

DEPARTMENT OF HEALTH & HUMAN SERVICES

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STRONG COMPETITION AND BENEFICIARY CHOICES CONTRIBUTE TO MEDICARE DRUG COVERAGE WITH LOWER COSTS THAN PREDICTED

Part D Overview

The vast majority of all Medicare beneficiaries, including over 10 million low-income beneficiaries, are receiving comprehensive prescription drug coverage through Medicare Part D, employer-sponsored retiree health plans or other creditable coverage such as the VA, TRICARE, or FEHBP (January 2007 press release).

The new drug benefit created an enormous challenge and a great opportunity. The promise is being fulfilled with approximately 100 million Part D prescriptions being filled every month. As a further sign of success, the estimated average 2008 monthly plan premium for standard coverage is nearly 40 percent lower than originally estimated.

Five separate surveys show that more than 75 percent of beneficiaries – and several polls report even higher totals – are satisfied with the program.

In addition to beneficiary participation and satisfaction, the program has also excelled in beneficiary savings and is operating at a significantly lower cost to taxpayers than originally estimated. Beneficiaries today are saving an average of \$1,200 a year versus those without coverage. Moreover, CMS actuaries estimated this past January that payments to Part D plans are projected to be \$113 billion lower over the next ten years than estimated the previous year, a reduction of 10 percent. Importantly, of the \$113 billion reduction in cost, \$96 billion is a direct result of competition and significantly lower Part D plan bids in 2007. Part D costs and premiums continue to be well below projections because of slower than expected growth in prescription drug costs generally, effective plan negotiation of discounts and rebates, and strong competition among plans. The program is 30 percent less expensive overall for the first 10 years than originally estimated. The impact of this year's bid process will be reflected in the President's budget for 2009.

Part D Open Enrollment Period – 2006 and 2007

Part D's second open-enrollment period, which ran from November 15 to December 31, 2006 for the 2007 plan year, was preceded by a broad local and national outreach campaign. In addition to helping new enrollees select a plan, the campaign was designed to encourage beneficiaries to compare their 2006 plans with 2007 plan options in order to make a confident decision in their health and drug coverage plan selection. This effort included 12,700 events coordinated with 40,000 partners in hundreds of cities across the nation. The 2008 open-enrollment period (Part D's third) will run from November 15 to December 31, 2007. CMS will continue its strong outreach and education efforts to ensure that beneficiaries make well informed decisions about their coverage needs in 2008.

The strong efforts to get beneficiaries to "prepare and compare" during the 2006 open-enrollment period paid off. CMS tracking surveys conducted earlier this year indicate that 85 percent of seniors were aware of the 2006 open-enrollment period and over 50 percent reviewed their current coverage. Among the 600 seniors surveyed, 34 percent reported comparing plans, and over half of these seniors evaluated premiums, deductible or co-pays, and coverage—that is, their comparisons appeared to be thorough.

The survey further noted that while only 6 percent reported switching plans during the open-enrollment period, 2 out of 3 switchers reported reviewing their coverage and comparing plans, and 4 out of 5 switchers were satisfied with the process.

Overall, during the 45-day open-enrollment period, there were about 900,000 enrollments, including 350,000 that were done online.

In addition to strong participation during the enrollment periods, the implementation of the Part D program, with hundreds of thousands of newly enrolled beneficiaries going to pharmacies for the first time, went smoothly in January 2007. Even before the New Year began, CMS officials worked with pharmacies and drug plans to closely monitor the program as it entered its second year. Very few of the problems people encountered at the program's implementation in January 2006 have been experienced this year. We continue to refine the enrollment process, improve our partner and online tools, and work with pharmacists to discover challenges early and have them resolved.

Low-Income Subsidy Beneficiary Outreach

Over 10 million low-income beneficiaries are getting comprehensive drug coverage for little or no cost, including almost 9.5 million who are enrolled in Medicare Part D. CMS continues to make additional efforts to encourage enrollment among the hard-to-reach population eligible for the low-income subsidy, which in 2008 is estimated to be worth \$3,660 (\$3,353 in 2007). In January, CMS waived the 2007 late-enrollment penalty for low-income beneficiaries who are traditionally harder to reach.

CMS is committed to ensuring not only that everyone who might qualify applies for extra help, but also that continuing eligibility determinations for those beneficiaries who currently qualify (“re-deeming”) are conducted promptly and fairly. The next round of re-deeming will occur this fall. In 2006, during the first round of re-deeming, about 630,000 beneficiaries lost their deemed status, and nearly 60 percent subsequently regained LIS eligibility – including those who regained their deemed status and those who reapplied and qualified for LIS with SSA.

Many people with limited income and resources qualify for these big savings and yet may not be aware of the LIS program. In advance of the upcoming open-enrollment period, this fall, CMS will continue to work with our expansive grassroots network to reach out to beneficiaries with no drug coverage, particularly those who may be eligible for extra help. CMS has worked hard over the past year to update its files on people who might be eligible for Part D and the low-income subsidy. CMS has been able to pinpoint Medicare beneficiaries in pockets of need, directly down to the ZIP-code level. CMS has also been working with our partners to identify best practices and develop new tools to make outreach more effective to help beneficiaries with low literacy and limited English skills understand how to apply for extra help. All of the data and materials are online at the CMS website at www.cms.gov.

2008 Part D Premiums

Due in large part to strong competitive bidding by health and prescription drug plans and beneficiaries’ choices, the Centers for Medicare & Medicaid Services (CMS) anticipates that the actual average premium paid by beneficiaries for standard Part D coverage in 2008 will be roughly \$25. This is nearly 40 percent lower than originally projected when the benefit was established in 2003 and also lower than projected earlier this year.

Approximately 87 percent of beneficiaries enrolled in a stand-alone prescription drug plan (PDP) will have access to Medicare drug plans that cost them the same or less than their coverage in 2007. Thus, the great majority of such beneficiaries could avoid any premium increase in 2008 by enrolling in a lower-cost plan in their region. Moreover, many beneficiaries have access to a Medicare Advantage plan with lower prescription drug premiums. It will be important for beneficiaries to compare their coverage options for 2008 based on overall cost, coverage, and convenience in order to select the plan that best meets their needs.

While competitive bids for both PDPs and MA-PDs have been lower than independent analysts projected at the outset of Part D, bids are notably lower for Medicare Advantage plans. On average, in 2007, the MA-PD premiums prior to rebates are \$7 lower than stand-alone prescription drug plans. In 2008, they will be \$11 lower. The lower bids reflect the effects of aggressive competition as well as lower costs resulting from better care coordination and drug benefit management techniques.

The increase in the average Part D premium for basic coverage, from about \$22 in 2007 to roughly \$25 in 2008, is due to certain technical factors in the law that govern the

allocation of plan costs between Medicare and beneficiaries. Among the most important of these factors is the normalization of the risk-adjustment model. This model allows for higher payments to plans that have sicker enrollees and lower payments to plans that have healthier enrollees. Risk adjustment relies on assigning a risk score to every Medicare beneficiary and must be normalized such that the average risk score is 1.00. If risk scores average greater than 1.00, then Medicare will pay more than it should for an average beneficiary. Similarly, if risk scores are on average less than 1.00, Medicare will pay less than it should. The great majority of enrollees will have plans available in their region with premiums below what they are currently paying.¹

For 2006 and 2007, the Part D risk scores were not normalized because of data limitations, resulting in average risk scores greater than 1.00 and higher Medicare payments. For 2008, the normalization process ensures that the average projected risk score is 1.00 and that Medicare payments will be based on a beneficiary with average health status.

The increase in the average premium for 2008 is also affected by the continued transition to the statutory method of determining the national weighted average bid. Again due to data limitations, it was not possible to calculate the national average bid in 2006 using actual plan enrollments as weights. Now that such enrollments are known, the computation is possible, and a transition to this method is in process.

With normalization of the risk-adjustment process and the transition to enrollment weights for the national average bid, the result is a somewhat faster increase in premiums and a somewhat slower growth in the Medicare subsidy. As noted above, the majority of beneficiaries could avoid any premium increase in 2008 by enrolling in a lower-cost plan in their region.

In addition to releasing the premium information discussed above, CMS is announcing the 2008 “national average monthly bid,” which is \$80.52; and the “base beneficiary premium,” which is \$27.93 per month. These amounts are used to determine the Medicare premium subsidy to Part D drug plans, which will be \$52.59 per month in 2008, down slightly from \$53.08 in 2007. The regional low-income subsidy payment amounts for 2008 and other data can be found at:

<http://www.cms.hhs.gov/MedicareAdvtgSpecRateStats/RSD/list.asp?listpage=3>

¹ All of the premium averages shown are for basic coverage, exclude the supplemental premiums payable for additional drug coverage, and are calculated before the application of MA rebates that reduce MA-PD premiums.