Overview

In 2003, Congress passed legislation to create a prescription drug benefit for seniors in Medicare – Medicare “Part D.” At the time, the new law was the first major change to Medicare in nearly 40 years. Today, more than 35 million seniors rely on Part D benefits, including 11 million low-income seniors at or near poverty.

Why did Congress pass Medicare Part D?

Before the creation of Part D, Medicare covered hospital costs (Part A) and doctor visits (Part B), but not prescription drugs.

In 2003, the Kaiser Family Foundation reported that seniors were spending an average of $2,318 in out-of-pocket drug costs and that one-third of seriously ill seniors without drug coverage were skipping doses to make their prescriptions last longer. Another 2003 survey by Health Affairs found that one-fifth of poor or chronically ill seniors were spending less on food and other basic needs because of high out-of-pocket drug costs. Nationally, one-fourth of all seniors and a third of low-income seniors lacked prescription benefits prior to passage of Part D.

Did this change after Part D passed?

According to the Congressional Budget Office (CBO), 53 percent of Medicare beneficiaries opted to enroll in a Part D drug plan during the first six months of its roll-out, including two-thirds of seniors who lacked drug coverage before.

The non-partisan Medicare Payment Advisory Commission (MedPAC) credits Part D with increasing the share of seniors who have prescription drug coverage from 75 percent to 90 percent today: “In general, Part D has improved Medicare beneficiaries’ access to prescription drugs.” Moreover, MedPAC reports, more than 80 percent of seniors enrolled in Part D in 2011 were satisfied with the drugs their plans covered, and 91 percent reported having good access to pharmacies. One 2005 Health Affairs study found that among previously uninsured seniors, out-of-pocket drug costs dropped on average between 37 and 58 percent.

Impacts of Medicare Part D

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<td>Share of seniors without</td>
<td>Share of seniors with</td>
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<td>prescription drug coverage: 1</td>
<td>prescription drug benefits:</td>
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<td>in 4</td>
<td>90 percent</td>
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<tr>
<td>Share of low-income seniors</td>
<td>Number of low-income seniors</td>
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<td>without drug coverage: 1 in 3</td>
<td>enrolled in Part D: 11 million</td>
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<td>Average annual out of pocket</td>
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Key Facts

- Medicare Part D offers prescription drug coverage to more than 35 million seniors, 11 million of whom are low-income.
- Before the passage of Part D, seniors spent an average of $2,318 on out-of-pocket drug costs.
- About 90 percent of Medicare-eligible seniors now have prescription drug coverage. Enrollees in Part D pay an average of $30 a month in premiums.
- Federal spending on Medicare totaled $62.5 billion in 2012, or about 10 percent of total Medicare spending. So far, Part D has cost roughly one-third less than original projections.

Essential Links

- Centers for Medicare and Medicaid Services, Medicare Advantage/Part D Contract and Enrollment Data.
How does Part D work?

Seniors get Part D coverage from private plans approved by the government. Some seniors receive Part D coverage through retiree plans offered by their former employers, while others choose a plan from the “marketplace” run by Medicare.gov (if this sounds similar to the “exchanges” under Obamacare, it is). Low-income seniors eligible for subsidies to help buy coverage are automatically assigned a plan if they don’t choose one on their own.

In 2013, seniors could choose from an average of 35 plans, including those that are part of so-called “Medicare Advantage” plans (see “Medicare Advantage: Medicare’s Private Option”). According to MedPAC’s 2014 report, monthly premiums averaged about $30 in 2013.

Under the “standard benefit” for 2014, seniors pay a $310 deductible in addition to their monthly premiums and 25 percent of drug costs (“coinsurance”) until their total spending reaches $2,850. After this amount, seniors face a gap in coverage (the “donut hole”) where they must pay more until total out-of-pocket spending reaches $4,550. At that point, more extensive coverage resumes.

How much does this program cost?

CBO originally predicted that Medicare Part D would cost $407 billion from 2004-2013. Actual program costs, however, have run about 30 percent lower than projected. In 2012, federal spending on Part D was $62.5 billion.

Experts say several factors account for these lower costs, including the competitive, market-based design of Part D, but also the greater use of generic medicines and slower-than-expected overall growth on prescription drug spending. A CBO analysis also concluded that improved access to medicines through Part D might lower costs elsewhere in Medicare because “people who received more generous prescription drug coverage through the implementation of Part D had fewer hospitalizations and used fewer medical services as a result.”

What’s the future of Part D?

Despite these results, cost control remains a concern as the Baby Boomers retire and demands for coverage increase.

Recently, the Centers for Medicare and Medicaid Services (CMS) contemplated new rules that would have limited the ability of private insurers to manage which pharmacies can participate in their networks (so called “preferred pharmacy networks”) – a strategy that plans use to help control costs. But after significant objections (including from MedPAC), CMS withdrew these proposed rules for the time
In the meantime, Part D has become an increasingly important element of Medicare. The Affordable Care Act ("Obamacare") included a significant expansion of Part D – a phase-out of the “donut hole.” According to CMS, more than 3.5 million Americans who hit the donut hole in 2012 received an average of $706 in new benefits under the law, for total savings of $2.5 billion.