

THE BASICS

The Medicare Drug Benefit (Part D)

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The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a voluntary outpatient prescription drug benefit for Medicare beneficiaries that began January 1, 2006. Total expenditures for the Medicare drug benefit are projected to be \$101.0 billion in 2016.¹ Medicare subsidizes the cost of the program, generally paying about 75 percent of program costs. Beneficiaries enrolling in Part D pay a monthly premium in addition to cost sharing and any deductible for their drugs. Low-income beneficiaries pay lower or no premiums, cost sharing, or deductibles.

The Medicare drug benefit is administered through private entities called prescription drug plans (PDPs) for beneficiaries in fee-for-service (also known as original or traditional) Medicare and through Medicare Advantage prescription drug (MA-PD) plans for beneficiaries enrolled in Medicare managed care. PDPs and MA-PDs perform such functions as:

- Designing and marketing drug benefit plans
- Negotiating drug prices with manufacturers and pharmacies
- Building and managing a network of pharmacies
- Paying claims
- Enrolling and disenrolling beneficiaries
- Managing a drug formulary and beneficiary appeals process
- Tracking beneficiary drug spending

Employers and unions offering retiree coverage that is at least as generous as Medicare's drug benefit may qualify for retiree drug subsidies (RDS) to help defray the cost of providing a drug benefit to their Part D-eligible retirees. (See "Employers and Part D" section below for more on these plans.)

BENEFICIARY PARTICIPATION

Medicare beneficiaries who are eligible for Medicare Part A or enrolled in Part B may enroll in a Medicare drug plan. In 2014, 37.9 million beneficiaries enrolled in a PDP or MA-PD. About 61 percent are enrolled in PDPs with the remainder obtaining coverage through Medicare Advantage drug plans. An additional 2.6 million beneficiaries enrolled in a drug plan through a former employer or union qualifying to receive RDS.² Beneficiaries can also receive drug coverage through sources that do not receive Medicare subsidies including TRICARE, the Federal Employees Health Benefits Program for retirees, Veterans Administration coverage, and employer-sponsored insurance for active workers with Medicare as a secondary payer. It is estimated that about 10 percent of Medicare beneficiaries have no known source of drug coverage.

BENEFIT STRUCTURE

The Part D **standard benefit** for 2016 includes a \$360 deductible, 25 percent coinsurance for covered drug spending between \$360 and \$3,310, and variable coinsurance for drug spending between \$3,310 and \$7,515 (a gap in coverage popularly known as the “donut hole”).³ After \$4,850 in beneficiary true out-of-pocket (or “TrOOP”)⁴ spending is reached, catastrophic coverage begins and beneficiaries are only responsible for 5 percent cost sharing. All drug plans must offer a standard benefit plan.

The Patient Protection and Affordable Care Act (ACA), as amended by the Health Care and Education Reconciliation Act of 2010, enacted changes to the Medicare drug benefit, most notably reducing beneficiary cost sharing in the coverage gap. The coverage gap changes are implemented gradually until the gap is eliminated in 2020. In 2016, beneficiaries will pay 45 percent of the cost for brand name drugs and 58 percent of the cost for generic drugs in the coverage gap. In 2020 and thereafter, beneficiary cost sharing in the coverage gap for brand name and generic drugs will be 25 percent. (**FIGURE 1**, next page.)

Medicare drug plans may offer **nonstandard benefit plans** that vary from this standard benefit. For example, Medicare drug plan sponsors may offer drug plans that are actuarially equivalent to the Medicare drug benefit. They may also offer plans that are more generous, or enhanced, as long as they also offer a basic benefit package. Nonstandard plans are popular with beneficiaries because they may have lower deductibles or cost sharing, albeit generally at higher premiums. The majority of beneficiaries are enrolled in nonstandard plans.

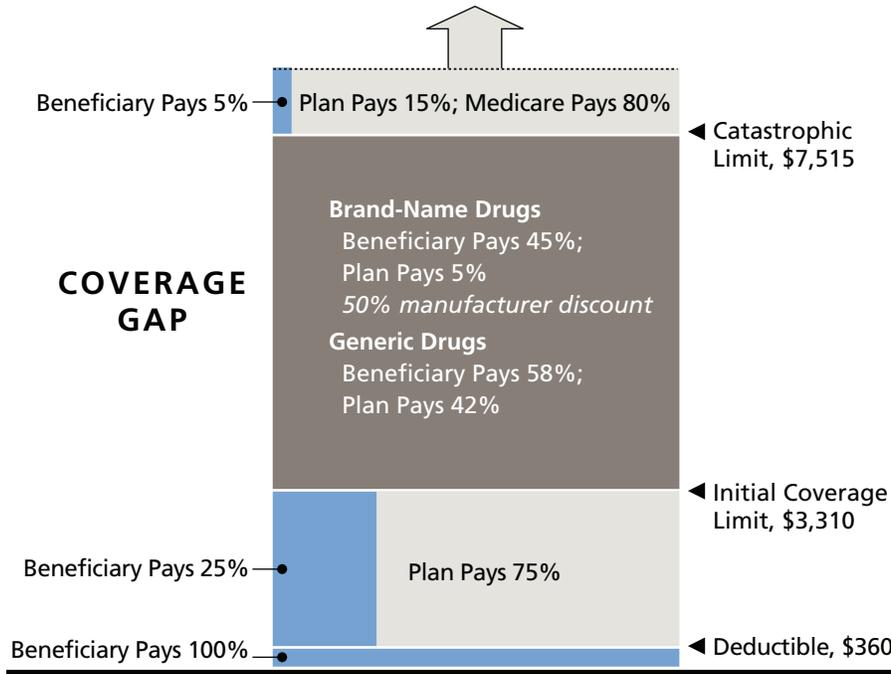
National Health Policy Forum

2100 Pennsylvania Avenue, NW
Suite 305
Washington, DC 20037

T 202/994-6491
E nhpf@gwu.edu
www.nhpf.org

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FIGURE 1: Standard Drug Benefit Design, 2016



Source: Kaiser Family Foundation, "The Medicare Prescription Drug Benefit," Fact Sheet, October 2015, <http://kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet>.

BENEFICIARY PREMIUMS AND PLAN PAYMENTS

Beneficiaries enrolled in PDPs typically pay a monthly premium for Medicare prescription drug coverage. Beneficiary premiums are determined by bids submitted by drug plans. A base premium of 25.5 percent of the national average of all bids is computed. The premium for an individual drug plan is the sum of the base premium and the difference between the plan’s bid and the national average of all bids. Beneficiaries joining plans with bids above the national average pay more than the base premium, and those joining plans with bids below the national average pay less than the base premium with a floor of no premium. Medicare Advantage plans have flexibility to allocate premium dollars between the drug benefit and other health benefits they offer. As a result, many Medicare Advantage plans are able to offer drug coverage for \$0 premium. They are also more likely than PDPs to offer coverage in the gap and a \$0 deductible. In 2016, the average⁵ monthly premium for stand-alone PDPs is projected to be \$41.46; the range of premiums is \$11.40 to \$174.70. Beneficiaries with incomes higher than \$85,000 (\$170,000 for couples) will also pay a monthly surcharge ranging from \$12.70 to \$72.90.

In addition to receiving beneficiary premiums (estimated to amount to \$14.4 billion in 2016⁶), Medicare drug plans receive payments from Medicare to subsidize the cost of providing the benefit. **Direct premium payments** represent Medicare's major subsidy to plans for all beneficiaries (an estimated \$19.5 billion in 2016). **Reinsurance** subsidizes catastrophic expenses (an estimated \$35.7 billion in 2016). **Low-income subsidy payments** subsidize premium and cost-sharing assistance for low-income beneficiaries (an estimated \$26.4 billion in 2016).⁷

ASSISTANCE FOR LOW-INCOME BENEFICIARIES

About 29 percent of Part D enrollees are expected to qualify for assistance in paying premiums, deductibles, and cost sharing in 2016.⁸ These individuals have incomes below 150 percent of the federal poverty level (\$17,655 for an individual and \$23,895 for a couple in 2015)⁹ and few assets, and include beneficiaries dually eligible for Medicare and Medicaid (often referred to as "dual eligibles"). The level of extra benefits Medicare provides depends on the person's income: lower income individuals receive more generous extra benefits including no or low premiums, deductibles, and cost sharing. The lowest income beneficiaries, dual eligibles, pay no premiums for drug plans with premiums below the average in an area, only very modest cost sharing for prescriptions, no deductible, and are not subject to the coverage gap.

Private plans are paid extra by Medicare for low-income enrollees to compensate for the additional benefits they receive. Private plans will be paid an estimated \$1,333 per enrollee for drug benefits in 2016, and an additional \$2,141 per low-income enrollee.¹⁰

Many low-income beneficiaries, including dual eligibles, received drug coverage through Medicaid prior to the implementation of the Medicare drug benefit in 2006. In order to help finance their participation in Part D, the MMA requires states to contribute 90 percent of the expected state cost of drugs for this population, phasing down over 10 years to 75 percent. This provision is commonly called the "clawback." State payments are expected to total \$9.8 billion in 2016.¹¹

EMPLOYERS AND PART D

Employers have several options for interacting with the Medicare drug benefit. Employers and union groups that provide prescription drug

insurance to their Medicare-eligible retired workers that is at least as generous as Part D coverage may apply to receive retiree drug subsidies (RDS) from Medicare. These payments are intended to help employers maintain drug coverage for their retirees, and are less expensive for Medicare than enrolling these beneficiaries in a Part D drug plan. In 2016 the average RDS payment is projected to be about \$659 per beneficiary.¹² Beginning in 2013, these payments were no longer tax-free for taxpaying employers. Employers not receiving the retiree drug subsidy may choose to “wrap around” Part D coverage by paying Part D premiums or contributing toward deductibles and/or cost sharing for their retirees.

FORMULARIES AND APPEALS

The law permits Medicare drug plans to pay for most drugs approved by the Food and Drug Administration (FDA). However, virtually all PDPs use formularies, or lists of covered drugs, that effectively limit the number and type of drugs paid for by the plan. Plans are required to include a relatively broad range of drugs on their formularies to help prevent a plan from systematically discouraging beneficiaries with certain health conditions from enrolling. Plans are also prohibited from limiting drugs in certain protected classes, which include anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants for the treatment of transplant rejection. Beneficiaries may appeal the decision of a plan to not pay (or require a higher copayment) for a particular drug.

ENDNOTES

1. *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*, July 22, 2015, p. 105, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2015.pdf>.
2. Jack Hoadley *et al.*, “Medicare Part D: A First Look at Plan Offerings in 2015,” Kaiser Family Foundation, Issue Brief, October 2014, <http://kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-plan-offerings-in-2015>; and 2014 *Annual Report of the Boards of Trustees*, p. 151, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/reportstrustfunds/downloads/tr2014.pdf>.
3. Kaiser Family Foundation, “The Medicare Prescription Drug Benefit,” Fact Sheet, October 13, 2015, <http://kff.org/medicare/fact-sheet/the-medicare-prescription-drug-benefit-fact-sheet/>.

4. Not all drug spending counts toward TrOOP. Actual out-of-pocket spending by the beneficiary counts toward TrOOP, but payments made by other insurers or third parties generally do not count toward TrOOP.
5. The average premium is weighted by 2015 enrollment, assuming beneficiaries remain in their current plan. Jack Hoadley, Juliette Cubanski, and Tricia Neuman, "Medicare Part D: A First Look at Part D Plan Offerings in 2016," Kaiser Family Foundation, Issue Brief, October 2015, <http://kff.org/medicare/issue-brief/medicare-part-d-a-first-look-at-plan-offerings-in-2016/>.
6. *Annual Report of the Boards of Trustees*, p. 146.
7. *Annual Report of the Boards of Trustees*, p. 146.
8. Calculation from *Annual Report of the Boards of Trustees*, table IV.B7, p. 142.
9. U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, "2015 Federal Poverty Guidelines," <http://aspe.hhs.gov/2015-poverty-guidelines#guidelines>.
10. *Annual Report of the Boards of Trustees*, p. 145.
11. *Annual Report of the Boards of Trustees*, p. 105.
12. *Annual Report of the Boards of Trustees*, p. 145.