PART D PAYMENT SYSTEM

*payment***basics**

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The policies discussed in this document were current as of September 30, 2024. This document does not reflect proposed legislation or regulatory actions.

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In 2022, Medicare spent $101.3 billion in subsidies for the Part D program. 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. 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. Overall, Medicare subsidizes premiums by about 75 percent and provides additional subsidies for beneficiaries who have low income and assets.[1] Medicare's payments to plans are determined through a competitive bidding process, and enrollee premiums are tied to plan bids. Part D has several mechanisms for risk sharing so that plans do not take all the insurance risk for their enrollees' drug spending.

The drug benefit

A number of changes in law have revised the structure of the Part D benefit over time, most recently under the Budget Reconciliation Act of 2022 (BRA). Most of the BRA's changes to Part D's standard benefit begin in 2025, including a single standard benefit design for all enrollees, whether receiving the low-income subsidy or not. For 2025, the standard benefit will include:

- a $590 deductible;
- coverage for 75 percent of allowable drug expenses in the initial coverage phase; and
- a $2,000 limit on true out-of-pocket (OOP) spending.[2]

CMS updates these benefit parameters each year to reflect estimated changes in average annual drug spending.

Also effective in 2025, the BRA eliminated the program's former coverage gap and made changes to plan liability, manufacturer discounts owed, and Medicare's reinsurance liability, as detailed in Figure 1.

Beginning in 2025, after reaching their deductible, beneficiaries pay 25 percent cost sharing until they reach the annual OOP limit. The BRA eliminated cost sharing above the OOP limit in 2024, and a lower cap of $2,000 in OOP spending will be implemented in 2025.

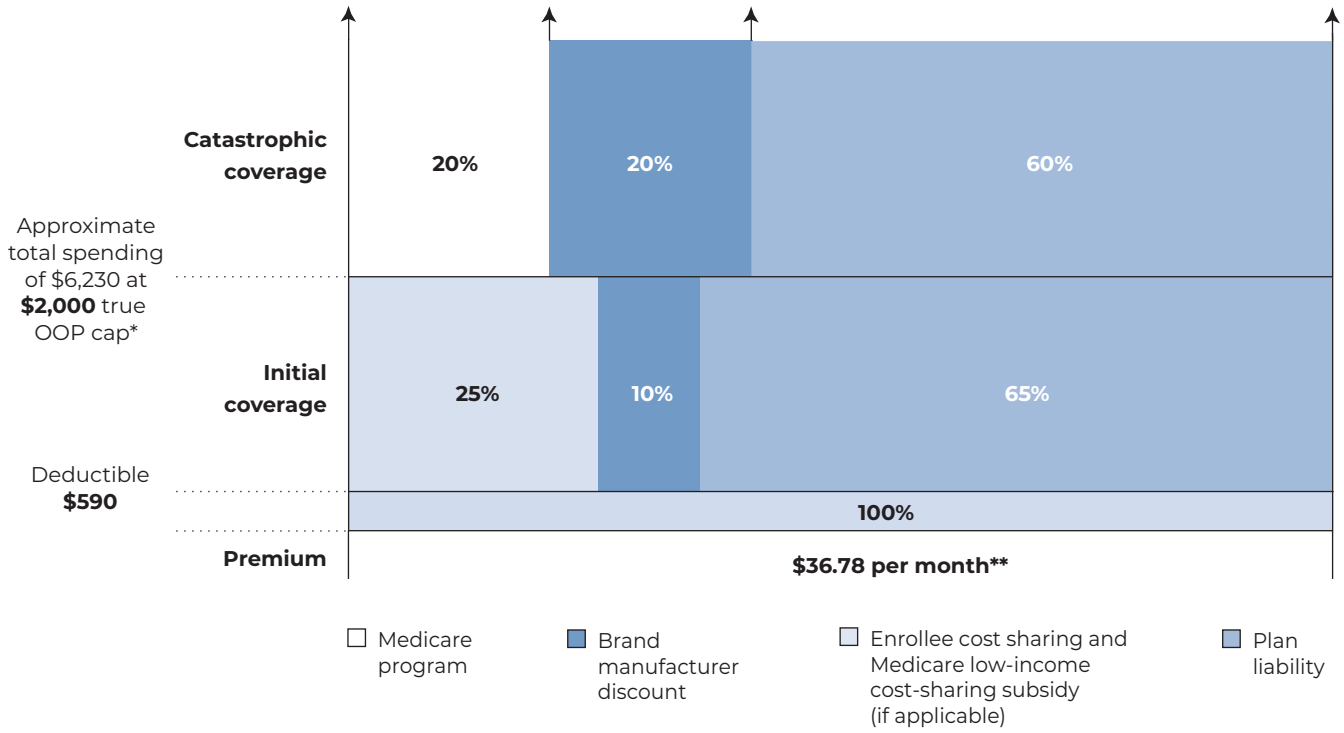
Under Part D, Medicare provides primary drug coverage for individuals with low income and assets (these individuals receive the low-income subsidy (LIS)). Beneficiaries dually eligible for Medicare and Medicaid with incomes up to 100 percent of the federal poverty level have no deductibles, nominal copays, and receive full premium subsidies. Beneficiaries who do not qualify for full Medicaid benefits but whose incomes are below 150 percent of the poverty level and who meet an asset test receive coverage for premiums and cost sharing.[3]

Plans can and often do offer alternative coverage structures to provide the basic Part D benefit. For example, a plan can offer a deductible lower than $590, 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 through an enhanced plan that supplements the standard benefit. Medicare payments to plans do not subsidize such supplemental coverage, and enrollees may have to pay additional premiums.[4]

Medicare's subsidy components

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 basic benefit costs for all types of beneficiaries. That average subsidy takes two forms:

Figure 1 Standard drug benefit in 2025



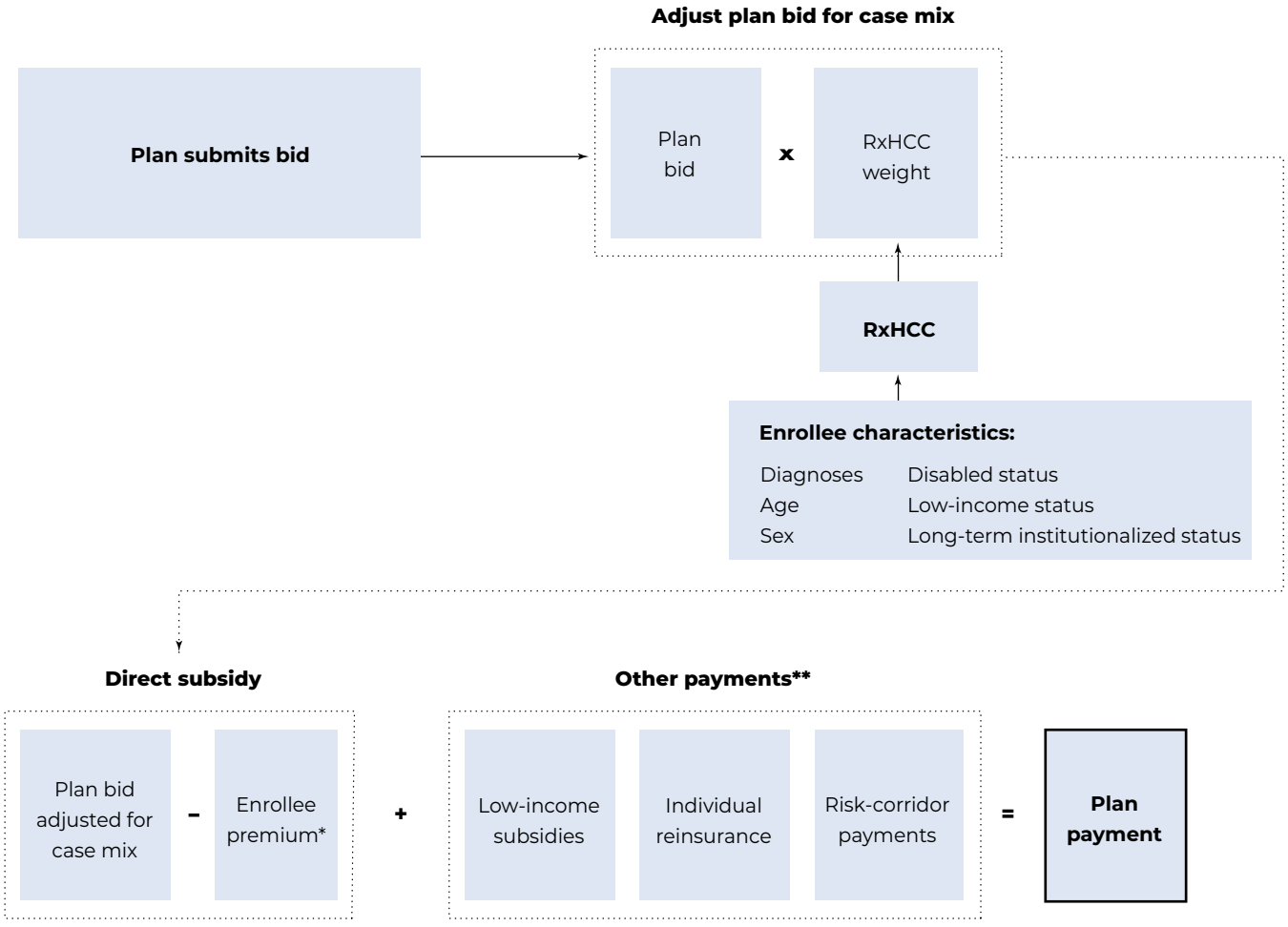
Note: OOP (out-of-pocket). This benefit structure is applicable to an enrollee who has no supplementary drug coverage and is taking an "applicable drug" (i.e., a brand-name drug, biologic, or biosimilar) for which a manufacturer will owe a discount under the Manufacturer Discount Program. For generic drugs, plan sponsors must cover 75 percent of enrollee spending between the deductible and OOP cap, and Medicare's reinsurance will pay for 40 percent of spending in the catastrophic phase. For LIS enrollees, Medicare's LIS pays for all cost sharing except nominal copayments.
* Equivalent to $2,000 in OOP spending: $590 (deductible) + $1,410 (25 percent cost sharing on $5,640). Total spending at the annual OOP limit would depend on the mix of drugs used and whether the individual received any supplemental benefits.
** There is a base beneficiary premium of $36.78 (about $441 per year), which is less than 20 percent 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.

- Direct subsidy—a capitated payment to plans calculated as a share of the adjusted national average of plan bids.
- Individual reinsurance—Medicare subsidizes a portion of drug spending above the annual OOP limit on an incurred cost basis. (Beginning in 2025, Medicare will reduce its reinsurance and increase capitated payments so that the overall subsidy will remain at 74.5 percent or above.) 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 plan's potential losses (or gains) by financing some of the higher-than-expected costs (or recouping excessive profits). Also, Medicare pays plans most of their LIS enrollees' cost sharing and premiums.

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 the individuals that each plan enrolls (e.g., income), as well as whether a plan's losses or profits trigger provisions of its risk corridors.

Figure 2 Part D payment system, 2025



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.

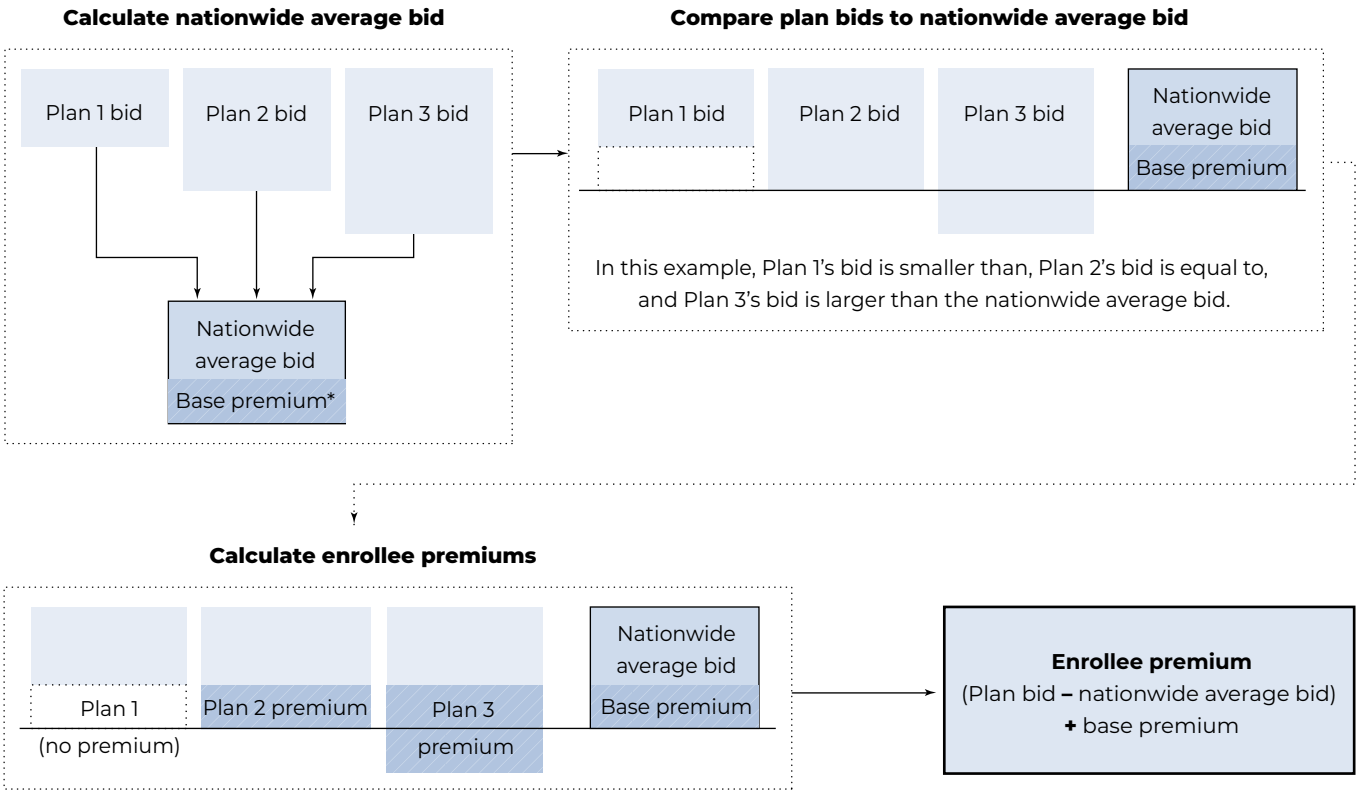
Part D serves as the primary source of prescription drug coverage for individuals who are dually eligible for Medicare and Medicaid. However, states continue to help finance the costs of drug coverage for dually eligible beneficiaries by making monthly lump sum payments to Medicare.

Medicare's payments to plans

Each plan submits a bid annually to CMS by the first Monday in June for plans that will be offered starting in January of the following year. The bid reflects the plan's expected basic benefit costs plus administrative costs and profits after deducting expected federal reinsurance subsidies. Plans base their bids on expected costs for a Medicare beneficiary with an average risk score.

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 enrollees' case mix and other

Figure 3 Calculating enrollee premiums for basic benefits, 2025



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 percent and a denominator of 100 percent minus CMS's estimate of aggregate plan revenues for Part D benefits that plans receive through federal individual reinsurance subsidies. Beginning in 2024, the Budget Reconciliation Act of 2022 limits the annual increase in the base premium to no more than 6 percent. When this provision is binding (as in both 2024 and 2025), the base premium's share of Part D benefit costs is less than 25.5 percent applied to the nationwide average bid amount. Beginning in 2011, Part D began collecting additional premiums from higher-income enrollees. The extra premium amount is equal to the difference between 35 percent, 50 percent, 65 percent, 80 percent, or 85 percent and the 25.5 percent applied to the nationwide average bid adjusted for individual reinsurance.

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.) The agency reconciles payments to reflect the actual levels of enrollment, risk factors, and levels of incurred allowable drug costs (after rebates and other discounts) after the end of each year.

The changes made under the BRA will cause much more of the program's subsidy of basic benefits to take the form of capitated direct subsidy payments rather than cost-based reinsurance payments, but Medicare's overall subsidy rate will remain unchanged at 74.5 percent (unless required to increase to accommodate the 6 percent cap on annual premium increases, included in the BRA, discussed below).

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.[5] 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.[6] Beginning in 2024, the BRA limits the annual increase in the base premium to no more than 6 percent. The base premium amount for beneficiaries is $36.78 per month in 2025. (Without the BRA change, the base premium amount would have been $55.98 per month in 2025.)

CMS announced that it would implement a new Part D Premium Stabilization Demonstration, a voluntary demonstration open only to stand-alone PDPs for 2025 and two subsequent years. For participating PDPs, the demonstration would lower the monthly beneficiary premium by up to $15, limit total monthly Part D premium increases for 2025 to no more than $35, and narrow the upper thresholds of the risk corridors to provide greater protection from losses.

Individuals with modified adjusted gross incomes exceeding certain income thresholds are subject to higher premiums, similar to the income-related premium under Medicare Part B.

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.

Mandatory rebates to Medicare for rapid price growth

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

1 As a result of the changes made by the Budget Reconciliation Act of 2022, beginning in 2024, the annual increase in the base premium is limited to no more than 6 percent. When this provision is binding (as has been the case for 2024 and 2025), the base premium's share of Part D benefit costs is less than 25.5 percent applied to the nationwide average bid amount, and, as a result, Medicare's subsidy rate can be higher than the 74.5 percent specified in law. In addition, 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" (TrOOP) refers to those costs that count toward the catastrophic threshold. In addition to a beneficiary's own OOP expenditures or payments made on behalf of the beneficiary (e.g., charity), beginning in 2025, the value of supplemental coverage provided by enhanced plans and employer group waiver plans also counts towards TrOOP. The inclusion of supplemental coverage towards TrOOP is a result of changes made by the BRA. Conversely, mandatory manufacturer discounts are no longer counted towards TrOOP, another change of the BRA. 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 $2,000 limit.

3 Starting in 2024, the BRA expanded the eligibility for the full LIS to beneficiaries who earn between 135 percent and 150 percent of the federal poverty level and meet the asset test. Prior to 2024, these beneficiaries qualified for a partial LIS that was less generous than the full LIS.

4 MA-PD plans may use Part C rebates earned through the MA Quality Bonus Program to "buy-down" their enrollees' premiums, including premiums for enhanced prescription drug coverage.

5 Premiums for individual plans vary widely, with many MA–PDs charging $0 after applying a portion of Part C quality bonus payments (or rebates) to offset premium costs that MA–PD enrollees would otherwise pay.

6 Beneficiaries (other than those who receive the LIS) 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.