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A Closer Look at the Medicare Part D Low-Income Benchmark Premium: How Low Can It Go?

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OVERVIEW — *This issue brief explains how the Medicare Part D low-income benchmark premium is calculated, what factors influence the level of the low-income benchmark premium in any given year, and the implications of the benchmark amount for Medicare drug plans and beneficiaries as it changes from year to year. The paper provides a simplified, two-year example of how the low-income benchmark premium is calculated in order to illustrate the key factors that influence it.*

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Imagine a game of limbo. After each player arches his back to slide under the pole, the announcer of the game lowers the pole another notch and shouts merrily, "how low can it go?" This lowering of the pole may be a suitable metaphor for the low-income benchmark premium under the new Medicare prescription drug benefit (known as Part D). The low-income benchmark premium amount determines how many drug plans are available to low-income Medicare beneficiaries for no or reduced premiums. The low-income benchmark premium has been widely expected by many experts to fall dramatically for 2007. Some have been greatly concerned that as the benchmark falls, fewer drug plans will be able to offer premiums beneath it, causing many low-income beneficiaries to change their drug plans as a result.

The benchmark affects over 9 million low-income Medicare beneficiaries who are placed in or choose among drug plans with premiums at or below this amount. In order to avoid having a large number of low-income beneficiaries change drug plans so soon after enrolling, the Centers for Medicare & Medicaid Services (CMS) announced in June 2006 that it will use its demonstration authority to postpone certain policies and cushion the fall in the benchmark amount for 2007. CMS's action will temporarily and partially stave off what could have been a significant disruption for millions of Medicare beneficiaries.

Without an extension or revision of the demonstration, or a statutory change, many expect the low-income benchmark to fall for 2008. This paper explores the factors that influence the amount of the low-income benchmark premium and offers some insight into whether the low-income benchmark premium will perform like a limbo pole, going lower and lower with fewer drug plans able to slide under it.

BACKGROUND

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) authorized the Medicare program to subsidize a voluntary outpatient prescription drug benefit starting January 1, 2006.[1] This new Medicare drug benefit is provided through private, stand-alone prescription drug plans (PDPs) to beneficiaries in traditional fee-for-service Medicare and through Medicare Advantage-Prescription Drug (MA-PD) plans for beneficiaries enrolled in Medicare managed care.[2]

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Beneficiaries enrolling in a Medicare Advantage (MA) plan receive all health care services, not just prescription drugs, through the plan. Nationwide, there were over 1,400 stand-alone PDPs and almost as many MA plans offering prescription drug coverage to Medicare beneficiaries in 2006. In implementing the drug benefit, CMS has divided the country into 34 PDP regions, and in each of these regions beneficiaries may choose among the many PDPs offered.[3] Most regions had roughly 40 to 45 PDP offerings, with a high of 52 PDPs in Pennsylvania and West Virginia and a low of 27 in Alaska.[4] Employers and unions offering retiree health plans with a drug benefit at least as generous as Medicare's drug benefit and meeting other requirements could also qualify for Medicare subsidies to defray the cost of providing a drug benefit to their retirees.

All PDPs have beneficiary cost-sharing requirements, such as deductibles, co-payments or coinsurance, and monthly beneficiary premiums. And most drug plans have a feature that has become popularly known as the "doughnut hole"—not a sugary breakfast treat, but a gap in prescription drug coverage in which beneficiaries generally pay 100 percent of the drug prices being offered by their plan. In 2006, this coverage gap starts when a beneficiary has incurred $2,250 in total drug spending ($2,400 in 2007) and ends when beneficiary out-of-pocket spending reaches $3,600 ($3,850 in 2007).[5] After reaching that point, catastrophic coverage begins and beneficiary cost sharing is greatly reduced.

Medicare contributes to the cost of the prescription drug benefit for all enrolled beneficiaries, with higher subsidies made on behalf of low-income beneficiaries. Defined as those with incomes below 150 percent of the federal poverty level (FPL), which was equal to $14,700 for an individual in 2006, low-income Medicare beneficiaries receive financial help from Medicare in paying prescription drug plan premiums and cost-sharing amounts. Beneficiaries with the lowest incomes pay no premium, as long as the drug plan they choose has a premium at or below the low-income benchmark premium for the region they live in. As previously stated, the low-income benchmark premium is the average monthly beneficiary premium for all plans in a region (both PDPs and MA-PDs), weighted by each plan's enrollment.[6] The low-income benchmark premium is important for policymakers to understand because it determines the number of drug plans available to low-income beneficiaries for no (or low) premiums. This calculation has the potential to affect millions of people, and the devil is in the details.

Enrollment

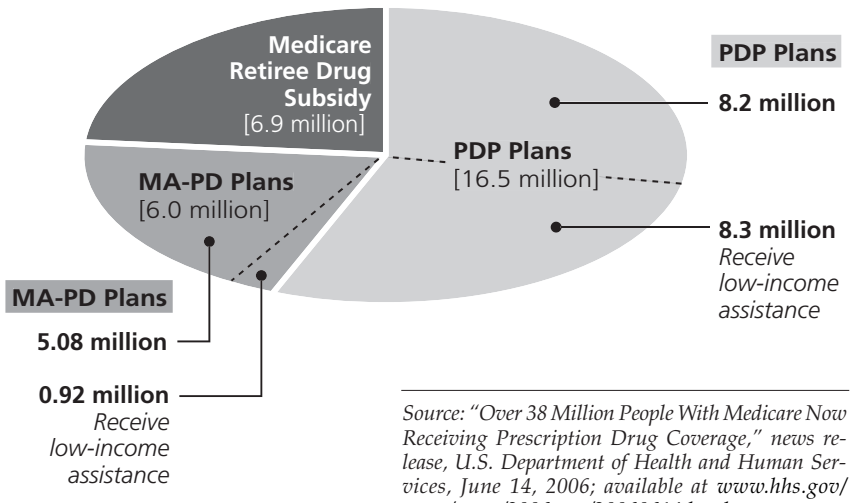
The first opportunity for most Medicare beneficiaries to sign up for prescription drug insurance through Medicare began on November 15, 2005 and ended on May 15, 2006. As of June 11, 2006, about 16.5 million Medicare beneficiaries had enrolled in PDPs and 6 million beneficiaries had enrolled in MA-PD plans. An additional 6.9 million beneficiaries were

receiving prescription drug coverage through a former employer who obtained a Medicare retiree drug subsidy for providing drug coverage.[7]

CMS enrollment figures indicate that enrollment in PDPs and MA-PDs is concentrated in plans offered by a relatively small number of companies. Only five companies account for 65 percent of PDP enrollment. Forty-five percent of Medicare beneficiaries who enrolled in a PDP enrolled in a plan being offered by either UnitedHealthCare-PacifiCare (including plans that are co-branded with AARP) or Humana, Inc. Similarly, enrollment is concentrated in a small number of MA-PDs: 47 percent of MA-PD enrollment is in plans offered by three companies.[8]

Of the roughly 16.5 million beneficiaries enrolled in PDPs, about half of them, or 8.3 million, are receiving low-income assistance during 2006, and almost 1 million of the 6 million beneficiaries enrolled in MA-PDs are receiving low-income assistance (Figure 1, right). There were considerably more low-income beneficiaries enrolled in PDPs in part because dual eligibles (those dually eligible for Medicare and Medicaid) were automatically enrolled (or "auto-enrolled") in PDPs, but not in MA-PDs.

FIGURE 1
Beneficiaries with Drug Coverage Through Medicare
(as of June 11, 2006)



Source: "Over 38 Million People With Medicare Now Receiving Prescription Drug Coverage," news release, U.S. Department of Health and Human Services, June 14, 2006; available at www.hhs.gov/news/press/2006pres/20060614.html.

One group of beneficiaries receiving much attention is the 6.1 million dual eligibles who were auto-enrolled in PDPs (effective January 1, 2006). Before the prescription drug benefit took effect, the dual eligibles received drug coverage through Medicaid. By many accounts, their transition to the Medicare drug benefit was marred by confusion and operational start-up problems. Low-income beneficiaries not dually eligible for Medicare and Medicaid had their enrollment "facilitated" by CMS; that is, they were given the opportunity to choose a plan on their own, but were enrolled in PDPs with lower-than-average premiums as of May 15, 2006, if they had not yet chosen a plan.

Millions of other Medicare beneficiaries receive drug coverage from sources other than PDPs, MA-PDs, and employers who receive the Medicare retiree drug subsidy. For example, about 2 million beneficiaries receive coverage through the Veterans Administration and over 2.5 million active workers receive prescription drug insurance through an employer, according to CMS.

Premiums

Beneficiaries typically pay a monthly premium for Medicare prescription drug coverage.[9] Premiums vary depending on the geographic area in which the beneficiary resides. Monthly beneficiary premiums are determined on the basis of (i) the bids submitted by drug plans and (ii) the average bid from all plans. The beneficiary premium is the national average bid, reduced by the amount the plan's bid is below the average or increased by the amount the plan's bid is above the average. Plans that bid lower have lower beneficiary premiums, and plans that bid higher have higher premiums. There is pressure on plans to bid competitively so that beneficiary premiums are as low as possible, thus attracting enrollment.

In 2006, monthly PDP premiums ranged from a low of $1.87 to a high of $104.89. Enrollment in PDPs is concentrated in plans that have lower premiums. According to CMS, 38 percent of PDPs offered premiums below the national average premium of $32.20, and a large majority of beneficiaries in 2006 enrolled in plans with premiums below the national average.[10] This skew toward participation in low-premium plans is due, in part, to the auto-enrollment of low-income beneficiaries into low-cost plans. The average PDP premium paid by beneficiaries in 2006 was $24.[11] MA-PD drug premiums ranged from $0 to $120.00 in 2006,[12] and enrollment was concentrated in a relatively small number of low-premium plans. Indeed, for 2006, a few plans with very low beneficiary premiums attracted a large share of total enrollment and thus set the stage for a low 2007 benchmark premium.

A Subsidized Medicare Drug Benefit

All beneficiaries—low-income or not—enrolling in a PDP or MA-PD receive a prescription drug benefit that is partially paid for, or subsidized, by Medicare. The real value to beneficiaries of the new drug benefit is that it is subsidized by Medicare, allowing plans to offer benefits at a much lower overall cost to enrollees than they could in the absence of the subsidy.

Medicare makes payments to drug plans, all of which subsidize the cost of providing the benefit, including direct premium and reinsurance subsidies that offset monthly premiums and catastrophic drug expenses for beneficiaries ($32.2 billion in 2006) and low-income subsidies that pay for certain premium and cost-sharing assistance for qualified low-income beneficiaries ($17.6 billion in 2006).[13] These payments to drug plans represent the bulk of Medicare's financial contribution to drug coverage. Medicare also makes payments to plans for certain administrative costs and may make additional payments if benefit costs are much higher than expected, providing some protection for plans from large financial losses.

Despite these significant subsidies to PDPs, Medicare beneficiaries still pay a substantial portion of their drug expenses. The CMS actuary estimates that Medicare will pay about half of the total drug costs (excluding premiums) for a typical, non–low-income beneficiary in 2006. A drug plan may actually pay more or less for an individual, depending on the drug plan chosen, the number of prescriptions filled, and the beneficiary's annual drug spending.

"Extra Help" for Low-Income Beneficiaries

Medicare pays drug plans more on behalf of low-income beneficiaries than non–low-income beneficiaries. The added payment to drug plans defrays the costs of premiums and cost sharing for people with limited means. Medicare and Social Security publications often refer to these payments as "extra help for beneficiaries with limited income and

FIGURE 2
The Low-Income Subsidy: Extra Assistance in 2006 for Beneficiaries with Limited Means

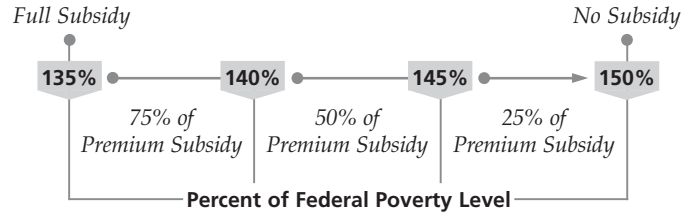
Over 13 million Medicare beneficiaries have annual incomes of less than 150 percent of the federal poverty level *($14,700 for an individual)* and meet certain asset requirements, making them eligible for financial help with their Part D premiums, deductibles, and copays. The amount of assistance available depends on the income and asset levels of the beneficiary.

	BENEFICIARY GROUPS				
	Full Benefit Dual Eligibles*		Non-Full Benefit Dual Eligibles		
Income	≤100% FPL	>100% FPL	<135% FPL		≥135% to 150% FPL
Assets [Individual	N/A†	N/A†	$6,000	>$6,000 *but* ≤$10,000	≤$10,000
Assets [Couple	N/A†	N/A†	$9,000	>$9,000 *but* ≤$20,000	≤$20,000
Premium Subsidy (%)	100%‡	100%‡	100%‡	100%‡	Partial *(see "Sliding Scale")*
Deductible	None	None	None	$50	$50
Copay (generic/brand)§	$1/$3	$2/$5	$2/$5	15% coinsurance	15% coinsurance
Above Catastrophic Limit?¶	No cost sharing	No cost sharing	No cost sharing	$2/$5 copay	$2/$5 copay

Premium Subsidies Taper Off for Dual Eligibles with Larger Incomes

For beneficiaries with incomes at or above 135% FPL and with assets valued above $10,000 *(for an individual, or $20,000 for a couple)*, the amount of premium subsidy decreases. Beneficiaries with incomes at or above 150% FPL receive no drug plan premium subsidy.

Sliding Scale: Partial Premium Subsidies



* *Individuals who are not living in an institution. Institutionalized dual eligibles are exempt from all cost sharing.*

† *Asset tests vary by state for full-benefit dual eligibles.*

‡ *No premium is required if the individual selects a PDP with a premium less than or equal to the low-income benchmark.*

§ *Copayment and deductible amounts are indexed in future years.*

¶ *The catastrophic limit is defined as the point at which an individual has spent $3,600 out of pocket on covered drugs in 2006. Because the beneficiaries described here pay low or no copays or coinsurance, the vast majority will never reach the catastrophic limit.*

Source: CMS-4068-F, Federal Register, *January 28, 2005, 4388–4389.*

resources." As Figure 2 illustrates (previous page), beneficiaries with incomes under 150 percent of the FPL and with assets not exceeding levels set in the statute are eligible to receive subsidized premiums, cost-sharing, or both. Through this low-income subsidy, beneficiaries may have no (or reduced) premiums and annual deductibles, may have lower co-payments or coinsurance, and may have coverage for their prescription drugs in the doughnut hole. The amount of extra financial assistance received depends on the beneficiary's levels of income and assets, his or her Medicaid status, and whether the beneficiary lives in a nursing home.

Beneficiaries with the lowest incomes receive the most assistance paying premiums and cost-sharing amounts. "Full benefit" dual eligibles pay no premiums for plans with premiums at or below the low-income benchmark premium amount. They also pay no deductible, are subject to reduced co-payments[14] ($1 for generic or preferred prescriptions and $3 for non-preferred prescriptions), and are not subject to the coverage gap. Other low-income beneficiaries receive varying levels of assistance paying premiums and cost sharing, depending on their income and assets.

Low-income beneficiaries pay no (or reduced) prescription drug premiums because Medicare makes premium payments on their behalf to PDPs and MA-PDs. These payments are called premium subsidies. Medicare beneficiaries dually eligible for Medicare and Medicaid who have incomes under 135 percent of the FPL and who meet certain asset requirements qualify for a full prescription drug premium subsidy and are often referred to as "full subsidy–eligible beneficiaries." Medicare will pay up to 100 percent of the regional low-income benchmark premium amount to the plan in which the beneficiary is enrolled. Beneficiaries with incomes between 135 and 150 percent of the FPL who meet certain asset requirements are eligible for a partial premium subsidy, determined on a sliding scale based on income and assets. For these beneficiaries, Medicare will subsidize a portion of the premium, not all of it. As of June 11, 2006, about half of beneficiaries enrolled in a PDP and about 15 percent of beneficiaries enrolled in MA-PDs were receiving assistance with payment of premiums and cost-sharing amounts.

These low-income subsidies result in Medicare paying the vast majority—but not all—of the costs of covered drugs for this population. The CMS actuary estimates that, in 2006, Medicare will pay approximately 96 percent of spending for covered drugs for beneficiaries receiving a low-income subsidy, on average. Dual eligibles receive assistance that pays, on average, 98 percent of their covered prescription drug costs in 2006.[15]

Premiums: Above and Below the Low-Income Benchmark

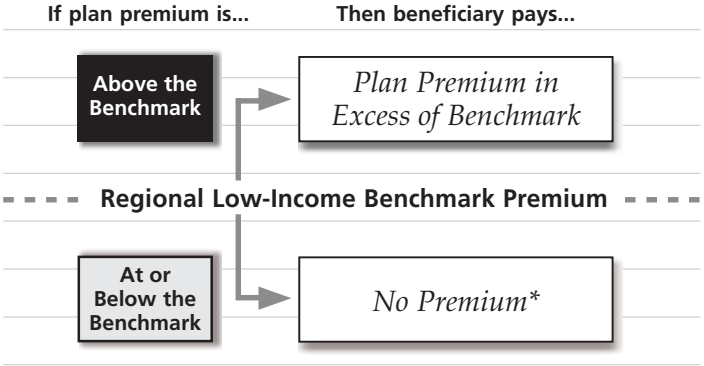
The low-income benchmark premium is the maximum monthly beneficiary premium Medicare will pay for drug plan coverage for beneficiaries who qualify for low-income financial assistance. Most low-income beneficiaries pay no premium for plans that have monthly premiums at or below the low-income benchmark premium.[16]

The low-income benchmark premium amount is the average monthly beneficiary premium for PDPs and MA-PD plans in the region, weighted by enrollment in each plan during a selected month in the previous year.[17] Thus, the premiums for plans with more enrollees have a larger effect on determining the low-income benchmark premium than plans with fewer enrollees. The low-income benchmark premium for 2006 was calculated using a special rule about enrollment weights. Because there was no PDP enrollment in 2005 to include in the calculation, all PDPs were given equal weight. MA plans that had enrollment in 2005 were given the enrollment weight they had in 2005, and new MA plans were excluded from the calculation.

Low-income beneficiaries who were auto-enrolled into a PDP by Medicare were enrolled in plans with basic benefits that had premiums below the low-income benchmark premium. However, beneficiaries are permitted to move to another plan with a premium below the regional low-income benchmark premium at any time during the year. Low-income beneficiaries may also select a plan with a monthly premium above the low-income benchmark premium amount for that region, but he or she is responsible for any premium amount above the low-income benchmark premium (Figure 3, below).

FIGURE 3
What's the Bottom Line?

How much of a drug plan premium is paid by dually eligible beneficiary depends on whether the premium amount for the chosen plan falls above (greater than) or below (less than) the regional benchmark premium.



**Individuals subject to the partial premium subsidy (on a sliding scale basis) will pay a portion of their plan premium, subject to income and asset determinations as described previously.*

In 2006, low-income beneficiaries could choose among about ten PDPs in each region that had premiums below the low-income benchmark premium. The number of PDPs with premiums below the regional low-income benchmark varied depending on where the beneficiary lives. Beneficiary choice of plans at or below the benchmark ranged between 6 and 16 plans, with fewer options for residents of some states (including Alaska and Florida) and more options in others (including Virginia and South Carolina).[18] Low-income benchmark premiums ranged from $23.25 in California to $36.39 in Mississippi.[19]

CALCULATING THE LOW-INCOME BENCHMARK PREMIUM

Although there are 34 different low-income benchmark premiums—one for each region—each is calculated in the same way (see "The Formula," below). Following is a series of illustrations that show how the low-income benchmark premium is calculated in a fictitious region, one that has fewer plans than any real region. The region in these illustrations has 13 PDP sponsors and 5 MA-PD sponsors. The first illustration shows an example of how the calculation works in the first year the drug benefit is available (Figure 4, next page). Two other illustrations (Figures 5 and 6, pages 12 and 13, respectively) show options for what could happen when some of the parameters change in year 2.

Determining the Benchmark in Year 1

Figure 4 shows a greatly simplified example of the first year's benchmark calculation, designed to convey the concepts involved and highlight the factors most relevant to the real calculation. Because this is for year 1 of the new benefit, and there was no actual enrollment in PDPs in the previous year, all PDPs were given the same enrollment weight; MA-PD plans were given weights reflective of enrollment they had in the prior year.

The Formula

The low-income benchmark premium is an average of all the plans' premiums, weighted according to how many beneficiaries have enrolled in the previous year in a given plan. Each sponsor (PDP or MA-PD) offers a plan, and the premium amount for that plan is used in this calculation. The calculation is as follows:

The dollar amount of the premium is multiplied by the percentage of all beneficiaries who have enrolled in that plan.

The product—the dollar amount times the percentage—represents the plan's share of the weighted premium.

Amount of Premium X **Percentage of Beneficiaries Enrolled** = **Share of Weighted Premium**

The weighted share for each plan sponsor is added to the others, and this total amount of weighted premiums is the benchmark amount.

Each plan's relative weight is calculated and all of the relative weights are added together; the sum is the low-income benchmark premium, which in this example (Figure 4) is $24.18. There are ten plans with premiums below $24.18: five PDPs and five MA-PDs. Beneficiaries who qualify for a full premium subsidy in this region could enroll in any of these ten plans and pay no monthly premium. Auto-enrolled beneficiaries would be randomly

FIGURE 4
Calculating the Benchmark in Year 1

First Calculation — This illustrative example assumes that each sponsor offers only one plan and enrollment for MA plans is based 2005 data. Note that all PDP plans are given equal weight in the calculation because there was no enrollment in these plans before year 1.

Determining the Benchmark in Year 1

Plan	Year 1 Premium ($)	X	Plan Enrollment (% of Beneficiaries Enrolled)	=	Plan Share of Average Weighted Premium
PDP	59.00		6		3.54
PDP	42.00		6		2.52
PDP	37.00		6		2.22
PDP	34.00		6		2.04
PDP	34.00		6		2.04
PDP	32.00		6		1.92
PDP	31.00		6		1.86
PDP	30.00		6		1.80
PDP	24.00		6		1.44
PDP	24.00		6		1.44
PDP	19.95		6		1.20
MA-PD	18.00		6		1.08
MA-PD	12.00		3		.36
PDP	10.00		6		.60
PDP	2.00		6		.12
MA-PD	.00		2		.00
MA-PD	.00		1		.00
MA-PD	.00		10		.00
Low-Income Benchmark Premium					$24.18

Year 1

Low-income
BENCHMARK = $24.18

assigned to one of the five PDPs below the benchmark, although they could change plans if they prefer another. Beneficiaries who qualify for a partial premium subsidy would have a portion of their premium paid by Medicare on a sliding scale; they would be responsible for what is not paid by Medicare. (And if they chose any of the other eight plans above the benchmark level, they would also be responsible for any amount of premium above $24.18.)

A Moving Target: Year 2 Changes to the Market and the Low-Income Benchmark

The Medicare drug plan market is expected to evolve over time, as plans update their business models and some plans enter or leave the market. These kinds of changes are not unexpected. In fact, it was assumed that the low-income benchmark premium would change every year as these factors and beneficiary premiums and plan enrollment vary.

In this fictitious region, the market has shifted such that the following changes have occurred for year 2:

- Two plans with premiums above the low-income benchmark drop out of the Medicare market
- Plans increase their premiums[20]
- First-year enrollment is concentrated in a few plans with relatively low premiums

These factors alone can affect the low-income benchmark premium. The following two options compare the low-income benchmark premium calculated according to the statute and under the CMS demonstration program. Figures 5 and 6 show two options, respectively, for what could happen to the low-income benchmark premium calculation in year 2 without the demonstration and with the demonstration.

Without demonstration — In this option (Figure 5, next page), the benchmark premium falls from $24.18 in year 1 to $17.37 in year 2. Low-income beneficiaries qualifying for the full premium subsidy and not wishing to pay a premium would have a choice of two PDPs, rather than five. The three PDPs that are no longer available premium-free accounted for 22 percentof the total enrollment in year 1; many of those beneficiaries could have been dual eligibles who were auto-enrolled by Medicare. Assuming that all five PDPs with premiums under the benchmark in year 1 had the same number of auto-enrolled dual eligibles, more than half of dual eligibles in this fictitious region would need to be switched to new PDPs.

It is worth noting again that this example is designed to be instructive about the key factors that affect the low-income benchmark, but it is not meant to be predictive. Although the benchmark would drop significantly

absent the demonstration, the exact magnitude of the change is not known. However, it is clear that a significant drop in the benchmark premium amount would mean that a substantial number of low-income beneficiaries would need to change drug plans.

FIGURE 5
The Year 2 Benchmark Calculation: Option 1

Premium weighted — In year 2, without the demonstration authorized by CMS in June 2006, the benchmark was to be recalculated every year to reflect changing premium amounts and shifting enrollment. Here, the substantial enrollment in very low-premium PDP plans—coupled with the two plans leaving the market altogether and several plans increasing their premiums—effectively "drags down" the low-income benchmark premium amount in year 2. Note that the fictional parameters used here are for illustrative purposes only, and are not intended to predict what might happen in any given year.

Without Demonstration in Year 2

Plan	Year 2 Premium ($)	X	Year 1 Plan Enrollment (% of Beneficiaries Enrolled)	=	Plan Share of Average Weighted Premium
PDP	*leaves program*		—		.00
PDP	45.00		1		.45
PDP	40.00		2		.80
PDP	39.00		1		.39
PDP	33.00		12		3.96
PDP	35.00		4		1.40
PDP	34.00		4		1.36
PDP	*leaves program*		—		.00
PDP	28.00		5		1.40
PDP	27.00		6		1.62
PDP	23.00		11		2.53
MA-PD	21.00		1		.21
MA-PD	16.00		4		.64
PDP	15.00		13		1.95
PDP	3.00		22		.66
MA-PD	.00		2		.00
MA-PD	.00		2		.00
MA-PD	.00		10		.00
Low-Income Benchmark Premium					$17.37

Year 1
Low-income
BENCHMARK = $24.18

Year 2
Low-income
BENCHMARK = $17.37

With demonstration — In this second option (Figure 6, below), the hypothetical regional low-income benchmark premium increases slightly from $24.18 to $24.49 (rather than falling to $17.37, as in the first example). As a result, there are three PDPs and five MA-PDs with premiums below the benchmark, and beneficiaries in these plans would be able to remain in them unless they choose to enroll in a new plan.

FIGURE 6
The Year 2 Benchmark Calculation: Option 2

Premium weighting postponed — This second example uses the same changes in plans and premiums as in the previous example (see "Option 1," page 12) to show the effects of the CMS demonstration in which the plan enrollment would be kept the same among all PDPs for purposes of the calculation to stabilize the low-income benchmark premium amount. Indeed, using the same enrollment percentage for each PDP results in nearly identical benchmark premiums from year 1 to year 2. Note that the fictional parameters used here are for illustrative purposes only, and are not intended to predict what might happen in any given year.

With Demonstration in Year 2

Plan	Year 2 Premium ($)	X	Plan Enrollment (% of Beneficiaries Enrolled)	=	Plan Share of Average Weighted Premium
PDP	*leaves program*		—		.00
PDP	45.00		7		3.15
PDP	40.00		7		2.80
PDP	39.00		7		2.73
PDP	33.00		7		2.31
PDP	35.00		7		2.45
PDP	34.00		7		2.38
PDP	*leaves program*		—		.00
PDP	28.00		7		1.96
PDP	27.00		7		1.89
PDP	23.00		7		1.61
MA-PD	21.00		7		1.47
MA-PD	16.00		3		.48
PDP	15.00		7		1.05
PDP	3.00		7		.21
MA-PD	.00		2		.00
MA-PD	.00		1		.00
MA-PD	.00		10		.00
Low-Income Benchmark Premium					$24.49

Year 2
Low-income
BENCHMARK = $24.49

Year 1
Low-income
BENCHMARK = $24.18

Other Considerations of the Demonstration

Although the demonstration will likely prevent a huge fall in the benchmark amount, the low-income benchmark may fall modestly for 2007. This could be attributed to many factors, most notably the inclusion of zero-premium MA plans in the calculation and the possibility that some of the higher-premium plans in the market will leave the Medicare program.

Absent a statutory change, CMS will eventually be required to move to a weighted average calculation. It is also possible that CMS will use its demonstration authority to phase in the weighted average over several years. Leaving the premiums unweighted for another year (or phasing the weighting in over several years) will likely have budgetary effects. Medicare will pay more in low-income subsidies for 2007 than it would have in the absence of the demonstration. Although there is a cost associated with the demonstration, there will also be budgetary savings from 2006 premiums that were lower than expected. CMS indicates that Medicare Part D will cost $34 billion less for 2006–2011 than had been projected in the President's budget in February 2006, and $110 billion less than projected in July 2005.[21]

CMS has also announced that plans with premiums below the regional low-income benchmark in 2006 but up to $1.00 above the low-income benchmark for 2007 will be permitted to charge low-income beneficiaries a premium equal to the low-income benchmark premium amount. This so-called "de minimus" premium policy prevents low-income beneficiaries from being moved out of a plan when the plan premium is just pennies above the low-income benchmark amount.

The Role of MA-PDs in the Benchmark Calculation

It is worth highlighting the effect of including the MA-PD premiums in the calculation of the low-income benchmark premium. MA-PD plans in some geographic areas are able to offer drug coverage with premiums considerably below premiums offered by PDPs. Nearly 40 percent of MA-PDs include prescription drug coverage for no additional premium.[22] This is because MA plans may—and do—use any excess payments from providing other Medicare services to cover the cost of prescription drug coverage, thus "buying down" the monthly beneficiary drug premium. Including these, often lower, MA-PD premiums in the calculation generally drives the low-income benchmark premium amount below what it would be if only PDP premiums were included in the calculation. This effect occurs regardless of whether or not a weighted average is used in the calculation of the low-income benchmark. The more MA plans in a region, the greater the effect. If enrollment in MA plans grows substantially over time, the effect of including their premiums would also grow.

Today, the effect of MA-PD premiums on the low-income benchmark premium calculation is slight, except perhaps in California. The regional low-income benchmark premium amount for California is $23.25 for 2006, the lowest in the nation. California has very high MA penetration and relatively low MA premiums, both of which contribute to its region's benchmark premium amount being lower than other regions.

Some experts believe that there will be fewer PDPs available for no premium to full subsidy–eligible beneficiaries if MA-PD penetration grows substantially over the coming years. However, the MMA does contain a provision stipulating that low-income beneficiaries eligible for a full premium subsidy always have at least one PDP available with no premium. If the low-income benchmark premium is lower than the lowest-premium PDP in the region, then the amount of premium assistance will equal the premium of the lowest-premium PDP. This ensures that low-income beneficiaries who qualify for the full premium subsidy always have access to at least one PDP with no premium.

KEY ISSUES

Looking toward the open enrollment period for 2007, which begins on November 15, 2006, a number of key issues will be of interest to policymakers.

- ***Will low-income beneficiaries have fewer choices of plans with premiums below the low-income benchmark premium in 2007?***

  There may be a slight reduction in the number of plans, but probably not a significant change. The demonstration program announced by CMS in June 2006 will minimize significant erosion of the benchmark premium amount.

  Several other factors may somewhat decrease the number of PDPs available in 2007. Some sponsors may pull out of the Medicare drug market for lack of enrollment, or for other business reasons. It is possible that others may not have their contracts renewed by CMS for failing to meet 2006 contract terms and conditions. In addition, most PDP sponsors will offer no more than two plan options in each region for 2007, unless a third plan option offers coverage that is much different from the two options already offered, such as coverage in the doughnut hole. Finally, many experts expect some market consolidation in future years. In all of these cases, if the plans that pull out of the Medicare market have generally higher-than-average premiums, the effect will be to lower the average premium and the low-income benchmark.

- ***Are plan sponsors likely to change their business strategies to try to offer premiums below the low-income benchmark premium for 2007?***

  Plans are likely working off of business models that may or may not need to be adjusted in light of experience and actual data gathered in 2006. For many plans, having dual eligibles auto-enrolled is important

to their business strategy. Indeed, for some plans, the dual eligibles represent a large percentage of their total Medicare business. The additional payment for dual eligibles is an added incentive for some plans to seek to enroll them. In addition, marketing costs are lower for dual eligibles because of auto-enrollment.

Some companies offering plans with premiums above the low-income benchmark premium in 2006 may attempt to price their premiums below what they estimate the benchmark will be for 2007. Other companies may price their premium to be more competitive with lower premium plans in an effort to boost enrollment, but this may be a difficult feat in the Medicare drug plan market.

Because 2007 plan bids had already been received by CMS when the demonstration project was announced in June 2006, CMS will permit plans to modify their bids. It is not yet clear whether these updated bids will result in higher premiums.

PDP and MA-PD premiums paid by non–low-income beneficiaries are expected to increase for 2007, complicating business strategies even further. In addition to the routine premium increases attributable to drug ingredient price growth, pharmacy costs, benefit management factors, or other issues, many experts believe that overall beneficiary premiums will increase because of a change in the way the monthly beneficiary premium will be calculated for 2007 and beyond. The 2006 monthly premium was calculated using a national average bid that was generally unweighted by enrollment of beneficiaries into different plans, similar to the calculation for the low-income benchmark premium. For 2007, the monthly beneficiary premium will be calculated using a weighted average of plan bids, unless CMS takes action to postpone or mitigate this effect. Because a large portion of enrollment is concentrated in a few low-premium plans, the net effect may be to lower the average premium. If the average premium is lower, beneficiary premiums for some plans will increase because the beneficiary premium is determined in part by the difference between a plan's bid and the average bid.[23] The effects of this expected premium increase in light of the low-income benchmark premium demonstration are unclear.

- ***Will the low-income benchmark premium fall for 2008, resulting in a large number of low-income beneficiaries switching drug plans at that time?***

  It is too early to tell. CMS has not yet indicated whether the demonstration program will operate for more than one year, or whether a phase-in of the weighted average will occur. To heighten competition and to encourage plans to offer low premiums, moving to a weighted average is perhaps preferable. A statutory change would be needed to permanently change the weighting methodology. Statutory changes could include a phasing-in of the enrollment weighting to avoid a precipitous drop in the low-income benchmark premium while moving toward a weighted premium.

CONCLUSION

The low-income benchmark premium calculation is a very technical Medicare drug benefit issue, but it is important to understand this calculation and the key factors that influence it because millions of beneficiaries are affected by it. Several key factors influence the level of the low-income benchmark premium amount in any given year, including PDP and MA-PD beneficiary premiums and enrollment levels in individual plans. Beneficiaries will choose plans based on premiums and other factors including plan formularies, familiarity with the company offering the plan, and co-pay amounts. The corporate strategies of plans also come into play. All of these and other factors influence the level of the low-income benchmark premium for 2007 and beyond. The ultimate success of the Medicare drug benefit will be measured, in part, by the reliability of the program for low-income beneficiaries. The level and stability of the low-income benchmark premium over time is an imporant contributor to that reliability, and to the overall success of Medicare Part D.

ENDNOTES

1. See Dawn M. Gencarelli, "The Basics: Overview of the New Medicare Prescription Drug Benefit," National Health Policy Forum, June 21, 2005; available at www.nhpf.org/pdfs_basics/Basics_MMA.DrugBenefit.pdf.

2. MA-PD plans include private fee-for-service plans (which are not required to offer prescription drug coverage) and special needs plans. Some beneficiaries may also receive drug coverage through the Program of All-Inclusive Care for the Elderly (PACE), which provides comprehensive health benefits for dual eligibles in certain geographic areas.

3. Each of the 34 PDP regions includes at least one state. MA regions overlap PDP regions but are not entirely the same.

4. Jack Hoadley, "Medicare's New Adventure: The Part D Drug Benefit," The Commonwealth Fund, March 2006, 7; available at www.cmwf.org/usr_doc/Hoadley_medicaresnewadventure_911.pdf.

5. Some drug plans pay for drugs in this coverage gap, but usually for generic drugs only.

6. Enrollment figures from a specified month in the preceding year are used.

7. "Over 38 Million People With Medicare Now Receiving Prescription Drug Coverage," news release, U.S. Department of Health and Human Services, June 14, 2006; available at www.hhs.gov/news/press/2006pres/20060614.html.

8. Centers for Medicare & Medicaid Services (CMS) enrollment figures as of April 27, 2006; available at www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp.

9. Some MA plans offer $0 premiums for prescription drugs, or for all medical benefits.

10. Mark B. McClellan, "Implementation of the Medicare Prescription Drug Benefit," testimony before the U.S. House of Representatives, Committee on Ways and Means, Subcommittee on Health, May 3, 2006, pp 23-24; HTML version available at www.hhs.gov/asl/testify/t060503a.html.

11. "Over 38 Million People With Medicare," June 14, 2006.

Endnotes / continued ➤

Endnotes / continued

12. Medicare Payment Assessment Commission (MedPAC), *Increasing the Value of Medicare*, June 2006, 164; available at www.medpac.gov/publications/congressional_reports/Jun06_EntireReport.pdf. The range includes premiums for basic and enhanced benefits but excludes demonstration programs, 1876 cost plans ("cost contracts"), and plans offered in the U.S. Territories.

13. *2006 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, May 1, 2006, 151; available at www.cms.hhs.gov/ReportsTrustFunds/.

14. Dual eligibles residing in nursing homes pay no copays. However, they must contribute the bulk of their income (minus a monthly "personal needs" allowance) to the cost of nursing home care.

15. CMS-4068-F, *Federal Register*, January 28, 2005, 4465.

16. Low-income beneficiaries are responsible for a portion of the premium for a drug plan with extra or enhanced benefits, even if the premium for that plan falls below the regional low-income benchmark amount.

17. Premiums for the following types of plans are included in the low-income benchmark premium calculation: basic plans, the portion of the monthly drug premium attributable to basic coverage for PDPs offering alternative coverage, and monthly beneficiary prescription drug premiums for MA-PDP plans. The premiums for cost contracts, private fee-for-service plans, and PACE plans are excluded. There are also rules for the treatment of late enrollment penalty payments.

18. Hoadley, "Medicare's New Adventure."

19. CMS, "2006 Low-income Premium Subsidy Amounts," note to Medicare Advantage organizations, Prescription Drug Plan sponsors, and other interested parties, August 9, 2005.

20. Some analysts predict that, unless there are methodological changes by CMS, the national average premium will rise significantly for 2007, having the effect of raising beneficiary premiums more than is indicated in our illustration.

21. CMS, "Medicare Part D Spending Projections Down Again, Part A and Part B Increases Highlight Need for Further Reforms," fact sheet, July 11, 2006; available at www.cms.hhs.gov/apps/media/press/release.asp?Counter=1895.

22. MedPAC, *Increasing the Value of Medicare*, 146.

23. See endnote 20.

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