



# **FOR THE RECORD**

**Statement  
on  
The Medicare Part D Prescription Drug Program**

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U.S. Senate Special Committee on Aging**

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## **I. Introduction**

America's Health Insurance Plans (AHIP) and our member companies are enthusiastic supporters of the Medicare Part D prescription drug program. This program is providing important benefits and peace of mind to millions of Medicare beneficiaries.

AHIP's membership includes most sponsors of both stand-alone prescription drug plans (PDPs) and Medicare Advantage plans that combine drug benefits with comprehensive health coverage (MA-PDs). These companies have a long track record of participation in Medicare and other public programs. Our members are strongly committed to the long-term success of the Part D program.

As the program begins its second year, more than 39 million Medicare beneficiaries – representing approximately 90 percent of the Medicare population – have prescription drug coverage either through Part D directly, an employer plan that is supported through Part D, or other sources. On a daily basis, these beneficiaries are personally experiencing the early success of the Part D program and the role that competition, choice, and innovation have played in providing them with high quality, affordable prescription drug coverage.

We appreciate the committee's interest in examining the Part D program's role in meeting the prescription drug needs of low-income beneficiaries. This statement offers our perspectives on this important priority and also discusses the program's overall track record during the past 13 months.

## **II. Savings and Value for Beneficiaries**

Part D prescription drug plans are exceeding expectations by offering more comprehensive benefits and lower premiums than were originally anticipated. According to the Centers for Medicare & Medicaid Services (CMS)<sup>1</sup>, beneficiaries who previously did not have drug coverage saved an average of \$1,200 in 2006 by enrolling in Part D plans. For millions of Medicare beneficiaries – particularly those who have low incomes with no other source of drug

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<sup>1</sup> Centers for Medicare & Medicaid Services, *Part D Medicare Prescription Drug Benefit Fact Sheet*, January 2007

coverage – this coverage ensures that they receive the medications they need at an affordable price.

To shed further light on the savings available through Part D, CMS<sup>2</sup> has reported that beneficiaries can save an average of 53 percent on commonly-used drugs tracked by the agency, compared to the amount they would have paid without prescription drug coverage. Beneficiaries who choose the lowest cost plan in their area can save up to 68 percent. Another study, conducted by the Lewin Group<sup>3</sup>, found that beneficiaries without previous drug coverage who have one or more of five chronic conditions – arthritis, diabetes, hypertension, osteoporosis, or respiratory illness – are saving 58 percent on their drug costs by enrolling in a Part D plan.

Plan sponsors are offering a range of prescription drug plans with high quality coverage, many of which go well beyond the minimum requirements of the Medicare Modernization Act of 2003 (MMA). Rather than establishing a one-size-fits-all benefits package, the Part D program creates incentives for plan sponsors to design different benefit packages that address beneficiaries' needs in three key areas – cost, coverage, and convenience. As a result, beneficiaries in all 50 states have the option of choosing at least one Part D plan that covers a portion of the costs in the coverage gap. In 41 states, beneficiaries have at least one MA-PD option with coverage in the gap and a zero Part D premium<sup>2</sup>.

Presented with these options, the vast majority of beneficiaries have selected benefit packages that differ from the minimum requirements set by the MMA. CMS data show that the standard defined benefit was selected by only 19 percent of beneficiaries in stand-alone prescription drug plans and by only five percent of beneficiaries in Medicare Advantage plans with prescription drug benefits last year<sup>2</sup>. All other beneficiaries are choosing plans that offer enhanced benefits or alternatives to the standard benefit.

While the vast majority of Medicare Part D enrollees have continuous prescription drug coverage throughout the year, a small percentage of enrollees are affected by the “coverage gap.” Part D plans provide these beneficiaries who reach the coverage gap with significant discounts off their prescription drug prices. According to one study<sup>4</sup>, these savings total more than 35 percent relative to retail prices. This means that beneficiaries are receiving significant savings through

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<sup>2</sup> Centers for Medicare & Medicaid Services, *Part D Medicare Prescription Drug Benefit Fact Sheet*, January 2007

<sup>3</sup> The Lewin Group, *Chronic Health Conditions & the New Medicare Part D Benefit: Savings on Frequently Used Medications*, April 12, 2006

<sup>4</sup> Pharmaceutical Care Management Association, press release, March 15, 2006

their Part D plans even when they have reached the coverage gap (i.e., after exhausting the initial coverage limit and before reaching the catastrophic benefit).

The value offered by Part D plans also can be seen in the lower-than-expected premiums that beneficiaries are paying. CMS data<sup>5</sup> show that the average premium paid by Part D enrollees last year was \$23 per month. This figure is 38 percent lower than the \$37 monthly premiums that were projected by the Medicare Board of Trustees in their 2005 report. Similarly, CMS has reported that beneficiary premiums in 2007 will average \$22 a month if enrollees remain in their current plans. This figure is 46 percent lower than the \$41 monthly premiums that the Medicare trustees projected for 2007.

Taxpayers also are benefiting from plans' success in delivering quality prescription drug coverage at an affordable price. The Congressional Budget Office (CBO)<sup>6</sup> recently announced that the projected costs for the Part D program over the next seven years (2007-2013) are now \$136 billion lower than the original estimate. CBO reported that a major factor contributing to the lower costs is that bids submitted by plan sponsors for 2007 under the program's competitive structure are about 15 percent lower than the 2006 bids.

### **III. An Important Safety Net for Low-Income Beneficiaries**

While beneficiaries of all income levels can save money by choosing Part D plans, financially vulnerable beneficiaries can expect to receive exceptionally large savings because of the low-income subsidies the MMA provides. More than 9 million Medicare beneficiaries are currently receiving this additional assistance. On average, Medicare will pay more than 95 percent of prescription drug costs for these low-income beneficiaries.

Many beneficiaries automatically qualify for low-income subsidies because they are dually eligible for both Medicare and Medicaid or because they receive Supplemental Security Income (SSI) benefits. However, others need to submit an application to the Social Security Administration (SSA) to determine whether they qualify for low-income subsidies based on their income and resources. AHIP's members have been working pro-actively to reach out to low-income beneficiaries to encourage them to apply for this additional assistance. During the Part D

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<sup>5</sup> CMS, *Projected Net Medicare Drug Costs Drop by Another Ten Percent*, January 8, 2007

<sup>6</sup> CBO, *The Budget and Economic Outlook: Fiscal Years 2008-2017*, January 2007

open enrollment period, AHIP members played a leadership role, while working in cooperation with CMS, in assisting beneficiaries who may be eligible for low-income assistance. Plans took the initiative in implementing pro-active steps in several key areas:

- Plan sponsors used a CMS model letter and outbound phone script to contact enrollees who automatically qualified for low-income subsidies in 2006, but who had to apply for the subsidy this year.
- Plan sponsors trained their customer service representatives to assist beneficiaries in completing and submitting the application for low-income subsidies to the SSA.
- Plan sponsors contracted with vendors to provide a “warm transfer” so beneficiaries could receive assistance from trained specialists in completing and submitting the application.
- Taking advantage of an opportunity provided under CMS guidance, plan sponsors have offered up to a three-month grace period for the collection of premiums and cost-sharing to individuals who lost their deemed status for low-income subsidies and are able to demonstrate that they have applied for this extra assistance.
- Plan sponsors are providing links on their websites to the SSA website ([www.socialsecurity.gov](http://www.socialsecurity.gov)), which includes general information about low-income subsidies and the application itself.

In addition, plan sponsors are supporting outreach efforts to low-income beneficiaries through partnerships with a variety of national, state, and community groups. Countless other plans have organized community events and health fairs across the nation to raise awareness among beneficiaries about low-income subsidies under Medicare Part D. Through all of these activities, AHIP’s members are demonstrating their strong commitment to ensuring that Medicare beneficiaries receive the full range of assistance offered by the Part D program.

Looking forward, AHIP stands ready to work with Congress to explore additional steps – including eliminating the assets test when determining eligibility for low-income subsidies – for further improving the Part D program’s effectiveness in serving beneficiaries who have limited financial resources. Additional funding for State Health Insurance Assistance Programs (SHIPs) also would help achieve this goal. Ensuring that low-income beneficiaries do not face

unreasonable barriers in their quest to receive extra assistance with their Part D premiums and cost-sharing should be a top priority in the ongoing debate and oversight of the program.

#### **IV. The Part D Program Is Valued by Beneficiaries**

Numerous surveys show that a large percentage of the Medicare population is pleased with the new Part D program and the benefits it is delivering. The positive attitudes of Medicare beneficiaries toward the Part D program are reflected in surveys sponsored by AHIP, the Medicare Rx Education Network, the *Washington Post/ABC News*, AARP, Medicare Today, JD Power and Associates, the *Wall Street Journal*, and the Kaiser Family Foundation.

Each of these surveys confirm that a significant majority of Medicare Part D enrollees are having a positive experience with their new prescription drug benefits. These surveys clearly show that most beneficiaries are satisfied with the program, are saving money on their prescription drugs, are not experiencing problems, and would recommend the program to others.

AHIP's most recent survey, conducted by Ayres, McHenry & Associates in September 2006, found that:

- 70 percent of self-enrolled seniors would recommend that others sign up for the new Medicare prescription drug benefit;
- 58 percent of enrollees said they were saving money with the new benefit;
- Two-thirds of enrolled seniors think passing the Medicare prescription drug plan was a good idea; and
- 88 percent have had no problems using the new benefit.

## V. Why the Medicare Part D Program is Succeeding

A major factor contributing to the success of the Part D program is the fact that plan sponsors are working aggressively to negotiate lower prescription drug prices for beneficiaries. A team of CMS economists and actuaries has published research findings<sup>7</sup> estimating that sponsors of Part D plans negotiated discounts and rebates of 27 percent in 2006. These savings represent nearly double the amount that plans were expected to negotiate at the time the MMA was enacted.

The program's success can also be attributed to the various tools and techniques plans have developed to limit out-of-pocket costs for beneficiaries and, at the same time, improve quality by reducing medication errors and promoting clinically sound drug use.

Formularies are an important tool that help control prescription drug costs. Medical professionals play a central role in developing formularies, which must comply with stringent standards to ensure that they include drugs necessary to treat all major diseases. To ensure that formulary decisions are clinically appropriate, health plan Pharmacy & Therapeutics Committees – composed principally of physicians and pharmacists – identify drugs for inclusion on health plan formularies based on documented safety, efficacy, and therapeutic benefit.

Part D sponsors' generic substitution programs encourage beneficiaries to use lower-cost prescription drugs when clinically appropriate. In the first half of 2006, more than 60 percent of prescriptions dispensed through Medicare Part D plans were for generic medications. Part D plan formulary management techniques such as step therapy and prior authorization also are working to reduce out-of-pocket costs for beneficiaries.

A number of studies demonstrate that these tools and techniques are highly effective in making prescription drugs more affordable for consumers. For example:

- CBO has estimated<sup>8</sup> that private sector management techniques employed by Medicare Part D plans would save individuals 20-25 percent off retail prices for prescription drugs.

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<sup>7</sup> *Health Affairs*, Health Spending Projections Through 2015: Changes on the Horizon, February 22, 2006

<sup>8</sup> CBO, *A Detailed Description of CBO's Cost Estimate for the Medicare Prescription Drug Benefit*, July 2004

- A 2003 study<sup>9</sup>, conducted by Associates and Wilson on behalf of AHIP, found that the PACE program in Pennsylvania – the largest state pharmacy assistance program in the nation – could save up to 40 percent by adopting the full range of private sector pharmacy benefit management techniques.
- In addition, the Government Accountability Office (GAO) has reported<sup>10</sup> that pharmacy benefit management techniques used by health plans in the Federal Employees Health Benefits Program (FEHBP) resulted in savings of 18 percent for brand-name drugs and 47 percent for generic drugs, compared to the average cash price customers would pay at retail pharmacies.

These findings clearly demonstrate that the private sector has a strong track record of using its experience and capabilities to deliver affordable prescription drug benefits. At a time when federal resources are severely strained, it is important for policymakers to recognize the ability of health insurance plans to implement strategies that are enabling Medicare beneficiaries to receive the greatest possible value for the dollars the Medicare program is spending on their prescription drug coverage.

## **VI. Conclusion**

The Medicare Part D prescription drug program is the most far-reaching expansion of Medicare in its 40-year history. The early data show that this program is delivering significant value to beneficiaries, including millions of low-income seniors who are receiving additional assistance with their premiums and cost-sharing. The availability of high quality choices – spurred by vigorous competition among plan sponsors – has played a pivotal role in generating these savings.

We urge the committee to continue to support the competition, choice, and innovation that have played such an important role in delivering savings and value to our nation’s Medicare beneficiaries.

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<sup>9</sup> Associates & Wilson, *Prescription Drug Benefit Management: Improving Quality, Promoting Better Access and Reducing Cost*, October 2003

<sup>10</sup> Government Accountability Office, *Federal Employees’ Health Benefits: Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees, and Pharmacies* (GAO-03-196), January 2003