November 2013 | Fact Sheet

The Medicare Part D Prescription Drug Benefit

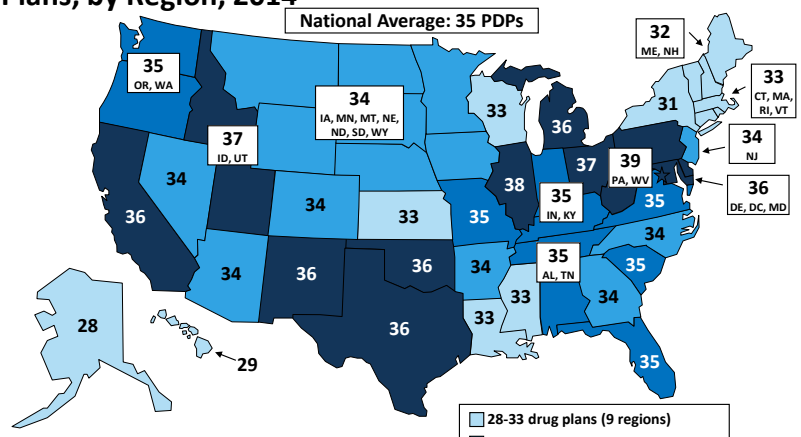
The Medicare Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for people on Medicare, known as Part D, that went into effect in 2006. All 52 million elderly and disabled beneficiaries have access to the Medicare drug benefit through private plans approved by the federal government. Beneficiaries with low incomes and modest assets are eligible for assistance with Part D plan premiums and cost sharing. The Affordable Care Act (ACA) of 2010 made some important changes to Part D—in particular, phasing out the coverage gap by 2020.

MEDICARE PRESCRIPTION DRUG PLANS

The Medicare drug benefit is offered through stand-alone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans (mainly HMOs and PPOs) that cover all Medicare benefits including drugs. In 2014, 1,169 PDPs will be offered across the 34 PDP regions nationwide (excluding the territories). Beneficiaries in each state will have a choice of more than two dozen stand-alone PDPs and multiple MA-PD plans (**Figure 1**).

Figure 1

Number of Medicare Part D Stand-Alone Prescription Drug Plans, by Region, 2014



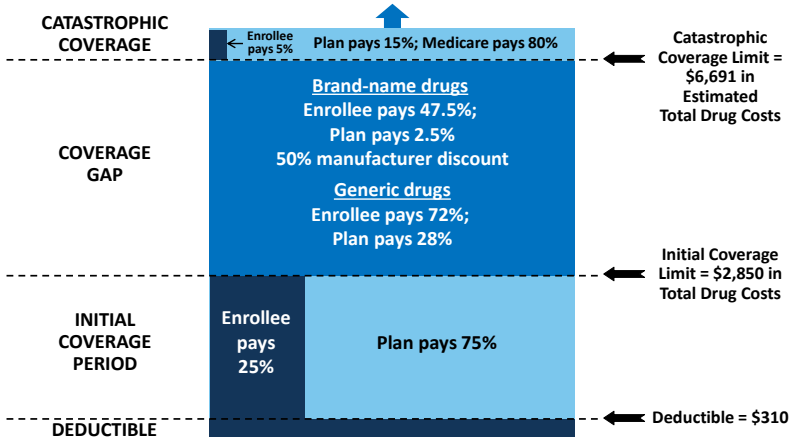
NOTE: PDP is prescription drug plan. Excludes plans in the territories. Includes 168 plans under CMS sanction and closed to new enrollees as of October 2013.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS PDP landscape source file, 2014.

PART D PLAN BENEFITS AND PREMIUMS

Part D sponsors offer plans with either a defined standard benefit or an alternative equal in value ("actuarially equivalent"), and can also offer plans with enhanced benefits. The standard benefit in 2014 has a $310 deductible and 25% coinsurance up to an initial coverage limit of $2,850 in total drug costs, followed by a coverage gap. During the gap, enrollees are responsible for a larger share of their total drug costs than in the initial coverage period, until their total out-of-pocket spending reaches $4,550 (**Figure 2**). Thereafter, enrollees pay either 5% of total drug costs or $2.55/$6.35 for each generic and brand-name drug, respectively. The standard benefit amounts increase annually by the Part D per capita spending growth rate.

Figure 2

Standard Medicare Prescription Drug Benefit, 2014



NOTE: *Amount corresponds to the estimated catastrophic coverage limit for non-low-income subsidy enrollees ($6,455 for LIS enrollees), which corresponds to True Out-of-Pocket (TrOOP) spending of $4,550 (the amount used to determine when an enrollee reaches the catastrophic coverage threshold.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2014 (standard benefit parameter update from Centers for Medicare & Medicaid Services, 2013). Amounts rounded to nearest dollar.

Only a small share of PDPs nationwide will offer the standard drug benefit in 2014, as in previous years. The majority of PDPs (53%) charge a deductible, with 49% charging the full amount ($310). Most plans charge tiered copayments for covered drugs rather than 25% coinsurance and a substantial majority of PDPs use specialty tiers for high-cost medications. And most PDPs (76%) will not offer additional gap coverage in 2013 beyond what is required under the standard benefit. Additional gap coverage, when offered, is generally limited to generic drugs only (not brands).

The ACA gradually lowers out-of-pocket costs in the coverage gap. Enrollees in plans with no additional gap coverage in 2014 will pay 47.5% of the total cost of brands and 72% of the total cost of generics in the gap until they reach the catastrophic coverage limit. Medicare will phase in additional subsidies for brands and generic drugs, ultimately reducing the beneficiary coinsurance rate in the gap to 25% by 2020.

The monthly Part D premium averages $39.90 in 2013 (weighted by 2013 enrollment), a 5% increase since 2013. Actual PDP premiums vary across plans and regions, ranging from $12.50 to $174.70. Part D plans vary in benefit design, cost-sharing amounts, and utilization management tools (prior authorization, quantity limits, and step therapy). Plans also vary in terms of formularies (covered drugs), provided they comply with requirements established by the Centers for Medicare & Medicaid Services (CMS) to ensure a minimum level of coverage and prohibit formularies that discourage enrollment of certain types of beneficiaries.

PART D ENROLLMENT

Enrollment in Medicare drug plans is voluntary, with the exception of beneficiaries who are dually eligible for both Medicare and Medicaid and certain other low-income beneficiaries who are automatically enrolled in a PDP if they do not choose a plan on their own. Unless beneficiaries have drug coverage from another source that is at least as good as standard Part D coverage ("creditable coverage"), they face a penalty equal to 1% of the national average premium for each month they delay enrollment.

In 2013, nearly 39 million Medicare beneficiaries are enrolled in Medicare Part D plans or in retiree drug subsidy plans (Medicare Trustees, 2013). Of this total, an estimated 35.7 million are in Part D plans—about two-thirds are enrolled in stand-alone PDPs and one-third are enrolled in Medicare Advantage drug plans, while another 3.2 million beneficiaries have drug coverage through employer-sponsored retiree plans where the employer receives subsidies equal to 28% of drug expenses between $325 and $6,600 per retiree in 2013 (decreasing to $310 and $6,350 in 2014) (Medicare Trustees, 2013). Several million beneficiaries are estimated to have other sources of drug coverage, including employer plans for active workers, FEHBP, TRICARE, and Veterans Affairs (VA). Yet an estimated 10% of the Medicare population lacks creditable drug coverage, according to CMS's most recent estimates from 2010.

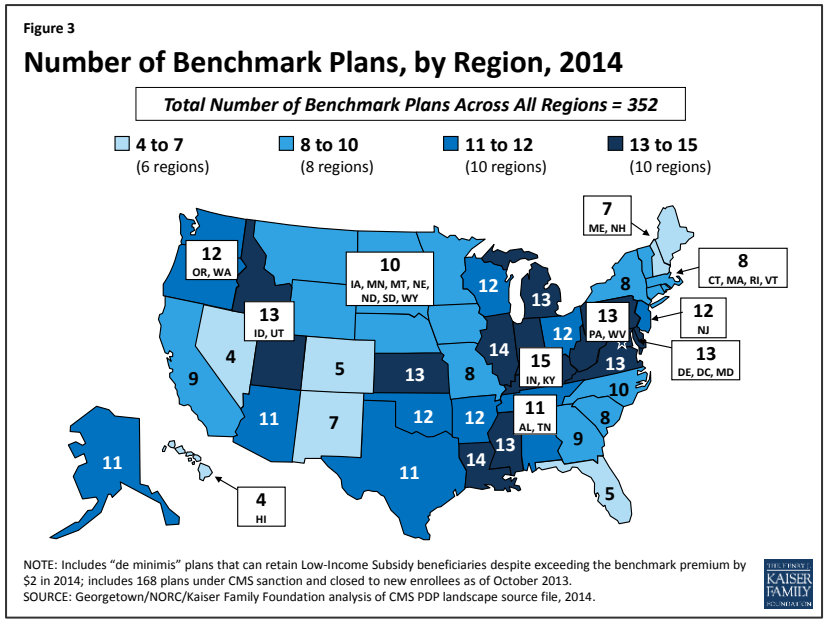
Part D enrollment is highly concentrated, with five firms—UnitedHealth, Humana, CVS Caremark, Express Scripts, and Aetna—accounting for 65% of enrollees in 2013. While beneficiaries have the option to choose among dozens of plans each year, and often could save money if they switched plans, most (7 out of 10) beneficiaries who were in a PDP during all four annual open enrollment periods from 2006 to 2010 did not voluntarily switch plans in any of the enrollment periods.

ASSISTANCE FOR LOW-INCOME BENEFICIARIES

Part D includes substantial premium and cost-sharing assistance for beneficiaries with low incomes (less than 150% of poverty, or $17,235 for individuals in 2013) and modest assets (less than $13,300 for individuals). Beneficiaries who are dually eligible, QMBs, SLMBs, QIs, and SSI-onlys automatically qualify for the additional assistance, and Medicare automatically enrolls them into PDPs with premiums at or below the regional average ("benchmark" plans) if they do not choose a plan on their own. Other beneficiaries are subject to both an income and asset test and need to apply for the low-income subsidy (LIS) through either the Social Security Administration or Medicaid. People determined eligible for LIS are assigned to a PDP if they do not enroll on their own.

Figure 3

Number of Benchmark Plans, by Region, 2014



NOTE: Includes "de minimis" plans that can retain Low-Income Subsidy beneficiaries despite exceeding the benchmark premium by $2 in 2014; includes 168 plans under CMS sanction and closed to new enrollees as of October 2013.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS PDP landscape source file, 2014.

Around 11 million beneficiaries are currently receiving the low-income subsidy, but CMS has estimated that approximately 2 million other low-income beneficiaries are eligible for but not receiving these subsidies. In 2014, 352 plans will be available for enrollment of LIS recipients for $0 premium, a 6% increase in plans from 2013 (**Figure 3**).

EXPENDITURES AND FINANCING FOR PART D

CBO estimates that Part D spending will total $58 billion in 2014, representing 11% of total Medicare spending in 2014 (net of offsetting receipts from premiums and state transfers). Total spending depends on several factors: the number of Part D enrollees, their health status and drug use, the number of low-income subsidy recipients, and plans' ability to negotiate discounts and rebates with drug companies and manage use (e.g. promoting use of generic drugs, prior authorization, step therapy, quantity limits, and mail order). The MMA prohibits Medicare from negotiating drug prices directly.

Financing for Part D comes from general revenues (75%), beneficiary premiums (12%), and state contributions (13%). The monthly premium paid by enrollees is set to cover 25.5% of the cost of standard drug coverage. Medicare subsidizes the remaining 74.5%, based on bids submitted by plans for their expected benefit payments. Part D enrollees with higher incomes ($85,000/individual; $170,000/couple) pay a greater share of standard Part D costs, ranging from 35% to 80%, depending on income). In 2014, the income-related monthly Part D premium surcharges will range from $12.10 to $69.30, in addition to the monthly premium paid by higher-income enrollees for their specific plan. The income thresholds are fixed at their current levels through 2019 (i.e., not indexed to increase annually).

In 2014, private plans are projected to receive average annual payments of $656 per enrollee overall and $2,124 for LIS enrollees; employers are expected to receive, on average, $605 for retirees in employer-subsidy plans (Trustees 2013). Plans also receive additional risk-adjusted payments for high-cost enrollees and reinsurance payments for a share of their enrollees' costs above the catastrophic threshold. Part D plans' potential losses or profits are limited by risk-sharing arrangements with the federal government ("risk corridors").

FUTURE CHALLENGES

The average annual Part D per capita growth rate was 0.7% between 2006 and 2012, but is projected to rise at a more rapid rate (6.6%) between 2013 and 2022 (Trustees 2013), in part due to slowing of the trend toward greater generic drug use. Over this time period, spending on Part D benefits is projected to rise from 11% to 16% of total Medicare spending (net of offsetting receipts). Monitoring the degree to which private plans are able to control costs and negotiate price discounts and rebates as more expensive biologics and other specialty drugs become available will be an important part of ongoing efforts to assess how the competitive Part D model is working.

Proposals have been made to achieve savings in Medicare Part D as part of larger efforts to reduce the federal budget deficit. One proposal would allow Medicare to receive the same price rebates that Medicaid receives for medications provided to people on Medicare receiving the low-income subsidy. CBO estimates this proposal would reduce Medicare spending by $134 billion over ten years (2014-2023).

The Medicare drug benefit has helped reduce out-of-pocket drug spending for enrollees, which is especially important to those with modest incomes or catastrophic drug costs. Closing the coverage gap by 2020 will bring additional relief to millions of enrollees. Research shows, however, that relatively few people on Medicare have used the annual opportunity to switch Part D plans voluntarily—even though those who do switch often lower their out-of-pocket costs as a result of changing plans. Understanding how well Part D is working and how well it is meeting the needs of people on Medicare will be informed by ongoing monitoring of the Part D plan marketplace and plan enrollment; exploring the relationship between Part D spending and spending on other Medicare-covered services; and evaluating the impact of the drug benefit on Medicare beneficiaries' out-of-pocket spending and health outcomes.