% of the total) will enroll in Part D plans in 2006 and 13.6 million beneficiaries will not participate in Part D.[24] We focus on projections of out-of-pocket drug spending in 2006 by the 29 million Medicare beneficiaries who are expected to participate in Part D. This group includes beneficiaries who stay in fee-for-service Medicare and enroll in stand-alone prescription drug plans (PDPs) and those who enroll in integrated Medicare Advantage (MA) plans such as HMOs or PPOs that cover prescription drugs along with other Medicare benefits (MA-PDs). In addition, our analysis incorporates CBO's assumption about take-up rates for low-income subsidies. According to CBO projections, 8.7 million Medicare beneficiaries (30% of Part D participants) are expected to receive low-income subsidies in 2006, which represents 61% of those eligible for low-income subsidies:

[24] Non-participants include 8.2 million beneficiaries who will receive drug coverage through qualified employer-sponsored plans, and 5.4 million who are either federal retirees retaining coverage through the Federal Employees Health Benefits Program (FEHBP) or TRICARE for Life (TFL), or who choose to go without any drug coverage in 2006.

6.4 million are dual eligibles, and 2.3 million are non-dual eligible beneficiaries with incomes below 150% of poverty.[25]

- **Employer coverage.** Consistent with CBO, our model assumes that 8.2 million beneficiaries have employer subsidy plans and 2.7 million beneficiaries switch from employer-sponsored plans to Part D plans in 2006. Total drug spending in the absence of the MMA for those who remain enrolled in employer plans under the MMA is consistent with the CBO benchmark ($3,815 in 2006), and their share of total spending paid out-of-pocket (34%) reflects the ARC baseline. Total and out-of-pocket drug spending for beneficiaries who switch from employer plans to Part D is consistent with the ARC baseline. In addition, similar to CBO, we assume that 5% of the total Medicare population (2.1 million beneficiaries) have Medicare as a secondary payer, which generally means that these beneficiaries are working elderly.

- **Medicare+Choice.** In ARC's 2006 baseline model, we assume 3.9 million enrollees receive drug coverage through a Medicare+Choice (now Medicare Advantage or MA) plan. Under the MMA, we assume that 5.2 million beneficiaries enroll in MA-PD plans, consistent with projections from CBO. We assume that some of the 3.9 million enrollees who enrolled in Medicare+Choice plans only for drug coverage prior to the MMA will switch back to Medicare-only fee-for-service coverage under the MMA, and some of the Medicare+Choice enrollees without drug coverage prior to the MMA will remain in their current plan and receive new drug coverage through the MA-PD plan.

- **Medigap.** We assume 3.2 million enrollees have drug coverage through Medigap prior to the MMA, consistent with CBO's benchmark of 8% of all beneficiaries in Part B. The model assumes that the majority (93%) of beneficiaries with Medigap drug coverage prior to 2006 will choose to sign up for Part D and give up their Medigap policy, and the remaining share (7%) will retain their Medigap drug coverage.

- **Medicaid.** The model assumes 6.4 million beneficiaries are "full-benefit" dual eligible Medicaid enrollees in 2006, consistent with CBO projections. Total and out-of-pocket drug spending for full-benefit duals is derived from the 2000 MCBS Cost and Use file, after corrections for the prescription drug undercount and differing trends in out-of-pocket spending for full-year and part-year Medicaid enrollees. The model assumes out-of-pocket drug spending for dual eligible beneficiaries is 8% of total spending in the absence of the MMA and falls to 2% of total spending under the MMA.

- **SPAP.** Our model assumes there are 1.6 million SPAP enrollees in 2006, all of whom enroll in Part D.[26] We assume this group includes only enrollees in direct-benefit SPAPs which are solely state-funded (i.e., they do not operate under Medicaid or Medicaid waivers). We assume that beneficiaries enrolled in SPAPs prior to 2006 who meet the requirements for

[25] CBO assumes that by 2013, 75% of beneficiaries with incomes below 135% of poverty receive low-income subsidies and 35% of those with incomes between 135%-150% of poverty receive low-incomes subsidies, including dual eligibles (CBO, July 2004). In addition, CBO assumes that in 2006, 1.8 million Medicare beneficiaries with incomes below 150% of poverty will not receive low-income subsidies because they have assets above the threshold defined in the law (July 2004).

[26] This enrollment assumption is derived from papers and testimonies by Kimberly Fox and Stephen Crystal through the Rutgers Center for State Health Policy (see sources).

low-income subsidies will enroll in Part D and receive low-income subsidies. However, we assume no supplementation of standard Part D coverage by SPAPs.

- **Other coverage.** This category includes federal retirees with drug coverage through the Federal Employees Health Benefits Program (FEHBP) or TRICARE for Life (TFL), who are assumed to retain these sources of drug coverage under the MMA. We assume that beneficiaries with coverage from sources other than these will participate in Part D.

- **Medicare-only (no drug coverage).** We assume that approximately 11.1 million enrollees lack prescription drug coverage at baseline in 2006 (prior to the MMA). The model assumes that a majority of these beneficiaries (9.6 million) will enroll in Part D plans and that a minority of this group (1.6 million beneficiaries, including 0.2 million who are enrolled in Part A only or are working aged with Medicare as a secondary payer) will remain without drug coverage under the MMA in 2006.

Projections in this Report

The analysis presented in this report focuses on spending estimates for 2006. Also the report focuses on the impact of the MMA for beneficiaries who participate in Part D. We focus on this population, rather than on those who do not enroll in Part D plans or who remain in an employer or union plan, because the provisions of the MMA most directly affect Part D participants.

The projections may not capture all changes in beneficiaries' out-of-pocket spending associated with prescription drugs, based on the following assumptions:

- **Standard Part D coverage without supplementation.** Our analysis assumes that all 29 million Part D participants in 2006 enroll in Part D plan that provides coverage equivalent to the standard benefit defined in the MMA (as shown in Exhibit 1), and that they do not have supplemental coverage. That is, our model assumes Part D participants are fully responsible for cost-sharing required under the standard benefit unless they receive low-income subsidies, and they do not receive additional or wraparound coverage from other sources, such as a state pharmacy assistance program (SPAP).

- **Premium payments.** The out-of-pocket spending projections do not incorporate costs associated with premiums for drug coverage – either the premiums beneficiaries might have paid for prescription drug coverage if the MMA had not been enacted (for example, Medigap premiums), or the premiums that Part D participants are expected to pay for standard Part D coverage (an estimated average annual cost of $420 in 2006, according to CBO). Premiums are excluded from baseline spending estimates because existing data sources do not provide sufficient information to measure the drug-related portion of premiums that beneficiaries pay out of pocket for different sources of supplemental coverage nor how premiums vary by beneficiary characteristics. Therefore, the only beneficiaries for whom we consider the effects of estimated Part D premiums are those beneficiaries who are assumed to lack drug coverage in the absence of the MMA, and therefore face no existing premiums, but who are expected to enroll in Part D plans in 2006.

- **Changes in the scope of drug coverage or covered benefits.** Other than assuming all Part D participants have coverage equivalent to the standard benefit defined in the MMA, the model makes no assumptions about the scope or nature of covered benefits under the MMA (beyond what is implicit in CBO's assumptions and projections). The estimates do not incorporate changes in the scope of drug coverage for Part D participants that could affect their out-of-pocket spending, such as more or less restrictive formularies. This could be a particular concern for vulnerable subgroups of Medicare beneficiaries such as those who are dually eligible for Medicare and Medicaid, whose Part D coverage could be more restrictive than what they currently receive through state Medicaid programs.

- **Non-Part D drug spending.** Because the analysis focuses on out-of-pocket spending for drugs covered under the standard Part D benefit, it does not account for spending that beneficiaries may incur for drugs not covered by their Part D plan – either non-formulary or non-preferred drugs or prescriptions filled at non-network pharmacies.

- **Changes prior to 2006.** Baseline spending projections for 2006 do not take into account potential changes in out-of-pocket spending that may be attributable to Medicare-approved drug discount cards, or other changes in drug spending and utilization that may occur following passage of the MMA, but prior to implementation of the Part D drug benefit in 2006.

Caveats

It is important to note that modeling a major change in public policy involves uncertainty. As with any effort of this type, the reliability of the projections depends to some degree on the underlying assumptions of the model. The analysis presented in this report uses conventional modeling techniques, and generally conforms to published CBO estimates and assumptions.

TABLE 1: Comparison of Congressional Budget Office and Office of the Actuary Modeling Assumptions

Assumptions and Targets	Congressional Budget Office[a]		Office of the Actuary	
Base Population	**2006**	**2013**	**2006**	**2013**
Total population (Parts A or B)	42.6 million	49.6 million	43.1 million	50.5 million
Part B participants	39.9 million	46.6 million	40.1 million	46.3 million
Dual eligibles	6.4 million	7.4 million	Not available	Not available
Medicare as secondary payer	5%	5%	5% [b]	5% [b]
Part D Participation	**2006**	**2013**	**2006**	**2013**
Part D participation, including those in qualified employer/ union plans	87% [c] 37.2 million	87% [c] 43.4 million	94% [b] 40.7 million	94% [b] 47.8 million
Part D participation, excluding those in qualified employer/ union plans	29.0 million	33.9 million	32.2 million	37.7 million
Participants in qualified employer/union plans	8.2 million	9.5 million	8.5 million	10 million
Low-income subsidy participation	75% of those below 135% FPL 35% of those 135%-150% FPL	75% of those below 135% FPL 35% of those 135%-150% FPL	75% of all subsidy-eligible individuals	75% of all subsidy-eligible individuals
Low-income subsidy recipients	8.7 million	11.2 million	10.9 million	12.7 million
FFS enrollees	37.4 million	43.7 million	33.5 million	35.8 million
Medicare Advantage/Part C enrollees	5.2 million	5.9 million	9.5 million	14.7 million
Prescription Drug Spending	**2006**	**2013**	**2006**	**2013**
Total per capita drug spending, under the MMA	All: $3,084 Employer/union plans: $3,815 Part D: $2,878	All: $5,420 Employer/union plans: $6,689 Part D: $5,017	All projections are 4% higher than CBO throughout 2006-2013 [b]	All projections are 4% higher than CBO throughout 2006-2013 [b]

Notes:
[a] The ARC model calibrates to projections and assumptions made by CBO.
[b] CBO, Letter to the Honorable Jim Nussle Regarding a Comparison of CBO and Administration Estimates of the Effect of H.R. 1 on Direct Spending, February 2, 2004.
[c] CBO excludes beneficiaries with generous employer-sponsored coverage and those without Part B.

TABLE 2: Projected Average Per Capita Total and Out-of-Pocket Prescription Drug Spending For All Medicare Beneficiaries, Baseline and Under the MMA, By Demographics, 2006

		Total Drug Spending		Out-of-Pocket Drug Spending	
	Total (Millions)	Baseline	Under the MMA	Baseline	Under the MMA
All Medicare beneficiaries	**42.6**	**$3,167**	**$3,156**	**$1,287**	**$970**
Total Part D participants	29.0	$2,894	$2,878	$1,257	$792
Non-enrolled	5.4	$3,650	$3,650	$1,416	$1,416
Employer coverage	8.2	$3,815	$3,815	$1,309	$1,309
Health Status					
Excellent/very good	15.8	$1,916	$1,897	$862	$652
Good	13.4	$3,202	$3,201	$1,366	$1,043
Fair	7.6	$4,788	$4,771	$1,734	$1,379
Poor	3.8	$5,848	$5,824	$2,173	$1,555
Age and Disability					
Disabled under 65	5.8	$4,653	$4,672	$1,334	$934
Aged over 65	36.8	$2,931	$2,915	$1,280	$976
MSA					
Rural (non-MSA)	9.7	$3,489	$3,486	$1,483	$1,074
Urban (MSA)	32.9	$3,072	$3,058	$1,229	$940
Race					
White	34.9	$3,256	$3,245	$1,372	$1,044
Black	4.2	$2,772	$2,754	$920	$668
Hispanic	2.5	$2,946	$2,931	$860	$576
Sex					
Male	19.7	$2,966	$2,933	$1,123	$938
Female	22.9	$3,340	$3,347	$1,428	$999
Age					
Under 45	2.2	$2,798	$2,801	$560	$392
45-54	1.5	$6,024	$6,040	$1,753	$1,219
55-64	2.2	$5,549	$5,588	$1,814	$1,276
65-74	20.2	$3,035	$3,004	$1,260	$1,005
75-84	12.6	$2,947	$2,944	$1,308	$983
85+	4.0	$2,361	$2,381	$1,290	$809

TABLE 3: Projected Average Per Capita Total and Out-of-Pocket Prescription Drug Spending for Medicare Beneficiaries Expected to Enroll in Part D Plans, Baseline and Under the MMA, By Demographics, 2006

		Total Drug Spending		Out-of-Pocket Drug Spending	
	Total (Millions)	Baseline	Under the MMA	Baseline	Under the MMA
Total Part D participants	**29.0**	**$2,894**	**$2,878**	**$1,257**	**$792**
Health status					
Excellent/very good	10.3	$1,856	$1,827	$933	$611
Good	8.8	$2,611	$2,608	$1,297	$808
Fair	5.4	$4,314	$4,289	$1,590	$1,080
Poor	2.9	$5,522	$5,492	$1,956	$1,154
Age and disability					
Disabled under 65	4.5	$4,077	$4,102	$1,035	$516
Aged over 65	24.5	$2,677	$2,653	$1,298	$842
MSA					
Rural (non-MSA)	7.1	$3,100	$3,097	$1,408	$849
Urban (MSA)	21.9	$2,827	$2,807	$1,208	$773
Race					
White	23.0	$2,931	$2,915	$1,364	$868
Black	3.2	$2,708	$2,686	$874	$545
Hispanic	2.0	$2,976	$2,957	$735	$383
Sex					
Male	12.9	$2,592	$2,542	$1,070	$786
Female	16.1	$3,135	$3,145	$1,406	$796
Age					
Under 45	1.8	$2,585	$2,588	$422	$226
45-54	1.1	$4,869	$4,892	$1,336	$588
55-64	1.6	$5,293	$5,347	$1,551	$807
65-74	12.3	$2,858	$2,807	$1,310	$891
75-84	9.0	$2,616	$2,611	$1,281	$827
85+	3.2	$2,163	$2,187	$1,298	$700
Low-income subsidy recipients					
All Medicaid	6.4	$4,301	$4,211	$357	$94
<135% FPL	2.1	$2,609	$3,224	$1,624	$153
135%-150% FPL	0.2	$2,702	$3,202	$1,834	$406
Income level					
<100% FPL	7.2	$3,593	$3,611	$831	$330
100%-134% FPL	4.9	$2,723	$2,838	$1,253	$629
135%-149% FPL	1.6	$2,749	$2,821	$1,442	$800
150%-300% FPL	10.6	$2,560	$2,493	$1,485	$1,048
>300% FPL	4.7	$2,799	$2,679	$1,338	$1,087

	Total (Millions)	Total Drug Spending		Out-of-Pocket Drug Spending	
		Baseline	Under the MMA	Baseline	Under the MMA
Income level, for low-income subsidy recipients					
<100% FPL	5.2	$4,175	$4,206	$572	$90
100%-134% FPL	2.4	$3,182	$3,445	$1,005	$149
135%-150% FPL	0.4	$4,558	$4,784	$1,254	$283
150%+ FPL	0.7	$3,318	$3,244	$317	$109
Total recipients	8.7	$3,852	$3,946	$701	$117
Income level, for low-income subsidy non-recipients					
<100% FPL	2.0	$2,106	$2,090	$1,495	$943
100%-134% FPL	2.5	$2,286	$2,262	$1,488	$1,086
135%-150% FPL	1.2	$2,123	$2,141	$1,508	$979
150%+ FPL	14.6	$2,600	$2,516	$1,495	$1,107
Total non-recipients	20.3	$2,484	$2,420	$1,495	$1,081

<u>TABLE 4</u>: Part D Participants With Projected Spending That Exceeds the Initial Coverage Limit, by Demographics, 2006

	Total (Millions)	Reach Initial Limit [a] (Millions)	% of Total Part D	In Doughnut Hole [b] (Millions)	% of Total Part D	Above Catastrophic Threshold [c] (Millions)	% of Total Part D
Total Part D participants	**29**	**6.9**	**24%**	**3.8**	**13%**	**3.1**	**11%**
Health status							
Excellent/very good	10.3	1.9	18%	1.3	13%	0.7	7%
Good	8.8	1.9	22%	0.9	10%	1.0	11%
Fair	5.3	1.9	36%	1.1	21%	0.8	15%
Poor	2.9	1.0	34%	0.4	14%	0.6	21%
Age and disability							
Disabled under 65	4.5	0.7	16%	0.3	7%	0.3	7%
Aged over 65	24.5	6.2	25%	3.5	14%	2.8	11%
MSA							
Rural (non-MSA)	7.1	1.8	25%	1.0	13%	0.8	12%
Urban (MSA)	21.9	5.1	23%	2.8	13%	2.2	10%
Race							
White	23	6.1	26%	3.4	15%	2.7	12%
Black	3.2	0.5	14%	0.3	8%	0.2	7%
Hispanic	2	0.2	10%	0.1	6%	0.09	4%
Sex							
Male	12.9	3.1	24%	1.7	13%	1.4	11%
Female	16.1	3.8	24%	2.1	13%	1.7	11%
Age							
Under 45	1.8	0.09	5%	0.03	2%	0.06	3%
45-54	1.1	0.2	18%	0.08	7%	0.1	9%
55-64	1.6	0.4	25%	0.2	13%	0.2	13%
65-74	12.3	3.3	27%	1.7	14%	1.5	12%
75-84	9.0	2.3	26%	1.3	14%	1.0	11%
85+	3.2	0.7	21%	0.4	13%	0.3	8%
Low-income subsidy recipients							
All Medicaid	6.4	0.0	0%	0.0	0%	0.0	0%
<135% FPL	2.1	0.0	0%	0.0	0%	0.0	0%
135%-150% FPL	0.2	0.06	30%	0.06	30%	0.0	0%
Income level							
<100% FPL	7.2	0.6	8%	0.3	4%	0.3	4%
100%-134% FPL	4.9	0.9	18%	0.5	10%	0.4	8%
135%-149% FPL	1.6	0.4	25%	0.3	19%	0.2	13%
150%-300% FPL	10.6	3.3	31%	1.8	17%	1.6	15%
>300% FPL	4.7	1.6	34%	0.9	19%	0.7	15%
Income level, for low-income subsidy recipients							
<100% FPL	5.2	0.0	0%	0.0	0%	0.0	0%
100%-134% FPL	2.4	0.0	0%	0.0	0%	0.0	0%
135%-150% FPL	0.4	0.06	15%	0.06	15%	0.0	0%
150%+ FPL	0.7	0.0	0%	0.0	0%	0.0	0%
Total recipients	8.7	0.06	1%	0.06	1%	0.0	0%

	Total (Millions)	Reach Initial Limit [a] (Millions)	% of Total Part D	In Doughnut Hole [b] (Millions)	% of Total Part D	Above Catastrophic Threshold [c] (Millions)	% of Total Part D
Income level, for low-income subsidy non-recipients							
<100% FPL	2.0	0.6	31%	0.3	16%	0.3	15%
100%-134% FPL	2.5	0.9	35%	0.5	20%	0.4	15%
135%-150% FPL	1.2	0.3	29%	0.2	16%	0.2	13%
150%+ FPL	14.6	5.0	34%	2.7	18%	2.3	16%
Total non-recipients	20.3	6.8	33%	3.7	18%	3.1	15%

Note: Numbers may not sum to total because of rounding.
[a] In 2006, the initial coverage limit begins when out-of-pocket drug spending exceeds $750.
[b] In 2006, the doughnut hole is the gap in coverage between $750 and $3,600 in out-of-pocket drug spending.
[c] In 2006, the catastrophic threshold is $3,600 in out-of-pocket drug spending.

TABLE 5: Part D Participants With Projected Spending That Exceeds the Initial Coverage Limit, by Demographics, 2006

	% of Part D Participants Who Reach Initial Limit [a]	Of Those in Demographic Who Reach Initial Limit		Out-of-Pocket Drug Spending	
		% In Doughnut Hole [b]	% Above Catastrophic Threshold [b]	In Doughnut Hole [c]	Above Catastrophic Threshold [c]
Total Part D participants	**100%**	**55%**	**45%**	**$1,724**	**$3,784**
Health status					
Excellent/very good	28%	65%	35%	$1,573	$3,738
Good	28%	47%	53%	$1,877	$3,741
Fair	28%	58%	42%	$1,792	$3,793
Poor	14%	40%	60%	$1,747	$3,908
Age and disability					
Disabled under 65	10%	50%	50%	$1,718	$3,797
Aged over 65	90%	56%	44%	$1,725	$3,783
MSA					
Rural (non-MSA)	26%	53%	47%	$1,667	$3,758
Urban (MSA)	73%	56%	44%	$1,744	$3,794
Race					
White	88%	55%	45%	$1,717	$3,780
Black	7%	54%	46%	$1,955	$3,890
Hispanic	3%	57%	43%	$1,631	$3,709
Sex					
Male	45%	55%	45%	$1,706	$3,773
Female	55%	55%	45%	$1,739	$3,793
Age					
Under 45	1%	33%	67%	$2,167	$3,830
45-54	3%	45%	55%	$1,741	$3,692
55-64	6%	50%	50%	$1,646	$3,844
65-74	48%	53%	47%	$1,718	$3,802
75-84	33%	57%	43%	$1,742	$3,749
85+	10%	62%	38%	$1,702	$3,795
Low-income subsidy recipients					
All Medicaid	n/a	n/a	n/a	n/a	n/a
<135% FPL	n/a	n/a	n/a	n/a	n/a
135%-150% FPL	1%	100%	0%	$848	n/a
Income level					
<100% FPL	9%	50%	50%	$1,491	$3,756
100%-134% FPL	13%	56%	44%	$1,831	$3,746
135%-149% FPL	6%	63%	37%	$1,433	$3,732
150%-300% FPL	48%	53%	47%	$1,803	$3,786
>300% FPL	23%	56%	44%	$1,679	$3,824

	% of Part D Participants Who Reach Initial Limit [a]	Of Those in Demographic Who Reach Initial Limit		Out-of-Pocket Drug Spending	
		% In Doughnut Hole [b]	% Above Catastrophic Threshold [b]	In Doughnut Hole [c]	Above Catastrophic Threshold [c]
Income level, for low-income subsidy recipients					
<100% FPL	n/a	n/a	n/a	n/a	n/a
100%-134% FPL	n/a	n/a	n/a	n/a	n/a
135%-150% FPL	1%	100%	0%	$848	n/a
150%+ FPL	n/a	n/a	n/a	n/a	n/a
Total recipients	1%	100%	0%	$848	n/a
Income level, for low-income subsidy non-recipients					
<100% FPL	9%	53%	47%	$1,491	$3,756
100%-134% FPL	13%	58%	42%	$1,831	$3,746
135%-150% FPL	5%	56%	44%	$1,615	$3,732
150%+ FPL	72%	54%	46%	$1,760	$3,798
Total non-recipients	98%	55%	45%	$1,739	$3,784

Note: Numbers may not sum to total because of rounding.

[a] Numerator represents the total number of Part D participants who have spending above the initial coverage limit. Numbers sum to 100% reading down. In 2006, the initial coverage limit begins when out-of-pocket drug spending exceeds $750.

[b] Numerators for each column represent the total number of Part D participants with each characteristic who have spending above the initial coverage limit and above the catastrophic threshold, respectively. Numbers sum to 100% reading across. In 2006, the doughnut hole is the gap in coverage between $750 and $3,600 in out-of-pocket drug spending. In 2006, the catastrophic threshold is $3,600 in out-of-pocket drug spending.

[c] Dollar amounts reflect average per capita spending among those who have spending above the initial coverage limit and above the catastrophic threshold, respectively.

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The Henry J. Kaiser Family Foundation:
2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400
Facsimile: (650) 854-4800

Washington, D.C. Office:
1330 G Street, N.W.
Washington, DC 20005
(202) 347-5270
Facsimile: (202) 347-5274

Website: www.kff.org

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