The Impact of Healthcare Reform on the Medicare Advantage and Prescription Drug Plan Programs

A Brief Summary

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EXECUTIVE SUMMARY

Healthcare reform was recently enacted into law by Congress in two phases. The Patient Protection and Affordable Care Act[1] (PPACA or HR 3590, aka the Senate Health Bill) was closely followed by the Health Care and Education Affordability Reconciliation Act of 2010[2] (HCEARA or HR 4872, aka the Health Reconciliation Bill). Both laws make major modifications to the Medicare Advantage (MA) and prescription drug plan (PDP) programs.

Of particular importance are the provisions of the new laws relating to reductions in payments to MA organizations over the next seven years, and to changes in prescription drug coverage beginning in 2011. This paper provides a summary of the combined effects of these two laws as they relate to the MA and PDP programs. This summary addresses key provisions of the new laws and is not intended to be all-inclusive.

- **Major provisions of PPACA were repealed by HCEARA**. Major sections of PPACA were replaced by provisions of HCEARA, potentially causing confusion about the final state of affairs in the MA and PDP marketplace. Specifically, sections of PPACA relating to setting MA benchmarks through competitive bidding, establishing core-based statistical areas (CBSAs) as the geographic units for rating, grandfathering benefits, transitional extra benefits, performance management incentives, risk score coding adjustments, and increasing the Part D initial coverage limit (ICL), among other things, have been eliminated or replaced with elements of HCEARA.

- **MA benchmarks for 2011 are set equal to the benchmarks for 2010**. The 3% reduction in PPACA has been eliminated.

- **MA benchmarks in 2012 and later years will be based on a percent of the fee-for-service (FFS) rates** in each county; the percentages applicable to each county will be based on the county's ranking relative to the FFS rates of all counties in the 50 states and Washington, D.C. When fully phased in, base payments to MA contractors (excluding quality bonuses) will range between 95% and 115% of FFS rates.

- **Benchmarks will be phased in to the new methodology** through a process of blending old and new benchmarks over a period of years. The number of years over which the benchmarks will be phased in varies by county depending on the difference between the old and new benchmarks for the county.

- **Quality of care will affect MA plan payments beginning in 2012**. Bonuses of up to 5% (10% in *qualified counties*) will be paid to plans that achieve four or more stars on a five-star quality-of-care rating system. However, bonuses in some counties may be reduced by the provision that limits payments under the new law to those under prior law. In addition, quality scores will determine the portion of *plan savings* that may be returned as additional benefits to members in the form of rebates.

- **The Centers for Medicare and Medicaid Services (CMS) must calculate the value of the MA coding intensity adjustment annually,** and the value of the adjustment must be at least 5.7% in 2019 and subsequent years. This provision applies until CMS *implements risk adjustment based on MA diagnostic, cost, and use data.*

- **New retrospective minimum loss ratio requirements for Medicare Advantage plans** will be implemented in 2014 and later years. Plans will be required to return to CMS any amounts exceeding what may be retained based on these requirements. Plans that fail to meet the requirements in multiple consecutive years may lose the ability to enroll new members or may be terminated from the program.

- **Benefit mandates**. Effective January 1, 2011, the copayments that MA plans may charge for certain services are mandated to be at levels equivalent to or lower than those under fee-for-service Medicare. Effective January 1, 2012, a specific order is mandated in which additional benefits may be offered to a plan's members, and an MA plan's ability to offer reduced Part B premiums as a benefit is eliminated.

1 The Patient Protection and Affordable Care Act (HR 3590). Retrieved April 28, 2010, from http://www.gpo.gov/fdsys/search/pagedetails.action?granuleId=&packageId=BILLS-111hr3590EAS

2 The Health Care and Education Affordability Reconciliation Act of 2010 (HR 4872). Retrieved April 28, 2010, from http://thomas.loc.gov/cgi-bin/bdquery/z?d111:h.r.04872:

- **Accountable care organizations (ACOs)**. ACOs are provider-based entities that will be allowed to enter into gain-sharing arrangements directly with CMS beginning January 1, 2012. An ACO that meets certain requirements will share gains with CMS beyond an initial risk corridor. ACOs will have at least 5,000 fee-for-service beneficiaries assigned to them by CMS; benchmarks used to determine the risk corridor will be set based on the historical claim experience of those beneficiaries.

- **Special Needs Plans (SNPs)**. SNPs are required to be National Committee for Quality Assurance (NCQA)-certified for 2012 and later years. Authority to restrict the types of members enrolling in a SNP is extended through 2013. CMS is also making a number of changes in how risk scores are handled for SNP populations, and may include a frailty adjustment in the payment methodology for dual-eligible SNPs in the future.

- **Other provisions relating to Medicare Advantage**. Additional provisions relating to cost contracts, the coordinated beneficiary election period, senior facility housing demonstrations, and Medigap plans are also part of the new law.

- **The prescription drug coverage gap (*donut hole*) is closed** over a period of years, but only for certain individuals, called *applicable beneficiaries*. This is initially accomplished through a rebate of $250 in 2010. In 2011 and later years this goal will be accomplished by decreasing beneficiaries' costs through decreases in drug costs and member cost sharing.

- **Other provisions relating to Part D coverage**. Means testing Part D government subsidies effective January 1, 2011, imposes an income-related premium increase for Medicare Part D beneficiaries whose modified adjusted gross income (MAGI) exceeds the thresholds used under Medicare Part B. Additionally a PDP whose difference between its premiums and the low-income benchmark amounts are sufficiently small (*de minimus* amounts defined by CMS at a later date) will qualify for auto-enrollment of low-income beneficiaries. Lastly, formularies for Part D plans are now mandated by law to include all drugs in certain *protected* classes.

This paper will analyze these key provisions. The description of this recently passed legislation remains preliminary, reflecting the authors' interpretation of the provisions of the law. Some provisions are sufficiently vague that they will require interpretation by CMS. Ultimately, CMS will be the authority on what each of the provisions means and how they will be implemented.

CLOSING THE MEDICARE PRESCRIPTION DRUG *DONUT HOLE*

The prescription drug coverage gap (also called the *donut hole*) is the gap between the ICL and the out-of-pocket threshold. Coverage in the gap is expanded for so-called *applicable beneficiaries* only. An applicable beneficiary is an MA prescription drug or PDP enrollee who meets all of the following conditions, which were originally introduced in PPACA:

- Is not enrolled in a qualified retiree drug plan

- Does not receive an income-related drug subsidy (i.e., is not a low-income beneficiary)

- Has Part D prescription drug claims that exceed the ICL, but do not exceed the annual out-of-pocket threshold (i.e., they are in the *donut hole*)

This means that Medicare beneficiaries receiving low-income subsidies and those enrolled in qualified prescription drug plans will not benefit from the prescription drug coverage changes in HCEARA.

PPACA had indicated that beneficiaries with incomes above the threshold amounts relating to payment of the part B premium (i.e., beneficiaries referenced in Social Security Law Section 1839[i]) would not benefit from the prescription drug coverage changes. However, HCEARA removed this provision, so that these beneficiaries will receive the same coverage in the donut hole as other beneficiaries.

An individual who is an applicable beneficiary in 2010 will receive a $250 rebate for 2010. It will be paid directly by the federal government, by the 15th of the third month following the end of the quarter in which the ICL is reached. Only one rebate is to be paid for any individual. This is not extended for future years.

After 2010, individual cost sharing is gradually reduced to 25% in 2020 and future years, through a combination of increased coverage and mandated drug manufacturer discounts. This increase in coverage applies only to applicable beneficiaries. The tables in Figures 1 and 2 show how the coinsurance phases in separately for generic drugs and non-generic drugs.

FIGURE 1: GENERIC COINSURANCE IN THE COVERAGE GAP FOR STANDARD BENEFITS

(FOR APPLICABLE BENEFICIARIES ONLY)

CALENDAR YEAR	INDIVIDUAL PAYS	CALENDAR YEAR	INDIVIDUAL PAYS
2011	93.0%	2016	58.0%
2012	86.0%	2017	51.0%
2013	79.0%	2018	44.0%
2014	72.0%	2019	37.0%
2015	65.0%	2020+	25.0%

Note: Coverage may be actuarially equivalent to coverage with these copays.

FIGURE 2: NON-GENERIC COINSURANCE IN THE COVERAGE GAP FOR STANDARD BENEFITS

(FOR APPLICABLE BENEFICIARIES ONLY)

CALENDAR YEAR	GAP PERCENTAGE	RX DISCOUNT	INDIVIDUAL PAYS
2011-12	100.0%	50.0%	50.0%
2013-14	97.5%	50.0%	47.5%
2015-16	95.0%	50.0%	45.0%
2017	90.0%	50.0%	40.0%
2018	85.0%	50.0%	35.0%
2019	80.0%	50.0%	30.0%
2020+	75.0%	50.0%	25.0%

Note: Coverage may be actuarially equivalent to coverage with these copays.

The non-generic discount amounts in the coverage gap will count toward the out-of-pocket threshold (also called *true out-of-pocket*, or TrOOP), just like member cost sharing amounts. The combined effect of reduced member cost sharing and no change in the out-of-pocket threshold implies that applicable beneficiaries will need to incur greater Part D prescription drug costs in order to reach the out-of-pocket threshold.

Therefore, the dollar amount at which catastrophic coverage begins will increase for applicable beneficiaries. For example, a member who has only generic prescriptions in the gap will have a higher catastrophic threshold amount (based on the plan's allowed claims) than a member who has generic and non-generic prescriptions in the gap.

MEDICARE ADVANTAGE PAYMENTS

The payment methodology for MA plans is substantially changed by HCEARA. It should be noted that the changes in payment methodology do not apply to Program of All-Inclusive Care for the Elderly (PACE) plans.

HCEARA introduces some important new concepts in the determination of Medicare Advantage payments. Among these are the following:

Applicable Percentage: the percent of estimated fee-for-service rates that an MA plan will ultimately be paid, excluding any quality incentive payments.

Base Payment Amount: the CMS-estimated FFS rate in a county, excluding a portion of indirect medical education (IME) expenses, as described in the law. The base payment amount is multiplied by the applicable percentage to calculate the *new benchmark*. At least once every three years, base payment amounts will be *rebased*, meaning that new FFS rates for each county will be developed by CMS.

Generally, the increase in base payment amounts each year will be equal to the national average per capita increase. However, for years in which benchmarks are rebased, the base payment amount for each county will be reset to 100% of the estimated FFS costs in the county, excluding the appropriate portion of IME for the year in question.

Qualified County: a county that meets the following three conditions:

- An MA capitation rate in 2004 based on the *Urban Legacy Floor*, which was the higher of the two rates used as minimum values under prior law. It was the minimum capitation rate established for counties in metropolitan statistical areas (MSAs) with more than 250,000 people.
- At least 25% MA penetration as of December 2009.
- An FFS rate below the national average FFS rate based on membership counts by county in Original Medicare (i.e., excluding those in MA plans).

Bonus payments for *qualified plans* are higher in qualified counties (see below).

Qualified Plan: a plan that has at least a four-star quality rating. These plans will receive quality-based bonus payments.

2011 BENCHMARKS

2011 benchmarks are set exactly equal to the 2010 benchmarks.

2012 AND LATER BENCHMARKS

In order to mitigate the significant impact of lowering the MA payment rates, the law allows for a phase-in from the prior-law benchmarks to the new benchmarks. The period of phase-in, starting in 2012, is either two, four, or six years, depending on the difference between the 2010 published benchmark and the percent of 2010 FFS rate that would have been in effect under the new law for a qualified plan–where smaller differences are phased in more quickly than larger differences, to mitigate changes.

Benchmarks under HCEARA may not exceed the benchmarks calculated under prior law. It is noteworthy that the law states that this limit is *determined taking into account subsection (o)*, which describes the quality incentive payments. This implies that MA plan quality incentives may be reduced if their payment would increase a plan's payments beyond what they would have been under prior law, potentially taking away some of the incentive to achieve high quality scores in some geographic areas.

In setting the base payment amount for the new benchmarks, all counties in the 50 states and the District of Columbia (3,144 of them in 2010) will be ranked from highest to lowest based on their CMS-estimated fee-for-service rates (i.e., CMS estimates of average fee-for-services costs by county). FFS rates will be calculated excluding a portion of IME as described in the law.

The *applicable percentage* that will be applied to the base payment amount for each county is based on the county's quartile ranking in the previous year. Quartiles will be determined based purely on the number of counties, without regard to the number of Medicare-eligible individuals who live in each county. Counties, municipalities, etc. in U.S. territories will be slotted into the four quartiles depending on the value of their benchmarks; generally, this will place them in the lowest quartile in each year.

The values of the applicable percentages for each quartile are provided in Figure 3.

FIGURE 3: PERCENT OF FFS RATES IN NEW MA BENCHMARKS

(ALSO CALLED THE *APPLICABLE PERCENTAGE*)

QUARTILE	BENCHMARK AS A PERCENTAGE OF FFS RATE
HIGHEST	95%
SECOND-HIGHEST	100%
THIRD-HIGHEST	107.5%
LOWEST	115%

For example, Miami-Dade County, Florida, with one of the highest FFS rates in the country, would be in the *highest* quartile and therefore the benchmark would be set at 95% of the county's FFS rate. The phase-in of benchmarks to these levels will occur over a period of years, and is described below.

Counties will be re-ranked each year, and some may move from one quartile to another. In that event, the *applicable percentage* for a county will be set as the average of the percentages in the county's old and new quartiles for one year.

TWO-, FOUR-, OR SIX-YEAR PHASE-IN

As noted above, the period of phase-in, starting in 2012, is either two, four, or six years, depending on the difference between the 2010 benchmark and the percent of 2010 FFS rates that would have been in effect under the new law for a qualified plan. The methodology for determining the length of the phase-in can be expressed in the following formulas:

$$D = [\text{(2010 Benchmark)} - \text{(2010 PBA)}]$$

where,

$$\begin{pmatrix}\text{2010}\\ \text{PBA}\end{pmatrix} = \left[\begin{pmatrix}\text{FFS\% from}\\ \text{Figure 3}\end{pmatrix} + \begin{pmatrix}\text{1.5\% for most countries, or}\\ \text{3.0\% for } \textit{Qualified Counties}\end{pmatrix}\right] \times \begin{pmatrix}\text{Count}\\ \text{FFS Rate}\end{pmatrix}$$

It should be noted that the *2010 PBA* is called the *projected 2010 benchmark amount* in the law. It should not to be confused with the 2010 published benchmark.

The number of years of phase-in is based on the value of *D* as shown in Figure 4.

FIGURE 4: DETERMINATION OF NUMBER OF YEARS OF PHASE-IN

VALUE OF *D*	LENGTH OF PHASE-IN
D < $60	2 YEARS
$60 ≤ D < $100	4 YEARS
D ≥ $100	6 YEARS

Note that the formulas and the values in Figure 4 have been simplified from what is presented in the law. We refer to values of *D*, whereas the law refers to values of *D/2*. Because of this, the values shown in Figure 4 are twice those shown in the law. Both sets of values are valid when used in the proper context.

QUALITY PAYMENTS

Additions to payments to reflect quality will begin in 2012. Quality incentives payable to qualified plans are provided in Figure 5. A qualified plan is one that achieves a four-star or higher rating on a five-star quality rating (QR) scale.

FIGURE 5: QUALITY INCENTIVES FOR QUALIFIED PLANS

(EXPRESSED AS A PERCENT OF *BASE* MA PLAN PAYMENTS)

CALENDAR YEAR	EXISTING PLANS IN NON-QUALIFIED COUNTIES[1]	EXISTING PLANS IN QUALIFIED COUNTIES[1]	NEW PLANS IN NON-QUALIFIED COUNTIES[2]	NEW PLANS IN QUALIFIED COUNTIES[2]
2012	1.5%	3.0%	1.5%	3.0%
2013	3.0%	6.0%	2.5%	5.0%
2014+	5.0%	10.0%	3.5%	7.0%

1. Low-enrollment plans are qualified plans in 2012; CMS is tasked to determine how to treat low-enrollment plans in 2013 and later.
2. A *new plan* is a plan from an MA organization that had no MA contract in the preceding three years.

The quality portion of the payment to MA plans is very important. Most plans will see significant reductions in their base payment rates over the coming years. Achieving high quality scores is a way to offset some or all of those reductions in some counties.

REBATES

The portion of savings in an MA plan's bids that can be used to provide additional benefits to its members is being reduced from the current level of 75% to a percent that varies based on the plan's quality rating, as shown in Figure 6.

FIGURE 6: REBATE PERCENTAGES BY PLAN QUALITY RATING (QR)

CALENDAR YEAR	QR < 3.5★	3.5★ ≤ QR < 4.5★ AND NEW PLANS	QR ≥ 4.5★ AND LOW-ENROLLMENT PLANS[1]
2011	75%	75%	75%
2012	66 2/3%	71 2/3%	73 1/3%
2013	58 1/3%	68 1/3%	71 2/3%[1]
2014+	50%	65%	70%[1]

1. HCEARA is silent on rebates for low-enrollment plans beyond 2012.

The impact of this is a significant reduction in the marketability of lower-quality plans, in that they likely cannot provide as much in additional benefits to their enrollees as higher-quality plans can provide from MA rebate dollars.

BENEFIT MANDATES

HCEARA leaves the benefit mandates of PPACA in effect. These restrict, effective January 1, 2011, the copayments that MA plans may charge for the following services to levels equivalent to or below those under Original Medicare:

- Chemotherapy administration
- Renal dialysis
- Skilled nursing care
- Other services that CMS deems appropriate

Effective January 1, 2012, an MA plan's ability to offer reductions in Part B premiums as a benefit is eliminated. In addition, the specific order in which additional benefits may be offered to a plan's members is mandated. In particular, rebates (effective 2012), quality bonuses (effective 2014), and supplemental premiums (effective 2012) must provide additional benefits in the following priority order:

First, to *use the most significant share to meaningfully* reduce cost sharing under Parts A, B, and D.

Second, to *use the next most significant share to meaningfully* add coverage of preventive and wellness benefits not covered by Original Medicare, such as smoking cessation, a free flu shot, and/or an annual physical.

Third, *to use the remaining share* to add other services, such as eye exams and dental coverage.

CMS is required to define *meaningfully* for purposes of this section.

Some vagueness surrounds just how this will be implemented. Further clarification from CMS, and perhaps further legislation, will be required to clear things up. For example, PPACA states that the order of the application of performance (i.e., quality) bonuses to additional benefits begins in 2014. This is consistent with the initiation of performance bonuses in 2014 in PPACA (now repealed); however, in HCEARA, quality bonuses begin in 2012, so the reference to 2014 appears inconsistent with the intent of the new law.

CODING INTENSITY ADJUSTMENT

HCEARA requires CMS to recalculate the coding intensity adjustment on an annual basis. This factor represents the difference in coding intensity between MA plan enrollees in total and Medicare fee-for-service beneficiaries in total (assuming all other things being equal). As in the past, the coding intensity adjustment is used to reduce payments to MA plans, on the theory that the plans are capturing more diagnostic codes for their beneficiaries than CMS captures for similar Medicare fee-for-service beneficiaries.

Currently, the coding intensity adjustment used by CMS is 3.41%. The law stipulates that this amount must be increased to at least 5.7% in years 2019 and beyond until CMS *implements risk adjustment based on MA diagnostic, cost, and use data*.

MINIMUM MEDICAL LOSS RATIOS

Effective for contract year 2014, CMS will implement an 85% retrospective minimum loss ratio (MLR) requirement for MA plans, similar in nature to those in place in many insurance markets for small-group and individual policies. A loss ratio is loosely defined as the ratio of benefit expenses to earned premiums. A retrospective loss ratio test requires plans to examine their experience after claims have run out and return to CMS amounts beyond those allowed to be retained by the plan (in this case, 15% of earned premium).

It is unclear exactly how CMS will define the loss ratio to be applied under this provision of the law. For example, will medical management expenses be treated as medical expenses or administrative expenses? Also, will the loss ratio be calculated at a plan, contract, or organization level? The answer to these and other related questions will have a significant effect on how burdensome the MLR requirement will be to MA plans.

If a plan fails to meet the retrospective loss ratio requirement, various sanctions will be applied to the plan. In all years, the plan must return to CMS any amounts exceeding the allowed 15% retention.

In addition:

- If the test fails for three consecutive years, the plan will not be allowed to enroll new members.
- If the test fails for five consecutive years, the plan will be terminated.

ACCOUNTABLE CARE ORGANIZATIONS (ACOS)

ACOs are introduced in PPACA via the *Medicare Shared Savings Program* as a new type of entity that may enter into a gain-sharing arrangement with CMS. The ACO essentially cuts out the health plan *middle man* by allowing provider groups to contract directly

with CMS. The program is effective January 1, 2012, and has the following goals, identified in the law:

- To promote accountability for a patient population
- To coordinate items and services under Parts A and B
- To encourage investment in infrastructure and redesigned care processes for high-quality and efficient service delivery

An ACO must have a formal legal structure (it must be able to receive and distribute payments for shared services) and be willing to be responsible for the quality, cost, and overall care of the 5,000 or more fee-for-service Medicare beneficiaries that are assigned to it for at least a three-year period. ACOs that meet CMS quality standards and produce financial savings for its beneficiaries are eligible to share in those savings. CMS takes 100% of the savings in the initial risk corridor (to be established by the Secretary of Health and Human Services), and a percentage of the savings beyond the initial risk corridor. The ACO receives the balance of any savings beyond the initial risk corridor, but a portion of this may be withheld by CMS against the possibility of future losses.

Benchmarks for the ACO are based on three years of historical experience for the beneficiaries assigned to the ACO by CMS. The benchmarks are to be adjusted for *beneficiary characteristics and such other factors* deemed appropriate by CMS. Annual increases in benchmarks are set equal to the growth in national average expenditures under Medicare Parts A and B.

SPECIAL NEEDS PLANS (SNPS)

SNPs are required to be NCQA-certified for 2012 and later years.

Authority to restrict the types of members enrolling in an SNP is extended through 2013. Existing members as of December 31, 2009, who are not classified in any of the SNP's classes of special needs individuals will be transitioned to other MA plans or to Original Medicare by January 1, 2013.

New chronic SNP members will no longer be assigned the default risk score for 2011 and later years. Instead, risk scores for new members will be assigned based on the *known underlying risk profile and chronic health status for similar individuals*.

CMS is charged with evaluating the validity of the risk adjustment system used for special needs populations. If the existing system is found deficient in reflecting the cost characteristics of those with special needs, CMS is authorized to revise the system to correct that deficiency. CMS is required to publish the results of any studies on this subject, as well as any changes in risk adjustment methodology that it intends to implement.

For SNPs that fully integrate Medicare and Medicaid benefits, the law allows CMS to adjust payment to the plan to reflect the frailty of the plan's members. This CMS authority is limited, however, to the extent necessary to deal with high concentrations of frail individuals.

OTHER PROVISIONS RELATING TO MEDICARE ADVANTAGE

A number of other items in the law relating to Medicare Advantage are summarized below.

Actuarial Certification. A certification of an MA plan's bids is required by a member of the American Academy of Actuaries. This is similar to requirements for commercial rate filings in many states.

Reasonable Cost Contracts. In areas where MA plans compete, Reasonable Cost contracts are allowed to renew up to January 1, 2013.

Change of Coordinated Beneficiary Election Period. October 15 to December 7 is the new coordinated election period for MA and prescription drug plans beginning in 2011, for 2012 and later plan years.

Authority to Deny Plan Bids. Interestingly, the law specifically provides CMS with the authority to deny bids because the MA plan is decreasing benefits significantly or increasing cost sharing significantly.

Senior Facility Housing Demonstrations. The law makes senior facility housing demonstrations permanent effective January 1, 2010. It allows the plan to define its service area to be the site of the senior housing facility and to restrict enrollment to residents of the senior housing facility.

Medigap Plans C and F. The law requests that the National Association of Insurance Commissioners (NAIC) review and revise the standards for Medigap Plans C and F beginning in 2015. In particular, the law requests updates in the plan structures to include nominal cost sharing in these plans *in order to encourage the use of appropriate physicians' services under Part B*.

OTHER PROVISIONS RELATING TO PRESCRIPTION DRUG PLANS

A number of other items in the law relating to prescription drug plans are summarized below.

Means Testing Part D Government Subsidies. Beginning January 1, 2011, the law imposes an income-related monthly adjustment amount (IRMAA) premium increase for Medicare Part D beneficiaries whose modified adjusted gross income (MAGI) exceeds the thresholds used under Medicare Part B (the 2010 MAGI is defined to be 2009 taxable income of $85,000 per individual, $170,000 per couple).

De Minimus Differences with the Low-Income Premium Benchmark. For the 2011 contract year PDPs whose differences between its member premiums and the low-income benchmarks amount is sufficiently small (*de minimus* amounts to be defined by CMS at a later date) will qualify for auto-enrollment of low-income beneficiaries. In past years, when CMS implemented a demonstration project to create de minimus amounts, the amounts were $1 (in CY 2008) and $2 (in CY 2007).

Mandated Coverage of Drugs Within a Part D Formulary. The law codifies the prior CMS regulation that protected six classes of drugs (antipsychotics, antidepressants, antiretrovirals, immunosuppressants, anticonvulsants and antineoplastics) and gives the Secretary of Health and Human Services the authority to identify classes of clinical concern through rulemaking.

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