Looking to the Future of Medicare Part D

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ABSTRACT

BACKGROUND: The future of the Medicare Part D benefit is of concern for all parties who are stakeholders in the health care system. There are a number of issues that are likely to emerge in the coming years that will have a significant impact on the future of Medicare Part D.

OBJECTIVE: To explore some issues that are most likely to affect the future viability of Medicare Part D.

SUMMARY: Medicare is one of the largest and fastest growing federal entitlement programs, and given the rapid increases in the cost of medical care, the long-term viability of the system is an ongoing concern. At the same time, the Medicare Part D marketplace is undergoing rapid change that is likely to continue for some years. While the initial design of Part D was intended to provide a wide choice of drug benefit plans, it is not clear whether the variety of plans will continue as the program evolves from the initial enrollment period. It is probable that the number of stand-alone prescription drug plans (PDPs) will decline as plans consolidate and merge into larger organizations that are better able to compete with the more cost-effective plans. Among the changes that are being investigated by the Centers for Medicare & Medicaid Services (CMS) are the mandatory enrollment of complex patients, such as the disabled, blind, and aged, the introduction of medical savings accounts, and increasing focus on the needs of low-income beneficiaries.

CONCLUSIONS: As the Medicare Part D drug benefit evolves beyond the initial roll out, there are significant concerns about how the benefit will be structured and financed in the future. The financial viability of Medicare is a major concern for all players in this market and financial constraints will continue to drive policy decisions at all levels.


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Introduction

The Medicare Part D benefit was initiated to help Medicare beneficiaries access the prescription drugs they need through privately run health plans. The drug benefit helps enrollees with out-of-pocket drug costs, which is particularly important for those with low incomes, individuals who lack other sources of drug coverage, and those who face catastrophic drug costs. The future of the Medicare prescription drug benefit is a concern for all of those with a stake in the success of the system: this includes the beneficiaries themselves, the federal government, the private plans that are charged with providing the drug benefit to beneficiaries, and the providers, including physicians and pharmacists.

In this section, we look at some issues that are likely to have a significant impact on the future of Medicare Part D. Perhaps most important, particularly in a period of economic uncertainty, is the financial viability of Medicare overall. In addition, as the Part D benefit continues to evolve, plans will re-evaluate strategies in efforts to improve the quality of benefits while increasing the potential for greater revenue. Finally, the Centers for Medicare & Medicaid Services (CMS) is also exploring changes to the Part D system in an attempt to address current gaps and improve quality and efficiency.

Sustainability Issues

The long-term financial viability of Medicare continues to be an issue of significant concern as Medicare is one of the largest and fastest growing federal programs. The combined effects of the high rate of growth in health care costs and emerging demographic trends are presenting a serious challenge to the future fiscal health of Medicare. At present, funding for Medicare Part D comes primarily from general revenues, the premiums paid by beneficiaries, and state payments for dual eligibles who previously received drug coverage under state Medicaid programs. As the U.S. population increases in age, the decreasing ratio of workers to beneficiaries promises to exert significant pressure on Medicare finances.

According to the Medicare actuaries’ most recent estimates (and based on “intermediate” assumptions about future economic and demographic factors and health care costs), annual payments from the Hospital Insurance (HI) Trust Fund will exceed annual income to the Trust Fund beginning in 2011, and by 2019 the Trust Fund will not have sufficient funds to cover the cost of inpatient hospital care and other Medicare Part A services (Figure). While this does not mean that Medicare will be “bankrupt” and unable to pay for Medicare benefits, it does mark the point at which there will be insufficient funds to meet all Trust Fund obligations. This shortfall will continue to accumulate each year unless some adjustment is made that either increases the revenue coming into the Trust Fund or decreases total Trust Fund expenditures.
The coming years. Further, there is uncertainty about what pro-
attract enrollees, they are likely to significantly raise premiums in
(close to 7%), if plans are charging artificially low premiums to
with CMS' projection of the increase in per enrollee drug costs
which could mean that there will be increases in beneficiary
subsidies will be entirely based on average bids for basic benefits,
premium by less than 4% between 2006 and 2007. Compared
average stand-alone prescription drug plan (PDP) increased its
artificially raised subsidies, effectively reducing average premium
sponsors, in 2007, CMS adjusted its computation such that it
premiums is based on an average of the bids submitted by plan
average plan costs. At some point in the future, CMS has indi-
artificially raised subsidies, effectively reducing average premium
is the possibility that some plans are temporarily maintaining
costs to beneficiaries. At some point in the future, CMS has indi-
subsides provided by the CMS. Although the federal contribution to
premiums is based on an average of the bids submitted by plan
sponsors, in 2007, CMS adjusted its computation such that it
artificially raised subsidies, effectively reducing average premium
costs to beneficiaries.3 At some point in the future, CMS has indi-
that will return to the federally mandated system wherein
subsides will be entirely based on average bids for basic benefits,
which could mean that there will be increases in beneficiary
premiums at that time.5
Another factor that could impact future costs of the program
is the possibility that some plans are temporarily maintaining
artificially low premiums to increase their market share. The
average stand-alone prescription drug plan (PDP) increased its
premium by less than 4% between 2006 and 2007.3 Compared
with CMS' projection of the increase in per enrollee drug costs
(close to 7%), if plans are charging artificially low premiums to
attract enrollees, they are likely to significantly raise premiums in
the coming years.3 Further, there is uncertainty about what pro-
portion of employers who are currently providing drug benefits
to retirees will continue to do so in the future. Some may decide
to discontinue drug coverage and begin instead to help retirees
cover Part D premiums. It is argued that it is those employers
whose retirees have the highest drug costs will be the most likely
to shift enrollees to Part D programs, resulting in increases in
average plan costs.3
Fortunately, employer-sponsored health care plans continue
to make a substantial contribution to the health care costs of
Medicare beneficiaries, with 1 in 4 Medicare beneficiaries receiv-
ing retiree benefits from either employer or union-sponsored
plans. It is estimated that 10.3 million beneficiaries receive pre-
scription drug benefits from such plans, while 2.6 million working
beneficiaries have employer plans as their primary health insurance coverage.1 While retiree health benefits are declining overall, the proportion of large companies offering retiree health benefits has fallen by more than half since 1988 (from 66% in 1988 to 35% in 2006); therefore, the Part D drug benefit does not appear to have further accelerated the erosion of employer-sponsored retiree health coverage.1
Ultimately, it will take years before it is clear whether the Part D program is truly sustainable, since future costs of the program (both to beneficiaries and to the federal government) will depend on the actions of numerous players, including plan sponsors, CMS, and the beneficiaries themselves.

Evolving Structures and Strategies
As Medicare Part D evolves, plans are looking at ways to provide
quality benefits while increasing the potential for greater revenue. This translates into the likelihood of significant changes in the
market over the next few years. One of the goals of Part D was
to provide a wide choice of drug benefit plans. While this goal
was met with the availability of many more plans than originally
anticipated, it is not clear whether the wide variety of plans
will continue as the program moves from the initial enrollment
period. For example, it is likely that the number of PDPs will
decline as plans consolidate and merge into larger organizations
that are better able to compete with the more cost-effective plans.4
In addition, analysts predict that as the market consolidates,
enrollees in search of better overall health benefits will migrate
into Medicare Advantage (MA) plans from stand-alone PDPs.4 In
fact, this may have been a strategy for some sponsors: to offer
inexpensive stand-alone PDPs to attract enrollees with a longer-
term plan to shift them into more profitable Medicare managed
care plans, which cover physician and hospital bills, as well as
drugs, and also receive higher payments from CMS for their ser-
services, as determined by local cost benchmarks.5
However, it is uncertain how the ongoing mergers and acquisi-
tions of companies offering MA-PDs will proceed. The Department
of Justice has expressed concern over managed care companies
acquiring too much market share in individual regions, recently
filing suit (and a proposed settlement) to require UnitedHealth
to divest itself of MA assets in order to acquire Sierra Health
Services, a seller of MA plans in the Las Vegas area.6
One potential new area of growth in that field will be in
customized prescription drug plans aimed at employers. As the
sponsors of current Medicare PDP plans develop a better under-
standing of the needs of employers, they will be positioned to
leverage their PDP infrastructure to compete for that segment of
the market with official Medicare plans. Medicare Advantage

FIGURE HI Trust Fund Solvency, 2001–2019

Note: The Medicare Trustees recommend that the HI Trust Fund assets should be
maintained at a level of at least 100% of annual expenditures.

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HI=Hospital Insurance (as in HI Trust Fund).
plans may also begin to see increased interest from employer groups looking for better coverage offerings for their retiree populations.4

**Potential CMS Changes**

In addition to the evolving strategies being advanced by the Part D plans currently providing benefits, CMS is also exploring changes to the Part D system in an attempt to address current gaps and improve quality and efficiency.

**New Populations**

Among the potential developments in the coming years will be the mandatory enrollment of disabled, blind, and aged Medicaid beneficiaries into managed care plans as a means of controlling costs. While this complex group of patients makes up only 16% of beneficiaries in Medicaid, they account for more than 45% of state Medicaid expenditures and may present an opportunity for a new type of special needs plan.7

**Medical Savings Accounts**

One area that is attracting greater attention among plan sponsors is the introduction of Medicare medical savings accounts (MSAs). Authorized in 2003 under the Medicare Prescription Drug, Improvement and Modernization Act (MMA), these accounts provide tax-sheltered investment funds that can be used to cover expenses not covered by Medicare Advantage plans with high deductibles and low monthly premiums. In 2007, 3 MSA plans were offered within Medicare Advantage: 2 are MA-MSA plans and 1 is an MA-MSA Demonstration plan. As of February 2007, 2,238 beneficiaries were enrolled in these plans.8

**Comparative Effectiveness Movement**

A recurring theme in any discussion of Medicare is the importance of improving the value of the health care that it pays on behalf of its beneficiaries. As the costs of paying for benefits begin to outpace financing of the system, Medicare is increasingly turning its attention to not only the overall costs of providing benefits, but to the quality of the care and the outcomes that are achieved. This emphasis on quality is playing out via the implementation of comparative effectiveness initiatives that attempt to provide a “head-to-head” look at drugs, procedures, and devices in an effort to offer guidance on choosing between different therapeutic options.9

As stated in its own strategic plan, CMS stresses the importance of supporting only high-value health care, in part by creating a system in which patients and clinicians are empowered to make informed decisions about the most effective medical care, “based on timely access to the latest evidence, and in a way that delivers the highest value care.”10 This includes promoting the use of secure electronic health records; electronic prescribing; increased system transparency based on immediate, accurate, and comparative quality and cost information; new plan designs and innovative prescription plan approaches; disease management and prevention programs; and value-driven payments.10

However, it is important to acknowledge that comparative effectiveness is only one part of the quality and value decision making process—providers and payers also have to know what additional cost is required for the improved benefit. In other words, cost-effectiveness also must be taken into consideration to prevent the risk of uncontrolled spending in pursuit of the most effective therapy.11

**Focus on Low-Income Beneficiaries**

With nearly half of all Medicare beneficiaries earning incomes that are below 200% of the federal poverty level, the Medicare system is compelled to address the provision of services to low-income beneficiaries. Part D includes substantial assistance for those with low incomes to help cover the costs of plan premiums and cost-sharing (e.g., the costs of copayments, coinsurance, and gap coverage). As of January 2008, it is estimated that 12.5 million beneficiaries are eligible for low-income assistance; of these, CMS estimates that 21% (2.6 million) are not receiving low-income subsidies.12 If beneficiaries are not automatically deemed eligible for low-income subsidies, they must apply through the Social Security Administration (SSA) or their state Medicaid programs. However, because SSA is not required to screen for Medicare Savings Program eligibility and does not automatically refer applicants to state Medicaid agencies, it is possible that beneficiaries may be unaware that they qualify for the Medicare low-income benefits.12

CMS stipulates that all individuals who are eligible for the low-income subsidy (LIS) and who do not choose a plan on their own, will be automatically enrolled in PDPs that have premiums at or below the regional average.13 In addition, Medicare Advantage organizations are charged with identifying both full benefit eligibles to be auto-enrolled and other LIS eligibles who are to be enrolled into a stand-alone PDP.14

From the plans’ perspective, the enrollment of LIS recipients may be viewed either as an opportunity or a liability. A potential incentive for plans that offer premiums at or below the subsidy level is the automatic enrollment of LIS beneficiaries without having to spend additional marketing dollars.3 However, plans may also have reservations about enrolling beneficiaries who can be particularly costly to cover. Although Part D risk provides higher payments for beneficiaries who are eligible for subsidies (8% for those with Medicaid and 5% for other subsidy recipients), it is more difficult for plans to control drug utilization in this population, which pays little or no cost-sharing.3

**Conclusions**

Medicare Part D was initiated to help Medicare beneficiaries access prescription drugs through privately run health plans and stand-alone PDPs. This benefit helps enrollees to reduce out-of-pocket drug costs, which is particularly important for individuals...
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with low incomes, who lack other sources of drug coverage, and those facing catastrophic drug costs.

The long-term financial viability of Medicare is a significant issue. Increasing health care costs and emerging demographic trends present serious challenges to the future fiscal health of Medicare. As the U.S. population continues to age, the decreased ratio of workers to beneficiaries will exert considerable pressure on Medicare finances, which by 2019 will not have sufficient funds to cover the cost of inpatient hospital care and other Medicare Part A services. In addition, future program costs could be affected by other factors, including decreases in the number and scope of privately financed retiree benefits.

As Medicare Part D evolves, plans are constantly assessing how to provide quality benefits while increasing the potential for greater revenue. This could lead to some potentially significant changes in the market over the next few years, including a decline in the number of PDPs, as plans consolidate and merge into larger organizations in order to compete with more cost-effective plans. Additionally, analysts predict that more enrollees will migrate from stand-alone PDPs to MA plans in search of better overall health benefits.

In addition to the evolving strategies being advanced by Part D plans, CMS is exploring changes to address gaps in the current Part D system and to improve quality and efficiency. One of these changes is the mandatory enrollment of disabled, blind, and aged Medicaid beneficiaries into managed care plans to control costs, which may be an opportunity for a new special needs plan. Furthermore, Medicare Advantage organizations are now charged with identifying beneficiaries eligible for low-income subsidies, which from the plans’ perspective, may be viewed either as an opportunity or a liability.

Clearly, the long-term financial viability of Medicare is a major concern for all stakeholders in this market, and these financial constraints will continue to drive policy decisions at all levels. In response, both MCOs and CMS are looking to manage costs more efficiently while continuing to provide quality benefits to enrollees. This undoubtedly will lead to significant structural changes in the future for Medicare Part D.

REFERENCES