September 2016 | Fact Sheet

The Medicare Part D Prescription Drug Benefit

Medicare Part D is a voluntary outpatient prescription drug benefit for people on Medicare that went into effect in 2006. All 57 million people on Medicare, including those ages 65 and older and those under age 65 with permanent disabilities, have access to the Part D drug benefit through private plans approved by the federal government; in 2016, nearly 41 million Medicare beneficiaries are enrolled in Medicare Part D plans. During the Medicare Part D open enrollment period, which runs from October 15 to December 7 each year, beneficiaries can choose to enroll in either stand-alone prescription drug plans (PDPs) to supplement traditional Medicare or Medicare Advantage prescription drug (MA-PD) plans (mainly HMOs and PPOs) that cover all Medicare benefits including drugs. Beneficiaries with low incomes and modest assets are eligible for assistance with Part D plan premiums and cost sharing. This fact sheet provides an overview of the Medicare Part D program and information about 2017 plan offerings, based on data from the Centers for Medicare & Medicaid Services (CMS) and other sources.

Medicare Prescription Drug Plan Availability in 2017

In 2017, 746 PDPs will be offered across the 34 PDP regions nationwide (excluding the territories). This represents a decrease of 140 PDPs, or 16%, since 2016, a 25% reduction since 2015, and the smallest number of PDPs available since Part D started in 2006 **(Figure 1)**.

Despite a reduction in overall PDP availability, beneficiaries in each state will continue to have a choice of multiple stand-alone PDPs in 2017, ranging from 18 PDPs in Alaska to 24 PDPs in Alabama/Tennessee, California, Idaho/Utah, Pennsylvania/West Virginia, and Wisconsin (in addition to multiple MA-PD plans offered at the local level) **(Figure 2)**.

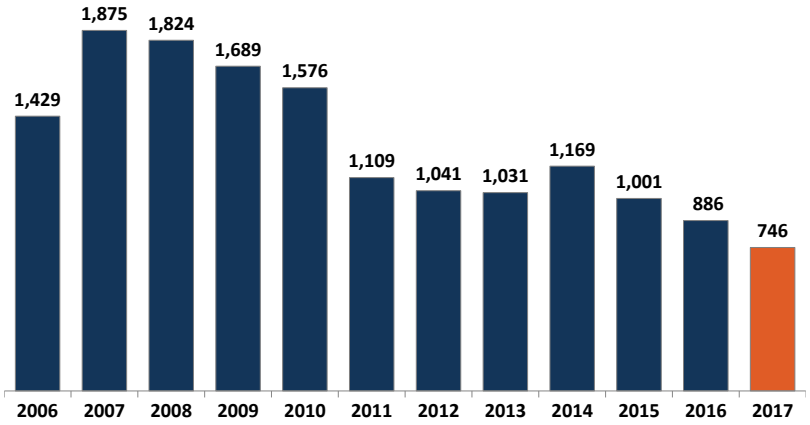
Low-Income Subsidy Plan Availability in 2017

Through the Part D Low-Income Subsidy (LIS) program, additional premium and cost-sharing assistance is available for Part D enrollees with low incomes (less than 150% of poverty, or $17,820 for individuals in 2016) and modest assets (less than $13,640 for individuals in 2016).[1]

In 2017, 231 plans will be available for enrollment of LIS beneficiaries for no premium, a modest (2%) increase in premium-free ("benchmark")

Figure 1

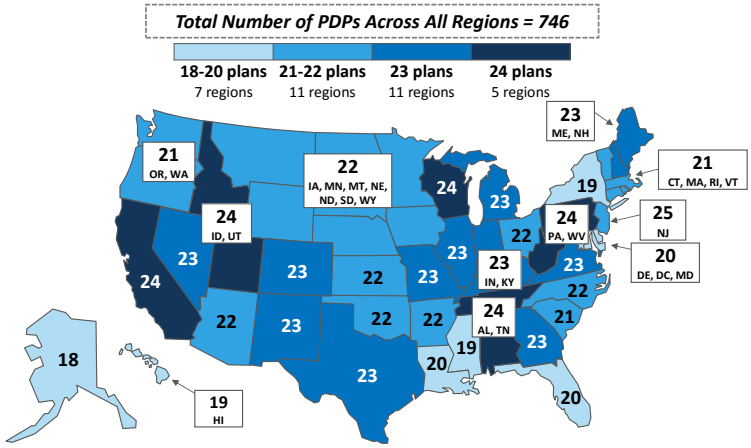
Number of Medicare Part D Stand-Alone Prescription Drug Plans, 2006-2017



NOTE: Excludes plans in the territories. 2017 total includes 68 sanctioned plans closed to new enrollees as of September 2016.
SOURCE: Kaiser Family Foundation analysis of CMS 2006-2017 PDP landscape source files.

Figure 2

Number of Medicare Part D Stand-Alone Prescription Drug Plans, by Region, 2017



NOTE: PDP is prescription drug plan. Excludes plans in the territories. Includes 68 sanctioned plans closed to new enrollees as of September 2016.
SOURCE: Kaiser Family Foundation analysis of CMS 2017 PDP landscape source file.

plans from 2016 but a decrease of 18% since 2015. Nearly one-third of all PDPs in 2017 (31%) are benchmark plans **(Figure 3)**.

Benchmark plan availability varies at the Part D region level **(Figure 4)**. The number of premium-free plans in 2017 ranges from a low of 3 plans in Florida to 10 plans in Arizona and Delaware/Maryland/Washington D.C. Most regions will have a similar number of benchmark plans in 2017 as in 2016, although Hawaii will experience the largest increase in premium-free plan availability between 2016 and 2017—from 2 benchmark plans in 2016 to 5 in 2017.

Part D Plan Premiums and Benefits in 2017

Premiums. According to CMS, the 2017 Part D base beneficiary premium is $35.63, a 4% increase from 2016.[2] Actual (unweighted) PDP monthly premiums for 2017 vary across plans and regions, ranging from a low of $14.60 for a PDP available in 11 out of 34 regions to a high of $179 for a PDP in Colorado.

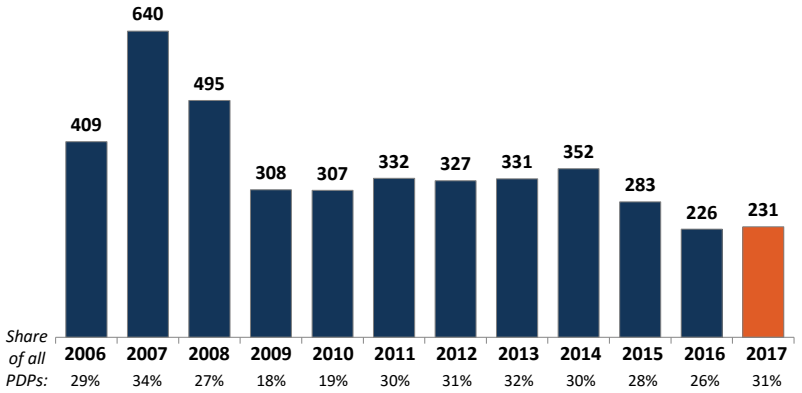
Part D enrollees with higher incomes ($85,000/individual; $170,000/couple) pay an income-related monthly premium surcharge, ranging from $13.30 to $76.20 in 2017 (depending on their income level), in addition to the monthly premium for their specific plan.[3] According to CMS projections, an estimated 2.9 million Part D enrollees (6%) will pay income-related Part D premiums in 2017.

Benefits. In 2017, the Part D standard benefit has a $400 deductible and 25% coinsurance up to an initial coverage limit of $3,700 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 in 2017 reaches $4,950 **(Figure 5)**.

After enrollees reach the catastrophic coverage threshold, Medicare pays for most (80%) of their drug costs, plans pay 15%, and enrollees pay either 5% of total drug costs or $3.30/$8.25 for each generic and brand-name drug, respectively. The standard benefit amounts are indexed to

Figure 3

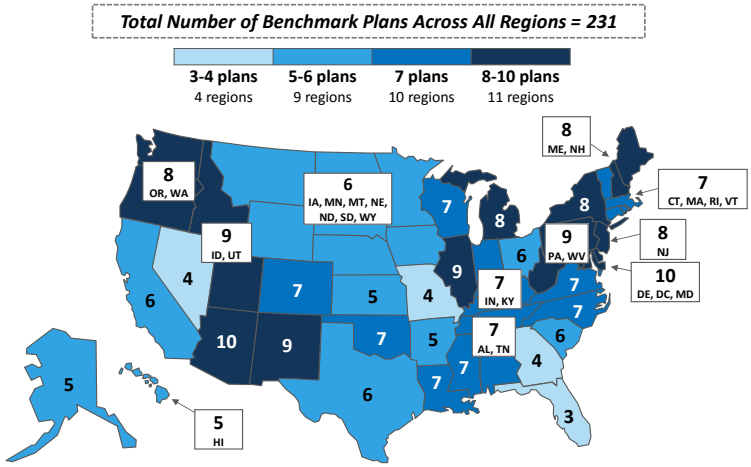
Number of Medicare Part D Stand-Alone Prescription Drug Plans Available Without a Premium to Enrollees Receiving the Low-Income Subsidy ("Benchmark" Plans), 2006-2017



NOTE: PDP is prescription drug plan. Excludes plans in the territories. Includes "de minimis plans" that can retain Low-Income Subsidy beneficiaries despite exceeding the benchmark premium by a nominal amount (up to $2 in 2017).
SOURCE: Kaiser Family Foundation analysis of CMS 2006-2017 PDP landscape source files.

Figure 4

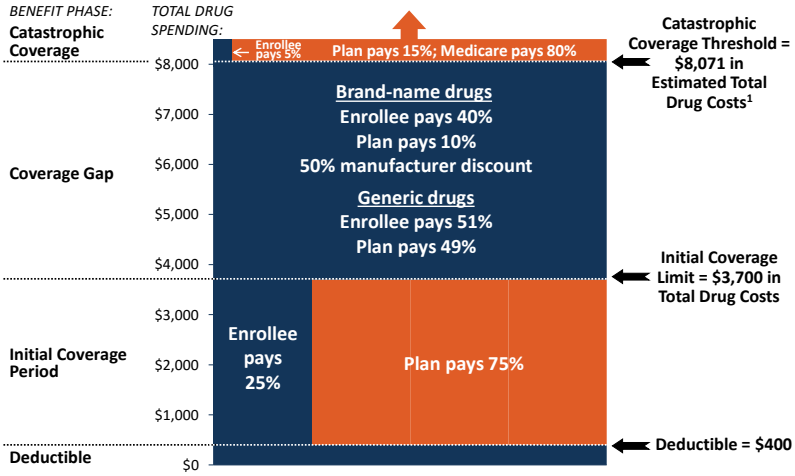
Number of Medicare Part D Benchmark Plans, by Region, 2017



NOTE: Includes "de minimis" plans that can retain Low-Income Subsidy beneficiaries despite exceeding the benchmark premium by up to $2 in 2017. Includes 25 sanctioned benchmark plans closed to new enrollees as of September 2016.
SOURCE: Kaiser Family Foundation analysis of CMS 2017 PDP landscape source file.

Figure 5

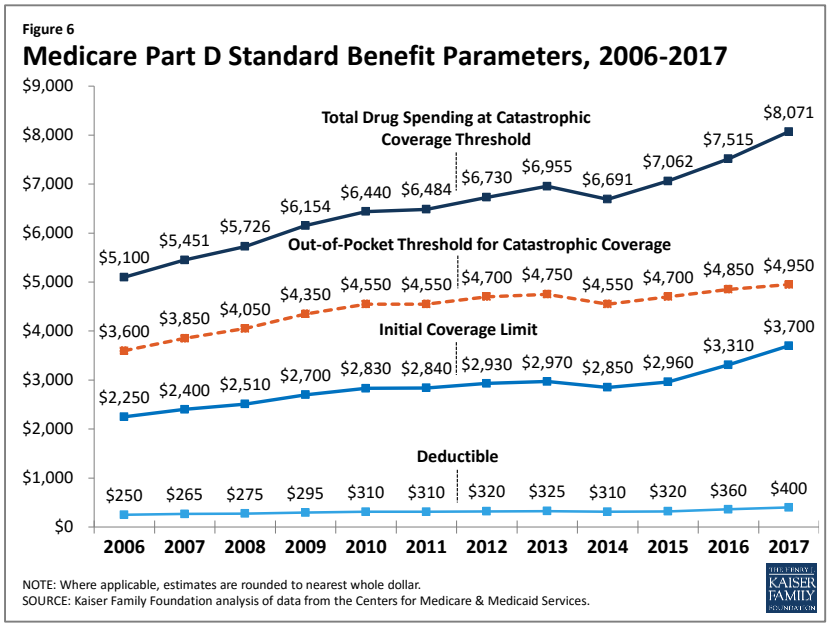
Standard Medicare Prescription Drug Benefit, 2017



NOTE: Some amounts rounded to nearest dollar. [1]Amount corresponds to the estimated catastrophic coverage limit for non-low-income subsidy (LIS) enrollees ($7,425 for LIS enrollees), which corresponds to True Out-of-Pocket (TrOOP) spending of $4,950, the amount used to determine when an enrollee reaches the catastrophic coverage threshold in 2017.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2017.

change annually by rate of Part D per capita spending growth, and, with the exception of 2014, have increased each year since 2006 **(Figure 6)**.

Part D plans must offer either the defined standard benefit or an alternative equal in value ("actuarially equivalent"), and can also provide enhanced benefits. But plans can (and do) vary in terms of their specific benefit design, cost-sharing amounts, utilization management tools (i.e., prior authorization, quantity limits, and step therapy), and formularies (i.e., covered drugs). Plan formularies must include drug classes covering all disease states, and a minimum of two chemically distinct drugs in each class. Part D plans are required to cover all drugs in six so-called "protected" classes: immunosuppressants, antidepressants, antipsychotics, anticonvulsants, antiretrovirals, and antineoplastics.



In 2017, almost half (48%) of plans will offer basic Part D benefits (although no plans will offer the defined standard benefit), while 52% will offer enhanced benefits, similar to 2016. Most PDPs (62%) will charge a deductible, with 48% of all PDPs charging the full amount ($400). Most plans have shifted to charging tiered copayments or varying coinsurance amounts for covered drugs rather than a uniform 25% coinsurance rate, and a substantial majority of PDPs use specialty tiers for high-cost medications. Most PDPs (72%) will not offer additional gap coverage in 2017 beyond what is required under the standard benefit. Additional gap coverage, when offered, has been typically limited to generic drugs only (not brands).

The 2010 Affordable Care Act gradually lowers out-of-pocket costs in the coverage gap by providing enrollees with a 50% manufacturer discount on the total cost of their brand-name drugs filled in the gap and additional plan payments for brands and generics. In 2017, Part D enrollees in plans with no additional gap coverage will pay 40% of the total cost of brands and 51% of the total cost of generics in the gap until they reach the catastrophic coverage threshold. Medicare will phase in additional subsidies for brands and generic drugs, ultimately reducing the beneficiary coinsurance rate in the gap to 25% by 2020.

Part D and Low-Income Subsidy 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 2016, nearly 41 million Medicare beneficiaries are enrolled in Medicare Part D plans, including employer-only group plans.[4] Of this total, 6 in 10 (60%) are enrolled in stand-alone PDPs and 4 in 10 (40%) are enrolled in Medicare Advantage drug plans. Medicare's actuaries estimate that around 2 million other beneficiaries in 2016 have drug coverage through employer-sponsored retiree plans where the employer receives subsidies equal to 28% of drug expenses between $400 and $8,250 per retiree in 2017 (up from $360 and $7,400 in 2016).[5] 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 13% of Medicare beneficiaries lack creditable drug coverage.[6]

Twelve million Part D enrollees are currently receiving the Low-Income Subsidy. 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 (the Low-Income Subsidy benchmark) 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 through either the Social Security Administration or Medicaid.

Part D Spending and Financing in 2017

The Congressional Budget Office (CBO) estimates that spending on Part D benefits will total $94 billion in 2017, representing 15.6% of net Medicare outlays in 2017 (net of offsetting receipts from premiums and state transfers).[7] Part D spending depends on several factors, including the number of Part D enrollees, their health status and drug use, the number of enrollees receiving the Low-Income Subsidy, and plans' ability to negotiate discounts (rebates) with drug companies and preferred pricing arrangements with pharmacies, and manage use (e.g., promoting use of generic drugs, prior authorization, step therapy, quantity limits, and mail order). Federal law prohibits the Secretary of Health and Human Services from interfering in drug price negotiations between Part D plan sponsors and drug manufacturers.[8]

Financing for Part D comes from general revenues (76%), beneficiary premiums (14%), and state contributions (10%).[9] 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.

According to Medicare's actuaries, in 2017, Part D plans are projected to receive average annual direct subsidy payments of $352 per enrollee overall and $2,197 for enrollees receiving the LIS; employers are expected to receive, on average, $693 for retirees in employer-subsidy plans.[10] Part D plans' potential total losses or gains are limited by risk-sharing arrangements with the federal government ("risk corridors"). Plans also receive additional risk-adjusted payments based on the health status of their enrollees and reinsurance payments for very high-cost enrollees.

Under reinsurance, Medicare subsidizes 80% of drug spending incurred by Part D enrollees above the catastrophic coverage threshold. In 2017, average reinsurance payments per enrollee are estimated to be $1,030; this represents a 10% increase from 2016. Medicare's reinsurance payments to plans have represented a growing share of total Part D spending, increasing from 16% in 2007 to an estimated 42% in 2017.[11] This is due in part to a growing number of Part D enrollees with spending above the catastrophic threshold, resulting from several factors, including the introduction of high-cost specialty drugs, increases in the cost of prescriptions, and a change made by the ACA to count the 50% manufacturer discount in enrollees' out-of-pocket spending that qualifies them for catastrophic coverage. Analysis from MedPAC also suggests that in recent years, plans have underestimated their enrollees' expected costs above the catastrophic coverage threshold, resulting in higher reinsurance payments from Medicare to plans over time.[12]

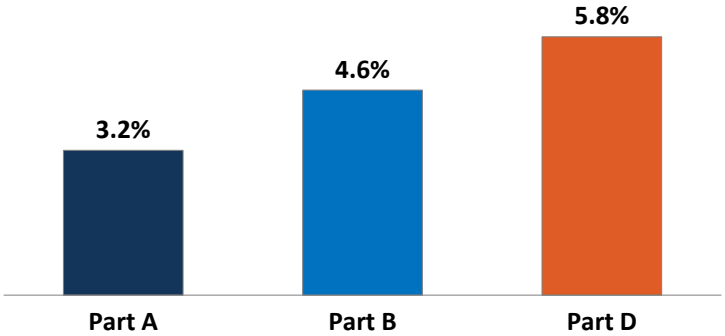
Issues for the Future

After several years of relatively low growth in prescription drug spending, growth has risen more steeply since 2013. The average annual rate of growth in Part D costs per beneficiary was 3.6% between 2006 and 2013, but it increased to 8.4% between 2013 and 2015, and is projected to increase by 5.8% between 2015 and 2025.[13]

Medicare's actuaries have projected that the Part D per capita growth rate will be comparatively higher in the coming years than the growth rate for the other parts of the program due to higher costs associated with expensive specialty drugs, which is expected to be reflected in higher reinsurance payments to plans **(Figure 7)**. Between 2015 and 2025, spending on Part D benefits is projected to increase from 13.7% to

Figure 7

Average Annual Growth in Medicare Beneficiary Costs for Part A, Part B, and Part D Between 2015 and 2025



Per beneficiary spending:	Part A	Part B	Part D
2015	$5,019	$5,522	$2,203
2025	$6,901	$8,642	$3,861

SOURCE: Kaiser Family Foundation analysis of Medicare spending data from the 2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Table V.D1).

17.8% of total Medicare spending (net of offsetting receipts).[14] Understanding whether and to what extent private plans are able to negotiate price discounts and rebates will be an important part of ongoing efforts to assess how well plans are able to contain rising drug costs. However, drug-specific rebate information is not disclosed by CMS.

The Medicare drug benefit helps to reduce out-of-pocket drug spending for enrollees, which is especially important to those with modest incomes or very high drug costs. Closing the coverage gap by 2020 will bring additional relief to millions of enrollees with high costs. But with average PDP premiums on the rise and more plans charging coinsurance rather than flat copayments for covered brand-name drugs, enrollees could face higher out-of-pocket costs for their Part D coverage. These trends highlight the importance of comparing plans during the annual enrollment period. 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.[15]

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; assessing coverage and costs for high-cost biologics and other specialty drugs; 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.

Endnotes

[1] Poverty and resource levels for 2017 are not yet available (as of October 2016).

[2] The base beneficiary premium is equal to the product of the beneficiary premium percentage and the national average monthly bid amount (which is an enrollment-weighted average of bids submitted by both PDPs and MA-PD plans). Centers for Medicare & Medicaid Services, "Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information," July 29, 2016, available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2017.pdf.

[3] Higher-income Part D enrollees also pay higher monthly Part B premiums.

[4] Jack Hoadley, Juliette Cubanski, and Tricia Neuman, *Medicare Part D in 2016 and Trends over Time*, Kaiser Family Foundation, September 2016, available at http://kff.org/medicare/report/medicare-part-d-in-2016-and-trends-over-time/.

[5] Board of Trustees, *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table IV.B7, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2016.pdf.

[6] Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2012 Cost and Use file.

[7] Congressional Budget Office, *March 2016 Medicare Baseline,* available at https://www.cbo.gov/sites/default/files/51302-2016-03-Medicare.pdf.

[8] Social Security Act, Section 1860D-11(i).

[9] Juliette Cubanski and Tricia Neuman, "The Facts on Medicare Spending and Financing," July 2016, Kaiser Family Foundation, available at http://kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/.

[10] *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*; Table IV.B9.

[11] Kaiser Family Foundation analysis of aggregate Part D reimbursement amounts from Table IV.B10, *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

[12] MedPAC, "Chapter 6: Sharing Risk in Medicare Part D," from *Report to the Congress: Medicare and the Health Care Delivery System*, June 2015, available at http://www.medpac.gov/documents/reports/chapter-6-sharing-risk-in-medicare-part-d-(june-2015-report).pdf.

[13] Kaiser Family Foundation analysis of Part D average per beneficiary costs from Table V.D1, *2016 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

[14] Kaiser Family Foundation analysis of Part D benefits spending as a share of net Medicare outlays (total mandatory and discretionary outlays minus offsetting receipts) from CBO, *March 2016 Medicare Baseline*.

[15] Jack Hoadley, Elizabeth Hargrave, Laura Summer, Juliette Cubanski, and Tricia Neuman, *To Switch or Not to Switch: Are Medicare Beneficiaries Switching Drug Plans To Save Money?* Kaiser Family Foundation, October 2013, available at http://kff.org/medicare/issue-brief/to-switch-or-not-to-switch-are-medicare-beneficiaries-switching-drug-plans-to-save-money/.