Prescription Drug Coverage for Medicare Beneficiaries: A Side-by-Side Comparison of Selected Proposals

Prepared by Health Policy Alternatives, Inc.
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PRESCRIPTION DRUG PROPOSALS IN THE 108th CONGRESS

	Senate Finance Committee (S.1), as reported June 13, 2003	House Ways and Means Committee (H.R. 2473), as reported June 17, 2003
Title of Bill	Prescription Drug and Medicare Improvement Act of 2003	Medicare Modernization and Prescription Drug Act of 2003
General Approach	Voluntary stand-alone drug benefit under Medicare Part D administered by new Center for Medicare Choices in the Department of Health and Human Services (DHHS) and delivered through private risk-bearing entities. Drug benefits integrated with enhanced Part A and B benefits provided by private plans under new Medicare Advantage (Part C). All private plans share risk with government for drug benefit. Interim prescription drug endorsed discount card program (2004-2005) with subsidized card for low-income.	Voluntary stand-alone drug benefit under Medicare Part D administered by new Medicare Benefits Administration in the Department of Health and Human Services (DHHS) and delivered through private risk-bearing entities. Drug benefits integrated with enhanced Part A and B benefits provided by private plans under Medicare Advantage (Part C) or new Enhanced Fee-for-Service (EFFS) plan options (Part E). Interim prescription drug endorsed discount card program (2004-2005) with subsidized card for low-income. Establishes competitive government contribution system (FEHB-style reforms) in 2010 that includes traditional Medicare.
Effective Date	1/1/2006	1/1/2006
Eligibility	Individuals eligible for Part A and enrolled in Part B may enroll in Part D, unless they are eligible for drug benefits through Medicaid.	Individuals entitled to Part A or enrolled in Part B may enroll in Part D.
Benefit Package	All Part D drug plans or Medicare Advantage plans must offer the standard benefit or its actuarial equivalent. Part D and Medicare Advantage plans (except Medical Savings Accounts plans) may also offer richer drug benefits.	All Part D drug plans, Medicare Advantage coordinated care plans and EFFS plans must offer at least the standard drug benefit or its actuarial equivalent. Plans may offer richer coverage.
Monthly Premium	Part D standard coverage – about $35 on average in first year (2006) – based on enrollee's choice of plan. In Medicare Advantage, drug premium calculated in same way but may be offset by savings from other benefits. In general, premiums are deducted from the beneficiary's monthly Social Security check.	Part D standard coverage – about $35 on average in first year (2006) – based on enrollee's choice of plan. In Medicare Advantage and EFFS, premium calculated in same way but may be offset by savings from other benefits. At enrollee option, premiums may be deducted from beneficiary's Social Security check or paid through an electronic funds transfer.
Deductible	$275 (indexed to growth in per capita drug spending by Medicare beneficiaries).	$250 (indexed to growth in per capita drug spending by Medicare beneficiaries).
Cost-Sharing	50% up to initial coverage limit of $4,500; 100% between initial limit and stop-loss threshold; 10% above stop-loss threshold. (Thresholds are indexed.)	20% up to initial coverage limit of $2,000; 100% between initial limit and stop-loss; nothing above stop-loss threshold. (Thresholds are indexed.)
Stop-Loss Threshold Applied to Out-of-Pocket Spending	$3,700 (indexed). After reaching threshold, 90% reimbursement. Excludes payments from other private insurance such as employer retiree health coverage.	$3,500 (indexed). After reaching threshold, 100% reimbursement. Excludes payments from other insurance such as employer retiree health coverage. Higher, income-related threshold for enrollees with incomes above $60,000/individuals and

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		$120,000/couples. Special rules for employer plans (see below).
Government Premium Subsidies for General Medicare Population	About 64% of total premium costs, plus reinsurance for 80% of costs above stop-loss threshold.	Direct premium subsidies of 43%; reinsurance of 30% of benefits in aggregate. Reinsurance payments of 20% for benefits $1,000-$2,000; 80% above stop-loss.
Government Subsidies for Low-Income Population—Premiums	Enrollees with incomes under 135% of poverty (including QMBs, SLMBs, QI-1s,[i] as well as others who do not meet asset test) would receive a full subsidy up to the national weighted average premium (or lowest-cost plan if none was below the national average). Beneficiaries with incomes between 135% and 160% of poverty (no asset test) would receive additional premium subsidies determined on a linear sliding scale.	Enrollees with incomes up to 135% of poverty and who meet asset test would receive a full premium subsidy for standard drug coverage. Those with incomes 135-150% of poverty and who meet asset test would receive additional premium subsidies on a sliding scale. The asset test is indexed to increase annually with inflation.[ii]
Government Subsidies for Low-Income Population—Cost-Sharing	QMBs would have no deductible; 2.5% coinsurance up to the initial limit, then 5% coinsurance to the stop-loss (i.e., the "donut hole") and 2.5% above the stop-loss. SLMBs and QIs would pay 5% coinsurance up to the initial limit, then 10% up to the stop-loss (i.e., the "donut hole") and 2.5% above the stop-loss. All other Part D enrollees with incomes below 160% of poverty would pay a $50 deductible; 10% coinsurance to the initial limit, then 20% to the stop-loss (i.e., "the donut hole") and 10% above the stop-loss. Dual eligibles qualified to receive Medicaid drug benefits continue under Medicaid and are not eligible for Part D.	Enrollees with incomes up to 135% of poverty who meet an asset test (indexed as above) would have no deductible and receive cost-sharing subsidies so that they pay no more than $2 for generics and $5 for brand drugs up to the initial coverage limit. Copayment amounts would be indexed to growth in per capita drug spending by Medicare beneficiaries. No subsidies for costs of drugs between the initial limit and the stop-loss threshold (i.e., the "donut hole"). Dual eligibles qualified to receive Medicaid drug benefits would have drug costs not covered by Medicare paid by Medicaid as a wrap-around benefit.
Role of Private Plans/Traditional Medicare	Benefits provided through private, risk-bearing plans (shared risk with government through risk corridors in first years and reinsurance). Government contracts with private non-risk-bearing entity to provide coverage in areas with fewer than 2 private stand-alone plans.	Benefits provided through private, risk-bearing plans (shared risk with government through reinsurance). Increased risk if necessary to guarantee 2 plan options (one stand-alone drug plan) in each area.
Payments to Drug Plan Sponsors	Part D - government pays plans an amount equal to the monthly approved premium, adjusted for risk and geographic price variations, from a combination of government contribution and enrollee premium. Government shares risk with drug plans through reinsurance (80% of allowable drug costs exceeding the catastrophic threshold) and risk corridors. Drug plans would be required to assume more but not total risk over time. Medicare Advantage plans are paid their premium amounts for drug coverage in a	Part D - government pays plans an amount equal to the monthly approved premium, adjusted for risk. Payment is combination of government premium subsidy and enrollee share of premium. Government also provides reinsurance of 20% for costs $1,000-$2,000 and 80% above stop-loss. Medicare Advantage and EFFS plans receive payments for drug coverage in a similar manner and also receive reinsurance payments.

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	similar manner. They receive the same reinsurance but do not have the risk corridor option for sharing risk.	
Role of Medicaid/State Financing Note: "duals" refers to Medicare beneficiaries also eligible for full Medicaid benefits (including drug coverage)	Medicaid continues to provide drug coverage for those eligible for Medicaid drug benefits. Federal government pays Part B premium costs for QMB eligibles with incomes between 74-100% of poverty for states agreeing to provide drug benefits to duals that meets certain standards (e.g., nominal cost-sharing, can't limit prescriptions, certain Part D requirements). States make eligibility determinations for subsidies and receive enhanced matching rate for associated administrative costs.	Medicare pays first for standard Medicare drug benefits of Medicaid-eligible beneficiaries (state government's obligation phased out). States would be required to maintain Medicaid benefits as a wrap-around to Medicare benefits; states could require that these persons elect Part D drug coverage. States make eligibility determinations for subsidies and receive enhanced matching rate for associated administrative costs.
Formularies	Plans may have a formulary so long as the formulary meets standards. Formularies must include drugs within each therapeutic class. Must have appeals process.	Plans may have a formulary so long as the formulary meets standards. Formularies must include drugs within each therapeutic class. Must have appeals process.
Treatment of Retiree Health Drug Coverage	Employer drug coverage at least actuarially equivalent to Part D coverage and that meets other standards would be eligible for same government subsidy per Medicare enrollee, based on national average premium (risk and geographically adjusted) for standard coverage. Also eligible for reinsurance of 80% of costs in excess of stop-loss threshold (but employer-covered costs do not count towards stop-loss).	Qualified retiree plans with drug coverage at least actuarially equivalent to standard Part D coverage receive subsidies of 28% of costs for coverage above deductible and up to $5,000 in spending per Medicare enrollee. The Administrator may adjust the rate of subsidy so that the subsidies in the aggregate do not exceed what would have been paid through Part D coverage.
Medicare Supplemental Insurance	No new Medigap policies providing drug coverage could be sold, issued, or renewed after January 1, 2006, to an individual enrolled in Part D. Medigap policies A through G must be guaranteed issued without preexisting condition exclusions to those terminating enrollment in Medigap plans with drug coverage (including nonstandard policies) and enrolling in Part D, if application is made during the Part D open-enrollment period. Medigap issuers must provide written notice during the 60 days before the initial Part D open-enrollment period to each policyholder with drug coverage of the ability to switch to a non-drug policy and that they are ineligible for Part D coverage as long as they retain a Medigap policy with drug coverage.	Beginning January 1, 2006, Medigap policies with drug coverage could no longer be sold except as replacements for policies with drug coverage. Beneficiaries with Medigap drug policies who enroll in Part D would be guaranteed issue a non-drug Medigap policy at the time of enrollment. NAIC would define 2 new Medigap packages that would cover some drug cost-sharing and partial coverage of beneficiary costs for other Medicare benefits. Medigap plans (other than the 2 new plans) would be prohibited from covering the deductible or more than 50% of the cost-sharing in an EFFS plan.
Interim Drug Program	Establishes a Medicare Prescription Drug Discount Card Endorsement Program to operate in 2004-2005. Card programs would have to meet specific requirements and charge no more than $25 in annual	Establishes a Medicare Prescription Drug Discount Card Endorsement Program to operate in 2004-2005. Card programs would have to meet specific requirements and charge no more than $30 in annual

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	enrollment fees. Low-income enrollees (QMB, SLMB, QI-1) would receive $600 per year, with balances carried forward on their cards from one year to the next. Government also pays enrollment fee for low-income.	enrollment fees. Low-income enrollees (<150% of poverty who meet asset test) would receive $500 per year, with balances carried forward on their cards from one year to the next.
Financing of Drug Benefit	Financing for the Part D coverage subsidies would come from general federal revenues.	Financing for the Part D coverage subsidies would come from general federal revenues.
Medicare Private Plan Reforms Not Related to Drug Coverage	Renames Medicare+Choice as Medicare Advantage and reforms plan payment method. Increases payments to Medicare Advantage plans beginning in 2006. Adds new Medicare PPO option for plans offering enhanced benefits and covering large regions; limited to 3 PPO plans per region. PPO plans paid in same manner as other MA plans, except have shared risk arrangements in first years.	Renames Medicare+Choice as Medicare Advantage and reforms plan payment method. Increases payments to Medicare Advantage plans (M+C until 2006) beginning in 2004, and moves to a competitive bidding approach by 2010. Establishes Part E with EFFS plans offering enhanced benefits and covering large regions; limited to 3 plans per region. Establishes competitive government contribution system in 2010 that includes traditional Medicare.
Administration	Creates new agency within the Department of Health and Human Services called the Center for Medicare Choices.	Creates new agency within the Department of Health and Human Services called the Medicare Benefits Administration.
CBO 10-year Estimate	$389 billion (CBO, June 18, 2003).	$391 billion (preliminary, based on Chairman's mark, June 17, 2003, as reported by BNA's Healthcare Daily).

[i] QMB, SLMB, and QI-1 refer to categories of Medicare beneficiaries who are not sufficiently poor to meet Medicaid's income and resource eligibility standards for full Medicaid benefits but do qualify for some degree of Medicaid assistance with Medicare cost-sharing. Specifically:

> **QMBs:** Qualified Medicare Beneficiaries. A Medicare beneficiary with an income below 100% of the federal poverty level and with limited assets. Medicaid pays the Medicare Part B premium and all required cost-sharing under Medicare.
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> **SLMBs:** Specified Low-Income Medicare Beneficiaries. A Medicare beneficiary with an income between 100% and 120% of the federal poverty level and with limited assets. Medicaid pays the Medicare Part B monthly premium for these individuals.
>
> **QI-1s**: Qualified Individuals. A Medicare beneficiary with an income between 120% and 135% of the federal poverty level and with limited assets. Medicaid pays the Medicare Part B monthly premium for these individuals. States receive capped allotments for these individuals, so participation may be limited by available funds.

[ii] The asset test is the same as that for QMBs, SLMBs, and QI-1s, generally less than $4,000 per individual/$6,000 per couple, excluding certain items such as a home.

The Henry J. Kaiser Family Foundation

2400 Sand Hill Road
Menlo Park, CA 94025
(650) 854-9400 Fax: (650) 854-4800

Washington Office:
1330 G Street, NW
Washington, DC 20005
(202) 347-5270 Fax: (202) 347-5274

www.kff.org

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