PART D PAYMENT SYSTEM

*payment***basics**

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October 2022

The policies discussed in this document were current as of September 30, 2022, and reflect any relevant changes implemented in response to the COVID-19 public health emergency as of that date. This document does not reflect proposed legislation or regulatory actions.

MEDPAC

425 I Street, NW
Suite 701
Washington, DC 20001
ph: 202-220-3700
www.medpac.gov

A combination of stand-alone prescription drug plans (PDPs) and Medicare Advantage (MA)–Prescription Drug plans (MA–PDs) delivers Medicare's voluntary outpatient drug benefit known as Part D. In each of 34 geographic regions, plans compete for enrollees on the basis of annual premiums, benefit structures, specific drug therapies covered, pharmacy networks, and quality of services. Plans bear some risk for their enrollees' drug spending. Overall, Medicare subsidizes premiums by about 75 percent and provides additional subsidies for beneficiaries who have low levels of income and assets.[1] Medicare's payments to plans are determined through a competitive bidding process, and enrollee premiums are tied to plan bids.

The drug benefit

A number of changes in law revised the structure of the Part D benefit over time, most recently under the Inflation Reduction Act (IRA) of 2022. Most of the IRA's changes to Part D's standard benefit—as well as its provisions to negotiate some drug prices—begin after 2023. For 2023, the standard benefit will include:

- a $505 deductible;
- coverage for 75 percent of allowable drug expenses up to an initial benefit limit of $4,660;
- a $7,400 catastrophic limit on true out-of-pocket (OOP) spending;[2]
- about 5 percent coinsurance for drug spending above the OOP threshold (Figure 1); and
- copayments capped at $35 for covered insulin products and no cost sharing for recommended vaccines.

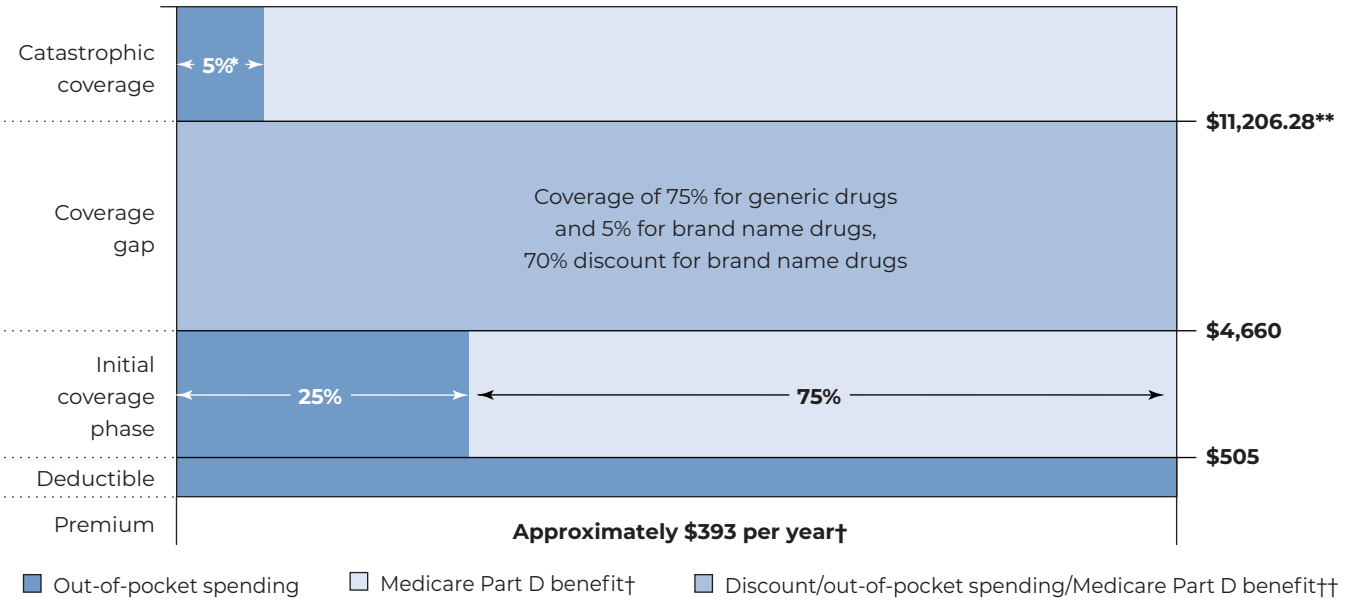
Prior to 2011, enrollees with standard benefits were responsible for paying the full cost of drug spending between the initial benefit limit and the out-of-pocket threshold. Subsequent changes in law reduced cost sharing in this coverage gap, and under the IRA, the coverage gap will be removed altogether beginning in 2025. Currently, beneficiaries pay 25 percent cost sharing until they reach an OOP threshold, after which they pay 5 percent cost sharing with no cap on OOP spending. The IRA will eliminate cost sharing above the OOP threshold in 2024 and introduce a cap of $2,000 in OOP spending in 2025.

Under Part D, Medicare provides primary drug coverage for individuals with low income and assets (these individuals receive the low-income subsidy (LIS)). Beneficiaries dually eligible for Medicare and Medicaid (individuals with incomes up to 100 percent of poverty) have no deductibles, nominal copays, and no coverage gap. Beneficiaries who do not qualify for full Medicaid benefits but whose incomes are below 150 percent of poverty and who meet an asset test receive coverage for premiums and cost sharing and do not face a coverage gap.

Currently, there are two distinct standard Part D benefit structures—one for beneficiaries who receive the LIS and another for all other beneficiaries. Beginning in 2025, both categories of beneficiaries will have the same standard benefit design. LIS enrollees will continue to make nominal copayments.

Plans can and often do offer alternative coverage structures. For example, a plan can offer a deductible lower than $505, or use tiered copayments rather than coinsurance—provided that the alternative benefit meets certain tests of actuarial equivalence. Also, plans may offer additional drug coverage that supplements the standard benefit. Medicare payments to plans do not subsidize such supplemental coverage.

Figure 1 Standard drug benefit in 2023



Note: Benefit structure applicable to an enrollee who has no supplementary drug coverage and does not receive Part D's low-income subsidy (LIS). The standard benefit for LIS enrollees differs from this because those beneficiaries are not permitted to receive brand discounts from manufacturers in the coverage-gap phase. Although their standard benefit continues to charge 100 percent cost sharing in the coverage gap, for most LIS enrollees, Medicare's LIS pays for all cost sharing except nominal copayments.
*Cost sharing above the out-of-pocket (OOP) threshold is the greater of either 5 percent coinsurance or a copay of $4.15 for generic drugs, or $10.35 for brand name drugs.
**Equivalent to $7,400 in OOP spending: $505 (deductible) + $1,038.75 (25% cost sharing on $4,155) + $5,856.25 (25% cost sharing for generic drugs, 25% cost sharing for brand name drugs, and 70% manufacturer discount for brand name drugs in the "coverage gap"). The amount of total covered drug spending at which a beneficiary meets the annual OOP threshold depends on the mix of brand name and generic drugs that the individual fills during the coverage gap.
†There is a base beneficiary premium of about $393 per year, which is 25.5% of expected Medicare Part D benefits per person, but the actual premiums that beneficiaries pay vary by plan. Federal subsidies pay for the remainder of covered Part D benefits.
††Cost sharing for drugs filled during the coverage gap is 25% for generic drugs (the remaining 75% will be picked up by the Part D benefit) and about 25% for brand name drugs. The actual cost sharing amount for brand name drugs will depend on the dispensing fee charged by a plan since the 5% covered by the Part D benefit applies to both the ingredient cost and the dispensing fee, while the 70% manufacturer discount applies only to the ingredient cost.

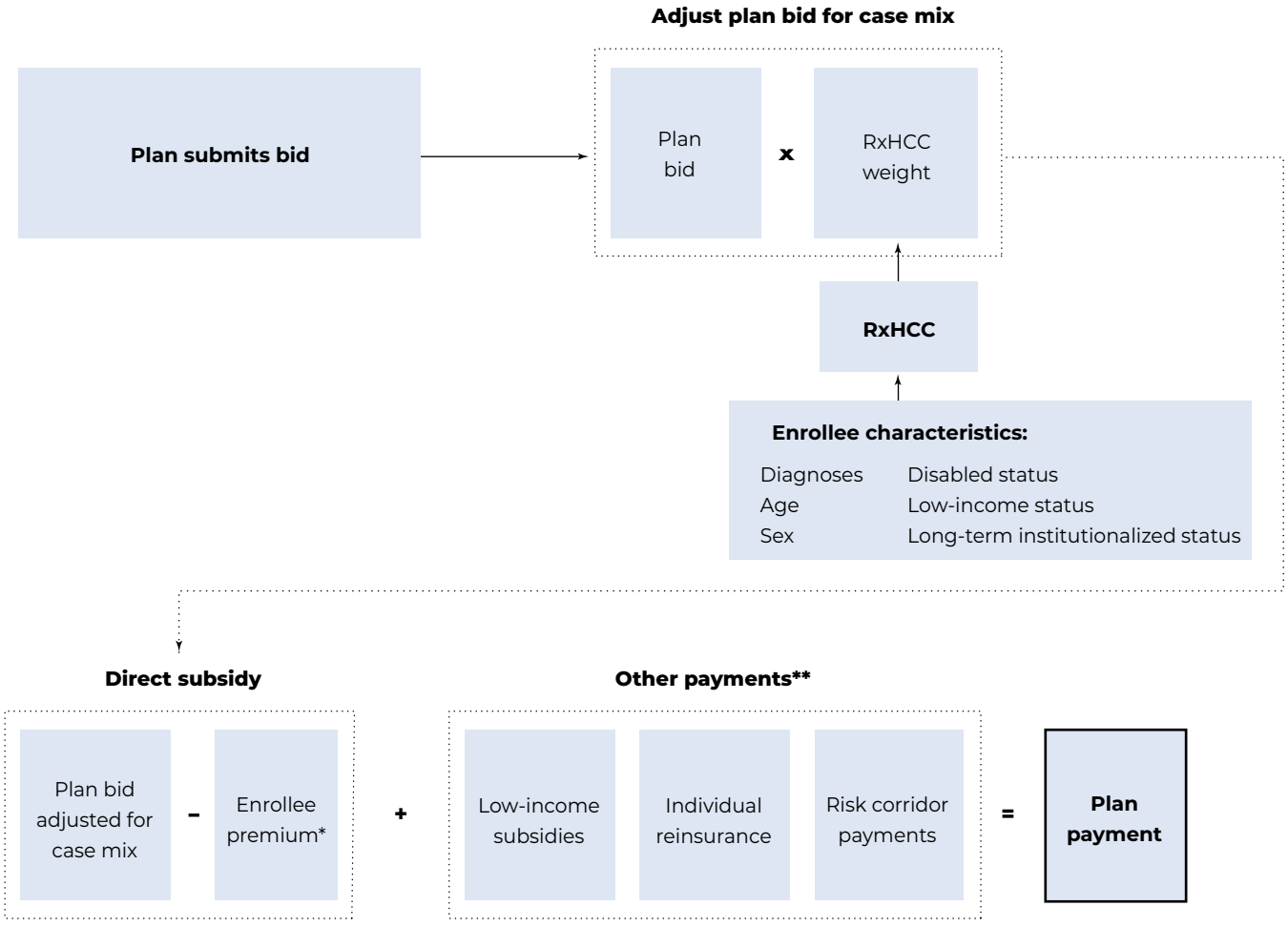
Medicare's subsidy amounts

For each Medicare enrollee in a plan (either stand-alone PDP or MA–PD), Medicare provides plans with a subsidy that aims to average 74.5 percent of standard coverage for all types of beneficiaries. That average subsidy takes two forms:

- Direct subsidy—a capitated payment to plans calculated as a share of the adjusted national average of plan bids.
- Individual reinsurance—Medicare subsidizes 80 percent of drug spending above the out-of-pocket threshold. (Beginning in 2025, Medicare will reduce its reinsurance and increase capitated payments so that the overall subsidy will remain at 74.5 percent.) Reinsurance acts as a form of risk adjustment by providing greater federal subsidies for the highest cost enrollees.

In addition, Medicare establishes symmetric risk corridors separately for each plan to limit a plan's overall losses or profits. Under risk corridors, Medicare limits a plans' potential losses (or gains) by financing some of the higher-than-expected costs (or recouping excessive profits). Also, Medicare pays plans that enroll low-income beneficiaries most of their enrollees' cost sharing and premiums.

Figure 2 Part D payment system, 2023



Note: RxHCC (prescription drug hierarchical condition category). The RxHCC is the model that estimates the enrollee risk adjuster. CMS uses five separate sets of model coefficients for: long-term institutionalized enrollees; aged low-income enrollees; aged non–low-income enrollees; disabled low-income enrollees; and disabled non–low-income enrollees.
* Figure 3 outlines the process for calculating enrollee premiums.
**Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.

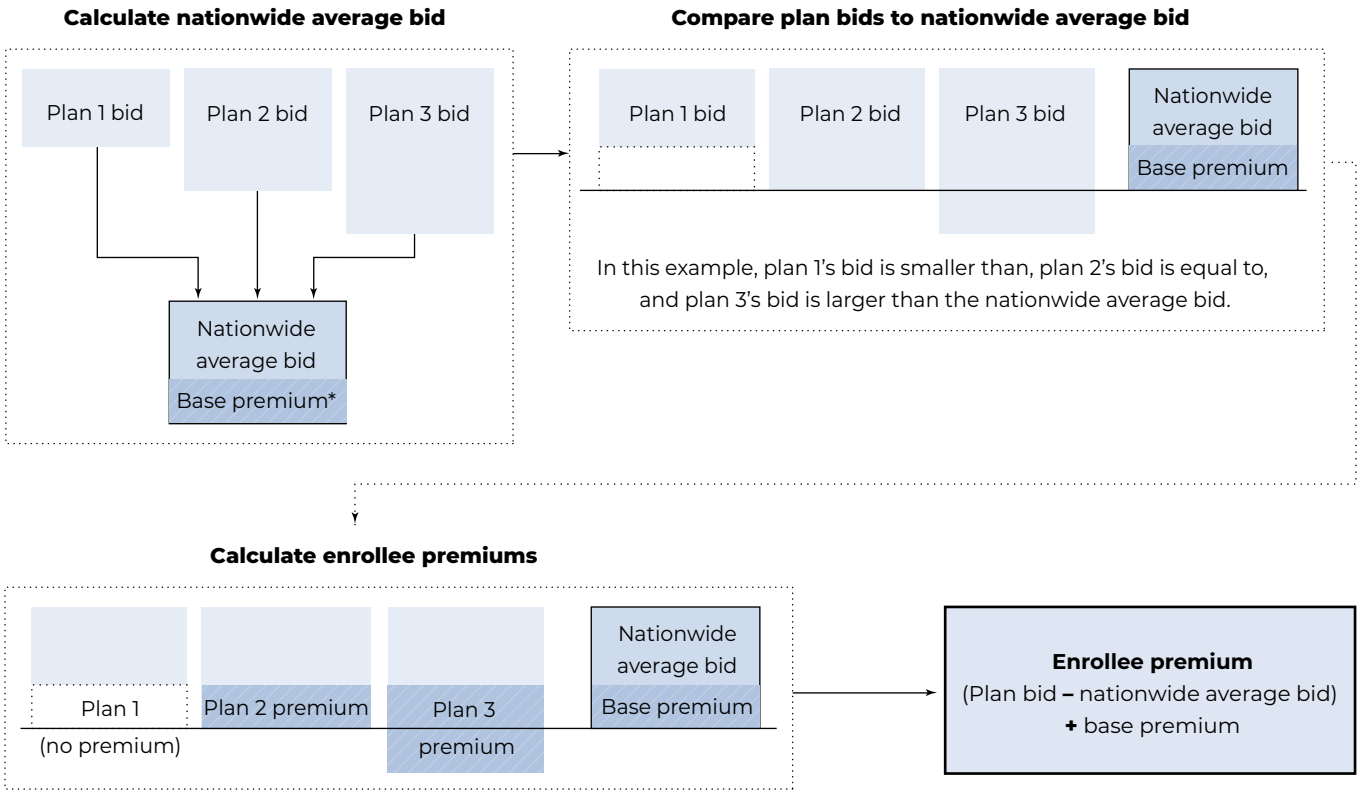
Note that although plans get essentially the same level of direct subsidy per enrollee (modified by risk adjusters), the level of other payments differs substantially from plan to plan. Other payments vary depending on the characteristics of individuals that each plan enrolls (e.g., income and health status), as well as whether a plan's losses or profits trigger provisions of its risk corridors.

Part D replaced Medicaid as the primary source of prescription drug coverage for individuals who are dually eligible for Medicare and Medicaid. However, states continue to help finance the costs of drug coverage for dually eligible beneficiaries by making monthly lump sum payments to Medicare.

Medicare's payments to plans

Each plan submits a bid annually to the Centers for Medicare & Medicaid Services (CMS) by the first Monday in June. The bids

Figure 3 Calculating enrollee premiums, 2023



Note: *The base premium is a share of the nationwide average bid. It equals the nationwide average times a factor with a numerator of 25.5% and a denominator of 100% minus CMS's estimate of aggregate plan revenues for Part D benefits that they receive through federal individual reinsurance subsidies. Beginning in 2011, Part D began collecting additional premiums from higher income enrollees. The extra premium amount is equal to the difference between 35, 50, 65, 80, or 85% and the 25.5% applied to the nationwide average bid adjusted for individual reinsurance.

reflect the plan's expected benefit payments plus administrative costs after deducting expected federal reinsurance subsidies. Plans base their bids on expected costs for a Medicare beneficiary of average health.

The direct subsidy that CMS pays to each plan takes the form of a monthly prospective payment for each enrollee based on the plan's approved bid. The plan bid is first adjusted by the enrollee's case mix and other factors, namely low-income status and long-term institutionalized status (Figure 2). A second adjustment to the plan's bid is the subtraction of the enrollee's premium. (See the following section on how premiums are calculated.) CMS also provides plans with interim prospective payment adjustments for individual reinsurance and low-income subsidies. The agency reconciles actual levels of enrollment, risk factors, levels of incurred allowable drug costs (after rebates and other discounts), reinsurance amounts, and low-income subsidies after the end of each year.

Calculating enrollee premiums

CMS takes plans' standardized bid amounts for basic benefits or the portion of plan bids attributable to basic coverage and calculates the average (Figure 3). The base premium is a share of the nationwide average bid. To enroll in a Part D plan, beneficiaries pay the base premium plus

any difference between their plan's bid and the nationwide average bid. The base premium amount for beneficiaries is $32.74 per month in 2023. Enrollees in costlier plans face higher-than-average premiums for standard Part D coverage; similarly, enrollees in less expensive plans pay lower-than-average premiums.[3]

Individuals with modified adjusted gross incomes exceeding income thresholds (in 2023, $97,000 (or $194,000 for couples)) are subject to higher premiums similar to the income-related premium under Medicare Part B.[4]

Medicare pays all or most of the premium for low-income beneficiaries up to a regional threshold amount, calculated as an enrollment-weighted average premium for each PDP region.

Benefit and payment updates

Medicare updates the deductible, benefit limit, and catastrophic threshold amounts in the standard Part D benefit each year. Plan payments are a function of plans' updated bids. The benefit's threshold amounts increase by CMS's estimate of the annual change in drug spending per person.

Mandatory rebates to Medicare for rapid price growth

As a result of the IRA, all covered Part D drugs are subject to inflation rebates, as of October 1, 2022. Manufacturers are required to provide to the Medicare program rebates for increases in the price of drugs sold in Part D greater than the increase in inflation over the same period, relative to a 2021 benchmark. Payment for the first inflation rebates will be due in July 2024. ■

1 The premium subsidy is reduced for higher income beneficiaries. For more information, refer to the section on calculating enrollee premiums.

2 The term "true out-of-pocket" refers to a feature of Part D that directs fewer federal subsidy dollars toward enrollees who have supplemental coverage. Specifically, only certain types of spending on behalf of the beneficiary count toward the catastrophic threshold: the beneficiary's own out-of-pocket (OOP) spending; that of a family member or official charity; and supplemental drug coverage provided through qualifying state pharmacy assistance programs or Part D's low-income subsidies. In addition, beginning in 2011, drug spending made on behalf of the beneficiary by the AIDS Drug Assistance Program and the Indian Health Service counts toward the OOP threshold, as does the 70 percent discount paid for by pharmaceutical manufacturers for brand-name drugs. Beneficiaries need to adhere to their plan's formulary, prior authorization, and formulary exceptions processes in order to receive credit for their OOP spending toward the $7,400 limit.

3 Beneficiaries (other than those who receive low-income subsidies) who delay enrolling in Part D until after their initial enrollment period and who do not have creditable coverage must also pay a late enrollment penalty each month similar to that for Part B. Creditable coverage refers to prescription drug benefits through sources such as a former employer that are at least as generous as the standard Part D benefit.

4 As a result of changes made under the Medicare Access and CHIP Reauthorization Act of 2015, as of 2018, a higher Part D premium surcharge applies to some beneficiaries who are subject to income-related premiums.