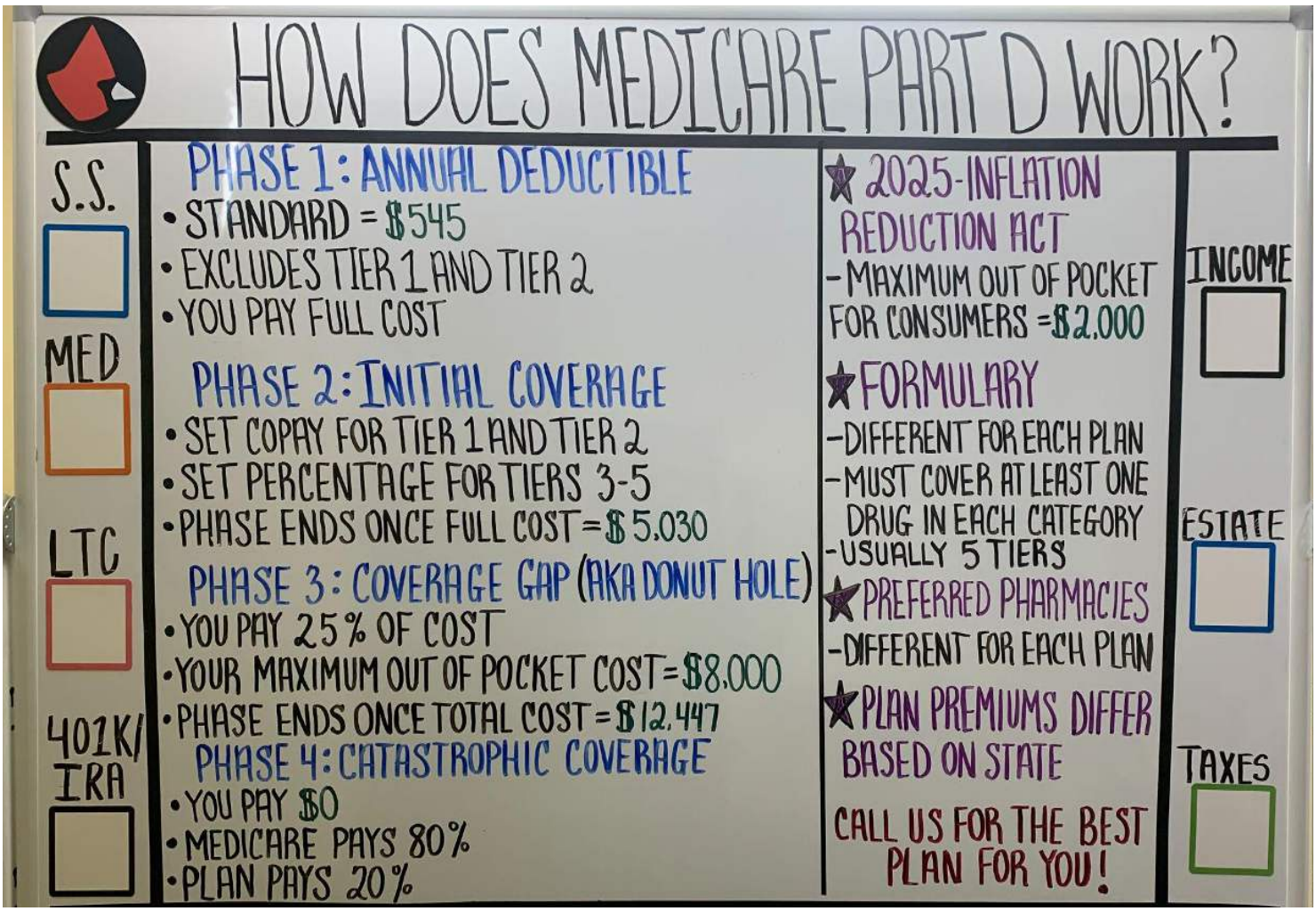
CARDINAL ADVISORS

How Does Medicare Part D Work?

In our video entitled “How Does Medicare Part D Work?” Hans and Tom use the following document to review the workings of Part D.



March 2024

KFF

The independent source for health policy research, polling, and news.

An Overview of the Medicare Part D Prescription Drug Benefit

Published: Oct 17, 2023

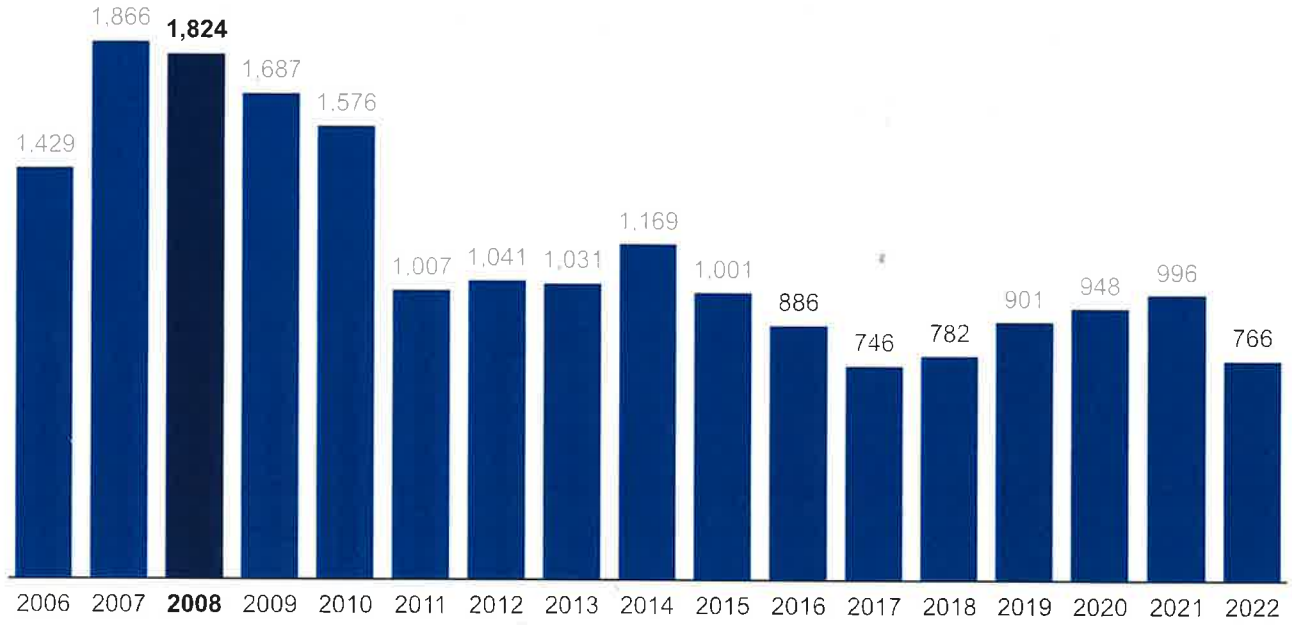
Medicare Part D is a voluntary outpatient prescription drug benefit for people with Medicare provided through private plans that contract with the federal government. Beneficiaries can choose to enroll in either a stand-alone prescription drug plan (PDP) to supplement traditional Medicare or a Medicare Advantage (https://www.kff.org/medicare/fact-sheet/medicare-advantage/) plan, mainly HMOs and PPOs, that provides all Medicare-covered benefits, including prescription drugs (MA-PD). In 2023, more than 50 million (https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-and-costs-in-2023/#:~:text=50.5%20million%20people%20with%20Medicare%20are%20currently%20enrolled%20in%20plans%20that%20provide%20the%20Medicare%20Part%20D%20drug%20benefit) of the 65 million people covered by Medicare are enrolled in Part D plans. This fact sheet provides an overview of the Medicare Part D program, plan availability, enrollment, and spending and financing, based on data from the Centers for Medicare & Medicaid Services (CMS), the Congressional Budget Office (CBO), and other sources. It also provides an overview of changes to the Part D benefit based on provisions in the Inflation Reduction Act (https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/).

Medicare Prescription Drug Plan Availability in 2024

In 2024, 709 PDPs will be offered across the 34 PDP regions nationwide (excluding the territories), an 11% decrease from 2023 and the lowest number of PDPs available since the Part D program's beginning in 2006 (Figure 1). While the availability of stand-alone PDPs has been trending downward over time, along with a decline in PDP enrollment, the availability of Medicare Advantage drug plans (https://www.kff.org/medicare/issue-brief/medicare-advantage-2023-spotlight-first-look/) has been expanding rapidly, and more people in Medicare are now getting Part D drug coverage through Medicare Advantage plans.

Figure 1

A Total of 709 Medicare Part D Stand-Alone Prescription Drug F Will Be Offered in 2024, an 11% Decrease From 2023

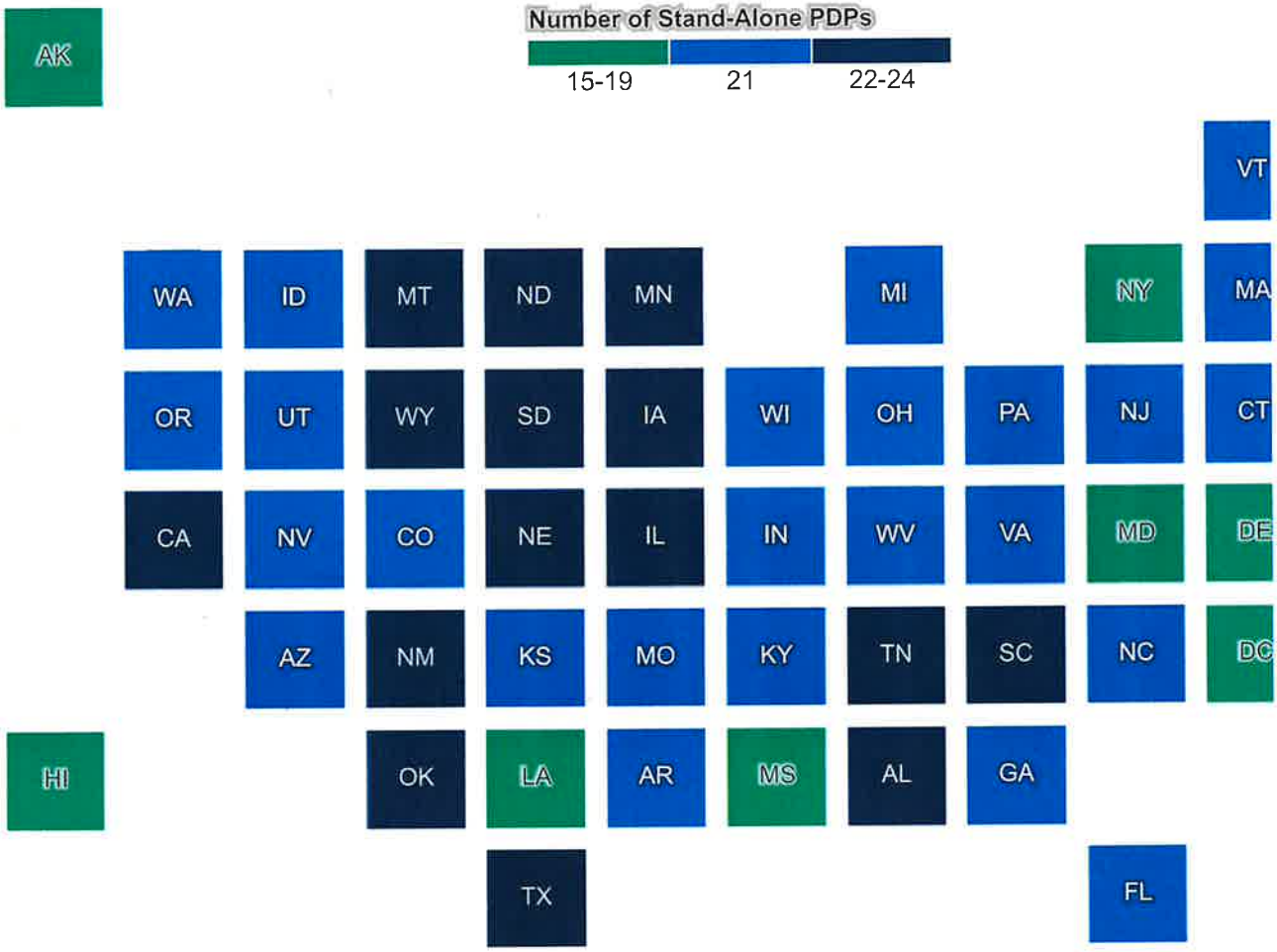


NOTE: PDP is prescription drug plan. Excludes PDPs in the territories (n=10 in 2024).
SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2006-2024 PDP landscape source files. • PNG

Despite the overall reduction in the number of PDPs in 2024, beneficiaries in each state will have a choice of multiple stand-alone PDPs, ranging from 15 PDPs in New York to 24 PDPs in Alabama and Tennessee (Figure 2). In addition, beneficiaries will be able to choose from among many MA-PDs available at the local level.

Figure 2

The Number of Medicare Part D Stand-Alone Prescription Drug in 2024 Ranges from 15 in New York to 24 in Alabama and Tenr



NOTE: PDP is prescription drug plan.
SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2024 PDP landscape source files. • PNG

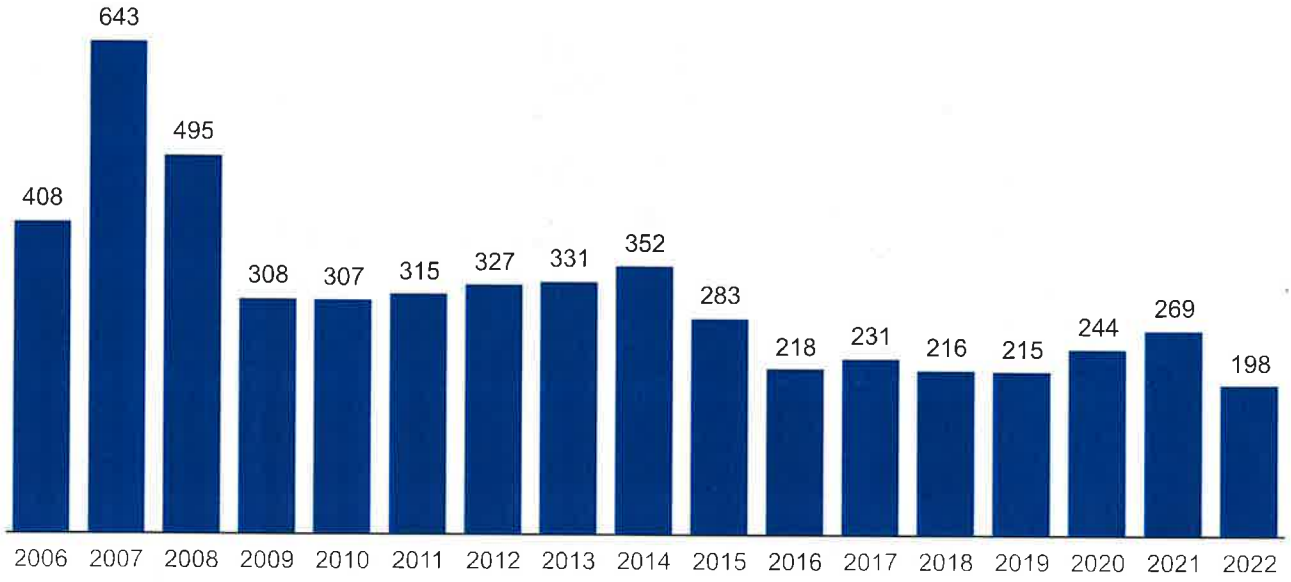
Low-Income Subsidy Plan Availability in 2024

Beneficiaries with low incomes and modest assets (https://www.cms.gov/files/document/2023medicarepartdlowincomesubsidylisincomeandresourcestandardsg.pdf) are eligible for assistance with Part D plan premiums and cost sharing. 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 $21,870 for individuals/$29,580 for married couples in 2023) and modest assets (up to $16,660 for individuals/$33,240 for couples in 2023). As of 2024, anyone who qualifies for the LIS program will receive full benefits, under a provision of the Inflation Reduction Act; in previous years, people with incomes between 135% and 150% of poverty received partial LIS benefits.

Compared to 2023, fewer plans will be available for enrollment of LIS beneficiaries for no premium in 2024 – 126 plans, a 34% reduction compared to 2023 (Figure 3). Less than one-fifth (18%) of PDPs in 2024 are benchmark plans.

Figure 3

In 2024, 126 Part D Stand-Alone Drug Plans Will Be Available V a Premium to Enrollees Receiving the Low-Income Subsidy ("Benchmark" Plans), a 34% Reduction from 2023

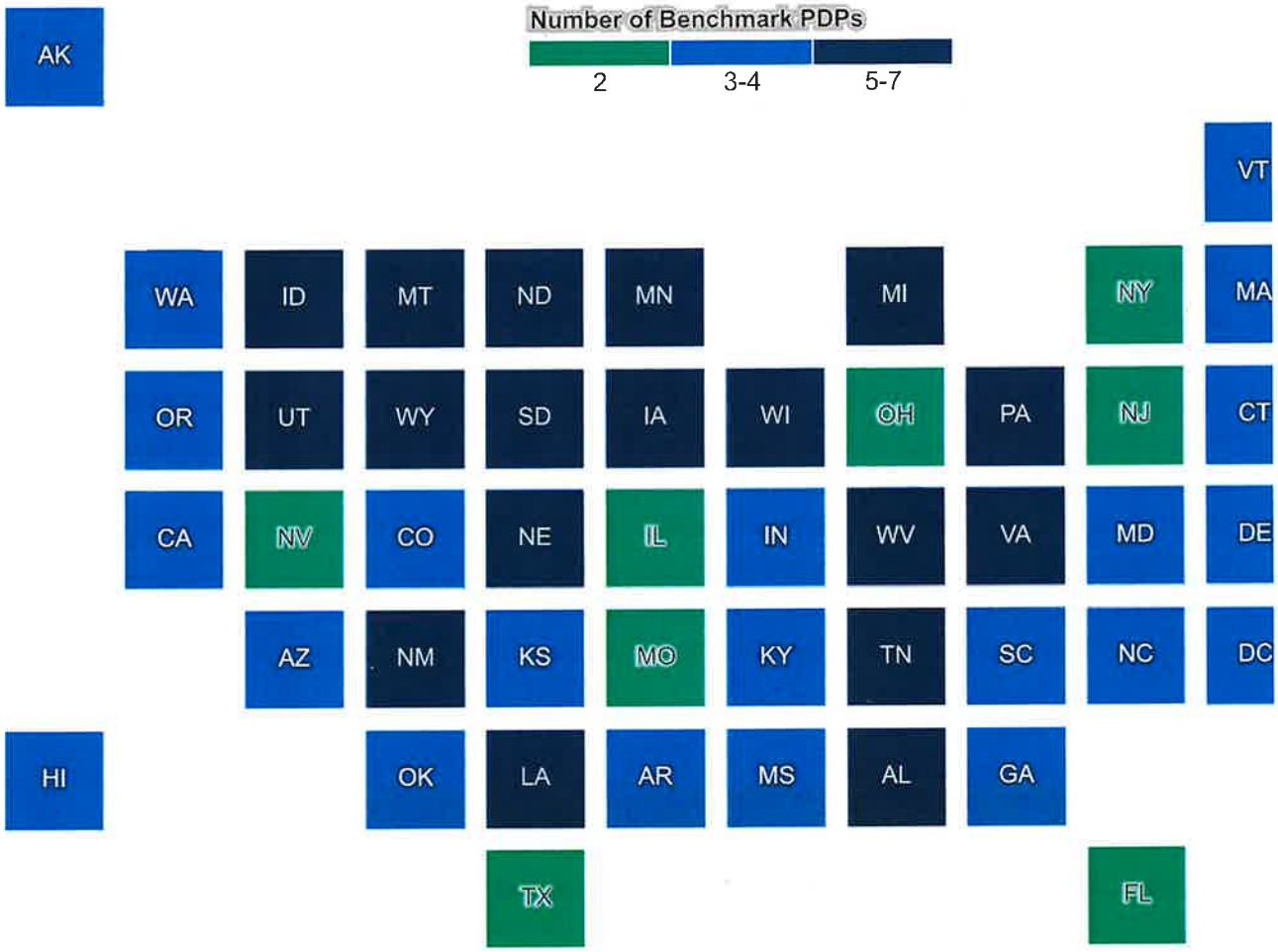


NOTE: PDP is prescription drug plan.
SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2006-2024 Part D plan files. • PNG

Some enrollees have fewer benchmark plan options than others because benchmark plan availability varies at the Part D region level. The number of premium-free PDPs in 2023 ranges across states from 2 plans in 8 states (Florida, Illinois, Missouri, Nevada, New Jersey, New York, Ohio, and Texas) to 7 plans in 1 state (Wisconsin) (Figure 4). LIS enrollees can select any plan offered in their area, but if they are enrolled in a non-benchmark plan, they may be required to pay some portion of their plan's monthly premium.

Figure 4

The Number of Medicare Part D Benchmark Plans at the State l in 2024 Ranges from 2 to 7



NOTE: PDP is prescription drug plan.
SOURCE: KFF analysis of Centers for Medicare & Medicaid Services 2024 PDP landscape source files. • PNG

Part D Plan Premiums and Benefits in 2024

Premiums

The 2024 Part D base beneficiary premium – which is based on bids submitted by both PDPs and MA-PDs and is not weighted by enrollment – is $34.70 (https://www.cms.gov/files/document/july-31-2023-parts-c-d-announcement-pdf.pdf), a 6% increase from 2023. Between 2024 and 2029, annual growth in the base beneficiary premium is capped at 6% due to the premium stabilization (https://www.congress.gov/bill/117th-congress/house-bill/5376/text#:~:text=Medicare%20Part%20D%20Premium%20Stabilization) provision in the Inflation Reduction Act. Absent this provision, the 2024 base beneficiary premium would have increased by 20% to $39.35, reflecting a higher average plan bid for offering Part D coverage

in 2024 (https://www.cms.gov/files/document/july-31-2023-parts-c-d-announcement-pdf.pdf#page=2) compared to 2023 (https://www.cms.gov/files/document/july-29-2022-parts-c-d-announcement-pdf.pdf#page=2).

The base beneficiary premium is not the same as the amount that Part D enrollees pay for coverage, and enrollees may see their premium increase by more than 6% (or less, or even decrease) if they stay in the same plan for 2024. Actual monthly premiums paid by Part D enrollees vary considerably. In 2024, PDP monthly premiums range from $0 (or less than $1) for a PDP available nationwide to nearly $200 for a PDP available in Pennsylvania and West Virginia (unweighted by plan enrollment). In addition to the monthly premium, Part D enrollees with higher incomes ($103,000/individual; $206,000/couple) pay an income-related premium surcharge (https://www.cms.gov/newsroom/fact-sheets/2024-medicare-parts-b-premiums-and-deductibles#:~:text=public%2Dinspection.-,Medicare%20Part%20D%20Income%2DRelated%20Monthly%20Adjustment%20Amounts,-Since%202011%2C%20a), ranging from $12.90 to $81.00 per month in 2024 (depending on income). For coverage in MA-PDs, most enrollees in 2023 pay no premium (https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/#:~:text=more%20than%207%20in%2010%20(73%25)%20enrollees%20in%20individual%20Medicare%20Advantage%20plans%20with%20prescription%20drug%20coverage%20pay%20no%20premium%20other%20than%20the%20Medicare%20Part%20B%20premium), beyond the monthly Part B premium (although high-income MA enrollees are required to pay a premium surcharge).

Benefits

The Part D defined standard benefit has several phases, including a deductible, an initial coverage phase, a coverage gap phase, and catastrophic coverage. Between 2023 and 2024, the parameters of the standard benefit are rising (https://www.cms.gov/files/document/2024-announcement-pdf.pdf#page=134), which means Part D enrollees will face higher out-of-pocket costs for the deductible and in the initial coverage phase, as they have in prior years, and will have to pay more out-of-pocket before qualifying for catastrophic coverage.

In a change from prior years, however, beneficiaries in 2024 will no longer pay 5% coinsurance once they qualify for catastrophic coverage, due to a provision in the Inflation Reduction Act that eliminated this cost-sharing requirement.

The standard benefit amounts are indexed to change annually based on the rate of Part D per capita spending growth, and, except for 2014, have increased each year since 2006 (Figure 5):

- The standard deductible is increasing from $505 in 2023 to $545 in 2024.
- The initial coverage limit is increasing from $4,660 to $5,030.
- The out-of-pocket spending threshold is increasing from $7,400 to $8,000 (equivalent to $12,447 in total drug spending in 2024, up from $11,206 in 2023). This amount includes what beneficiaries themselves pay out of pocket plus the value of the manufacturer

discount on the price of brand-name drugs in the coverage gap phase. Based on the $8,000 catastrophic threshold for 2024, enrollees themselves will pay about $3,300 out of pocket before reaching the catastrophic phase (this estimate is based on using brand drugs only).

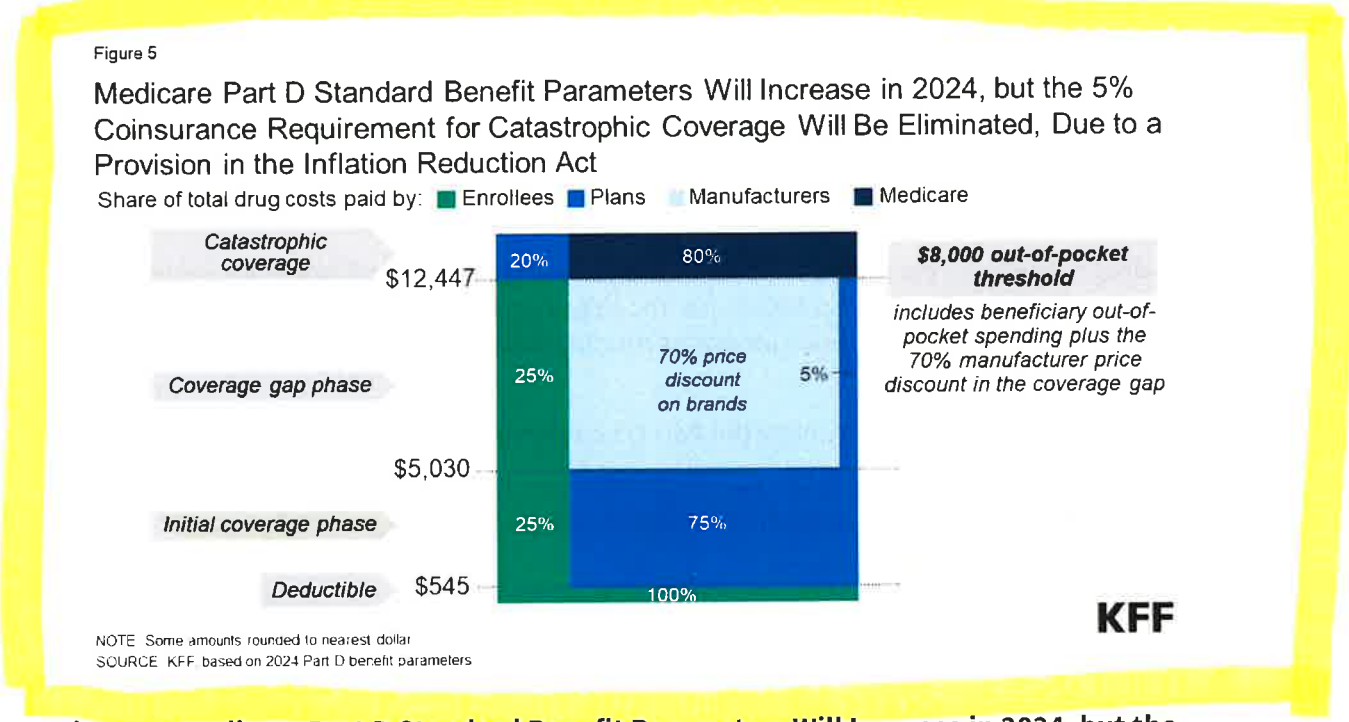


Figure 5: Medicare Part D Standard Benefit Parameters Will Increase in 2024, but the 5% Coinsurance Requirement for Catastrophic Coverage Will Be Eliminated, Due to a Provision in the Inflation Reduction Act

For costs in the coverage gap phase, beneficiaries pay 25% for both brand-name and generic drugs, with manufacturers providing a 70% discount on brands and plans paying the remaining 5% of brand drug costs and the remaining 75% of generic drug costs. For total drug costs above the catastrophic threshold in 2024, Medicare will pay 80% and plans will pay 20%.

Part D plans must offer either the defined standard benefit or an alternative equal in value ("actuarially equivalent") and can also provide enhanced benefits. Both basic and enhanced benefit plans vary in terms of their specific benefit design, coverage, and costs, including deductibles, 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.

Changes to Part D Under the Inflation Reduction Act

With the passage of the Inflation Reduction Act, which includes several provisions to lower prescription drug spending (https://www.kff.org/medicare/issue-brief/explaining-the-prescription-drug-provisions-in-the-inflation-reduction-act/) by Medicare and beneficiaries, major changes are coming to the Medicare Part D program. These provisions started to take effect in 2023 and will continue phasing in over the next couple of years. The law:

- Limits the price of insulin products to no more than $35 per month in all Part D plans and makes adult vaccines covered under Part D available for free, as of 2023.
- Requires drug manufacturers to pay a rebate to the federal government if prices for drugs covered under Part D and Part B increase faster than the rate of inflation, with the initial period for measuring Part D drug price increases running from October 2022-September 2023.
- Expands eligibility for full benefits under the Part D Low-Income Subsidy program in 2024.
- Adds a hard cap on out-of-pocket drug spending under Part D by eliminating the 5% coinsurance requirement for catastrophic coverage in 2024 and capping out-of-pocket spending at $2,000 in 2025.
- Shifts more of the responsibility for catastrophic coverage costs to Part D plans and drug manufacturers, starting in 2025.
- Authorizes the Secretary of the Department of Health and Human Services to negotiate the price of some drugs covered under Medicare (https://www.kff.org/medicare/issue-brief/faqs-about-the-inflation-reduction-acts-medicare-drug-price-negotiation-program/), with negotiated prices first available for 10 Part D drugs in 2026.

CBO estimates that taken altogether, the drug pricing provisions in the law will reduce the federal deficit by $237 billion (https://www.cbo.gov/system/files/2022-09/PL117-169_9-7-22.pdf) over 10 years (2022-2031).

Part D and Low-Income Subsidy Enrollment in PDPs and MA-PDs

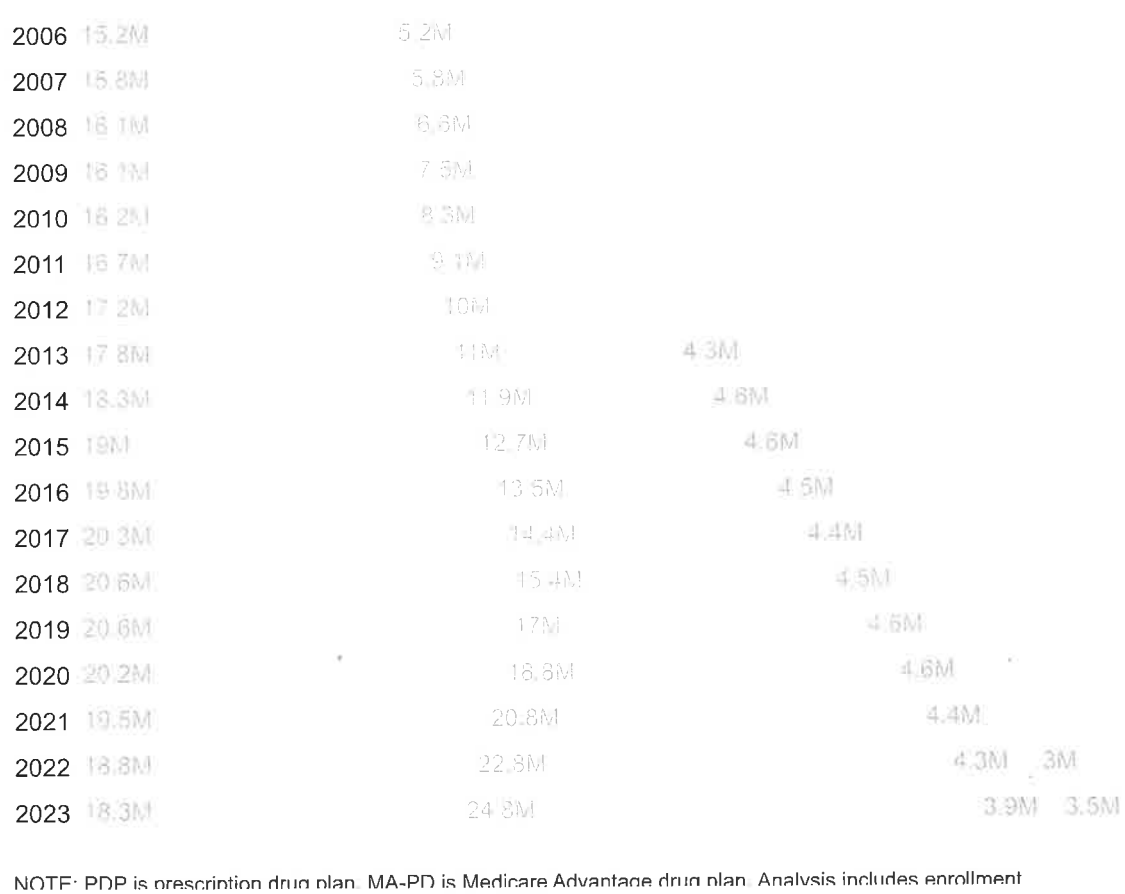
Enrollment in Medicare Part D plans is voluntary, except for beneficiaries who are eligible for both Medicare and Medicaid and certain other low-income beneficiaries who are automatically enrolled in a PDP if they do not choose a plan on their own. Unless beneficiaries have drug coverage from another 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 2023, 50.5 million Medicare beneficiaries are enrolled in Medicare Part D plans, including employer-only group plans; of the total, 56% are enrolled in MA-PDs and 44% are enrolled in stand-alone PDPs (Figure 6). Another 0.9 million beneficiaries (https://www.cms.gov/oact/tr/2023#page=153) are estimated to have drug coverage through employer-sponsored retiree plans where the employer receives a subsidy from the federal

government equal to 28% of drug expenses between $545 and $11,200 per retiree (in 2024). Several million beneficiaries are estimated to have other sources of drug coverage, including employer plans for active workers, FEHBP, TRICARE, and Veterans Affairs (VA). Around 12% of people with Medicare (https://www.medpac.gov/wp-content/uploads/2023/03/Ch12_Mar23_MedPAC_Report_To_Congress_SEC.pdf#page=14) are estimated to lack creditable drug coverage.

Figure 6

Medicare Part D Enrollment Has Declined in Stand-Alone PDPs While Increasing Steadily in Medicare Advantage Drug Plans



NOTE: PDP is prescription drug plan. MA-PD is Medicare Advantage drug plan. Analysis includes enrollment

In 2023, 13.4 million Part D enrollees (https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-and-costs-in-2023/#:~:text=In%202023%2C%2013.4%20million%20Part%20D%20enrollees%20(27%25%20of%20all%20Part%20D%20enrollees)%20receive%20premium%20and%20cost%2Dsharing%20assistance%20through%20the%20Part%20D%20Low%2DIncome%20Subsidy%20(LIS)%20program) receive premium and cost-sharing assistance through the LIS program. 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

Part D Spending

The Congressional Budget Office (CBO) estimates that spending on Part D benefits will total $120 billion in 2024 (https://www.cbo.gov/system/files/2023-05/51302-2023-05-medicare.pdf), representing 14% of net Medicare outlays (net of offsetting receipts from premiums and state transfers). Part D spending depends on several factors, including the total number of Part D enrollees, their health status and the quantity and type of drugs used, the number of high-cost enrollees (those with drug spending above the catastrophic threshold), the number of enrollees receiving the Low-Income Subsidy, and the ability of plan sponsors to negotiate discounts (rebates) with drug companies and preferred pricing arrangements with pharmacies, and to manage use (e.g., promoting use of generic drugs, prior authorization, step therapy, quantity limits, and mail order).

Part D Financing

Financing for Part D (https://www.cms.gov/oact/tr/2023#page=19) comes from general revenues (74%), beneficiary premiums (14%), and state contributions (11%). The monthly premium paid by enrollees is set to cover 25.5% of the cost of standard drug coverage. Medicare subsidizes the remainder, based on bids submitted by plans for their expected benefit payments. Higher-income Part D enrollees pay a larger share of standard Part D costs, ranging from 35% to 85%, depending on income.

Payments to Plans

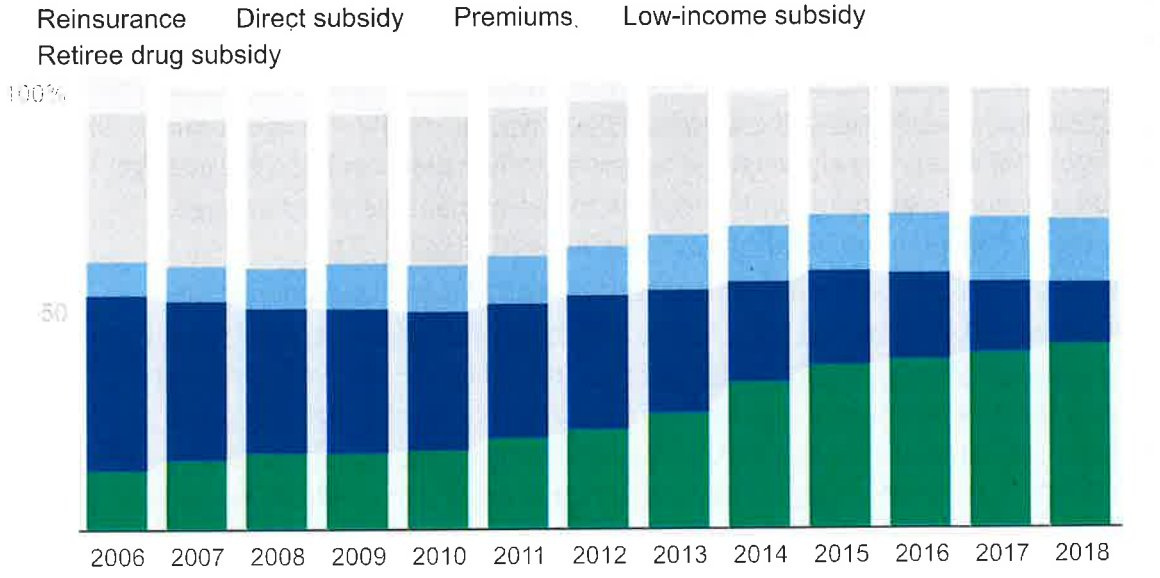
For 2024, Medicare's actuaries estimate (https://www.cms.gov/oact/tr/2023#page=158) that Part D plans will receive direct subsidy payments averaging $383 per enrollee overall, $2,588 for enrollees receiving the LIS, and $1,153 in reinsurance payments for very high-cost enrollees; employers are expected to receive, on average, $591 for retirees in employer-subsidy plans. Part D plans also receive additional risk-adjusted payments based on the health status of their enrollees, and plans' potential total losses or gains are limited by risk-sharing arrangements with the federal government ("risk corridors").

In 2024, as in previous years, Medicare's reinsurance payments to plans subsidize 80% of total drug spending incurred by Part D enrollees above the catastrophic coverage threshold. (This share will drop to 20% for brand-name drugs and 40% for generic drugs, beginning in 2025, due to a provision in the Inflation Reduction Act.) In the aggregate, Medicare's

reinsurance payments to Part D plans now account for close to half of total Part D spending (48%), up from 14% in 2006 (increasing from $6 billion in 2006 to $57 billion in 2022 (https://www.cms.gov/oact/tr/2023#page=159)) (Figure 7). Higher benefit spending above the catastrophic threshold is a result of several factors, including an increase in the number of high-cost drugs, drug price increases, and a change made by the ACA to count the manufacturer discount on the price of brand-name drugs in the coverage gap towards the out-of-pocket threshold for catastrophic coverage; this change has led to more Part D enrollees with spending above the catastrophic threshold over time (https://www.kff.org/medicare/issue-brief/millions-of-medicare-part-d-enrollees-have-had-out-of-pocket-drug-spending-above-the-catastrophic-threshold-over-time/).

Figure 7

Spending for Catastrophic Coverage ("Reinsurance") Now Accounts for Nearly Half (48%) of Total Medicare Part D Spending, up from 14% in 2006



SOURCE: KFF analysis of data from the 2016-2023 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, Table IV.B10. • PNG

KFF

Issues for the Future

Since its inception, the Medicare drug benefit has helped to limit growth in average out-of-pocket drug spending by Medicare beneficiaries enrolled in Part D plans. More recently, however, a combination of factors, including rising drug prices, more plans charging coinsurance rather than flat copayments (https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-and-costs-in-2023/#:~:text=most%20MA%2DPD%20enrollees%20(91%25)%20are%20in%20plans%20that%20charge%20copayments%20while%20virtually%20all%20PDP%20enrollees%20are%20in%20plans%20that%20charge%20co

insurance) for covered brand-name drugs, and annual increases in the out-of-pocket spending threshold, has increased the out-of-pocket cost burden faced by some enrollees, especially those with high drug costs.

Provisions in the Inflation Reduction Act that started rolling out as of 2023 are designed to address several concerns related to Part D, including the lack of a hard cap on out-of-pocket spending for Part D enrollees; the inability of the federal government to negotiate drug prices with manufacturers; the significant increase in Medicare spending for Part D enrollees with high drug costs; prices for many Part D covered drugs rising faster than the rate of inflation; and the relatively weak financial incentives faced by Part D plan sponsors to control high drug costs.

Recent years have seen a growing divide in the Part D plan market between stand-alone PDPs, where the number of plans has generally been trending downward over time in conjunction with a reduction in PDP enrollment, and MA-PDs, where plan availability and enrollment have experienced steady growth. MA-PD sponsors can use rebate dollars from Medicare payments to lower or eliminate their Part D premiums (https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/#:~:text=plans%20are%20allocating%20some%20of%20those%20rebate%20dollars%20to%20lower%20the%20part%20D%20portion%20of%20the%20MA%2DPD%20premium), so the average premium for drug coverage in MA-PDs is heavily weighted by zero-premium plans. In 2023, the average monthly PDP premium is substantially higher than the enrollment-weighted average monthly portion of the premium for drug coverage in MA-PDs ($40 vs. $10) (https://www.kff.org/medicare/issue-brief/key-facts-about-medicare-part-d-enrollment-and-costs-in-2023/#:~:text=average%20monthly%20premium%20for%20Part%20D%20drug%20coverage%20is%204%20times%20more%20in%20PDPs%20than%20in%20MA%2DPDs). This premium imbalance between PDPs and MA-PDs could be exacerbated as plans assume greater liability for high drug costs above the catastrophic threshold in 2024 and 2025. The increasing availability of low or zero-premium MA-PDs, while PDPs charge substantially higher premiums, could tilt enrollment even more towards Medicare Advantage plans in the future. And while provisions in the Inflation Reduction Act to make the Part D benefit more generous will help enrollees, especially those with high drug costs, they could also make it harder for some plan sponsors to continue to offer competitively priced coverage, particularly sponsors of stand-alone drug plans.

Understanding how well Part D continues to meet the needs of people on Medicare as the various provisions of the Inflation Reduction Act are implemented will be informed by ongoing analysis of the Part D plan marketplace, formulary coverage and costs for new and existing medications, and trends in Medicare beneficiaries' out-of-pocket drug spending.