NATIONAL PACE ASSOCIATION
Issue Brief
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Pass the PACE Part D Choice Act

Ensure That Medicare-Only PACE Participants Left Out of Inflation Reduction Act Part D Relief Receive Help

Issue

The Inflation Reduction Act (IRA) contains a $2,000 cap on Part D prescription drug out-of-pocket expenses (e.g., deductibles and coinsurance) for Medicare beneficiaries. However, Medicare-only beneficiaries enrolled in Programs of All-Inclusive Care for the Elderly (PACE) will not benefit from this cost protection. In PACE the sole Part D expense borne by Medicare beneficiaries is the monthly premiums. There are no copays and no deductibles. However, because PACE Part D plans do not receive these payments and do not receive Medicare or manufacturer subsidies that other Medicare Part D plans receive, the premiums for the plans average move than $1,105 per month or approximately $13,000 per year. This amount is well above the $2,000 cost limit protection enacted by the IRA.

As a result, the IRA establishes a significant financial disincentive for Medicare beneficiaries to enroll in PACE. While the higher PACE Part D premium may be offset for some PACE participants by savings from not having to pay cost- sharing amounts, the cost of their PACE Part D plan will be prohibitive for many. Further, the cost of their PACE Part D plan relative to other Part D options is increased by the IRA cost protections. Consequently, the lack of affordable Part D plan options for Medicare-only PACE participants limits their access to the PACE program that would, in many cases, improve their quality of care and quality of life as they seek a community-based alternative to a nursing home.

Recommended Action

Passing the PACE Part D Choice Act would provide Medicare-only beneficiaries enrolled in PACE to access the same cost protections available to all other Medicare beneficiaries. The PACE Part D Choice Act accomplishes this by allowing PACE participants to choose a marketplace Part D plan and the $2,000 out-of-pocket cost protections it affords or, if the participant prefers, to choose the PACE Part D plan.

Background

Enactment of the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) significantly changed how PACE organizations are paid to provide prescription drug coverage to their participants. Prior to implementation of Medicare Part D, prescription drugs were not covered by Medicare. The cost was paid by Medicaid or as part of the PACE private pay premium. Upon implementation of Part D, payment for covered prescription drugs required that PACE organizations establish themselves as Part D plans. Today, all PACE organizations operate as Part D plans.

PACE regulations prohibit PACE Part D plans from charging participants deductibles and coinsurance. In addition, participants are not subject to the coverage gap. Under existing Part D regulations, for a PACE Medicare-only participant in the benefit coverage gap, the PACE organization does not receive manufacturer discounts for brand name drugs or federal reinsurance for drug costs exceeding the catastrophic benefit limit. Other factors contributing to the high cost of PACE Part D plans include higher drug acquisition prices for PACE Part D; higher acuity and financial risk (in 2022 the average marketplace Part D beneficiary risk score was 1.00, compared to 1.76 for PACE participants); uncommon use of formularies in PACE Part D plans; and serving a small risk pool, with higher administrative costs per beneficiary.

Therefore, the Part D coverage offered by PACE organizations provides a generous 100 percent benefit level but comes with a significant Part D premium for Medicare-only participants. The national average monthly premium for PACE Part D plans is $1,015.03, in contrast to the national

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average monthly premium of $43 for stand-alone Part D plans in 2022. As such, only 212 Medicare-only beneficiaries were enrolled in PACE as of Jan. 1, 2022.

Need for Action

Access to community-based alternatives to nursing homes will be critical to meet the needs of Medicare beneficiaries in the coming years. According to MedPAC, approximately 10,000 baby boomers turn 65 each day and become eligible for Medicare, leading to a 50 percent increase in beneficiaries that will result in more than 80 million in 2030.[i] While individual care needs vary, people age 65 and over have a 68 percent probability, on average, of experiencing cognitive impairment or requiring assistance with at least two activities of daily living (ADLs).[ii] Increased access to PACE is vital for Medicare beneficiaries as these older Americans with cognitive and functional impairments seek community-based long-term care options.

More than three-fourths (77 percent) of adults age 40 and over prefer to receive any necessary long-term care services in their home, according to a poll by the Associated Press and NORC Center for Public Affairs Research.[iii]

Today, PACE serves more than 61,000 older Americans who have complex, chronic medical conditions and need long-term services and supports. Of these, the vast majority are Medicaid- eligible, either dual-eligible or Medicaid-only (99 percent). Less than 1 percent have Medicare-only coverage.

Looking to the future, enabling Part D plan choice would increase the affordability of PACE for existing Medicare-only participants, as well as increase access to and affordability of PACE for Medicare-only beneficiaries thinking about enrolling. Of the more than 60 million Medicare beneficiaries in 2019, many had modest incomes. Fifty percent had incomes below $29,650, and 25 percent had incomes below $17,000. Just 5 percent had incomes greater than $117,000 and 1 percent had incomes above $205,500.[vi] Given these income levels, many Medicare-only beneficiaries cannot afford to forgo the $2,000 cap on out-of-pocket expenses in all other Part D plans.

Cost and Benefits of Action

A recent study by Mathematica Policy Research determined that PACE costs are comparable to the costs of other Medicare options, while delivering better quality of care for an extremely frail, complex population. [iv] PACE enrollees were found to experience lower mortality rates than comparable individuals, either in nursing facilities or receiving home- and community-based waiver services.

In addition, the assistant secretary for Planning and Evaluation in the U.S. Department of Health and Human Services (HHS) recently reported PACE to be a consistent "high performer." [v] PACE participants were found to be notably less likely to visit the emergency room, be admitted to the hospital, or require nursing home placement. PACE also incorporates many of the reforms the Medicare program seeks to promote, including person-centered care that is delivered and coordinated by a provider- based, comprehensive system, with financial incentives aligned to promote quality and cost-effectiveness through capitated financing.

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