The Medicare Drug Benefit:
Options for Low-Income Californians in 2008

California HealthCare Foundation

FACT SHEET

Overview

At the end of 2007, approximately 500,000 low-income Californians participating in the Medicare Part D drug benefit were re-assigned to a different plan by the Center for Medicare & Medicaid Services (CMS). The reassignment was done without regard to the drugs a beneficiary was using or differences in drug coverage among these plans, including whether their prescriptions would continue to be covered under the new plan. This change has important implications for low-income Medicare beneficiaries in California, as there are often sizeable and important differences among the nine prescription drug plans to which these beneficiaries were reassigned.

While the opportunity for higher income Medicare beneficiaries to enroll in a Medicare Part D prescription drug plan or switch plans for 2008 ended on December 31, 2007, beneficiaries who are eligible for the full low-income subsidy can change plans throughout the calendar year. These beneficiaries should carefully examine their options and consider whether to enroll in a different plan based on their specific drug needs—as well as factors not reflected here, such as the location of pharmacies that accept the plan—before deciding what is best for them.

Part D Benefits for Low-Income Beneficiaries

Of the 4.4 million Medicare beneficiaries in California, approximately 1.1 million qualify for a full or partial subsidy for their prescription drug coverage.[1] Known as the low-income subsidy, or LIS, it is available to two groups: Those who qualify for both Medicare and Medicaid, a population referred to as dual eligibles, and certain other low-income beneficiaries earning less than 150 percent of the federal poverty level ($15,315 for an individual), provided they do not have assets above specified levels (Table 1).

These subsidized premiums are for beneficiaries who enroll in a basic prescription drug plan, or "PDP," that charges no more than $1 above the benchmark level for their region.[2] All low-income beneficiaries, regardless of the amount of subsidy

Table 1. Low-Income Beneficiary Tiered Subsidy Levels, 2008

INCOME AND ASSETS CRITERIA	PREMIUM	DEDUCTIBLE	DRUG CO-PAYS	COVERAGE GAP
Income up to 100% of the federal poverty level (FPL) *and* a dual eligible	None	None	$1.05 generic / $3.10 brand; none after $5,726.25	None
Those eligible for Medicare Savings Programs and individuals with incomes; up to 135% FPL and assets of less than $7,790 (individual) or $12,440 (couple)	None	None	$2.25 generic / $5.60 brand; none after $5,726.25	None
Income from 135 to 150% FPL and assets of less than $11,990 (individual) or $23,970 (couple)	Sliding scale from 25% to 75% of premium	$56	15% of cost; $2.25 generic / $5.60 brand after $5,726.25	None
Over 150 percent FPL	Varies by PDP	$275	25% of cost; 5% after $5,726.25	Yes (between $2,510 and $5,726.25)

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they receive through the LIS program, are required to pay the full price for any drug not covered by their plan.

Assignment into Medicare Part D Plans

Prior to the implementation of Medicare Part D, dual-eligible beneficiaries received coverage for prescription drugs through Medicaid. Benefit policies varied by state, so dual eligibles had better coverage in some states than others. Low-income Medicare beneficiaries who did not qualify for Medicaid could either purchase private Medigap coverage or enroll in a Medicare Advantage (formerly Medicare+Choice) plan that included prescription drug coverage, or enroll in pharmaceutical manufacturer patient assistance programs or state pharmacy assistance programs, where available.

In January 2006, dual-eligible beneficiaries were required to switch to Medicare Part D to continue receiving drug benefits. To prevent disruptions in coverage and to ensure all dual eligibles were enrolled in a Medicare drug plan, CMS automatically assigned these beneficiaries into qualifying PDPs. Today, CMS continues to automatically assign Medi-Cal beneficiaries when they become eligible for the Medicare program. However, these new enrollments are done on a random basis, and the assignment process does not take into account a particular beneficiary's drug needs or the differences in coverage among the nine qualified plans whose premiums fall below the LIS benchmark.

Among beneficiaries already enrolled in Part D, CMS automatically re-assigns individuals eligible for the full low-income subsidy into new plans in two situations: they are enrolled in a plan that left the Medicare program, or they are enrolled in a plan that raised premiums more than $1 above the low-income benchmark. Re-assignment is conducted by CMS to ensure that these beneficiaries do not have to pay a premium. At the end of 2007, CMS re-assigned over 500,000 Californians into new PDPs for calendar year 2008.[3] Approximately 400,000 of these beneficiaries were re-assigned into plans offered by different company sponsors, and 100,000 beneficiaries were re-assigned into a plans offered by the same company sponsor.[4]

CMS does not automatically re-assign beneficiaries who are eligible for the partial low-income subsidy. It also does not re-assign full-subsidy beneficiaries who actively switched from their assigned plan to another PDP, even if that plan is no longer eligible for the full premium subsidy because its premiums have risen above the benchmark limit. Nearly 100,000 Californians eligible for the full subsidy are expected to have made such a switch; instead of re-assigning these beneficiaries, CMS sent them a letter that explained that their current plan is no longer eligible for the full premium subsidy. Should they want to avoid paying a share of the monthly premium, they must switch into one of the nine plans in California that have qualified for the full subsidy in 2008.

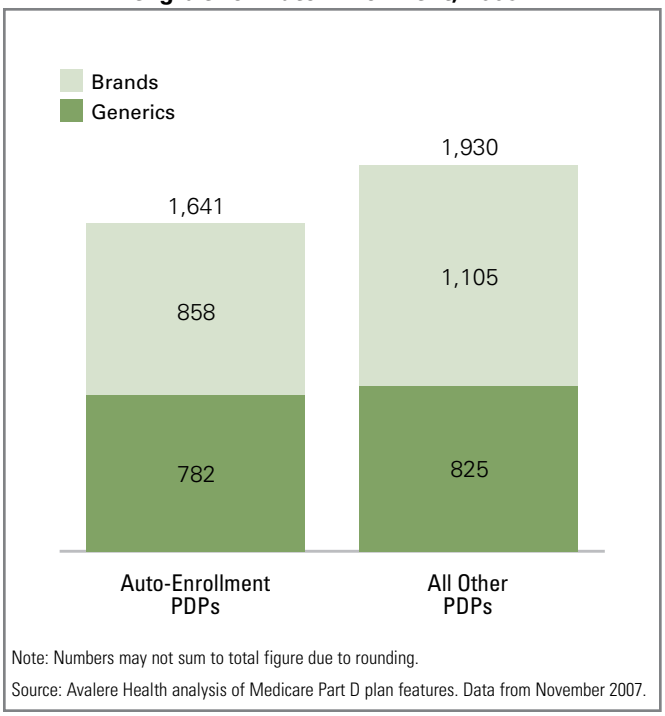
Variation in Coverage among Drug Plans

Formulary and Cost Controls

To better frame the choices available to California Medicare beneficiaries eligible for the full premium subsidy, this analysis examines differences among the nine qualified PDPs, known formally as "Auto-Enrollment PDPs." It also compares these nine plans with the 47 PDPs that do not qualify for the full premium subsidy.[5] For this analysis, the number of drugs covered in a given Part D plan is compiled by counting brand name drugs and their generic equivalents separately. For example, Zocor and its generic simvastatin are counted as two separate drugs. Drug form and dosage are not taken into account in the aggregate drug counts reported here.

The nine Auto-Enrollment PDPs cover fewer drugs, on average, than the plans that do not qualify (Figure 1). Auto-Enrollment PDPs cover 1,641 drugs compared to 1,930 drugs for all other Part D plans. This difference is primarily due to variations in coverage for brand name drugs: Auto-Enrollment PDPs cover 29 percent fewer brand name drugs, on average, than other PDPs.

Figure 1. Number of Covered Drugs in California's Auto-Enrollment Plans Compared with Plans Ineligible for Auto Enrollment, 2008



Note: Numbers may not sum to total figure due to rounding.

Source: Avalere Health analysis of Medicare Part D plan features. Data from November 2007.

Among the nine Auto-Enrollment PDPs, there is also substantial variation in prescription drug coverage (Table 2). The number of covered drugs ranges from 1,121 to 2,153. The differences are greater for brand-name drugs than generic drugs. For example, the Auto Enrollment plan that covers the highest number of brand-name drugs (1,285) provides more than twice as many as the plan that covers the least (541). Plans also apply different cost controls, such as prior authorization (required for 10 to 21 percent of covered drugs) and quantity limits (placed on 2 to 22 percent of covered drugs). Plans that cover above-average number of drugs tend to impose a greater number of quantity limits than those plans with a smaller number of covered drugs. Step therapy—requiring the use of a generic before a brand-name medication is prescribed—is applied to a very small percentage of covered drugs across plans.

Coverage of 100 Most Commonly Used Drugs

This analysis also found important similarities and differences among the nine Auto-Enrollment PDPs in their coverage for 100 drugs most commonly used by dual-eligible beneficiaries. Since there is no recent, publicly available list of these drugs from CMS, the results presented here are based on a list of the most commonly prescribed drugs to dual-eligible beneficiaries generated in 2006 by the Office of the Inspector General (OIG) from data collected in 2005 (prior to the implementation of Part D), and 2006 Medicare plan finder data.[6]

Table 2. Formulary Comparison of PDPs Eligible for Auto Enrollment, Coverage of Commonly Prescribed Drugs, 2008

	NUMBER OF DRUGS ON FORMULARY			PERCENTAGE OF DRUGS WITH…		
PLAN NAME	TOTAL	BRANDS	GENERICS	PRIOR AUTHORIZATION	QTY LIMITS	STEP THERAPY
Advantage Star Plan	1,370	748	622	20%	2%	1%
Blue Cross Medicare Rx Value	1,829	914	915	11%	15%	0%
Bravo Rx	1,611	810	801	10%	14%	~0%
First Health Part D Premier	1,592	853	739	18%	22%	2%
Health Net Orange Option 1	2,153	1,285	868	21%	15%	~0%
HealthSpring PDP	1,455	771	684	12%	9%	~0%
MedicareRx Rewards Standard	1,816	901	915	11%	14%	0%
MedicareRx Rewards Value	1,818	903	915	11%	14%	0%
WellCare Classic	1,121	541	580	13%	4%	~0%
Average	**1,641**	**858**	**782**	**14%**	**13%**	**~0%**

Source: Avalere Health analysis of Medicare Part D plan features. Data from November 2007.

On average, the nine Auto-Enrollment PDPs cover 96 of the top 100 most commonly used drugs prescribed to dual-eligible beneficiaries on their formulary (Table 3).[7] Among these PDPs, coverage ranges from 89 to 99 percent. The application of cost control mechanisms also varies. For example, one Auto-Enrollment PDP does not require prior authorization on any of the most prescribed drugs to dual eligibles, while another requires prior authorization on 11 percent of covered drugs. There is also substantial variation in the percentage of drugs that require quantity limits (1 to 44 percent). Auto-Enrollment PDPs impose quantity limits with greater frequency among the 100 most commonly prescribed drugs than overall (28 percent and 13 percent, on average, respectively). Very few drugs require step therapy, although it is more common among this group of medications than overall.

Table 3. Coverage of 100 Commonly Used Drugs, by Dual Eligibles, 2008*

	NUMBER	PERCENTAGE		
PLAN NAME	ON FORMULARY	PRIOR AUTHORIZATION	QTY LIMITS	STEP THERAPY
Advantage Star Plan	97	4%	1%	6%
Blue Cross Medicare Rx Value	99	2%	32%	0%
Bravo Rx	92	7%	34%	2%
First Health Part D Premier	98	11%	44%	5%
Health Net Orange Option 1	96	4%	41%	0%
HealthSpring PDP	95	0%	29%	1%
MedicareRx Rewards Standard	97	1%	30%	0%
MedicareRx Rewards Value	98	1%	31%	0%
WellCare Classic	89	5%	10%	2%
Average	**96**	**4%**	**28%**	**2%**

*Commonly used drug list is based on a list generated by the Office of the Inspector General in 2006 based on 2005 data and data pulled from Medicare Plan Finder Web site in 2006.

Source: Avalere Health analysis of Medicare Part D plan features. Data from November 2007.

Conclusion

There are important differences among the nine Medicare prescription drug plans that are eligible for both the auto enrollment of dual eligibles and the full premium subsidy for low-income beneficiaries. Identifying the most appropriate plan for dual eligibles and other low-income beneficiaries is difficult, since the generosity of the formularies varies according to which measure is used. However, a few plans stand out. Blue Cross Medicare Rx Value and two MedicareRx Rewards plans (Standard and Value) cover more brand and generic drugs than average, and use prior authorization on a smaller-than-average share of drugs. By contrast, Advantage Star Plan and First Health Part D Premier cover fewer brand and generic drugs while using prior authorization on a greater-than-average number of drugs. Nevertheless, before choosing whether to switch plans, beneficiaries should consider their specific circumstances and needs, such as which drugs they are taking and any characteristics of drug plans that are important to them but not reflected in this analysis.

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About the Foundation

The California HealthCare Foundation, based in Oakland, is an independent philanthropy committed to improving California's health care delivery and financing systems. Formed in 1996, our goal is to ensure that all Californians have access to affordable, quality health care. For more information about the foundation, visit us online at www.chcf.org.

Endnotes

1. Centers for Medicare and Medicaid Services, LIS Eligible Medicare Beneficiaries with Medicare Prescription Drug Coverage by State, January 2008.
2. Regional low-income subsidy benchmarks are based on the average Prescription Drug Plans and Medicare Advantage Prescription Drug plan premiums, weighted by plan enrollment. Centers for Medicare and Medicaid Services, *Release of the 2008 Part D National Average Monthly Bid Amount, the Medicare Part D Base Beneficiary Premium, the Part D Regional Low-Income Premium Subsidy Amounts, and the Medicare Advantage Regional Benchmark,* August 2007. For California, the 2008 benchmark is set at $19.80 per month
3. Centers for Medicare and Medicaid Services, *Year 2007 Re-Assignment Data-Premium Increase,* November 2007.
4. Ibid.
5. The authors used DataFrame®, a proprietary database of Medicare Part D plan features.
6. The list of the top 200 drugs can be found at www.oig.hhs.gov/oei/reports/oei-05-06-00090.pdf. Approximately a dozen brand name drugs on the Office of the Inspector General list had generic counterparts enter the market between January 1, 2006 and the publication of Part D plan formularies in November 2007. Given the rapid adoption of new generics onto Part D plan formularies, the analysis replaced brand name drugs whose patent had expired on the list of commonly used drugs with their generic counterparts. The revised list does not, however, incorporate brand name drugs introduced after the commonly used drug list was generated because there is no publicly available utilization data to determine their use among the dual eligible population. Because of inevitable differences between the most commonly used 100 drugs in 2006 and 2008, what is most pertinent for this analysis is the relative coverage among plans rather than the absolute numbers.
7. When excluding generic versions of the commonly prescribed drugs that were introduced between 2006 and 2008, plan coverage ranges from 78 to 96 percent of these top 100 drugs.