Chapter 5:
Medicare Prescription Drug Program

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("Medicare Modernization Act" or MMA) became law in December 2003. Among other provisions, the MMA created the Part D drug benefit, which became available to Medicare beneficiaries on January 1, 2006.

Before the MMA, Medicare covered no outpatient drugs, an omission that created an increasingly large hole in the program’s benefits.1 Prior to passage of the MMA, Medicare did cover certain physician-administered drugs under Part B.2 Passage of the MMA came after extended debate in which policymakers were sharply divided over the design of the drug benefit, its structure and its cost – particularly whether it could be restricted to the $400 billion, 10-year budget established by the Bush Administration.3

On May 15, 2006, the initial enrollment period ended.4 Some 22.5 million beneficiaries (out of 43 million overall)5 enrolled in either stand-alone Part D plans or in drug plans affiliated with Medicare Advantage plans. Most of these beneficiaries were automatically enrolled, either because of their status as dual eligibles (participants in both Medicare and Medicaid) or as current enrollees in Medicare Advantage plans.6 By the Administration’s numbers, an additional 15.8 million beneficiaries have coverage as good as Part D.7

Instead of offering the benefit itself, Medicare relies on private drug plans that compete among themselves. The benefit is available either from stand-alone private prescription drug plans (PDPs) or drug plans sponsored by Medicare Advantage organizations for those who get their overall benefits from these private health plans.8 These affiliated drug plans are known as “MA-PDs.” (For more on Medicare Advantage plans, See Chapter 4, “Medicare”). These organizations are at risk for the cost of the benefit although the government shares some of the risk.9

The general outlines of the standard benefit are established by law, though plans have the option of modifying the benefit design. Most plans are using cost management tools (e.g., formularies and prior authorization) to leverage their buying power to negotiate price discounts and thus manage drug costs and to encourage appropriate utilization.10

The success of the Medicare drug benefit may be judged by a number of factors, only a few of which will be known in the short term. Furthermore, this program is may

For story ideas on the Medicare prescription drug program, see page 70. A list of experts and websites also begins on page 70.
undergo administrative and potentially legislative changes in its early years, making it a moving target. This chapter assesses the Part D benefit at this early stage, including a look ahead at the prospects for 2007.

THE SHAPE OF MEDICARE PART D

Medicare Part D relies on private drug plans competing in 39 regions to make the benefit available to beneficiaries covered under traditional Medicare. MA organizations are required to offer at least one plan with a qualified drug benefit to enrollees in each area they serve. MA enrollees, if they want a drug benefit, must get it from their MA plan. 

The benefit has a complex design shaped by a combination of political and budget factors. Under the standard benefit,* beneficiaries are subject to an initial deductible ($250 in 2006) and then must pay 25 percent of drug costs up to an initial coverage limit ($2,250 in 2006). Above the initial coverage limit, beneficiaries are responsible for paying the entire cost of their drugs until they reach $3,600 in out-of-pocket costs, equivalent in 2006 to $5,100 in total drug costs under the standard benefit. This coverage gap is often referred to as the “doughnut hole.” After reaching the threshold for out-of-pocket spending, catastrophic coverage kicks in with only modest cost-sharing, generally 5 percent of the cost of the drug.12 (See table, “Shape of the Standard Benefit in 2006.”)

Plans may substitute their own benefit design for this standard benefit but it must be actuarially equivalent (i.e., covers the same amount of drug costs on average). Substitute coverage may, for example, replace percentage coinsurance with flat copayments or eliminate the deductible. Plans also may enhance their coverage by adopting a more generous benefit structure. For example, a plan can choose to pay some of a beneficiary's drug costs in the coverage gap.13 Beneficiary premiums and not federal dollars must cover the cost of the value of enhanced coverage.14 Beneficiaries pay a premium to the drug plan they select. In 2006 the average premium, excluding retiree coverage, is less than $24.15

The drug benefit - unlike other parts of the Medicare program - varies according to income. Beneficiaries with incomes below 135 percent of the federal poverty level ($13,230 for a single person and $17,820 for a couple in 2006) are eligible for a subsidy if they also have assets below a specified level ($6,000 for an individual and $9,000 for a couple in 2006). Once enrolled, they typically face no premiums and only minimal out-of-pocket costs. Those with Medicaid coverage do not have to meet the federal asset test.

* The Medicare Modernization Act (MMA) defines a “standard” prescription drug benefit. Plans are free to modify the actual benefits they offer as long as benefits are actuarially equivalent to the standard benefit outlined under MMA.

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### Shape of the Standard Benefit in 2006

<table>
<thead>
<tr>
<th>Program</th>
<th>Total Drug Spending</th>
<th>Amount Paid by Beneficiary Under Standard Benefit</th>
<th>Amount Paid by Low-Income Beneficiary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premium</td>
<td>Average of $24 per month</td>
<td>None for eligible plan</td>
<td></td>
</tr>
<tr>
<td>Deductible before initial coverage begins</td>
<td>Up to $250</td>
<td>$250</td>
<td>None</td>
</tr>
<tr>
<td>During initial coverage period</td>
<td>$250 to $2,250</td>
<td>25% of cost</td>
<td>$1 to $5 (varies by type of drug, income, Medicaid status)</td>
</tr>
<tr>
<td>In the coverage gap</td>
<td>$2,250 to $5,100</td>
<td>Pay full cost</td>
<td>No coverage gap</td>
</tr>
<tr>
<td>Once catastrophic coverage begins</td>
<td>Over $5,100</td>
<td>Greater of 5%, $2 (generic), $5 (brand)</td>
<td>No cost sharing above $3,600 in out-of-pocket costs</td>
</tr>
</tbody>
</table>

Note: Excludes those eligible for partial subsidies. Most amounts are indexed and will be higher in 2007.

although some states apply their own asset test. Beneficiaries with incomes between 135 and 150 percent of the federal poverty level and with somewhat higher assets may receive partial subsidies.16

In exchange for taking over from the states coverage of drugs for Medicaid beneficiaries, the federal government recoups a share of the cost from the states.17 States will now be required to send monthly payments to the federal government based on estimates of how much the state would have had to pay through its Medicaid program if it were not for the Medicare prescription drug benefit.18 Known as the "clawback", these payments have been challenged (unsuccessfully, as of September 2006) by states in court for a variety of technical and policy reasons.19 Many states maintain that "clawback" costs will exceed their previous Medicaid costs, since many had taken effective steps to manage their costs.20

PLANS IN THE PART D MARKET

Approximately 65 different organizations offered PDPs in 2006. Ten organizations offered plans in all 39 regions covering the states.21 Four other organizations offered plans in most regions, while others (especially locally based insurers) participated in a smaller set of regions. Most organizations, mainly large insurance companies and pharmacy benefit management chose to offer three plan options in each region, thus guaranteeing that beneficiaries across the country have a large array of options.22 Nationally, more than 1,400 plan options were available through Part D in 2006. In most regions, beneficiaries faced between 40 and 45 plan options.23

In the first year, two organizations dominated the market nationally, controlling nearly half the stand-alone PDP market and about one-third of the MA-PD market, according to partial data released by CMS.24 United HealthCare (including its merger partner, PacifiCare) has the largest share, due in part to its affiliation with AARP, while Humana obtained the second largest share, probably as a result of its aggressive strategy of offering low-premium plans. No other organization topped 10 percent of national enrollment in the PDP market. United/PacifiCare, Humana, and Kaiser Permanente have the strongest enrollment numbers in the MA market.25

Monthly premiums across all stand-alone prescription drug plans range from $1.87 to $104.89 (See chart, “Range of Premiums for All Stand-Alone Prescription Drug Plans.”)26 Some plans are available at no premium charge to enrollees who are eligible for the low-income subsidy.27,28 In order for the subsidy to be applicable, plans must be priced below a regional benchmark that is defined as the average of plan premiums, including MA premiums but excluding the value of enhanced benefits.28 Benchmarks in 2006 ranged from $23.25 a month in California to $36.39 in Mississippi. On average, subsidy-eligible beneficiaries have between five and 14 options.29

Drug plans have taken full advantage of the flexibility allowed by law to vary their benefit designs and formulae. A majority of plans chose to lower or eliminate the standard deductible, substitute flat copayments for coinsurance (e.g., $25 for a one-month supply instead of 25 percent of the cost), and adopt tiered cost-sharing where the beneficiary pays different amounts for different types of drugs (See chart, “Cost-Sharing Designs for Stand-Alone Prescription Drug Plans”).
The most common approach was to use three tiers with different copayment amounts for generic drugs, preferred brand-name drugs and non-preferred brand-name drugs. Sometimes there is a separate tier for specialty drugs (e.g., biotechnology products or injectable drugs). Relatively few plans chose to fill in the doughnut hole at all, and most that did cover only generic drugs in this gap.30

Median copayment levels for 2006 are about $5 for generic drugs, $25 for preferred brand-name drugs, and $53 for non-preferred drugs.31 But there is substantial variation among plans. Several have no copayments for generic drugs, while others charge as much as $15. Copayments typically range from about $15 to $40 for preferred brand drugs and from about $40 to $72.50 for non-preferred drugs.32

The MMA limits plan flexibility around formularies and other cost management approaches by requiring that plan bids be rejected if the proposed design and benefits are “likely to substantially discourage enrollment by certain part D eligible individuals.”33 This aims to protect beneficiaries by ensuring that formularies are not overly restrictive and that commonly needed drugs are available.34 A plan must cover at least two drugs in each therapeutic class and most or all drugs in certain designated classes (e.g., drugs used to treat mental health conditions and HIV/AIDS).35 Beneficiaries may request exceptions and appeal most situations where coverage of a drug is denied.36

The competing drug plans made significantly different decisions about their formularies. The national and near-national plans covered between 64 percent and 97 percent of a sample of 152 drugs. While nearly all these plans covered the ten most commonly prescribed generic drugs, only about half the plans covered the ten brand-name drugs (See table, “Number and Percentage of Plans Covering Top 10 Brand-Name and Generic Drugs”). Plans sometimes omitted drugs with therapeutically similar competitors, for example, covering Lipitor but not Zocor as a treatment for high cholesterol.37 When a drug is not listed on the formulary, beneficiaries must pay for the drug out of pocket, switch to an alternative or request an exception.38

Placement on different tiers can also mean substantially different costs for the beneficiary. An enrollee could pay from $15 to $62 for Norvasc (a common drug for high blood pressure), $15 to $100 for Namenda (for Alzheimer’s disease) or even $20 to $1,276 for Enbrel (for rheumatoid arthritis), depending on the plan selected.39

**RELATIONSHIP OF PART D TO EXISTING COVERAGE**

The role of Medicare Part D differs substantially depending on a beneficiary’s situation. Some people have chosen to stay with their previous source of drug coverage. For others, Medicare Part D provides coverage not previously available or replaces their current source of coverage.

Most beneficiaries with coverage through former employers were able to retain it in 2006 and avoid the disruption of moving into Part D.40 As an incentive for employers to continue offering retiree drug coverage at least equivalent to Part D (referred to as “creditable coverage”), Medicare pays a tax-free subsidy equal to 28 percent of allowable drug costs between $250 and $5,000. Although four of every five large employers reported that they would accept the subsidy and continue to provide benefits in 2006, only about half indicated they are likely to do so in 2010.41

About 6.6 million dually eligible beneficiaries—who had been receiving drug coverage from Medicaid—were required to switch to Part D plans.42 Dually eligible beneficiaries were automatically enrolled for the low-income subsidy and were randomly auto-enrolled in a Part D plan with an option of switching to a different plan.43
Medicaid beneficiaries, if enrolled in eligible Medicare drug plans, do not pay premiums or deductibles, and do not face a coverage gap. Although some beneficiaries had no copayments under Medicaid, they generally now face copayments of between $1 and $5 (depending on their income level and whether a drug is generic or brand). Some may also find that drugs they take are not on their Part D plan’s formulary. CMS required Part D plans to establish transition plans to accommodate, at least temporarily, beneficiaries in this situation.

Most beneficiaries who were enrolled in MA plans in 2005 took the option of receiving Part D coverage from their plan. Nearly 40 percent of MA plans offered drug coverage in 2006 without an added premium and about two-thirds provided enhanced drug coverage. In recent years many MA plans had reduced the scope of their drug coverage so most beneficiaries enrolled in MA plans should have seen improvements to their previous drug coverage.

Most beneficiaries with privately purchased supplemental insurance, called Medigap, were expected to switch into Part D plans. No new Medigap policies with drug coverage can be sold, although those with such coverage have the option of retaining it. Medigap policies have high premiums for relatively thin benefits and do not qualify as creditable coverage. As a result, policyholders should have better coverage at a lower price by switching to Part D plans.

In some states, beneficiaries have had coverage available through state pharmacy assistance programs. Typically, these state-funded programs provided coverage to beneficiaries with incomes below a certain threshold but not low enough to make them eligible for Medicaid. Most larger state programs continue to be available, though modified to wrap around Part D. Beneficiaries eligible for these state pharmacy assistance programs typically have maintained coverage at least as generous as they had previously, while the states save money because Medicare now pays a portion of the drug costs.

**EDUCATION, MARKETING, AND ENROLLMENT**

Medicare faced a great challenge in educating beneficiaries about the new benefit. One incentive to enroll is the penalty for late enrollment, which discourages people from deferring enrollment until they have substantial drug costs. Beneficiaries who sign up after the end of the initial open enrollment season without creditable coverage from another source will pay a larger premium (increased by 1 percent of the national average premium for each month not enrolled) for the duration of their participation in the program. Such a beneficiary deciding in July 2006 to enroll must wait for the November open season to choose a plan effective in January 2007; in addition, this beneficiary will pay a 7 percent premium surcharge (probably about $2 per month in 2007).

Confusion about the drug benefit has been a major implementation concern. About 40 percent of beneficiaries reportedly found the process of researching a plan selection to be difficult. CMS ran an extensive information campaign that included mailings, flyers, advertising, a toll-free telephone line (1-800-Medicare), and website (www.medicare.gov). Yet only one-fifth of surveyed beneficiaries reported that either they or someone helping them used the toll-free line, and only 11 percent used the website. Only 6 percent of surveyed respondents reported using a counselor.

Despite considerable confusion along the way, CMS reported enrollment of 22.5 million beneficiaries in the prescription drug plan as of June 11, 2006. Over half of these were dually eligible beneficiaries assigned to plans or beneficiaries adding Part D coverage to existing Medicare Advantage coverage (See table, “Enrollment in Part D and Other Sources of Drug Coverage, June 2006.”)

<table>
<thead>
<tr>
<th>Top 10 Brand-Name and Generic Drugs</th>
<th>18</th>
<th>51%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Top 10 Brands</td>
<td>18</td>
<td>51%</td>
</tr>
<tr>
<td>All Top 10 Generics</td>
<td>32</td>
<td>91%</td>
</tr>
</tbody>
</table>

Note: The analysis is based on coverage of 152 drugs from Medicare.gov Drug Plan Finder for 35 different stand-alone Medicare Prescription Drug Plans offered by 14 sponsor organizations, representing 1,222 of the 1,429 plans nationwide.

As of June 2006, 1.8 million beneficiaries had applied and qualified for the low-income subsidy (in addition to dual eligibles and others who were automatically deemed eligible). According to CMS estimates, another 3.3 million have not applied despite being eligible. CMS has committed to ongoing outreach to these individuals. Some 2.3 million applicants were rejected as a result of excess income, assets, or both.

### MONITORING IMPLEMENTATION

It is too early to evaluate the overall success of Medicare Part D, which will be measured in the court of public opinion by enrollment numbers and the general satisfaction of beneficiaries. In the meantime, Congress may decide to make mid-course corrections or more fundamental changes to the program’s design. Beneficiaries, although sometimes frustrated by the enrollment process and the early transition, generally have been satisfied with the benefit itself. Whether they will remain so as they hit the coverage gap or face decisions about whether to switch plans in future open enrollment periods is unknown.

Several measures beyond enrollment should be examined as indicators of success. One is the overall cost of the program—a matter of debate prior to its inception. In 2003, CBO estimated its cost at $394 billion over 10 years while in 2004 the Health and Human Services Office of the Actuary priced the program at $534 billion. In 2005, the Administration released an estimate pricing the program at $720 billion between 2006 and 2015.

Part of the reason for the discrepancy between the

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### Enrollment in Part D and Other Sources of Drug Coverage, June 2006

<table>
<thead>
<tr>
<th>Category of Beneficiaries</th>
<th>Enrollment (millions)**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug Coverage from Medicare Plans</td>
<td></td>
</tr>
<tr>
<td>· Standalone PDPs</td>
<td>10.4</td>
</tr>
<tr>
<td>· Dual Eligibles in PDPs</td>
<td>6.1</td>
</tr>
<tr>
<td>· Medicare Advantage Plans (MA-PDs)*</td>
<td>6.0</td>
</tr>
<tr>
<td><strong>TOTAL ENROLLMENT IN PART D PLANS</strong></td>
<td>22.5</td>
</tr>
<tr>
<td>Subsidized Drug Coverage from Former Employer</td>
<td>6.9</td>
</tr>
<tr>
<td><strong>TOTAL PART D-RELATED COVERAGE</strong></td>
<td>29.4</td>
</tr>
<tr>
<td>Other Sources of Creditable Coverage</td>
<td></td>
</tr>
<tr>
<td>· Federal Retiree Coverage (FEHB, TRICARE)</td>
<td>3.5</td>
</tr>
<tr>
<td>· Federal Benefits (VA, Indian Health Service)</td>
<td>2.1</td>
</tr>
<tr>
<td>· Active Workers with Medicare Secondary Payer</td>
<td>2.6</td>
</tr>
<tr>
<td>· Other (Unsubsidized Retiree Coverage, SPAPs)</td>
<td>0.7</td>
</tr>
<tr>
<td><strong>TOTAL BENEFICIARIES WITH CREDITABLE DRUG COVERAGE</strong></td>
<td><strong>38.2</strong></td>
</tr>
<tr>
<td><strong>TOTAL MEDICARE BENEFICIARIES ELIGIBLE FOR DRUG COVERAGE</strong></td>
<td><strong>42.6</strong></td>
</tr>
</tbody>
</table>

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* About 500,000 dual eligibles are enrolled in MA-PDs and are listed in this category.

** Numbers do not sum because of rounding.

earlier and later figures is that the earlier numbers included in their 10-year estimates initial start up years before seniors were fully using the new benefit. Later estimates consider a 10-year span after the program has been fully implemented.\textsuperscript{59} The Bush Administration in mid-2006 reported that lower-than-expected plan premiums and decisions by beneficiaries to enroll in the lowest-premium plans have reduced total estimated costs by nearly $180 billion (or 20 percent of the most recent administration estimate - $926 billion for the period 2006-2015).\textsuperscript{60}

As plans report their actual first-year results, low costs more generally may signify that plans have negotiated low prices and managed drug utilization successfully, but can also result from low enrollment or the failure of beneficiaries to fill needed prescriptions. Policy makers will undoubtedly look at indicators of quality, such as whether beneficiaries receive needed drugs and whether their use of services is inappropriately reduced.

**PROSPECTS FOR 2007 AND BEYOND**

In the short term, Congress may consider making changes to the late-enrollment penalty\textsuperscript{61} or address the concerns of some pharmacies that they are not being paid on a timely basis.\textsuperscript{62} Advocates are urging Congress to consider more transition protections for dual eligibles, a first-year need that could be repeated if changes to plan premiums force many low-income beneficiaries to be assigned to new plans, or to eliminate the asset test for eligibility for the low-income subsidy).\textsuperscript{63}

Some lawmakers may also push for stronger guidelines for formulary adequacy, or steps to reduce beneficiary confusion through greater standardization of plans’ benefits and procedures.\textsuperscript{64} In addition, some members of Congress want to grant the Secretary negotiating authority over drug prices, \textsuperscript{65} or reduce the coverage gap.\textsuperscript{66}

The projected cost of the Medicare Part D benefit was a major political issue surrounding enactment of the MMA, and actual costs will have a huge impact on the benefit’s future. Some fiscal conservatives have already proposed repealing Part D because of its high costs,\textsuperscript{67} while others have revived prior proposals to restrict it to low-income beneficiaries.\textsuperscript{68} On the other side of the political spectrum, policy leaders may push proposals to integrate the drug benefit into the broader Medicare package\textsuperscript{69} or to create a government plan option.\textsuperscript{70}

On November 15, 2006, beneficiaries will once again be able to enroll in Part D or switch plans (effective January 1, 2007).\textsuperscript{71} In advance of that date, several questions will be answered: Will the same plans be offered? Will premiums go higher? Will plan formularies become more restrictive? The 2006 open season will include some new enrollees and some who switch to different plans. Both CMS and the plans should be in a better position to avoid the initial problems faced in January 2006, when some beneficiaries could not get their prescriptions filled at the correct price.

Some experts believe that significant market consolidation might wait until 2008, after plans have been able to see a full year’s claims experience and after some of the initial financial protections begin to phase out.\textsuperscript{72} It remains to be seen what impact such consolidation would have on access to prescription drug coverage, quality of coverage and costs for beneficiaries.

Even sooner than the end of 2006, new problems could arise as more beneficiaries hit the coverage gap and may be startled when they are billed full price for a prescription they have been getting for a $15 copayment. Similarly, beneficiaries who are prescribed new drugs may run into denials of coverage for the first time if the drug is off formulary or requires prior authorization.

**CONCLUSION**

Policymakers will have at least some indicators of Medicare Part D’s success within the first year of the program, and beneficiaries’ reactions to the benefit could play an important role in the 2006 congressional elections. Other signs of success or failure will only be available after a full year, when various types of data can be collected and made available to Congress and the public. As is true for many complex public policy issues, political decisions may have to be made more quickly than data can be collected and analyzed. One thing is certain: Medicare Part D will continue to receive considerable attention from researchers, journalists, beneficiaries, and policymakers.
STORY IDEAS

- When new plan offerings are announced, beneficiaries face an open season for the year to come. What organizations are leaving the program in your area and why? For organizations that are staying in the program, are they modifying their plan offerings? How many “dual eligibles” (enrolled in both Medicare and Medicaid) will have to change plans for 2007? Are premiums lower or higher, and by how much? How many beneficiaries in general will need to switch to new plans?

- Does your state have a state pharmacy assistance program (SPAP) in 2006? How many enrollees are getting coverage through it? How smooth has coordination been between the SPAP and the Part D benefit? Are there any new issues facing these programs or are further program changes expected in 2007?

- Are beneficiaries still having problems getting access to needed drugs? To what extent have beneficiaries needed to request exceptions or request prior authorization? How hard has this process been for beneficiaries? For pharmacists and physicians?

- How are beneficiaries handling their costs as they reach the coverage gap? Does the gap come as a surprise, or were they prepared for it? Are they cutting back on needed medications?

- Plans report quarterly to the government on such topics as call center performance, generic drug dispensing rates, use of the exceptions and appeals processes, etc. Are those figures being made available? How do plans in your area compare on these measures? What implications does this have for educating beneficiaries during the next open enrollment season?

- What has been the experience of counselors – those who are part of the state counseling (“SHIP”) program, members of the ABC coalition, or others – in working with beneficiaries? What lessons can they offer for future years? What challenges have they faced? What resources do they have available?

- States now pay directly for lesser amounts of drugs through Medicaid, because Medicare now finances drugs for those enrolled in both programs. Has this affected the state’s bargaining power with drug companies for the drugs they still buy? Is the state making its “clawback” payment to the federal government, to compensate for its lowered drug costs? Does your state consider the payment to be the fair amount?

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Websites
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AARP Drug Benefit Calculator
http://sites.stockpoint.com/AARP/drugbenefit.asp
Access to Benefits Coalition
www.accessstobenefits.org
Aetna
www.aetna.com
Alliance of Community Health Plans
www.achp.org
American Institutes for Research
www.air.org
American Society of Health-System Pharmacists
www.ashp.org
American Society on Aging - Medicare
www.asaging.org/medicare/index.cfm
Avalere Health
www.avalerehealth.net
BenefitsCheckUpRx (NCOA)
www.benefitscheckup.org/
Blue Cross Blue Shield Association
www.bcbs.com
Center for Medicare Advocacy
www.medicareadvocacy.org
Center on Budget and Policy Priorities
www.cbpp.org
Centers for Medicare and Medicaid Services
www.cms.hhs.gov
CMS Resources for Partners
www.cms.hhs.gov/partnerships
The Commonwealth Fund
www.cmwf.org
Congressional Budget Office
www.cbo.gov
Consumer Reports Best Buy Drugs
www.crbestbuydrugs.org
Consumers Union
www.consumersunion.org
Employee Benefit Research Institute
www.ebri.org

Families USA - Medicare Drug Coverage Center
www.familiesusa.org/issues/medicare/rx-drug-center/

Generic Pharmaceutical Association
www.ghpaonline.org

George Washington University Department of Health Policy
www.gwhealthpolicy.org

Georgetown University Public Policy Institute
http://gppi.georgetown.edu/welcome.html

Government Accountability Office
www.gao.gov

Harvard Medical School
department of Health Care Policy
www.hcp.med.harvard.edu

Health Policy and Strategy Associates
www.healthpol.com

The Heritage Foundation
www.heritage.org

Humana - Medicare
www.humana-medicare.com

IMS Health
www.imshealth.com

Jennings Policy Strategies
www.jenningsps.com

Kaiser Family Foundation
www.kff.org

Kaiser Family Foundation - Medicare Rx Drug Benefit
www.kff.org/medicare/rxdrugbenefit.cfm

Kaiser Family Foundation Drug Benefit Calculator
www.kff.org/medicare/rxdrugcalculator.cfm

Kaiser Foundation Health Plan Inc.
www.kaiserpermanente.org

The Lewin Group, Drug Calculator
http://webstudies.lewin.com/pdb/medicare2.htm

Medco Health Solutions
www.medcohealth.com

Medicare Rights Center
www.medicarerights.org

Medicare Rx Connect
www.maprx.info

Medicare Rx Education Network
www.medicarerxeducation.org

Medicare Rx Outreach & Education Project
www.medicarerxoutreach.org

Medicare Today
www.medicaretoday.org

Medicare.gov - U.S. Government Site for People with Medicare
www.medicare.gov

Merck & Company, Inc.
www.merck.com

National Academy for State Health Policy
www.nashp.org

National Association of Chain Drug Stores
www.nacds.org

National Association of State Medicaid Directors
www.nasmd.org

National Association of State Units on Aging
www.nasua.org

National Committee to Preserve Social Security and Medicare
www.ncpssm.org

National Conference of State Legislatures, Health Program
www.ncsl.org/programs/health/health.htm

National Council on Aging
www.ncoa.org

National Governors Association
www.nga.org

Pennsylvania Department of Aging
www.aging.state.pa.us

Pharmaceutical Care Management Association
www.pcmanet.org

Pharmaceutical Research and Manufacturers of America (PhRMA)
www.phrma.org

Project HOPE
www.projecthope.org

Robert Wood Johnson Foundation
www.rwjf.org

Rutgers Center for State Health Policy
www.cshp.rutgers.edu

Social Security Administration
www.ssa.gov/prescriptionhelp/
ENDNOTES


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24 The data released by CMS as of this writing do not report on plans with low enrollment. In addition, they do not include enrollment numbers for the individual plan options offered by an organization. For CMS raw data see: http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp.


27 These qualifying plans cannot offer enhanced benefits. If they do, beneficiaries must pay for the value of the enhanced benefit even if the premium is lower than the benchmark. See: MedPAC (2006). “Report to Congress: Increasing the Value of Medicare.” June, 152. (http://www.medpac.gov/publications/congressional_reports/June06_EntireReport.pdf). Retrieved on July 24, 2006. Note that this is not specifically stated in the source; however, it is the implication since beneficiaries are always required to pay extra for enhanced benefits.


