September 2014 | Fact Sheet

The Medicare Part D Prescription Drug Benefit

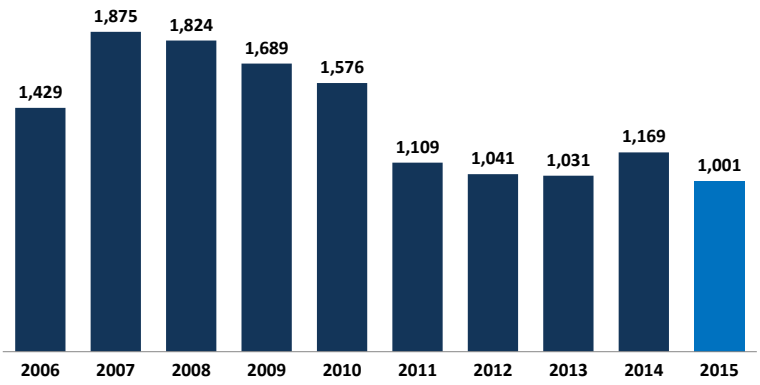
The Medicare Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for people on Medicare known as Part D, which went into effect in 2006. All 54 million people on Medicare, including those ages 65 and older and those under age 65 with permanent disabilities, have 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 of 2010 (ACA) 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 2015, 1,001 PDPs will be offered across the 34 PDP regions nationwide (excluding the territories). This represents a decrease of 168 PDPs, or 14%, since 2014, and the smallest number of PDPs available since Part D started in 2006 **(Exhibit 1)**. Despite a reduction in PDP availability, beneficiaries in each state will have a choice of at least two dozen stand-alone PDPs and multiple MA-PD plans **(Exhibit 2)**.

Exhibit 1

Number of Medicare Part D Stand-Alone Prescription Drug Plans, 2006-2015



NOTE: Excludes plans in the territories. Total for 2015 includes 36 plans under CMS sanction and closed to new enrollees as of September 2014.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS 2006-2015 PDP landscape source files.

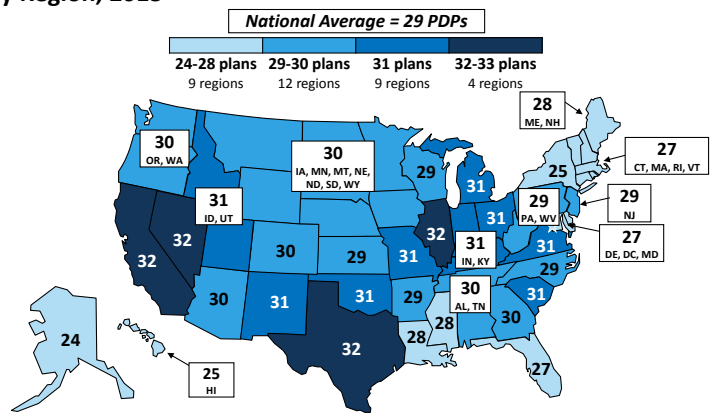
Part D Enrollment

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 2014, more than 37 million Medicare beneficiaries are enrolled in Medicare Part D plans, including employer-only group plans.[1] Of this total, about two-thirds are enrolled in stand-alone PDPs and one-third are enrolled in Medicare Advantage drug plans. The Medicare Trustees estimate that another 2.6 million beneficiaries in 2014 have drug coverage through employer-sponsored retiree plans where the employer receives subsidies equal to 28% of drug expenses between $310 and $6,350 per retiree in 2014 (increasing to $320 and $6,600 in 2015).[2] 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 estimates from 2010.

Exhibit 2

Number of Medicare Part D Stand-Alone Prescription Drug Plans, by Region, 2015



NOTE: PDP is prescription drug plan. Excludes plans in the territories. Includes 36 plans under CMS sanction and closed to new enrollees as of September 2014.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS 2015 PDP landscape source file.

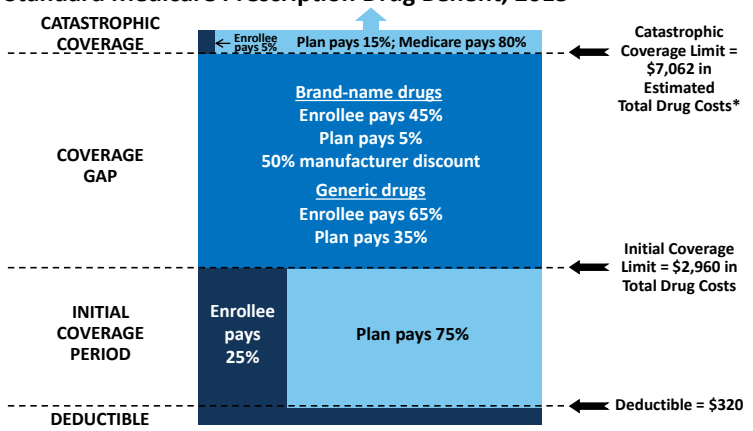
Part D enrollment is highly concentrated, with five firms—UnitedHealth, Humana, CVS Caremark, Express Scripts, and Aetna—accounting for 63% of enrollees in 2014.[3] While beneficiaries have the option to choose among dozens of plans each year, and often could save money if they switch plans, most (7 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.[4]

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 2015 has a $320 deductible and 25% coinsurance up to an initial coverage limit of $2,960 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 $4,700 **(Exhibit 3)**. Thereafter, enrollees pay either 5% of total drug costs or $2.65/$6.60 for each generic and brand-name drug, respectively. The standard benefit amounts increase annually by the Part D per capita spending growth rate.

Exhibit 3

Standard Medicare Prescription Drug Benefit, 2015



NOTE: *Amount corresponds to the estimated catastrophic coverage limit for non-low-income subsidy enrollees ($6,680 for LIS enrollees), which corresponds to True Out-of-Pocket (TrOOP) spending of $4,700 (the amount used to determine when an enrollee reaches the catastrophic coverage threshold.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2015 (standard benefit parameter update from Centers for Medicare & Medicaid Services, 2014). Amounts rounded to nearest dollar.

In 2015, 45% of plans will offer basic Part D benefits (although no plans will offer the defined standard benefit), while 55% will offer enhanced benefits. The majority of PDPs (58%) charge a deductible, with 44% charging the full amount ($320). 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 (74%) will not offer additional gap coverage in 2015 beyond what is required under the standard benefit. Additional gap coverage, when offered, has been typically 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 2015 will pay 45% of the total cost of brands and 65% 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.

According to CMS, the 2015 Part D base beneficiary premium will be $33.13, a 2% increase since 2014.[5] Actual PDP premiums in 2015 vary across plans and regions, ranging from $12.60 to $171.90. 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.

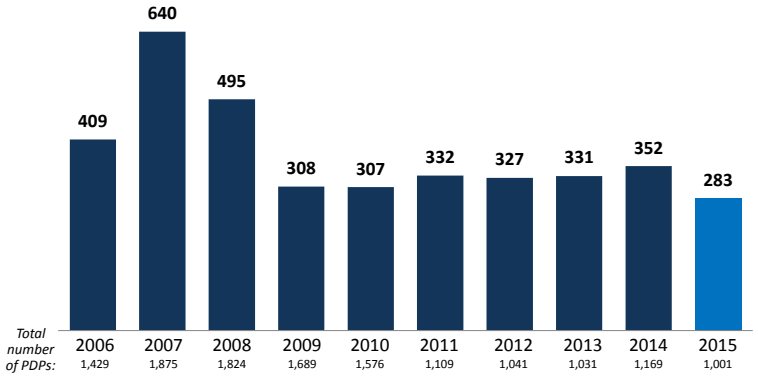
Assistance For Low-Income Beneficiaries

Part D includes substantial premium and cost-sharing assistance for beneficiaries with low incomes (less than 150% of poverty, or $17,505 for individuals in 2014) and modest assets (less than $13,440 for individuals in 2014).

In 2015, 283 plans will be available for enrollment of Low-Income Subsidy (LIS) recipients for $0 premium, a 24% decrease in zero-premium ("benchmark") plans from 2014 and the lowest number of such plans since the program's start in 2006 **(Exhibits 4 and 5)**.

Exhibit 4

Number of Medicare Part D Stand-Alone PDPs Available Without a Premium to Low-Income Subsidy Recipients, 2006-2015

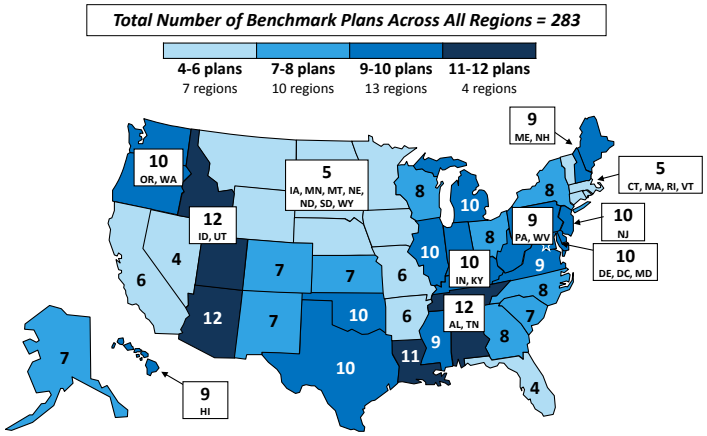


NOTE: PDP is prescription drug plan. Excludes plans in the territories. Includes "de minimis plans" which can retain Low-Income Subsidy beneficiaries despite exceeding the benchmark premium by $2 in 2007, $1 in 2008, and $2 in 2011-2015.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS 2006-2015 PDP landscape source files.

Around 11 million beneficiaries are currently receiving the Low-Income Subsidy, according to the Medicare Trustees. CMS has estimated that many other low-income beneficiaries are eligible for but not receiving these subsidies. 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. People determined eligible for the Low-Income Subsidy are assigned to a PDP if they do not enroll on their own.

Exhibit 5

Number of Benchmark Plans, by Region, 2015



NOTE: Includes "de minimis" plans that can retain Low-Income Subsidy beneficiaries despite exceeding the benchmark premium by $2 in 2015. Includes 27 benchmark plans under CMS sanction and closed to new enrollees as of September 2014.
SOURCE: Georgetown/NORC/Kaiser Family Foundation analysis of CMS 2015 PDP landscape source file.

Part D Spending And Financing

The Congressional Budget Office (CBO) estimates that Part D spending will total $76 billion in 2015, representing 14% of total Medicare spending in 2015 (net of offsetting receipts from premiums and state transfers). Part D 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.

Financing for Part D comes from general revenues (73%), beneficiary premiums (14%), and state contributions (13%).[6] 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 2015, the income-related monthly Part D premium surcharges will range from $12.30 to $70.80, 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 2015, private plans are projected to receive average annual payments of $548 per enrollee overall and $1,996 for LIS enrollees; employers are expected to receive, on average, $604 for retirees in employer-subsidy plans.[7] 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 2.3% between 2006 and 2013, but is projected to rise at a more rapid rate (6.0%) between 2014 and 2023.[8] Over this time period, spending on Part D benefits is projected to rise from 14% to 17% of total Medicare spending (net of offsetting receipts).[9] 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 federal spending. 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 $116 billion over ten years (2015-2024).[10]

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.

[1] Jack Hoadley, Laura Summer, Elizabeth Hargrave, Juliette Cubanski, and Tricia Neuman. "Medicare Part D in Its Ninth Year: The 2014 Marketplace and Key Trends, 2006-2014," Kaiser Family Foundation, August 2014, available at http://kff.org/medicare/report/medicare-part-d-in-its-ninth-year-the-2014-marketplace-and-key-trends-2006-2014/.

[2] 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

[3] Jack Hoadley, Laura Summer, Elizabeth Hargrave, Juliette Cubanski, and Tricia Neuman. "Medicare Part D in Its Ninth Year: The 2014 Marketplace and Key Trends, 2006-2014," Kaiser Family Foundation, August 2014, available at http://kff.org/medicare/report/medicare-part-d-in-its-ninth-year-the-2014-marketplace-and-key-trends-2006-2014/.

[4] 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/.

[5] The base beneficiary premium is equal to the product of the beneficiary premium percentage and the national average monthly bid amount; this calculation includes both stand-along PDPs and Medicare Advantage drug plans. Centers for Medicare & Medicaid Services, "Annual Release of Part D National Average Bid Amount and Other Part C & D Bid Information," July 31, 2014, available at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2015.pdf.

[6] Kaiser Family Foundation, "The Facts on Medicare Spending and Financing," July 2014, available athttp://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/.

[7] 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

[8] Growth rates based on Kaiser Family Foundation analysis of Part D average per beneficiary costs from Table V.D1, 2014 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.

[9] Based on 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 the Congressional Budget Office April 2014 Medicare baseline, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2014-04-Medicare.pdf.

[10] Congressional Budget Office, "Estimated Effects on Direct Spending and Revenues for Health Care Programs of Proposals in the President's 2015 Budget," April 2014, available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/45250-Health_Programs_Proposals.pdf.