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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 55 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. 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 2016 plan offerings, based on data from the Centers for Medicare & Medicaid Services (CMS) and other sources.

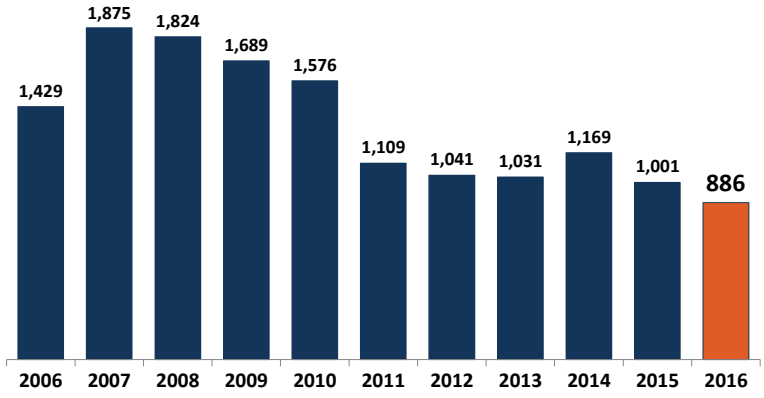
Medicare Prescription Drug Plan Availability in 2016

In 2016, 886 PDPs will be offered across the 34 PDP regions nationwide (excluding the territories). This represents a decrease of 115 PDPs, or 11%, since 2015, a 24% drop since 2014, 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 2016, ranging from 19 PDPs in Alaska to 29 PDPs in Pennsylvania/West Virginia (in addition to multiple MA-PD plans offered at the local level) **(Figure 2)**.

Figure 1

Number of Medicare Part D Stand-Alone Prescription Drug Plans, 2006-2016



NOTE: Excludes plans in the territories. Total for 2016 includes 91 plans under CMS sanction and closed to new enrollees as of September 2015.
SOURCE: Kaiser Family Foundation analysis of CMS 2006-2016 PDP landscape source files.

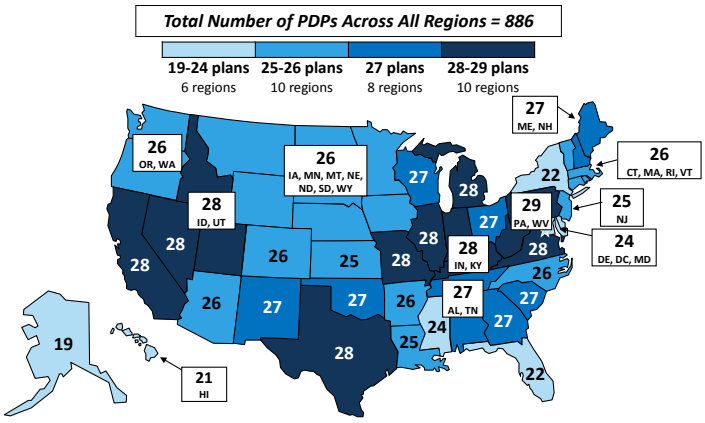
Low-Income Subsidy Plan Availability in 2016

Part D includes premium and cost-sharing assistance for beneficiaries with low incomes (less than 150% of poverty, or $17,655 for individuals in 2015) and modest assets (less than $13,640 for individuals in 2015).[1] In 2016, 226 plans will be available for enrollment of Low-Income Subsidy (LIS) recipients for $0 premium, a 20% decrease in zero-premium ("benchmark") plans from 2015, a 36% decrease since 2014, and the lowest number of such plans since the program's start in 2006 **(Figure 3)**. The share of benchmark plans as a share of all PDPs is 26% in 2016, but this has varied over time, from a high of 34% in 2007 to a low of 18% in 2009.

Benchmark plan availability varies widely at the state level. The number of premium-free plans in 2016 ranges from a low of 2 plans in Hawaii and 3 plans in Florida to 10 plans in Nevada, Idaho/Utah, and Pennsylvania/West Virginia **(Figure 4)**. Hawaii will experience the largest reduction in premium-free plan availability between 2015 and 2016—from 9 benchmark plans in 2015 to 2 in 2016; the next largest reduction will occur in Alabama/Tennessee, Louisiana, and Oklahoma, each of which is losing 3 benchmark plans between 2015 and 2016.

Figure 2

Number of Medicare Part D Stand-Alone Prescription Drug Plans, by Region, 2016



NOTE: PDP is prescription drug plan. Excludes plans in the territories. Includes 91 plans under CMS sanction and closed to new enrollees as of September 2015.
SOURCE: Kaiser Family Foundation analysis of CMS 2016 PDP landscape source file.

Part D Plan Premiums and Benefits in 2016

According to CMS, the 2016 Part D base beneficiary premium is $34.10, a 3% increase from 2015.[2] Actual PDP monthly premiums in 2016 will vary across plans and regions, ranging from a low of $11.40 for a PDP in Arkansas to a high of $174.70 for a PDP in Florida. Part D enrollees with higher incomes ($85,000/individual; $170,000/couple) pay an income-related monthly premium surcharge, ranging from $12.70 to $72.90 in 2016, in addition to the monthly premium for their specific plan.[3] According to CMS, an estimated 2.5 million Part D enrollees (6%) are expected to pay income-related Part D premiums in 2016.

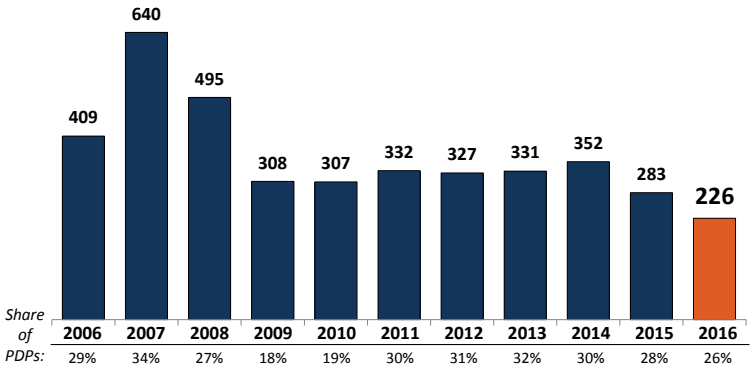
Plans must offer either a defined standard benefit or an alternative equal in value ("actuarially equivalent"), and can also provide enhanced benefits. But plans can (and do) vary in terms of their specific benefit design, cost-sharing amounts, utilization management tools (i.e., prior authorization,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

The standard benefit in 2016 has a $360 deductible and 25% coinsurance up to an initial coverage limit of $3,310 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 2016 reaches $4,850 **(Figure 5)**. After enrollees reach the catastrophic coverage limit, Medicare and plans together pay for most, but not all, of their drug costs. In the catastrophic coverage period, enrollees pay either 5% of total drug costs or $2.95/$7.40 for each generic and brand-name drug, respectively. The standard benefit amounts are indexed to 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)**.

In 2016, almost half (49%) of plans will offer basic Part D benefits (although no plans will offer the defined standard benefit), while 51% will offer enhanced benefits. The majority of PDPs (67%) will charge a deductible, with 53% of PDPs charging the full amount ($360). Most plans will charge tiered copayments for covered drugs rather than 25% coinsurance and a substantial majority of PDPs will use specialty tiers for high-cost medications.

Figure 3

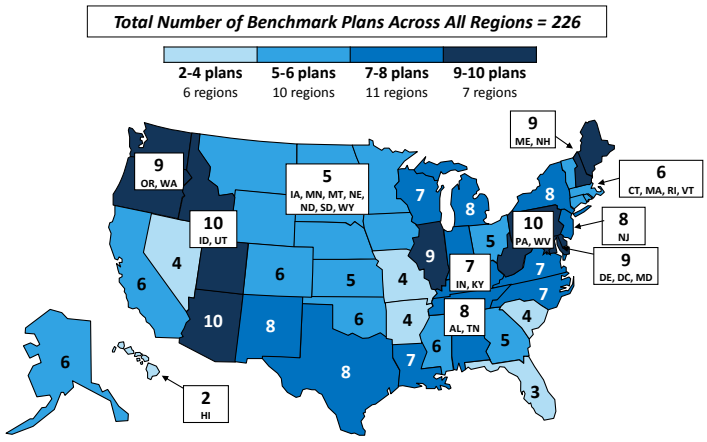
Number of Medicare Part D Stand-Alone Prescription Drug Plans Available Without a Premium to Low-Income Subsidy Recipients, 2006-2016



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 up to $2 in 2007, $1 in 2008, and $2 in 2011-2016.
SOURCE: Kaiser Family Foundation analysis of CMS 2006-2016 PDP landscape source files.

Figure 4

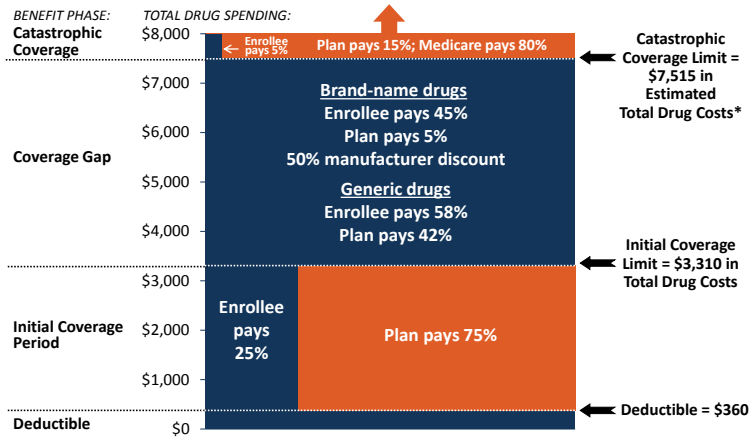
Number of Medicare Part D Benchmark Plans, by Region, 2016



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

Figure 5

Standard Medicare Prescription Drug Benefit, 2016



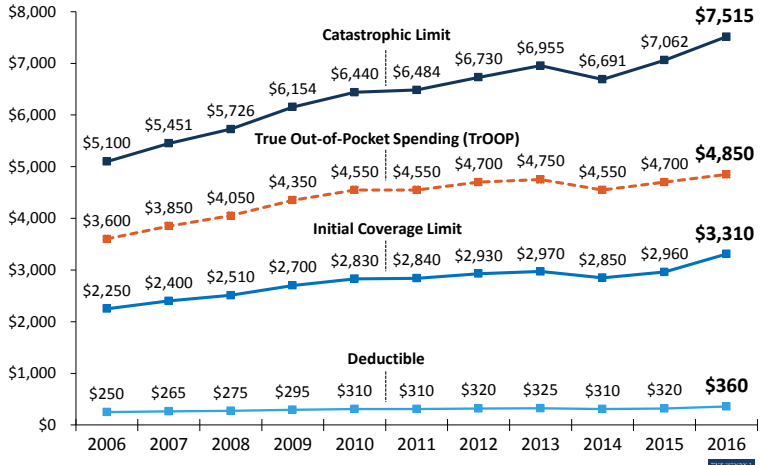
NOTE: Amounts rounded to nearest dollar. *Amount corresponds to the estimated catastrophic coverage limit for non-low-income subsidy enrollees ($7,062.50 for LIS enrollees), which corresponds to True Out-of-Pocket (TrOOP) spending of $4,850 (the amount used to determine when an enrollee reaches the catastrophic coverage threshold.
SOURCE: Kaiser Family Foundation illustration of standard Medicare drug benefit for 2016.

And most PDPs (78%) will not offer additional gap coverage in 2016 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. In 2016, enrollees in plans with no additional gap coverage will pay 45% of the total cost of brands and 58% 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.

Figure 6

Medicare Part D Standard Benefit Parameters, 2006-2016



NOTE: Estimates are rounded to nearest whole dollar.
SOURCE: Kaiser Family Foundation analysis of data from the Centers for Medicare & Medicaid Services.

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 2015, more than 39 million Medicare beneficiaries are enrolled in Medicare Part D plans, including employer-only group plans.[4] Of this total, just over 6 in 10 (61%) are enrolled in stand-alone PDPs and nearly 4 in 10 (39%) are enrolled in Medicare Advantage drug plans. The Medicare Trustees estimate that around 2 million other beneficiaries in 2015 have drug coverage through employer-sponsored retiree plans where the employer receives subsidies equal to 28% of drug expenses between $360 and $7,400 per retiree in 2016 (up from $320 and $6,600 in 2015).[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 12% of the Medicare population lacks creditable drug coverage, according to MedPAC.[6]

Twelve 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.

Part D Spending And Financing in 2016

The Congressional Budget Office (CBO) estimates that Part D spending will total $88 billion in 2016, representing 15.5% of net Medicare outlays in 2016 (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 Low-Income Subsidy enrollees, and plans' ability to negotiate discounts and 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). The MMA 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 (74%), beneficiary premiums (15%), and state contributions (11%).[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.

In 2016, private plans are projected to receive average annual direct subsidy payments of $471 per enrollee overall and $2,141 for LIS enrollees; employers are expected to receive, on average, $659 for retirees in employer-subsidy plans (these amounts are up slightly from their 2015 levels).[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 enrollees above the catastrophic threshold. In 2016, average reinsurance payments per enrollee are estimated to be $862; this represents a 9% increase from 2015. Medicare's reinsurance payments to plans have represented a growing share of total Part D spending, increasing from 14% in 2007 to an estimated 37% in 2015.[11] Analysis from MedPAC suggests that in recent years, plans have underestimated their enrollees' expected costs above the catastrophic threshold, resulting in higher reinsurance payments from Medicare to plans over time.[12]

Future Challenges

The average annual rate of growth in Part D costs per beneficiary was 3.2% between 2006 and 2014, but is projected to rise at a more rapid rate (5.7%) between 2014 and 2024.[13] Over this time period, spending on Part D benefits is projected to rise from 12.7% to 16.8% of total Medicare spending (net of offsetting receipts).[14] The Medicare Trustees expect a comparatively higher per capita growth rate in the coming years for Part D than 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. Monitoring the degree to which private plans are able to 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 well plans are able to control costs.

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.[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; 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.

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[1] 2016 poverty and resource levels are not yet available (as of October 2015).

[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, 2015, available at https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/PartDandMABenchmarks2016.pdf.

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

[4] Kaiser Family Foundation analysis of Centers for Medicare & Medicaid Services data from "Medicare Advantage, Cost, PACE, Demo, and Prescription Drug Plan Contract Report - Monthly Summary Report (Data as of September 2015)".

[5] *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, Table IV.B7.

[6] MedPAC, *A Data Book: Health Care Spending and the Medicare Program*, June 2015, available at: http://www.medpac.gov/documents/data-book/june-2015-databook-health-care-spending-and-the-medicare-program.pdf.

[7] CBO, *Medicare Baseline, March 2015*, available at https://www.cbo.gov/sites/default/files/cbofiles/attachments/44205-2015-03-Medicare.pdf.

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

[9] Kaiser Family Foundation, "The Facts on Medicare Spending and Financing," July 2015, available at http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/.

[10] *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*; Table IV.B9.

[11] Based on Kaiser Family Foundation analysis of aggregate Part D reimbursement amounts from Table IV.B10, *2015 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] Based on Kaiser Family Foundation analysis of Part D average per beneficiary costs from Table V.D1, *2015 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*.

[14] 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 CBO, *Medicare Baseline, March 2015*.

[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/.