Congressional Budget Office
Nonpartisan Analysis for the U.S. Congress

Paying for Drugs in Medicare Part D Under Current Law and Under Proposals to Redesign the Program

November 2021

Background on Medicare Part D

Part D is Medicare's optional prescription drug benefit. Medicare beneficiaries obtain coverage from private insurers, either through a stand-alone drug plan or through a Medicare Advantage plan.

In 2020, about 47 million Medicare beneficiaries (or 75 percent) were enrolled in Part D. Roughly 13 million of them receive a low-income subsidy that pays most or all of their premium and cost-sharing requirements; as a result, those enrollees face only limited costs. The base Part D premium is about $33 per month.[a]

Part D plans receive a fixed payment per enrollee from the federal government and bear financial risk for part of enrollees' drug costs, so plan administrators have an incentive to control costs by managing drug utilization and negotiating lower prices.

When enrollees reach a high level of spending known as the catastrophic threshold, the federal government reimburses plans for 80 percent of spending above that limit, which reduces plans' incentives to control costs.

a. A number of factors, including income, affect the premium that an enrollee pays; for example, enrollees with higher income have to make an additional payment to Medicare.

Structure of the Part D Benefit

Part D plans have a standard benefit in which costs are shared by four parties—the enrollee, the plan, the drug manufacturer, and the federal government.

Plans usually deviate from the standard benefit but must provide benefits that are either actuarially equivalent to it or more generous than it. For plans offering actuarially equivalent benefits, one plan's cost-sharing requirements for certain drugs might differ from another plan's requirements, but the plans cover the same average percentage of total expected drug spending.

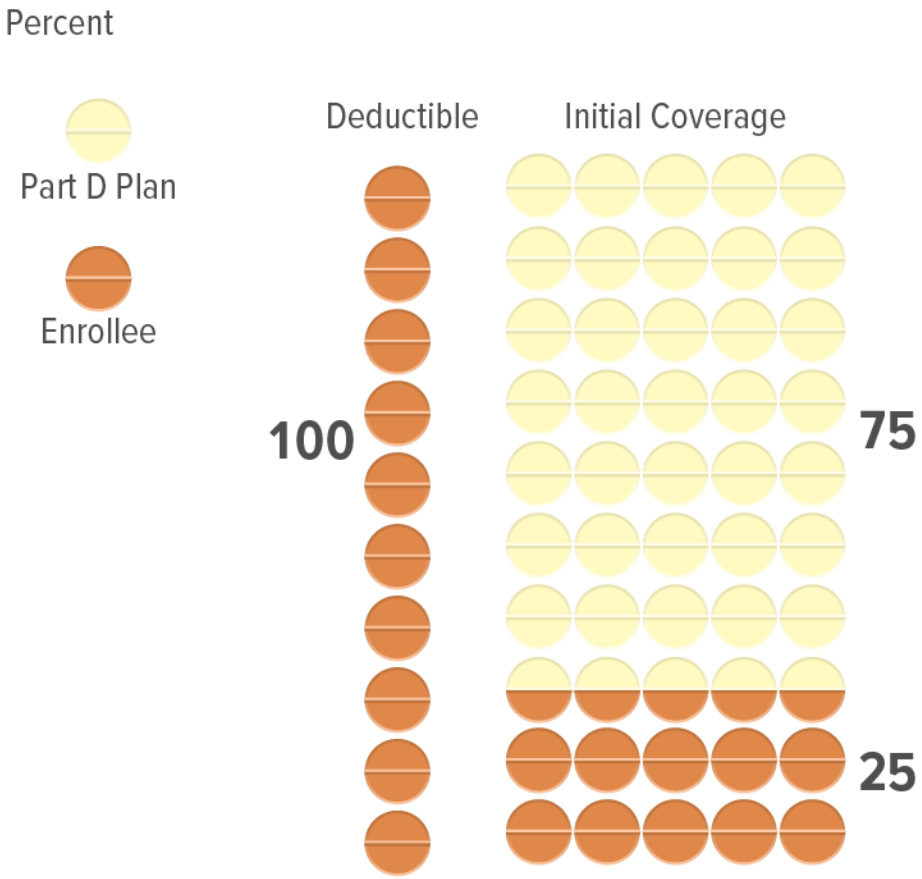
Many plans offer more-generous "enhanced" coverage—benefits that cover a greater fraction of total expected spending than the standard benefit—with lower cost-sharing requirements. Part D plans do so by charging enrollees an additional, unsubsidized premium. Medicare Advantage drug plans may cover that premium using supplemental payments from the Medicare program.[a]

The shares of costs paid by each party differ in each of the benefit's four coverage phases:

Deductible → Initial Coverage → Coverage Gap → Catastrophic

a. As a result, some Medicare Advantage enrollees might receive benefits that exceed the standard benefit at no added cost. Medicare Advantage plans receive supplemental payments when their expected costs are below a certain amount.

The Deductible and Initial Coverage Phases of the Standard Part D Benefit for Enrollees Who Do Not Receive the Low-Income Subsidy

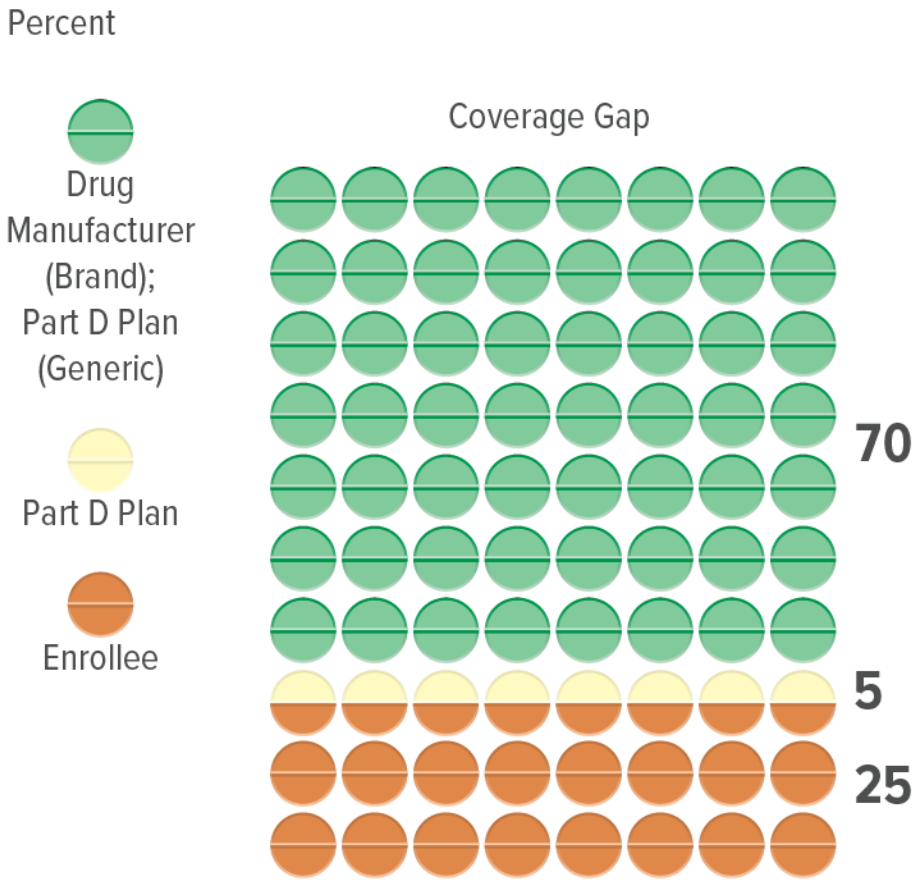


In the first phase, which starts at the beginning of a calendar year, the enrollee pays 100 percent of his or her drug costs up to the **deductible**, which is $445 in 2021.

When total spending exceeds that amount, the enrollee enters the **initial coverage phase**, in which he or she pays 25 percent of costs and the Part D plan pays 75 percent. That second phase continues until the enrollee reaches the initial coverage limit, which is $4,130 in total costs in 2021.

Relative widths of the figures in this document are not to scale.

The Coverage Gap Phase of the Standard Part D Benefit for Enrollees Who Do Not Receive the Low-Income Subsidy

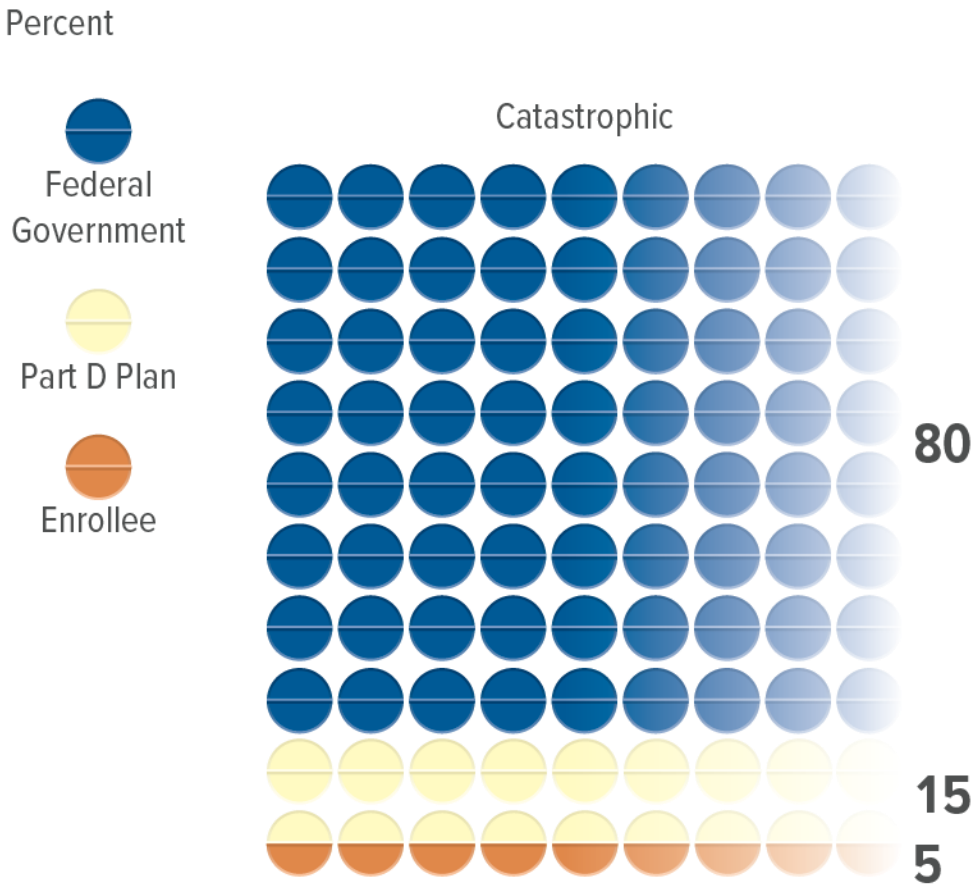


When an enrollee's total spending exceeds the initial coverage limit of $4,130 in 2021, he or she enters phase three, the **coverage gap**.

In this phase, the enrollee continues to pay 25 percent of drug costs. For brand-name drugs, the manufacturer provides a mandatory discount of 70 percent, and the Part D plan pays 5 percent. For generic drugs, the plan pays 75 percent. The enrollee remains in this phase until his or her out-of-pocket spending reaches the catastrophic threshold, which is $6,550 in 2021.

This phase became known as the coverage gap because enrollees in this phase paid all costs under Part D's original design. As defined, out-of-pocket spending includes the manufacturer's discount.

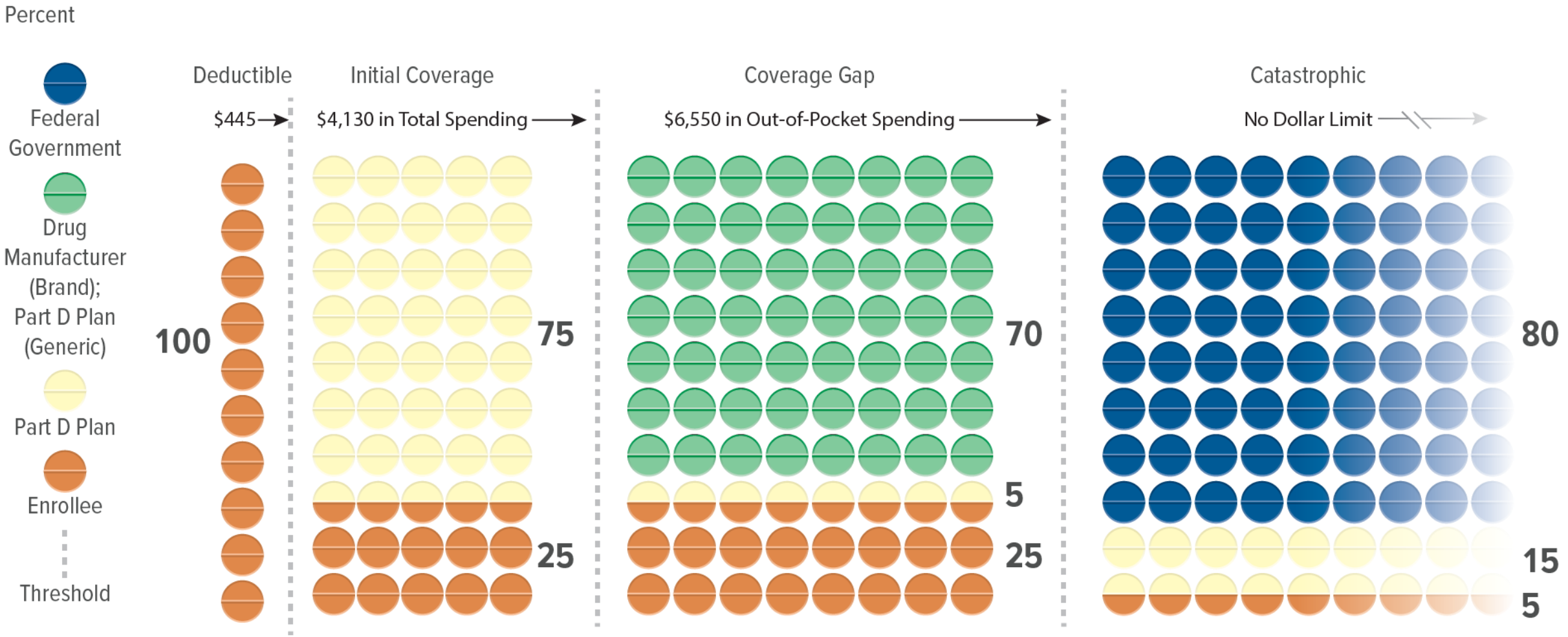
The Catastrophic Phase of the Standard Part D Benefit for Enrollees Who Do Not Receive the Low-Income Subsidy



When an enrollee's out-of-pocket costs exceed the catastrophic threshold of $6,550 in 2021, he or she enters phase four, the **catastrophic phase.**

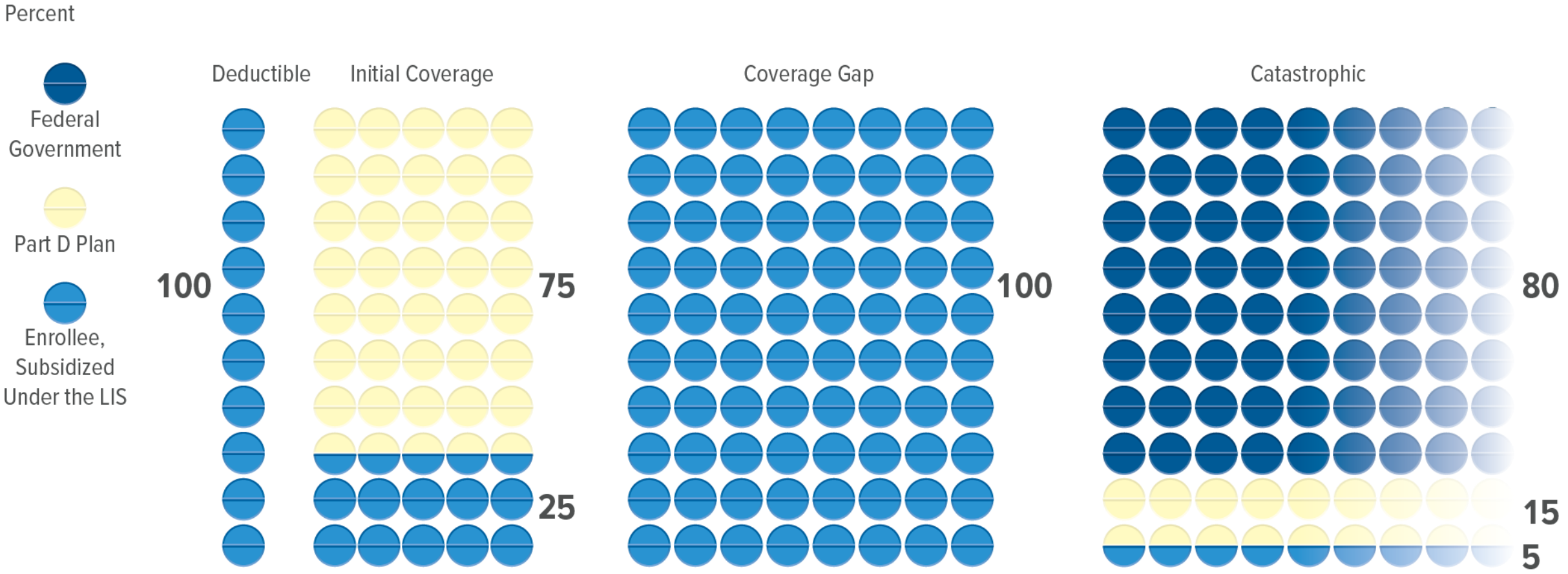
Part D plans pay 15 percent of all remaining drug costs in that year, the federal government pays 80 percent, and the enrollee is responsible for 5 percent. There is no cap on spending in this phase of the benefit.

All Phases of the Standard Part D Benefit for Enrollees Who Do Not Receive the Low-Income Subsidy



The relative widths of the coverage phases are not to scale, and the threshold spending amounts are for 2021. As defined, out-of-pocket spending includes the manufacturer's discount.

Part D Benefit Structure for Enrollees Who Receive the Low-Income Subsidy



For enrollees who receive the low-income subsidy (LIS), the manufacturer and plan pay nothing in the coverage gap; instead, 100 percent of drug costs are assigned to the enrollee. In actuality, though, relatively few costs are paid by the enrollee. Most of those costs are paid by the federal government through the subsidy.

Spending and Incentives in Part D Under Current Law

Federal spending for Part D was an estimated $96 billion in fiscal year 2021 and, under current law, will total $1.6 trillion from 2022 to 2031, CBO projects.[a]

Plans have weak incentives to control drug costs for high-cost enrollees. That is because plans bear risk for only 5 percent of spending in the coverage gap (for enrollees who do not receive the low-income subsidy) and 15 percent of spending in the catastrophic phase.

Over time, that weak incentive has become more important as the share of spending in the catastrophic phase has risen—roughly doubling from about 20 percent in 2007 to about 40 percent in 2020. The shift in spending resulted from changes in prescription drug spending as well as changes to the standard benefit enacted through legislation.[b]

a. Part D outlays are net of premiums that enrollees pay directly to their plans but not net of income-related premiums and premiums deducted from Social Security checks.

b. The discount for brand-name drugs in the coverage gap was introduced under the Patient Protection and Affordable Care Act (Public Law 111-148) and expanded under the Bipartisan Budget Act of 2018 (Public Law 115-123). Under those laws, discounts are included in the calculation of out-of-pocket spending, so enrollees reach the catastrophic threshold earlier.

Common Elements in Proposed Redesigns of the Part D Benefit

Proposals to revamp the Part D benefit would generally make these changes:

- Eliminate the coverage gap, extending the initial coverage phase to the catastrophic threshold.
- Significantly increase plans' liability for spending that exceeds the initial coverage limit (that is, spending that occurs in the coverage gap and in the catastrophic phase of the current-law benefit).
- Cap beneficiaries' out-of-pocket costs at a fixed dollar amount.
- Shift some or all of the discount that manufacturers are obliged to provide from the coverage gap to the catastrophic phase (or, possibly, the initial coverage phase).

Potential Effects of Those Proposals on Manufacturers' Drug Pricing Incentives

Shifting the placement of the manufacturers' discount would have ambiguous effects on prices if the dollar amount of the discount was held constant. Whether the average price of a drug increased or decreased would depend on the particular drug and manufacturer, along with the specifics of the proposed policy.

- For example, shifting the discount to the catastrophic phase of coverage could reduce manufacturers' incentives to charge high prices for some drugs in an effort to move beneficiaries through the coverage gap and minimize the share of total spending subject to the discount.

- However, shifting the discount to the catastrophic phase could create an incentive for manufacturers to raise prices for some drugs to increase the revenues that they retain after paying the discount.

Proposals that changed the total dollar amount of the discount would probably affect prices. For example, manufacturers would have an incentive to raise prices if they were obliged to provide a greater discount overall. However, the resulting effect on prices would depend on the specifics of the proposed policy, as well as any other policy changes affecting the market for prescription drugs.

Potential Effects on Enrollees' Spending and Incentives

Capping enrollees' yearly out-of-pocket spending by eliminating their share of costs in the catastrophic phase would modestly boost their use of prescription drugs and push up total Part D spending.

Empirical evidence suggests that, when lower out-of-pocket costs lead to more use of prescription drugs, beneficiaries use fewer medical services. That reduction in spending on other health care services, such as hospital care and physicians' services, would partially offset the higher cost of their increased drug utilization.

Potential Effects on Part D Plans' Spending and Incentives

Increasing the share of costs for which Part D plans are responsible would strengthen their incentives to control costs. To manage beneficiaries' access to drugs, plans already use tools such as formularies (approved lists of drugs), prior authorization, and step therapy (requirements to try lower-cost drugs before higher-cost alternatives are allowed).

- Greater use of those tools could shift patients to lower-cost medications while increasing the negotiating leverage of plans.
- But use of those tools would be limited by competitive pressure to offer generous coverage as well as statutory requirements that set a minimum threshold for the numbers and types of drugs that plans must cover.

Potential Effects on the Federal Government's Spending

Capping enrollees' out-of-pocket costs would push up federal spending by shifting spending from enrollees to plans. The federal subsidy covers 74.5 percent of plans' expected spending, so an increase in those costs translates into higher federal spending. A cap also would increase prescription drug utilization by enrollees and thus raise the government's costs for the Part D program. That rise in spending would be partially offset by reduced Medicare spending on other health care services, such as hospital care and physicians' services.

Extending the required manufacturer discount on brand-name drugs to other phases could either increase or decrease federal spending depending on how those changes affected total discounts as a share of that spending. If manufacturer discounts rose, then federal spending would tend to decline; conversely, if discounts fell, then federal spending would tend to rise. That is because the federal government subsidizes the costs paid by plans but not the discounts extended by manufacturers.

About This Document

This document was prepared to enhance the transparency of CBO's work and to encourage external review of that work. In keeping with CBO's mandate to provide objective, impartial analysis, the document makes no recommendations.

Colin Baker and Scott Laughery prepared the document with assistance from Tamara Hayford. Carrie H. Colla, Stuart Hammond, Leo Lex, Paul Masi, Asha Saavoss, Joshua Varcie, and Chapin White provided comments.

Mark Doms, Jeffrey Kling, and Robert Sunshine reviewed the document. Christine Bogusz edited it and prepared the text for publication, and R. L. Rebach created the graphics. The document is available at www.cbo.gov/publication/57461.

CBO seeks feedback to make its work as useful as possible. Please send comments to communications@cbo.gov.