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Changes to Medicare Part D: Who Benefits?

As part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Congress created a new drug benefit—Medicare Part D—that would provide drug coverage for Medicare beneficiaries. In the months that followed enactment of this law, pharmacists were busy educating patients regarding their choice of plan, as many pharmacies advertised that they could help senior citizens select the best plan for them based on their medication history. As of February 2010, 27.6 million Medicare beneficiaries, or 60% of all beneficiaries, received drug coverage under Medicare Part D.¹ Another 31% are covered under programs like TRICARE (military health insurance), Federal Employee Health Benefits Plans (FEHBP), Veterans Affairs, or employer plans, while 9% of Medicare beneficiaries have no drug coverage. Medicare Part D plans vary greatly in benefit design, covered drugs, and utilization management strategies.

Although Medicare Part D has helped many senior citizens and disabled people receive needed medications, the program has also often been criticized because many enrollees are forced to pay large sums out-of-pocket when they reach the coverage gap or “doughnut hole.” The 2010 coverage gap falls between \$2830 and \$6440, an amount easily reached by someone taking an oral anticancer agent. Once an enrollee and his or her plan have paid \$2830 for medications (after the deductible is satisfied), the enrollee is responsible for the next \$3610 or until total costs reach \$6440, the so-called *catastrophic coverage* level. Coverage resumes after this upper expense limit is reached, and the Medicare Part D plan then pays 95% of the drug costs, with the enrollee responsible for 5%. Aside from cancer patients, many of the people who hit the coverage gap take expensive medications to treat diseases like rheumatoid arthritis and anemia.

Medicare Part D plans vary in terms of providing assistance within the coverage gap. Approximately 80% of all plans offer no assistance in the coverage gap, while a small percentage (15%) offer some assistance for generic drugs. However, this is often a limited list of generic drugs.² Medicare enrollees must carefully choose which Medicare Part D plan to enroll in so that they receive as much assistance as possible at the lowest overall cost (including premiums, deductibles, coinsurance, and copayments).

Despite the best efforts of many enrollees to choose the best plan (with or without pharmacist help), an estimated 3.4 million Part D enrollees (representing 14% of all enrollees and 26% of those using prescription drugs that are not eligible for the low-income subsidy) reached the coverage gap in 2007.³ Extrapolating that estimate suggests that 3.9 million Part D enrollees will reach the coverage gap in 2010. The Kaiser Family Foundation also reported that, on average, 15% of those using drugs in 8 select drug classes stopped taking medications in that class on reaching that gap. Considering today’s economy, it is difficult to imagine that more enrollees are not forgoing medicine or reducing doses inappropriately.

The new health care reform law, the Patient Protection and Affordable Care Act (P.L. 111-148), signed into law on March 23 by President Obama,

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and the subsequent changes made by the Health Care and Education Reconciliation Act of 2010 will bring many changes to Medicare Part D that will reduce Part D enrollees' out-of-pocket liability when they reach the coverage gap. In 2010, Part D enrollees who reach the coverage gap will receive a tax-free \$250 rebate. However, for many, this amount will not begin to help them afford medications while in the coverage gap. Fortunately, more help for Part D enrollees is on the horizon in 2011. Beginning in 2011, Part D enrollees who reach the coverage gap will receive a 50% discount on the total cost of brand-name drugs while in the coverage gap. This discount will be paid by pharmaceutical manufacturers; to participate in the Medicare Coverage Gap Discount Program, manufacturers must sign an agreement with CMS to provide the discount on all applicable drugs. Beginning in 2011, only those applicable drugs that are covered under a signed manufacturer agreement with CMS will be covered under Part D.⁴

Part D enrollees' coinsurance in the coverage gap will continue to drop through 2020, when it reaches 25%. Medicare will gradually phase in additional subsidies in the coverage gap, starting in 2013 for brand-name drugs and in 2011 for generic drugs. Brand-name drug manufacturers will provide a 50% discount, and the federal government will provide a 25% subsidy, introduced over 7 years (2013–2020). By 2020, 75% of the cost of generic drugs in the coverage gap will be subsidized by Medicare. These changes to Medicare Part D will greatly help Medicare beneficiaries afford their medications, but what effect will they and other Medicare Part D changes have on employers and pharmaceutical manufacturers?

Part of the Medicare Modernization Act in 2003 was a \$600 tax-free benefit for employers to maintain drug coverage for retired workers, because Congress was worried that these employers would drop coverage, forcing millions of retired workers into Medicare Part D.⁵ The health care reform law includes a provision to trim this corporate tax deduction for retiree drug coverage. The law does not eliminate the subsidy, but starting in 2013, companies can no longer deduct the part of the drug benefit that is paid for by the subsidies. The proposed savings of \$5 billion over the next 10 years are a revenue source to pay for health care reform. Affected companies like AT&T (\$1 billion), Boeing (\$150 million), and Lockheed Martin (\$96 million) are taking the charges now because they maintain that accounting rules require them to book the costs immediately, even if the loss of benefits is spread over several years.⁶ Benefits consultant Towers Watson has estimated that 1400 for-profit companies are affected by the tax change.

Many people are left wondering how many companies will stop offering retiree drug plans and how many additional people will be added to the rolls of Medicare Part D. Navistar International Corporation, a truck and engine maker, plans to drop some retirees' prescription benefits to reduce its costs for retiree benefits and trim its exposure to additional federal taxes by shifting coverage from their insurance to Medicare Part D. Benefit experts estimate that hundreds of other companies will likely follow suit.⁷ If this estimation comes to fruition, the Medicare Part D program will continue to face increasing demands and any savings planned from the tax change will be lost in the addition of Part D enrollees and higher costs in the long term.

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Pharmaceutical manufacturers will be responsible for providing the 50% discount for brand-name medications in the coverage gap, and Avalere Health LLC has estimated that the cost to industry to help close the coverage gap over 10 years could reach \$32 billion.⁸ Nevertheless, pharmaceutical manufacturers also stand to benefit from the changes to Medicare Part D, because the discount should help seniors continue to take their medications through the coverage gap. Furthermore, after the coverage gap, Medicare will resume coverage of drug costs, facilitating continued use of the brand-name medication. Although estimating the total economic burden on pharmaceutical manufacturers from the Medicare Part D changes is difficult, it is feasible to envision that pharmaceutical manufacturers will benefit in the long-term.

Health care reform will bring many changes, both positive and negative, to patients, providers, and pharmaceutical manufacturers. Who stands to benefit from the health care reform changes to the Medicare Part D program? Certainly, enrollees will benefit from the gradual closing of the coverage gap. The effects of these changes on pharmaceutical manufacturers may be negative in the short-term but may well be positive over time. It remains to be seen how these changes will affect employers, retired employees with employer-sponsored drug coverage, and the overall cost and sustainability of the Medicare Part D program itself. Despite doubts about the future, however, pharmacists and other providers may be glad to see these changes take effect because medications will be more affordable to the nation's senior citizens. Further, these changes may offer providers a reprieve from explaining to patients the complex price structure of the "doughnut hole" and needing to discuss how much medication will cost. Ultimately, closing the coverage gap should ensure greater compliance with drug regimens, with less oversight from pharmacists and providers.

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