MEDICARE PART D 2008 DATA SPOTLIGHT: LOW-INCOME SUBSIDY PLAN AVAILABILITY

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The Medicare Part D drug benefit provides premium and cost-sharing assistance to beneficiaries who qualify for the program's low-income subsidy (LIS). Medicare beneficiaries who qualify for full Medicaid benefits (dual eligibles), those enrolled in Medicare Savings Programs (MSP), and those receiving Supplemental Security Income (SSI) are automatically qualified for the LIS. Other beneficiaries qualify for full or partial subsidies if they meet certain income and asset standards; they must apply for the LIS through Social Security or Medicaid.[1] LIS beneficiaries with full subsidies have no monthly premiums, deductibles, or coverage gap. The federal government pays plans for these costs on their behalf. However, LIS beneficiaries must pay modest copayments for each on-formulary prescription and pay the full cost of any drugs not on their plan's formulary.

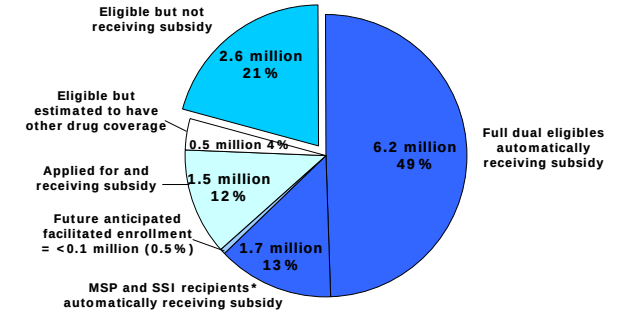
There are several key issues under discussion by policymakers with regard to the LIS, including lower-than-expected take-up of the LIS, particularly among hard-to-reach populations; the process for determining which plans can enroll LIS beneficiaries for a zero premium; and the plan reassignment process required for certain LIS beneficiaries at the end of the year. This Part D Data Spotlight focuses on the market dynamics for Part D plans related to these issues, and implications for LIS beneficiaries.

2008 Enrollment in the Low-Income Subsidy

As of January 2008, 12.5 million beneficiaries are eligible for the low-income subsidy based on their estimated income and assets or Medicaid status.[2] Of this total, about 9.4 million are enrolled in Part D plans, including 6.2 million full-benefit dual eligibles, 1.7 million who were deemed eligible through MSP or SSI, and 1.5 million who actively applied for the subsidy (Exhibit 1). A small number (about 0.5 million) have other sources of equivalent coverage, mostly through the Department of Veterans Affairs. The remaining 2.6 million—more than half of those estimated to be eligible but not deemed into the program—are not enrolled in the subsidy.[3] Some may be enrolled in a Part D plan without knowing about their LIS eligibility, while others may be going without drug coverage entirely.

Exhibit 1

Medicare Drug Benefit Low-Income Subsidies: HHS Estimates of Eligibility and Participation, 2008



Beneficiaries Eligible for Low-Income Subsidies = 12.5 million

NOTES: MSP is Medicare Savings Program; SSI is Supplemental Security Income.
SOURCE: HHS, January 31, 2008 (Data as of January 2008).

Full-benefit dual eligibles are randomly assigned to certain Part D plans (auto-enrollment), while other LIS beneficiaries can choose a Part D plan on their own but are randomly assigned to a plan if they do not enroll on their own (facilitated enrollment). Unlike other Part D enrollees, those receiving the LIS can switch plans at any time during the year.

LIS enrollment is not necessarily automatic or stable from one year to the next. LIS beneficiaries can lose their eligibility for Medicaid, MSP, or SSI during the year, which affects their automatic ("deemed") LIS status for the following year. This was the case for about 450,000 beneficiaries who lost their LIS eligibility between 2007 and 2008. Although they may still qualify for the subsidy, they must apply for the LIS on their own. Another 500,000 beneficiaries with LIS in 2007 were required to provide updated income and assets information in order to maintain their LIS eligibility for 2008.

The Availability of Benchmark Plans for LIS Beneficiaries

Although LIS beneficiaries can enroll in any Part D plan, only about a quarter of the 1,824 stand-alone Part D plans offered in 2008 (excluding the territories) qualify for automatic or facilitated enrollment of LIS beneficiaries. These plans, known as benchmark plans, have monthly premiums below a benchmark amount calculated for each region and offer the basic Part D benefit (or one that is actuarially equivalent). Plans offering enhanced benefits cannot qualify as benchmark plans even if their premiums are below the benchmark. Regional benchmarks are calculated based on the average

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premium for basic benefits for all participating stand-alone prescription drug plans (PDPs) and Medicare Advantage drug plans (MA-PD plans). Variation in the benchmark amounts across regions results in regional variation in the number of benchmark plans. Moreover, as a result of annual changes in the regional benchmarks, the availability of benchmark plans has varied from one year to the next.

REGIONAL VARIATION IN THE NUMBER OF BENCHMARK PLANS IN 2008

The number of benchmark plans in 2008 varies greatly across regions, from 2 plans in Nevada to 19 plans in Illinois. This variation in benchmark plan availability partly reflects strategic decisions by plans in setting their premiums. Some organizations may actively seek the enrollment of LIS beneficiaries and the guaranteed subsidy payments they bring, and thus may attempt to ensure that their premiums come in lower than the regional benchmarks. Other organizations may wish to avoid LIS beneficiaries out of concern that risk-adjustment payments will not adequately compensate for these enrollees' drug expenses, and therefore may aim to set their premiums higher than expected benchmarks.

The variation in benchmark plan availability is also a function of variation in the regional benchmarks, which average about $28 in 2008 but range from a low of $15.92 in Arizona to a high of $36.42 in Alaska. Regional variation in the benchmarks is due in part to how MA-PD drug premiums are calculated and the statutory requirement for using enrollment-weighted average premiums.

On average, MA-PD plan premiums are lower than stand-alone PDP premiums, in part because Medicare Advantage plans can use savings from other health services (rebates) to reduce their drug benefit premiums. As a result, lower regional premium benchmarks are observed in regions with a higher penetration of MA-PD plans. Of the 9 regions with high MA-PD plan penetration (above 35 percent), 8 regions have benchmarks under $30, whereas of the 14 regions with relatively low MA-PD plan penetration (under 20 percent), 12 regions have benchmarks for 2008 above $30.

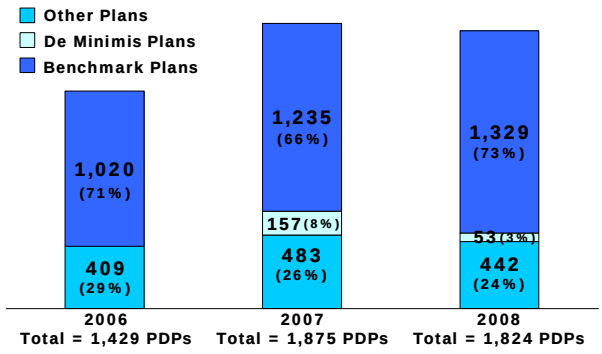
Enrollment-weighted average premiums are also lower than the non-weighted averages. Beneficiaries receiving the LIS are exclusively assigned to plans with low premiums, while those not receiving the LIS are disproportionately enrolled in lower-premium plans. In turn, using enrollment weighting in the benchmark reduces the number of plans available to LIS recipients, causing even more concentrated enrollment in low-premium plans.[4] The law requires regional benchmarks to be weighted by plan-level enrollment after the program's first year. For the 2007 plan year, CMS used its demonstration authority to forgo enrollment weighting in calculating regional benchmarks, thus creating more benchmark plans than would otherwise have been the case.[5] The use of enrollment weighting in calculating the regional benchmarks was phased in starting in 2008, with full implementation expected in 2010.

ANNUAL VARIATION IN THE NUMBER OF BENCHMARK PLANS, 2006-2008

The overall proportion of benchmark plans declined modestly in the program's first three years—from 29 percent in 2006 to 24 percent in 2008 (Exhibit 2). However, as a result of the "de minimis" policy instituted by CMS, the share of plans with LIS beneficiaries was slightly higher in 2007 and 2008. Under the de minimis policy, LIS beneficiaries who are enrolled in a plan losing benchmark status are allowed to stay in that plan and retain the full premium subsidy as long as the new monthly premium does not exceed the regional benchmark by more than a small (de minimis) amount ($2 in 2007 and $1 in 2008).[6] De minimis plans do not receive new auto-enrollments or facilitated enrollments. This policy affected 157 plans in 2007 and 53 in 2008.

Exhibit 2

Distribution of Medicare Prescription Drug Plans, by Benchmark Plan Status, 2006-2008



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

Annual Variation by Plan. About three-fifths (61.5 percent) of the 483 benchmark plans offered in 2007 maintained their status as benchmark plans in 2008; the others either no longer qualified as benchmark plans (33 percent) or left the market (5.6 percent) (Exhibit 3). Of the 505 non-benchmark plans in 2007, about 15 percent qualified as benchmark plans in 2008, and over a quarter left the market. A substantial majority of the 84 new basic plans entering the market in 2008 were benchmark plans.

Annual Variation by Organization. No Part D plan sponsor has had a benchmark plan in all regions in all three years of the program. This may reflect deliberate strategies on the part of some plans, or it may reflect the difficulty organizations face estimating the regional benchmarks and targeting their bids. Some organizations lost benchmark plan status in a considerable number of regions between 2007 and 2008 (Exhibit 4). For example, the number of regions with benchmark plans sponsored by United HealthCare (sponsor of the AARP plans) fell from 34 regions in 2007 to 10 regions in 2008. (United, like several other organizations, shifted benchmark status to a newly introduced plan in 2007, creating another source of instability.) The availability of benchmark plans sponsored by MemberHealth decreased from 32 regions in 2006 to 14 regions in 2007, but increased to 29 regions in 2008. Aetna had benchmark plans in 24 regions in 2008, up from 6 regions in 2006.

Exhibit 3: Changes in Benchmark Plan Status Among Basic Plans, 2007-2008

Status of Basic Plans in 2007	Number of Plans, 2007	Status of Basic Plans in 2008		
		Benchmark plans	Other plans	Plans left market
Benchmark plans	483	61.5%	32.9%	5.6%
Other plans	505	14.7%	56.4%	28.9%
Plans not offered	84	84.5%	15.5%	0
TOTAL	**1,072**	**41.2%**	**42.6%**	**16.1%**

NOTE: Excludes de minimis plans.
SOURCE: Georgetown/NORC analysis of CMS PDP landscape files, 2007-2008, for the Kaiser Family Foundation.

Annual Variation by Region. The number of benchmark plans by region has varied annually. In the majority of regions, at least 10 benchmark plans were available in 2006, 2007 and 2008. However, the minimum number of benchmark plans available has decreased over time. In 2006, the minimum number of benchmark plans in a region was six (in Arizona and Florida), falling to a low of two benchmark plans available in 2008 (in Nevada). Regions with the fewest benchmark plans tend to be those with high Medicare Advantage penetration. The transition to full enrollment weighting of the regional benchmarks is likely to reduce the number of eligible plans in most regions in future years.

Exhibit 4: Number of Regions Where Major Part D Organizations Offer Benchmark Plans, 2006-2008

Organization (Plan)	2006	2007	2008
Aetna	6	21	24
Blue Cross (Local)	23	16	17
Cigna	7	27	19
Coventry / First Health	13	14	17
Envision Rx	N/A	0	0
Health Net	12	33	29
Health Spring	4	29	31
Humana	31	34	25
Other Local/Regional PDPs	20	19	21
Medco	19	0	25
MemberHealth (CCRx)	23	14	29
Prescription Pathway	26	28	30
Rx America (Advantage)	14	27	32
Silverscript	27	20	30
Sterling	0	4	9
United American	2	3	1
United HealthCare (AARP)	33	34	10
Wellcare	33	34	19
Wellpoint (Medicare Rx Rewards)	34	23	34

NOTES: Excludes de minimis plans and organizations no longer in the market in 2008.
SOURCE: Georgetown/NORC analysis of CMS PDP landscape files, 2007-2008, for the Kaiser Family Foundation.

IMPLICATIONS OF BENCHMARK PLAN AVAILABILITY FOR LIS BENEFICIARIES

Each year, LIS beneficiaries who were auto-enrolled in plans that will lose benchmark status are randomly reassigned to a new benchmark plan. For some beneficiaries, the reassignment may be to a different plan offered by the same sponsoring organization, while for others it may be to an entirely new organization. CMS does not re-assign LIS beneficiaries who selected their Part D plan on their own or made a decision to switch out of their initial auto-assigned plan (referred to as "choosers"). These individuals must enroll in a new benchmark plan on their own or pay the amount of the premium that exceeds the benchmark.

Between 2006 and 2007, CMS reassigned 1.1 million beneficiaries to new benchmark plans. With the phasing in of enrollment-weighted regional benchmarks, the number of reassignments between 2007 and 2008 was much higher; CMS reassigned 2.1 million beneficiaries (22 percent of all LIS enrollees), to new benchmark plans. CMS also notified about 443,000 beneficiaries (the "choosers") that they needed to choose a new benchmark plan in order to avoid paying a premium for Part D coverage in 2008, but the agency has not reported how many switched.

LIS beneficiaries assigned to new benchmark plans maintain the same level of subsidy, but may face disruptions in filling their prescriptions because random assignment does not match an individual's prescription drug use with the list of drugs covered by benchmark plans. The new benchmark plan may have different drugs on formulary or different utilization management (UM) requirements. CMS requires plans to allow beneficiaries to refill any prescription for 30 days without imposing UM requirements and to provide a 90-day period before applying rules that were not imposed by the beneficiary's previous plan. Beneficiaries also can request an exception or appeal a plan's decision regarding coverage of a particular drug, and all LIS beneficiaries retain the right to switch plans at any

time. LIS beneficiaries, particularly those who are dually eligible for Medicare and Medicaid, may be more likely than other Part D enrollees to need these protections because they tend to have higher than average medical and prescription drug needs.

COMPARING BENCHMARK PLANS TO OTHER PLANS

In evaluating beneficiary access to benchmark plans, an important question is whether benchmark plans are equivalent to other plans. Overall, our analysis shows no significant difference between benchmark and non-benchmark plans, as measured by key features of Part D plans such as formularies and use of utilization management restrictions.[7] Organizations offering benchmark plans in at least 30 of 34 regions have somewhat smaller formularies than other organizations (80 percent versus 85 percent of a sample of 169 drugs listed on the formulary), but are less likely to impose utilization management restrictions on the drugs they list on formulary (25 percent versus 37 percent). Plans offered by these organizations are less likely to use quantity limits and step therapy (where enrollees must try one drug before getting approval for the requested drug), but the use of prior authorization (where the plan must give approval before paying for the requested drug) is similar across both types of plans.[8]

POLICY ISSUES RELATED TO BENCHMARK PLANS

The varying availability of benchmark plans across time and across regions is an ongoing concern for beneficiaries. Although it may be reassuring that benchmark plans appear to be similar to other plans across important dimensions of coverage, the year-to-year change in their availability has created substantial instability for many LIS beneficiaries. The number of beneficiaries experiencing changes is even larger as a result of policies to require periodic redetermination of eligibility.

The current policy of using random assignment to enroll LIS beneficiaries in benchmark plans can have unintended negative consequences on enrollees' access to medications. Because LIS beneficiaries are at risk for the cost of off-formulary drugs, assignment to a plan not listing their drugs means they pay out of pocket or possibly skip filling their prescription. The random assignment policy could be replaced by a beneficiary-centered approach that would assign beneficiaries in much the same way as other beneficiaries select plans using the Medicare Prescription Drug Plan Finder. The range of options could be expanded by allowing assignment of beneficiaries to plans with enhanced benefits (such as those with some coverage in the gap), provided that such an assignment would reduce costs for both the beneficiary and the government.[9]

The use of enrollment-weighted average premiums in the calculation of regional benchmarks has contributed to the instability in benchmark plan availability. As CMS phases in enrollment weights, most regions are likely to have fewer benchmark plans. This trend could be accentuated if market consolidation leads to fewer participating Part D plans overall or if Medicare Advantage penetration increases. The de minimis policy was designed to allow LIS beneficiaries to remain in plans with premiums only slightly above the benchmark each year. CMS recently issued a proposed rule to revise this policy for regions that would otherwise have fewer than five benchmark plans and eliminate it elsewhere. Another means of addressing the instability in benchmark plan availability would be to revise the calculation of the regional benchmark to exclude premiums from Medicare Advantage plans, since few LIS beneficiaries are enrolled in these plans and they do not receive auto-enrollments. Alternatively, MA-PD plan premiums could be adjusted prior to inclusion in the benchmark calculation by removing the amount of the rebate MA-PD plans use to reduce drug premiums. A careful review of these alternatives could help to promote greater stability in the Part D marketplace for beneficiaries who qualify for low-income Part D subsidies.

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[1] In 2008, LIS eligibility for an individual is determined by income less than $15,600 (150% of poverty) and assets less than $7,790 (amounts are higher for married couples).
[2] U.S. Department of Health and Human Services (HHS), "Medicare Prescription Drug Benefit's Projected Costs Continue to Drop", January 31, 2008 (data as of January 2008).
[3] The CMS estimate of those not enrolled in LIS is down from 3.3 million in 2007, but this primarily reflects an adjustment in the estimated number of eligible beneficiaries from 13.2 million to 12.5 million in 2008.
[4] For more on the impact of enrollment weighting, see "A Closer Look at the Medicare Part D Low-Income Benchmark Premium: How Low Can It Go?" National Health Policy Forum, http://www.nhpf.org/pdfs_ib/IB813_LowIncomeBenchmark_08-02-06.pdf.
[5] CMS Memorandum to All Part D Plan Sponsors and MA Organizations, June 8, 2006.
[6] CMS Memorandum to All Part D Plan Sponsors, August 30, 2006.
[7] Enhanced plans are excluded from the analysis, since they can never be designated as benchmark plans.
[8] A comparison of plans using performance ratings on the Medicare Prescription Drug Plan Finder is limited because ratings are reported at the organization level, not the plan level.
[9] For further discussion of beneficiary-centered assignment, see http://www.medpac.gov/documents/June07_Bene_centered_assignment_contractor.pdf.