Medicare Part D

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What is Medicare Part D?

Medicare Part D is the most recent expansion of the Medicare program, authorized in 2003 under the Medicare Modernization Act (MMA).[i] Part D refers to prescription drug coverage, which was not previously included in the traditional Medicare benefits package. The Part D program includes multiple prescription drug plans (PDPs), which are administered by private plans that have been approved by the Centers for Medicare and Medicaid (CMS).

Enrollment

All beneficiaries enrolled in Medicare Parts A or B are eligible to enroll in Part D, and currently more than 35 million, or roughly 67 percent, of beneficiaries are enrolled.[ii] Enrollees generally have cost-sharing requirements including monthly premium, deductible, copayments or coverage gap costs. The average premium for 2013 was $38.54, though this amount ranged from $15.00 to $165.40 across plans.[iii]

Beneficiaries may enroll in a Part D plan during an initial enrollment period (three months before or after they become eligible for Parts A or B) or during other predetermined early or special enrollment periods.[iv] If beneficiaries sign up for Part D outside of these enrollment periods and lacked comparable coverage for their prescriptions during that time, they may face a penalty of 1 percent of their premium cost for every month they did not have adequate coverage.[v]

Plan Types and Benefits

Medicare beneficiaries who choose to enroll in Part D have the option of enrolling in either a stand-alone PDP or enrolling in a Medicare Advantage (MA) plan that offers prescription drug coverage as part of its overall benefit package (also known as Medicare Part C). Approximately two-thirds of Part D enrollees opt for stand-alone plans, which account for 1,031 plan options across the country.[vi] While plan options vary across the regions, beneficiaries have access to at least 25 stand-alone PDPs and multiple Medicare Advantage plans (MA-PDs) in each state.[vii] Plans must offer beneficiaries a defined standard benefit, or some alternative that is equal or greater in value.[viii] The 2014 standard benefit is detailed in the table below:[ix]

Coverage	Part D Plan Pays	Beneficiary Pays
Annual Deductible ($310)	$0	$310
Initial Coverage Period (>$310-2,850) You and your plan cover costs up to $2,540 (initial coverage limit less the deductible) at a rate of 25% and 75%, respectively.	75% (up to $1,905)	25% (up to $635)
Coverage Gap ("Donut Hole") Once your total drug costs (what you and your plan pay) exceed $2,850 ($310 + $2,540), you are in the 'donut hole.'	$0 (The 50% discount for brand name drugs comes from drug manufacturers + 2.5% subsidy, and the 28% subsidy for generic drugs comes from Medicare.)	47.5% of covered brand name drugs plus dispensing fee; 72% of covered generic drugs
Catastrophic Coverage This begins once you've reached your 'out-of-pocket threshold' of $4,550 in 2014. ($310 deductible + $635 initial coverage + $3,605 'donut hole')	95% or the drug cost minus the copay	Greater of 5% of the drug costs or $2.55 for a generic drug or $6.35 for a brand name drug

Source: California Health Advocates, Prescription Drug Coverage: An Overview: http://www.cahealthadvocates.org/drugs/overview.html

It is important to note that in previous years beneficiaries were responsible for 100 percent of drug costs that fell in the "donut hole" or coverage gap. With the passage of the Affordable Care Act (ACA), beneficiary responsibility for these costs began to lessen in 2012 and the law will completely eliminate the coverage gap and associated costs to beneficiaries by 2020.[x]

Financing and Spending

The major sources of revenue for the Part D program are general revenues, premiums paid by eligible persons who voluntarily enroll, and contributions from states. In 2012, general revenues accounted for $50.1 billion or 75 percent of total Part D revenue, while premiums and payments from states represented a lesser share, $8.3 billion and $8.4 billion, respectively.[xi] Total expenditures for the Part D program in 2012 were $66.9 billion, of which a very small portion were attributed to administrative expenses ($0.4 billion) and the majority are related to subsidizing benefits.[xii] In part to raise more revenue for the program, the ACA required beneficiaries who pay an income-related Part B premium to also pay an income-related Part D premium. Beginning in 2011, individuals and couples earning more than $85,000 and $171,000 respectively were subject to these higher cost-sharing requirements.

Part D does provide assistance for low-income beneficiaries, often referred to as "Extra Help" or the Low-Income Subsidy (LIS).[xiii] Certain low-income beneficiaries automatically qualify, including those that qualify to receive both Medicaid and Medicare benefits, known as "dual eligibles" (these individuals are also automatically enrolled if they fail to choose a plan).[xiv] Other low-income beneficiaries must meet certain income and asset standards (income below 150 percent of the poverty level and assets no greater than $13,300 for individuals) in order to qualify.[xv] These individuals can apply for Extra Help on their own and may receive full or partial subsidies based on their income and asset levels.

It is important to note that the Part D program has yielded far lower costs than were originally projected when the program began. Consensus does not exist on an exact reason for the program's lower than expected costs, rather there are a number of possible contributing factors, including lower than expected enrollment, increased use of generic drugs, fewer brand name drugs approved by the FDA, manufacturer rebates, overall lower public and private spending on prescription drugs and competition among plans in the Part D program.[xvi] There is disagreement among policymakers as to what has been most valuable in keeping costs low, but the fact remains that Part D spending has been approximately 30 percent lower than 2003 projections.[xvii]

Looking Ahead

There is a general consensus that Medicare Part D is good for beneficiaries overall and has been successful in providing beneficiaries access to prescription drug coverage while keeping overall out-of-pocket costs relatively low.[xviii] Additionally, the ACA's closure of the "donut hole" provides important relief for beneficiaries who fall in the coverage gap and face significant costs as a result. However, despite the program's positive attributes, contention still exists around the complexity of the program, Medicare's inability to negotiate prices, and the fact that the program represents trillions of dollars in an unfunded liability for the federal government. As with the entirety of the Medicare program, it will be important to continue to monitor the Part D program to ensure that it continues to meet beneficiary needs and is not increasing overall spending.

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[i] http://www.gpo.gov/fdsys/pkg/BILLS-108hr1enr/pdf/BILLS-108hr1enr.pdf
[ii] http://kff.org/medicare/issue-brief/medicare-part-d-prescription-drug-plans-the-marketplace-in-2013-and-key-trends-2006-2013/#KeyFacts
[iii] http://kff.org/medicare/issue-brief/medicare-part-d-prescription-drug-plans-the-marketplace-in-2013-and-key-trends-2006-2013/#KeyFacts
[iv] http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx#WhenJoinDrugPlan
[v] http://www.medicare.gov/navigation/medicare-basics/medicare-benefits/part-d.aspx#LateEnrollmentPenalty
[vi] http://kff.org/medicare/issue-brief/medicare-part-d-prescription-drug-plans-the-marketplace-in-2013-and-key-trends-2006-2013/#KeyFacts
[vii] http://www.medpac.gov/chapters/Mar12_Ch13.pdf
[viii] http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2012.pdf

[ix] http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Announcement2012.pdf
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