

Healthcare reform and Medicare Part D



Closing the donut hole—and more

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Now that the long-debated healthcare reform legislation has become law through the signing of H.R. 3590, Patient Protection and Affordable Care Act, and H.R. 4872, Health Care and Education Reconciliation Act of 2010, we can analyze what the effects will be on Medicare Part D (Part D), the prescription drug plan for seniors and other Medicare-eligible patients. Part D is not the primary focus of the new law, but portions of the act impact Part D in significant ways, primarily in the areas of:

- Closing the coverage gap, commonly known as the *donut hole*
- Eliminating the tax deductibility for the Medicare Retiree Drug Subsidy (RDS)
- Increasing premiums for certain high-income individuals
- Low-income benchmark calculation and related changes intended to minimize the migration of low-income subsidy recipients between Part D plans

The following discussion explains the major provisions of the new law and the implications for patients, the government (mainly through the Centers for Medicare and Medicaid Services, CMS), health plans, and employers.

CLOSING THE COVERAGE GAP

The *donut hole* under the prescription drug benefit added to Medicare in 2006 left a coverage gap for individuals between the initial coverage limit and the catastrophic coverage threshold.¹ At the time, the donut hole was intended to keep Part D program costs down. Now, Medicare enrollees will see that coverage gap disappear by 2020 and be replaced by 25% cost sharing across the board for both generic and brand drugs. This will come about partly through subsidies agreed to by pharmaceutical companies (Pharma) and partly through gradual increases in Medicare funding.

The following changes will occur within the current coverage gap:

PROVISIONS:

- Many patients whose drug costs reach the coverage gap in 2010 will receive a \$250 refund.
- Pharma will subsidize brand-name drugs in the coverage gap at 50% of cost sharing beginning in 2011.
- For these brand-name drugs, patients will initially pay the remaining 50% under the Standard Part D benefit. Beginning in 2013, Medicare will pay a gradually increasing portion of that 50% until patient cost sharing levels off at 25% of the total. (That is, by 2020 Pharma subsidies = 50%, Medicare payment = 25%, and patient cost = 25%.)
- For generic drugs, CMS phases in coverage, reducing patient cost sharing by 7% increments beginning in 2011 until patient cost levels off at 25% in 2020.
- Beginning in 2014, the law reduces the growth rate of the true-out-of-pocket (TrOOP) maximum that qualifies an enrollee for catastrophic coverage.

IMPLICATIONS:

Patients get additional benefits with lower cost sharing. This particularly helps those with high pharmacy needs (e.g., specialty drug users). Premiums will increase for everyone and there may be confusion during the transition period.

Government sees program expenses rise, but the change helps to end a politically sensitive issue.

Plans are concerned about reduced incentives to use generics because the Pharma subsidy applies only to brand drugs. Enhanced plan offerings, such as employer group waiver plans (EGWPs²) with supplemental benefits will be redesigned to accommodate the subsidy. Lower costs to patients could mean improved compliance with drug regimens, which could help reduce overall medical costs.

¹ On the donut hole, see Thomas D. Snook, "Climbing out of the 'donut hole,'" *Milliman Perspective*, May 1, 2006, available online at <http://www.milliman.com/perspective/articles/climbing-out-donut-hole-insight05-01-06.php>.

² On EGWP, see Brian N. Anderson, "Medicare Part D: Optimizing the Opportunities for Employer Plans," *Benefits and Compensation Digest*, April 2009, available online at <http://www.milliman.com/expertise/healthcare/publications/published/pdfs/medicare-part>.

LOSS OF TAX DEDUCTIBILITY FOR RDS

Reversing a provision in the 2003 Medicare Modernization Act, the 2010 law removes a tax deduction for employers who provide drug coverage for retirees enrolled in Medicare. This change will apply to taxable years beginning after December 31, 2012. Even though this change will not occur until 2013, this provision has the most immediate impact of any in the healthcare reform law, as plans must immediately book the financial statement impact for all future years if they are currently collecting the RDS. The total cost to large corporate plan sponsors will likely be in the hundreds of millions or billions of dollars. For example, AT&T has estimated that the change will cost it \$1 billion and Verizon has estimated \$970 million.³

This change to the tax status of RDS means that plan sponsors should consider evaluating whether the RDS continues to be the right option or if switching to an EGWP or another option for providing retiree prescription drug benefits is more advantageous. The results of such an analysis will depend on the size of the employer and the relative richness of the plan, and there is no one-size-fits-all solution.

PROVISION:

Employers receiving CMS subsidies in the form of the RDS for providing qualified drug coverage can no longer deduct the amount of those subsidies from their taxable income. The subsidies, however, will continue to be available.

IMPLICATIONS:

Patients may see changes in their employment-based retiree prescription drug coverage.

Government will benefit from the elimination of the tax deduction. Over time, Part D program costs may rise for the federal government if plans drop coverage and members sign up for individual Part D plans. The end result may be that the cost under reform could balance out if enrollment in individual PDPs increases and RDS subsidies decrease.

Plans may have their employer clients shift from RDS plans to EGWPs. Employers that relied on the RDS could see an impact on their retiree healthcare liabilities under FAS-106,⁴ resulting in more employers considering EGWPs.

HIGH-INCOME PREMIUM HIKES

Beginning in 2010, Medicare Part D premiums increase for people with annual incomes of \$85,000 or more for single people and \$170,000 or more for married couples. This change parallels the subsidy provisions already existing for Medicare Part B premiums.

PROVISION:

Part D subsidies from the government are reduced for individuals and couples in higher-income categories, causing their Part D premiums to rise.

IMPLICATIONS:

High-income Patients are already accustomed to higher Part B premiums. The amount is generally withheld from Social Security checks for Part B, but the reform bill is unclear on the operational mechanics for Part D.

Government will shoulder a greater administrative burden, but the similarity to Part B will make this change easy to implement. The additional revenue will help pay for the closure of the donut hole and may become a future target for increasing revenue further.

³ Amy Thomson and Olga Kharif, "Verizon Joins AT&T in Booking Costs from Health-Care (Update 1)," Bloomberg.com, April 2, 2010, available online at <http://www.bloomberg.com/apps/news?pid=20601087&sid=acOdGHWujF9l>.

⁴ Financial Accounting Board statement describing standards for employers' accounting for postretirement benefits other than pensions.

LOW INCOME BENCHMARK CALCULATION CHANGES AND DE MINIMIS RULES

Effective in 2011, the new law changes the formula for calculating the Part D low-income benchmark (LIB) premiums to remove the impact of Part C subsidies and to allow waivers of de minimis premiums. Both of these changes are targeted to minimize low-income beneficiary movement between plans.

PROVISIONS:

- The reform legislation removes the impact of Part C savings from Medicare Advantage (MA) prescription drug bids in the LIB calculation (currently true for 2010 only).
- In addition, it provides for a de minimis policy that allows plans to retain auto-assigned members in cases where a plan's bid slightly exceeds the benchmark. (CMS will determine the de minimis premium level.)

IMPLICATIONS:

Patients will not be shifted from one plan to another as often as they are now and will thus experience more stability in their plan.

Government will pay out more in low income premium subsidies, but will gain the operational benefit of not having to move low-income auto-enrollees from one plan to another every year.

Plans will receive higher subsidies from CMS, but they may experience more uncertainty in the LIB bidding process. The effect will be particularly large in areas with high MA enrollment, such as Florida, California, and Arizona. Given the proposed reductions in Part C reimbursement, such changes could take some pressure off of MA plans facing benefit reductions and/or premium increases. These changes will reduce the amount of savings required on the Part C side to meet the LIB on the Part D side.

SUMMARY

Among the constituents of Medicare Part D, the primary beneficiaries of healthcare reform are patients, who, despite some likely confusion when the new provisions are implemented, appear to gain benefits. The exceptions to this are higher-income patients, who will pay more for their Part D premiums. Healthcare plans should benefit from higher CMS subsidies and may have lower long-term medical costs resulting from improved patient compliance with drug regimens. Many employers will reevaluate the alternatives to RDS as a result of the change in RDS rules, and some may consider the option of shifting to a type of EGWP. Government's role will increase, and, if employer-funded drug plans decline, taxpayer costs will rise. Closing the coverage gap will also increase taxpayer costs, as the increased premiums from higher-income patients will offset only a portion of the cost to close the donut hole.

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