

Part D Benefit Redesign:

Perspectives Q&A

By Jackie Lee

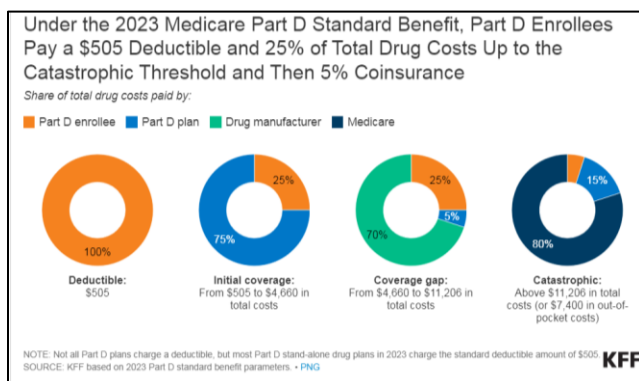
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Introduced under the Medicare Prescription Drug, Improvement, and Modernization Act ([MMA](#)) of 2003, Medicare Part D is the voluntary prescription drug benefit, a crucial part of healthcare coverage for millions of Americans. As of 2022, around 65 million beneficiaries were enrolled in Part D, comprising [nearly 25% of total healthcare spending](#). However, Part D is subject to challenges regarding the structure of premiums, cost-sharing and financial incentives for plans.

The [Inflation Reduction Act \(IRA\) of 2022](#) introduced substantial changes to Medicare Part D, with the intention of easing the financial burden of prescription drug expenses for Medicare beneficiaries. These reforms are set to roll out in 2024 and 2025 and represent a pivotal measure in addressing the escalating healthcare costs faced by many. This article explores the essential adjustments, concentrating on the evolving framework of Medicare Part D and the advantages these revisions offer to recipients.

Q: What does the current benefit structure look like?

The benefit structure for Part D involves four parties: enrollee, plan, drug manufacturer, and the federal government. The current Medicare Part D benefit aims to balance cost-sharing among involved parties and is comprised of four phases, as shown in the figure below.



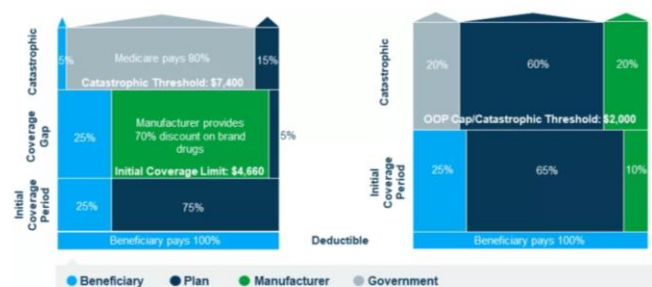
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In the deductible phase, enrollees pay [100% of drug costs up to \\$505](#). After the deductible has been met, enrollees pay [25%](#) of total drug costs [until \\$4,660](#) during the initial coverage phase. Next, in the coverage gap phase (donut hole), enrollees pay 25% for both brand-name and generic drugs while Part D plans pay 75% of generic and 5% of brand-name drug costs. Moreover, drug manufacturers give a [70%](#) discount on brand-name drugs. Enrollees qualify for catastrophic coverage when the amount paid out-of-pocket exceeds \$7,400. In this phase, Medicare pays 80%, Part D plans pay 15%, and enrollees pay 5% of total drug costs. Though the current design is an improvement, beneficiaries have no hard cap on out-of-pocket drug costs, a vital drawback that the IRA intends to resolve.

Q: How is the benefit structure changing?

A notable change in 2024 is in the catastrophic phase, wherein [the 5% coinsurance requirement is eliminated](#), meaning that when enrollees qualify for catastrophic coverage, their out-of-pocket spending is capped. With the threshold set at \$8,000, those prescribed high-cost medications are likely to see significant savings. Additionally, Part D plans will assume a greater share of costs above the catastrophic threshold, increasing from [15% to 20%](#).



The introduction of the maximum-out-of-pocket (MOOP) limit of \$2,000 (set to roll out in 2025), subject to annual inflationary increases, is expected to bring about financial relief to beneficiaries; those who take high-cost drugs are

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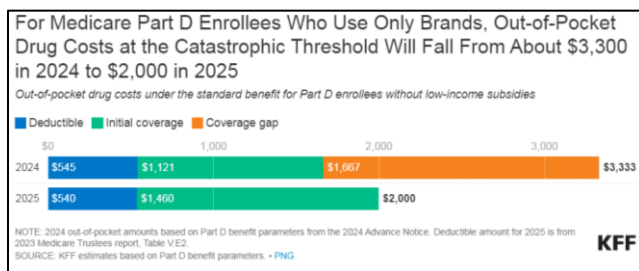
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expected to see savings up to \$1,300 in 2025. The current coverage gap phase will be replaced by a new [manufacturer discount program \(MDP\)](#). In the initial coverage phase, manufacturers will be required to give a 10% discount on brand-name drugs and Part D Plans will pay 65% of the brand-name drug costs. In the catastrophic phase, manufacturers will assume a larger financial responsibility while Medicare will assume a smaller role. Specifically, manufacturers will see an increase from 15% to 60% cost-sharing for brand-name and generic drugs above the cap while Medicare will see a decrease in cost-sharing from 80% to 20% for brand-name drugs and to 40% for generic drugs.

The IRA also allows for drug price negotiation for select Part D drugs starting in 2026. The negotiated price for the first ten drugs will go into effect in January 2026 with more drugs being added in later years. The IRA requires a [“maximum fair price” \(MFP\)](#) for these selected drugs.

Another notable change to Part D is that the out-of-pocket cost of insulin are capped at \$35 per month and adult vaccines are of no cost starting in 2023. Additionally, in 2024, individuals with incomes up to 150% of the poverty level will qualify for full benefits under the Part D Low-Income Subsidy Program, thereby ensuring affordability and simplifying access of crucial medications.

A [premium stabilization provision](#) will also be included, where adjustments to the base beneficiary premium calculation will be made to ensure that the increases in base premium are capped at 6% from the previous year. Moreover, an option for enrollees to spread out their out-of-pocket costs over the year will help in increased flexibility and financial predictability to the Part D landscape. The proposed redesign cost-sharing benefit structure is shown below.



Q: What are the implications of the proposed changes?

Proposed redesigns aim to introduce a MOOP cap for beneficiaries when they reach the catastrophic spending phase, providing protection against high out-of-pocket costs. The redesign also aims to shift financial responsibility to Part D plans, incentivizing them to promote drugs offering the most value at the lowest cost. Additionally, the changes require drug manufacturers to provide cost discounts in order to address the steep prices of specialty drugs. Overall, the redesign allows for a reduced cost-sharing during the initial and coverage gap phases, and creates a more sustainable model for program spending.

Capping out-of-pocket costs is expected to increase drug utilization, ultimately leading to a higher total Part D spending. However, [empirical evidence suggests](#) that these increased costs could be offset by reduced spending on other healthcare services. According to the Congressional Budget Office (CBO), the redistribution of financial responsibility to Part D plans is likely to result in increased federal spending.

The Inflation Reduction Act of 2022 marks a significant turning point in Medicare Part D by enhancing accessibility and affordability for its beneficiaries. The abovementioned modifications underscore a commitment to addressing the evolving healthcare needs and ensuring the long-term sustainability of Medicare Part D.