Medicare Part D After 2 Years

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Objective: To assess the broad impacts of Medicare Part D and the extent to which prior concerns have been realized.

Methods: We used administrative data to summarize beneficiary enrollment and plan participation in Part D, and compared pharmaceutical use and out-of-pocket spending before and after the introduction of Part D. We characterized the benefit designs of the 10 largest Part D plans in 2006 and compared them with the benefit designs of 7 non–Part D plans often cited as examples of low-cost or comprehensive drug benefits.

Results: By 2008, nearly 90% of seniors had drug coverage at least as generous as the standard Part D benefit. Excluding premiums, annual out-of-pocket spending in the 10 largest Part D plans was comparable to that of other private and public drug benefits, with the most prominent differences attributable to out-of-pocket spending on drugs not covered in the plan. Poorer beneficiaries have gained the most from Part D in terms of increased access to medications and reduced out-of-pocket spending.

Conclusions: Coverage under Part D is comparable to that under non–Part D plans with respect to key features that are likely to be important to Medicare beneficiaries—access to medications and out-of-pocket costs. Nonetheless, concerns remain over drug pricing and gaps in coverage. The government should continue to monitor the competitiveness of the Part D market to ensure it meets the diverse needs of Medicare beneficiaries.

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For author information and disclosures, see end of text.

Prior to the introduction of Medicare Part D in 2006, there were concerns that the program would not appeal to all types of beneficiaries, nor entice a sufficient number of health plans to offer a benefit. Failing to attract a broad cross-section of beneficiaries could jeopardize the long-term viability of the program if, for example, only the sickest patients enrolled. Similarly, failing to attract a sufficient number of plan sponsors would diminish competition, which was widely viewed as the cornerstone of a well-functioning program. Other concerns focused on low-income beneficiaries, many of whom were previously covered by Medicaid's prescription drug benefit. Would they be negatively affected by potentially more expensive private plans with more restrictive formularies? Would seniors be able to navigate the myriad of plan choices and benefit options, including the gap in coverage ("doughnut hole") in Part D? Finally, many analysts feared that the cost of the program would exceed original Congressional Budget Office estimates if private plans could not obtain sufficient price discounts or constrain growth in per capita utilization.

Nearly 3 years into the Medicare Part D program, enough data have accumulated on the program's performance for a preliminary picture to emerge. We examined beneficiary and plan participation in the program, and how Part D has affected beneficiaries' access to medications, utilization, and financial risk. We compared the 10 largest Part D plans in 2006 with 7 non–Part D plans often cited as examples of low-cost or generous pharmacy benefits. We found that although Part D has exceeded expectations in many ways, several questions remain that warrant careful monitoring in the future.

METHODS

Beneficiary Enrollment and Plan Participation

We used data from the Centers for Medicare & Medicaid Services to characterize beneficiaries' drug coverage and plan participation in Medicare Part D. Estimates of Medicare beneficiaries with prescription drug coverage were from enrollment files. Data on plan participation were derived from the Prescription Drug Plan Landscape File.

Benefit Design and Formulary Coverage

To characterize the Part D program, we examined the 10 largest prescrip-

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tion drug plans (PDPs) based on 2006 enrollment. These 10 plans accounted for 46% of total Part D enrollment in 2006. We compared these 10 plans with 7 public and private plans often cited as examples of low-cost or comprehensive drug benefits with respect to formulary coverage, cost-sharing features, and out-of-pocket costs. The 7 non–Part D plans included the Federal Employees Health Benefits Program (FEP Basic), the California Public Employees' Retirement System (CALPERS Choice/CALPERS Care), the California State Medicaid program (Medi-Cal), the Veterans Affairs plan (VA National Formulary), the Department of Defense plan (TRICARE), Anthem Blue Cross, and Kaiser Permanente.

Take-Away Points

After more than 2 years of experience, data are starting to accumulate on the performance of Medicare Part D.

- Nearly 90% of Medicare beneficiaries have prescription drug coverage as generous as the standard Part D benefit.
- Part D was associated with a 16% annual decrease in out-of-pocket spending and a 7% increase in the number of prescriptions.
- Coverage under Part D is comparable to that of other private and public drug benefits with respect to access to medications and out-of-pocket costs.
- Poorer beneficiaries have gained the most from Part D.

We used data from the Fingertip Formulary and Internet sources to characterize the benefit designs and cost-sharing arrangements of each of these 17 plans. The Fingertip Formulary is an online database of formulary designs for nearly all commercial, Medicare, Medicaid, and public insurance plans (http://www.fingertipformulary.com). The data in our analysis contain formulary designs as of July 16, 2007. In cases where there were discrepancies between sources, we contacted the plans directly to resolve any ambiguities.

We compared coverage in each plan for the 300 drugs most widely prescribed to seniors between January and October 2006. The list of medications was based on Verispan's Vector One data, a national-level prescription and patient tracking service that collects nearly half of the retail prescriptions dispensed each month in the United States. The list of 300 drugs was reduced to 252 in some analyses because of 33 generic/brand duplicates and 15 drugs not covered under Part D. We also examined how broadly plans cover medications for chronic diseases of the elderly to assess the potential clinical consequences of formulary exclusions.

Public programs with statutory or regulatory limits on cost-sharing often use formulary restrictions or other types of administrative requirements to limit access to specific medications. For example, plans may require prior authorization (requiring permission before certain drugs can be dispensed), step therapy (requiring use of lower-cost medications before providing coverage for more expensive alternatives), or quantity limits (which restrict the number of pills or prescriptions dispensed per month or per patient) to control utilization and improve patient safety. We examined the extent of these restrictions in each of the 17 plans.

Relative Plan Generosity

It often is difficult to translate the stated pharmacy benefit into actual prices that consumers face. Multitier formularies are the standard for most private plans, and they also have gaps in coverage, out-of-pocket limits, and discounts for purchases through mail-order or in-network pharmacies. These added complexities mean that the price a consumer will pay for a given drug depends in which tier it is placed, where it is dispensed, and at what time of year. To address this issue, we estimated average beneficiary out-of-pocket costs in each plan for a standardized set of pharmacy claims. The set of drug claims was generated by drawing a random sample of seniors from 14 large employers providing retiree drug coverage in 2004 (non–Part D plans, national in scope). The sample included beneficiaries age 65 years and older who were continuously enrolled in a plan for the entire year and who had at least 1 pharmacy claim for the 300 most common drugs. We randomly selected 10% of enrollees from each plan, up to a maximum of 500 per plan. We then created a "market basket" of drug claims used by this random sample of retirees, restricted to the 300 most common drugs. This fixed set of pharmacy claims then was processed through the benefit designs of each plan to calculate the average out-of-pocket costs in each of the 17 plans. This approach incorporates the plan's cost-sharing arrangements and other factors such as where the drug was dispensed (eg, network or mail-order pharmacy) and cumulative spending to date.

For drugs that were not covered by the plan—either because they were excluded from the formulary or because the beneficiary's cumulative spending was below the deductible or in the doughnut hole—we assigned an out-of-pocket payment equal to the full price of the drug (excluding rebates). We used the full price of the drug for each Part D plan as reported on the Medicare Web site in July 2007. Some Part D plans did not report prices for all of the drugs. In those cases, we imputed the average price of a drug across all other Part D plans with pricing data. Similarly, because we did not have price data for the employer plans, we assigned the average price of each drug in the Part D plans.

Our approach to estimating out-of-pocket costs for a fixed basket of pharmacy claims had 2 principal limitations. Most

importantly, it assumed no demand response (ie, that patients' drug use or "bundle of claims" was fixed across plans and thus invariant to the benefit design). In reality, patients will alter their choice of drugs in response to changes in cost-sharing.[1] Second, the price we used for uncovered drugs was measured with some error, given the limitations on quantity and dosage and our use of average prices in the 10 largest Part D plans. Given these limitations, our out-of-pocket estimates provide a useful measure of *relative* plan generosity, but should not be viewed as an accurate measure of the *actual* cost burden to beneficiaries.

Changes in Utilization

We estimated the effects of Part D on pharmacy utilization and spending using a "before and after" design. For the baseline period, we analyzed data from the 2004 Medicare Current Beneficiary Survey (MCBS). For the follow-up period, we analyzed 2006 enrollment and claims data from a large Part D plan. These datasets are not perfectly comparable. First, the MCBS relies on self-reports and has been shown to undercount drug spending.[2] Second, the MCBS is a stratified national sample of Medicare enrollees, whereas the Part D data are a convenience sample, albeit a large one.

To address the first problem, MCBS spending was adjusted upward from 2004 to 2006 using the consumer price index prescription drug series, and both spending and number of fills were adjusted upward by 15% to account for the undercount. To address the second problem, we constructed demographic weights based on age, sex, and state of residence so the Part D enrollees were demographically representative of the Medicare population. We re-weighted the Part D data to match the MCBS for each age-sex-state-subsidy cell and used these weights in all reported analyses.

We also approximated low-income subsidy (LIS) eligibility in the MCBS prior to Part D introduction based on a reported household income less than 150% of the federal poverty line. No asset information is available in the MCBS. Prior work suggests that nearly 14 million Medicare beneficiaries would qualify for the LIS based on this income test alone, of which 2.4 million (17%) would be ineligible based on assets.[3]

For each of the 3 eligibility groups (dual-eligible, LIS, general), we examined the distribution of prescriptions and out-of-pocket spending before and after the introduction of Part D. In particular, we compared the means, variances, and various quartiles of the distributions of these variables.

RESULTS

Enrollment

Table 1 shows the breakdown of prescription drug coverage among Medicare beneficiaries as of January 2008. Nearly 90% of seniors had drug coverage at least as generous as the standard Part D benefit. More than 57% were enrolled in a Part D plan (15% dual-eligibles), with the remainder covered by employer plans (15%) or some other creditable plan (17%).

Table 1. Drug Coverage Among Medicare Beneficiaries[a]

	Eligible Beneficiaries	
Type of Coverage	**Number (millions)**	**Percentage[b]**
Medicare stand-alone prescription drug plans	**17.4**	**39.4**
General beneficiaries	9.5	21.5
Dual-eligibles	5.3	12.0
Low-income subsidy	2.6	5.9
Medicare Advantage prescription drug plans	**8.0**	**18.1**
General beneficiaries	6.5	14.7
Dual-eligibles	1.3	2.9
Low-income subsidy	0.2	0.5
Medicare Retiree Drug Subsidy[c]	**6.7**	**15.2**
Other creditable drug coverage[d]	**7.5**	**17.0**
No creditable coverage	**4.6**	**10.4**
Total	**44.2**	**100.0**

[a] Authors' calculations were based on Centers for Medicare & Medicaid Services enrollment data as of January 2008.
[b] Bolded percentages do not sum to 100.0 because of rounding.
[c] Employer coverage with Medicare Retiree Drug Subsidy.
[d] A plan other than a Part D plan that offers prescription drug coverage and that meets certain Medicare standards.

Table 2. Coverage of the 300 Most Common Prescription Drugs for the Elderly in 2007, by Plan[a,b]

Plan	No. of Drugs Covered			No. of Drugs Not Covered	Prescription Use Accounted for by Excluded Medications, %
	Tier 1	Tier 2	Tier 3		
Part D plans					
Humana Complete	157	63	26	6	7.0
Humana Enhanced	157	63	26	6	7.0
Humana Standard[c]	NA	NA	NA	6	7.0
AARP Medicare Rx	150	67	31	4	4.4
UnitedHealth Rx Basic	147	49	52	4	4.4
Community Care Rx Basic	155	61	12	24	4.7
Caremark Silverscript	149	70	NA	33	7.3
Prescription Pathway Bronze[c]	NA	NA	NA	30	5.1
Medicare Rx Reward Values	157	59	NA	36	7.8
WellCare Signature	156	40	15	41	12.6
Non–Part D plans					
Medi-Cal	251	NA	NA	1	0.0
TRICARE	154	81	11	6	1.9
CALPERS	158	78	14	2	0.3
Anthem Blue Cross	157	59	36	0	0.0
FEP Basic	161	75	16	0	0.0
VA National Formulary	168	NA	NA	84	24.7
Kaiser Permanente	151	26	NA	75	24.6

CALPERS indicates California Public Employees' Retirement System; FEP Basic, Federal Employees Health Benefits Program; Medi-Cal, California State Medicaid program; NA, not applicable; VA, Veterans Affairs.
[a]Sources were the Fingertip Formulary, 2007, and Verispan's Vector One National Audit. Benefit designs can vary by region. Results shown here are for Centers for Medicare & Medicaid Services Region 32 (California).
[b]The 300 most common drugs were reduced to 252 because of 33 generic/brand duplicates and 15 drugs not covered under Part D. The percentage of total prescriptions accounted for by excluded medications was calculated using Verispan's Vector One National Audit.
[c]These plans had a coinsurance rate that applied to all drugs.

Plan Participation

Widespread enrollment in Part D is partly attributable to robust plan participation across states. In January 2006 alone, there were on average 43 PDPs in each state, with states at the 25th percentile having 41 plans. In 2007 and 2008, this number rose to 54 plans, with states at the 25th percentile having 53 plans on average. Despite the large number of plan offerings, beneficiaries enrolled in Part D were highly concentrated in a few plan sponsors. Nearly 44% of enrollees in 2007 were in plans offered by UnitedHealth and Humana, while almost a quarter were covered by Universal American Financial, WellPoint, WellCare, Kaiser Permanente, and Coventry. A similar degree of concentration occurred in the Medicare Advantage market prior to Part D.[4]

Formulary Design and Coverage

Table 2 characterizes the formulary coverage and cost-sharing arrangements of the 10 largest Part D plans, as well as the 7 comparison plans. For each of the plans, we show the number of covered drugs in each tier (or a single tier in plans where only 1 tier exists), as well as the number of drugs not covered. Among the 10 largest Part D plans, between 147 and 157 of the 300 most common medications were covered in tier 1. Further, the most (least) expansive plans excluded 4 to 6 (24 to 41) medications. There was little variation across plans in the number of drugs assigned to the first 2 tiers. Thus, variation in the number of covered drugs across Part D plans was driven by how many products were assigned to the third tier versus not covered at all. Coverage under the largest Part D plans was comparable to that under many of the non–Part D plans such as Anthem Blue Cross, FEP Basic, CALPERS, and TRICARE, which excluded 0 to 6 medications. By contrast, the Kaiser Permanente and VA plans excluded 75 and 84 medications, respectively.

Because certain drugs are more widely used than others, excluded medications may account for a relatively smaller or larger fraction of total prescriptions. The last column of Table 2 shows the proportion of total national prescriptions accounted

Table 3. Formulary Coverage Within the Top 5 Therapeutic Classes, by Plan[a,b]

	Antidiabetic Tier (8 Drugs)				Diuretic Tier (8 Drugs)				Beta-Blocker Tier (10 Drugs)				ACEI/ARB Tier (22 Drugs)				Antilipidemic Tier (11 Drugs)			
Type of Coverage	**NC**	**1**	**2**	**3**	**NC**	**1**	**2**	**3**	**NC**	**1**	**2**	**3**	**NC**	**1**	**2**	**3**	**NC**	**1**	**2**	**3**
Part D plans																				
Humana Complete	0	7	6	0	0	8	0	0	0	9	1	0	0	10	7	5	0	5	6	0
Humana Enhanced	0	7	6	0	0	8	0	0	0	9	1	0	0	10	7	5	0	5	6	0
Humana Standard	0	NA	NA	NA	0	NA	NA	NA	0	NA	NA	NA	0	NA	NA	NA	0	NA	NA	NA
AARP Medicare Rx	0	7	6	0	0	8	0	0	0	9	1	0	4	10	4	4	2	5	3	1
UnitedHealth Rx Basic	0	7	5	1	0	8	0	0	0	9	1	0	0	10	5	7	0	5	5	1
Community Care Rx Basic	1	7	5	0	0	8	0	0	0	9	1	0	8	10	4	0	3	5	3	0
Caremark Silverscript	0	7	5	1	0	8	0	0	0	9	1	0	0	10	4	8	0	5	4	2
Prescription Pathway Bronze	0	NA	NA	NA	0	NA	NA	NA	1	NA	NA	NA	6	NA	NA	NA	1	NA	NA	NA
Medicare Rx Rewards Value	1	7	5	0	0	8	0	0	0	9	1	0	5	10	7	0	2	4	5	0
WellCare Signature	1	7	5	0	0	8	0	0	0	9	1	0	6	10	6	0	4	4	3	0
Non–Part D plans																				
Medi-Cal	0	13	0	0	0	8	0	0	0	10	0	0	0	22	0	0	0	11	0	0
TRICARE	0	8	5	0	0	8	0	0	0	9	1	0	0	9	11	2	0	5	5	1
CALPERS	0	7	6	0	0	8	0	0	0	9	1	0	0	10	10	2	0	5	5	1
Anthem Blue Cross	0	7	6	0	0	8	0	0	0	9	1	0	0	10	5	7	0	5	3	3
FEP Basic	0	7	6	0	0	8	0	0	0	9	1	0	0	10	6	6	0	5	5	1
VA National Formulary	7	6	0	0	1	7	0	0	2	8	0	0	12	10	0	0	5	6	0	0
Kaiser Permanente	4	7	2	0	0	8	0	0	1	8	1	0	11	10	1	0	6	5	0	0

ACEI indicates angiotensin-converting enzyme inhibitor; ARB, angiotensin II receptor blocker; CALPERS, California Public Employees' Retirement System; FEP Basic, Federal Employees Health Benefits Program; Medi-Cal, California State Medicaid program; NA, not applicable; NC, not covered; VA, Veterans Affairs.
[a]Sources were the Fingertip Formulary, 2007, and Verispan's Vector One National Audit.
[b]Among the top 300 selling drugs based on total scripts.

for by the list of excluded drugs in each plan. For exam=ple, the 84 drugs excluded from the VA National Formulary accounted for nearly one-quarter (24.7%) of all prescriptions dispensed to seniors in 2006 among the 300 most common medications. By contrast, drugs excluded from even the most restrictive Part D plan accounted for only 12.6% of total prescriptions, and drugs excluded from the least restrictive Part D plan accounted for just 4.4% of total prescriptions.

To assess the potential clinical consequences of excluding drugs from the formulary, we also examined how broadly plans cover medications for chronic diseases of the elderly, specifically diabetes, heart disease, hypertension, and high cholesterol. Table 3 shows the number of excluded drugs in each plan. The 10 largest Part D plans covered the vast majority of the drugs in these therapeutic classes, with the exception of angiotensin-converting enzyme inhibitors and angiotensin II receptor blockers (ACEIs/ARBs). The most restrictive Part D plan excluded just 4 of 11 antihyperlipidemic agents, 1 of 13 antidiabetic agents, and 1 of 10 beta-blockers. Although coverage was less generous for ACEIs/ARBs, even the most restrictive Part D plans covered 14 to 18 of the 22 drugs in the class. In contrast, the VA National Formulary excluded 7 of 13 antidiabetic agents, 12 of 22 ACEIs/ARBs, and 5 of 11 antihyperlipidemic agents.

Plans also can place administrative restrictions on specific drugs or classes of medications that can greatly limit access. Table 4 shows the number of drugs in each plan subject to prior authorization requirements, quantity limits, step therapy, and other restrictions. The most common formulary restriction in Part D plans is a quantity limit, where the plan will only cover a drug up to a designated quantity. If prescribing physicians feel it is medically necessary to exceed the set limit, they must get prior approval from the plan. Among the 10 largest Part D plans, the median quantity limit applies to 54 of the top 300 drugs.

Prior authorization is commonly used in state Medicaid programs as a cost containment tool, but is far less common in Part D plans. Half of the 10 largest plans do not impose prior authorization requirements on any drug, while the most restrictive Part D plan requires it for just 7 medications. Step therapy is used in some Part D plans, but is typically applied to a small number of drugs. Although VA does not use any of

Table 4. Formulary Restrictions on the 300 Most Common Prescription Drugs for the Elderly, by Plan[a]

Plan	Type of Formulary Restriction[b]			
	Prior Authorization	Quantity Limits	Step Therapy	Other
Part D Plans				
Humana Complete	0	90	5	0
Humana Enhanced	0	90	5	0
Humana Standard	0	90	5	0
AARP Medicare Rx	0	55	12	0
UnitedHealth Rx Basic	2	59	12	0
Community Care Rx Basic	2	53	14	0
Caremark Silverscript	1	14	0	0
Prescription Pathway Bronze	0	0	0	0
Medicare Rx Rewards Value	3	34	0	0
WellCare Signature	7	7	7	0
Non–Part D plans				
Medi-Cal	70	6	4	6
TRICARE	4	12	0	4
CALPERS	0	0	0	0
Anthem Blue Cross	4	8	0	0
FEP Basic	35	8	0	3
VA National Formulary	0	0	0	36
Kaiser Permanente	0	0	0	0

CALPERS indicates California Public Employees' Retirement System; FEP Basic, Federal Employees Health Benefits Program; Medi-Cal, California State Medicaid program; VA, Veterans Affairs.
[a]Source was the Fingertip Formulary, 2007.
[b]Prior authorization requires permission from the plan before certain drugs can be dispensed. Step therapy requires use of lower-cost medications before providing coverage for more expensive alternatives. Quantity limits restrict the number of pills or prescriptions dispensed per month or per patient. Other restrictions typically include coverage only for a specific indication or dosage/form.

these formulary restrictions, it imposes other types of restrictions to control utilization. For example, 34 of the 180 formulary drugs in the VA National Formulary (among the top 300 drugs) are only covered for specific indications, dosages, or intake formulations.

Table 5 presents predicted annual out-of-pocket costs (excluding premiums) under each plan for our market basket of claims and decomposes these costs into out-of-pocket expenditures for covered and noncovered drugs. Predicted out-of-pocket spending for the 5 least expensive Part D plans was roughly $1000 annually, which was modestly higher than spending in Anthem Blue Cross, FEP Basic, and CALPERS. With the exception of WellCare Signature, out-of-pocket spending in the remaining Part D plans was between $1300 and $1400 annually, making these plans more comparable in spending to the VA plan.

Changes in Pharmacy Use and Spending

A critical question is how Part D affected pharmaceutical use and spending, both overall and for specific groups of beneficiaries. Our analyses comparing MCBS data in 2004 with Part D claims in 2006 suggest that Part D was associated with a 16% annual decrease in out-of-pocket spending and a 7% increase in the number of prescriptions (results not shown). These estimates are consistent with other findings using 2006 data from a large national pharmacy chain.[5,6] Our analysis also suggests that these changes were concentrated among the poor. Average out-of-pocket spending among the dual-eligibles and LIS population declined markedly, but was largely unchanged for the general Part D population. Equally important, Part D was associated with reduced financial risk for low-income populations, as measured by the variance of out-of-pocket spending (Table 6). Prior to Part D, the probability of having out-of-pocket drug spending higher than $1000 in a year was 24% in the LIS population and 3.6% in the dual-eligible population. After Part D, those probabilities were less than 1% for each group.

Table 5. Mean Out-of-Pocket Expenses for Covered and Noncovered Drugs in the "Market Basket" of Drug Claims[a]

Plan	Average Out-of-Pocket Spending for Drugs, $		
	All	Covered	Not Covered
Part D plans			
Humana Complete	995	994	1
Humana Enhanced	1020	1019	1
Humana Standard	1047	1046	1
AARP Medicare Rx	1064	1063	1
UnitedHealth Rx Basic	1176	895	281
Community Care Rx Basic	1324	869	455
Caremark Silverscript	1376	832	544
Prescription Pathway Bronze	1452	909	543
Medicare Rx Rewards Value	1458	840	618
WellCare Signature	1943	753	1190
Non–Part D plans			
Medi-Cal	38	38	0
TRICARE	454	252	202
CALPERS	755	747	8
Anthem Blue Cross	769	769	0
FEP Basic	846	846	0
VA National Formulary[b]	1348	188	1160
Kaiser Permanente	2006	276	1730

CALPERS indicates California Public Employees' Retirement System; FEP Basic, Federal Employees Health Benefits Program; Medi-Cal, California State Medicaid program; VA, Veterans Affairs.
[a]Authors' calculations were based on formulary restrictions and benefit designs of 10 major Part D plans and 7 non–Part D plans. Because the 300 most common drugs sometimes included branded and generic versions of the same drug, the calculated expenditure in the VA plan treated branded drugs as covered if a generic equivalent was covered.
[b]Our market basket of drug claims included multisource brands (brand drugs with generic equivalents) that may not be covered under the VA National Formulary. We assumed that patients in the VA plan received the generic equivalent and paid an $8 copayment.

DISCUSSION

Medicare Part D generated much confusion at the time of its introduction in January 2006. Some beneficiaries did not understand the benefit designs and were not sure how Part D interacted with existing drug coverage or whether they might gain or suffer financially from enrolling.[7] However, after more than 2 years of experience, the assessment has changed. Nearly 90% of Medicare beneficiaries have prescription drug coverage at least as generous as the standard Part D benefit. Policies to protect plans from excessive losses in the first few years (through reinsurance and risk corridors) as well as efforts to educate beneficiaries about plan choices led to a large number of sponsors and a wide array of options for beneficiaries to choose from. Despite the large number of plans, it appears that most beneficiaries who enroll in the program are making plan choices that reflect both their health status and the market circumstances.[7]

Enrollment in Part D was widespread for several reasons. First, the large federal subsidy for Part D plans—74.5% of the premium is paid by Medicare—dramatically reduced the cost of coverage for most beneficiaries. Second, individuals previously covered under Medicaid were automatically enrolled in a private Part D plan. Third, the widespread availability of low premium plans (less than $20 per month), combined with penalties for late enrollment, made coverage more appealing to healthy seniors who might otherwise have been dissuaded from enrolling. However, there remains a substantial core of seniors who need to be educated that enrolling in Part D is in their own interest, and reaching them should continue to be a health policy priority.[7]

Despite the variation across Part D plans, annual out-of-pocket spending in the 10 largest plans was only modestly higher than that in the other private and public drug plans, with the most prominent differences attributable to out-of-pocket spending on drugs not covered in the plan. Poorer beneficiaries, specifically dual-eligibles and those eligible for additional LISs, have gained the most from Part D in terms of increased access to medications and reduced financial risk.

Despite these successes, several concerns remain.[8,9] First and foremost is the doughnut hole or gap in Part D coverage whereby beneficiaries with intermediate levels of spending face full coinsurance prior to reaching catastrophic coverage.[10-12] Recent work suggests that more than 3 million Part D enrollees reached the coverage gap in 2007, and about 20% of them either stopped taking a medication, skipped doses, or switched to a different medication in the class.[13] Second, given the significant amount of consolidation that has occurred in plans offering Part D coverage (8 organizations accounted for nearly 65% of enrollment in 2007), one must question the future impact of consolidation on competition. Further consolidation is likely inevitable given the sheer number of plans operating. Will competition diminish and prices rise with increased market power in the hands of a few plans? Or will consolidation lead to increased ability of plans to negotiate

lower drug prices that ultimately get passed down via lower premiums? These are open questions that warrant careful monitoring in the future, especially given the importance of competition in justifying a privately administered benefit.

Some members of Congress argue that the federal government could provide a simpler benefit at lower cost by negotiating directly with drug manufacturers.[13] Currently under Part D, prices are determined through negotiations between drug manufacturers and PDPs. The forces of competition tend to result in larger rebates and lower net prices for drugs that have closer available substitutes and for insurers that establish narrower lists of preferred drugs or are more effective in steering doctors and patients toward those drugs.

By contrast, the government negotiating lower prices for all Medicare beneficiaries would have to be thought through very carefully. The process of choosing which drugs to exclude from a national Medicare formulary would likely be dominated by stakeholders such as manufacturers and patient advocacy groups, and in some cases, might determine whether particular manufacturers stay in business.[14] However, in the absence of a formulary, Medicare would be unable to exclude any drug and thus would have no bargaining leverage. It was for this reason that the Congressional Budget Office estimated that the Secretary would not be able to negotiate prices significantly lower than those already achieved by the private plans.[15]

Our analysis has several limitations. First, we compared pharmaceutical use and out-of-pocket spending from the 2004 MCBS with the use and spending of a large Part D plan in 2006. Because these datasets are not perfectly comparable and there is likely to be some selection into Part D plans, these results are not definitive. However, our estimates are consistent with other findings using 2006 data from a large national pharmacy chain.[6,7] Second, our sample consists of the 10 largest Part D plans, which accounted for 46% of total Part D enrollment in 2006. The profiles and out-of-pocket costs of smaller PDPs may be different. Third, it is not necessarily detrimental to offer enrollees a narrower list of preferred drugs as VA and Kaiser do. A narrow, but well-designed, formulary can help steer doctors and patients toward more cost-effective medications, reducing overall drug costs. Finally, we did not examine coverage of specialty drugs, which is a modest, but rapidly growing, fraction of total drug spending.

Our analysis suggests that coverage under Part D is comparable to that under selected non–Part D plans with respect to key features likely to be important to Medicare beneficiaries—access to medications and out-of-pocket costs. However, the government should continue to monitor the competitiveness of the Part D market to ensure it meets the diverse needs of Medicare beneficiaries.

Table 6. Changes in Out-of-Pocket Spending and Utilization Before and After Medicare Part D, by Eligibility Status[a]

	Annual Out-of-Pocket Spending, $		No. of Filled Prescriptions	
Eligibility	2004	2006	2004	2006
Dual-eligible	164	45[b]	41.3	38.9
Low-income subsidy	741	160[b]	32.7	38.8[b]
General	842	897	30.8	31.1

[a]Sources were the 2004 Medicare Current Beneficiary Survey and 2006 claims and enrollment data from a large Part D plan.
[b]$P < .01$ for change in outcome between 2004 and 2006. All expenditures are in 2006 dollars.

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