

Fact Sheet



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Part D Options for Medicare-Only PACE Participants

Issue

Participants in the Program of All-Inclusive Care for the Elderly (PACE) must enroll in the Medicare Part D prescription drug plan offered by their PACE program rather than be able to choose an alternative stand-alone Part D plan in the marketplace that might offer a more affordable alternative.

Recommended Action

Support the PACE Part D Choice Act, which would allow Medicare-only PACE participants to choose between the PACE Part D plan as currently designed, with an all-inclusive premium and no deductible or coinsurance, or a marketplace Part D plan with a lower premium and related deductible and coinsurance amounts.

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 the implementation of Medicare Part D, prescription drugs were not covered by Medicare. Their costs were 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 Part D plans.

Current 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, a PACE Medicare-only participant who is in the benefit coverage gap receives neither manufacturer discounts for brand-name drugs nor federal reinsurance for drug costs exceeding the catastrophic benefit limit. Other factors contribute to the high cost of PACE Part D plans: the drug acquisition price for PACE Part D plans is higher; the average marketplace Part D beneficiary risk score is 1.00, whereas it is 1.754 for PACE participants; there is a common lack of a formulary in PACE Part D plans; and the pool for each PACE Part D plan is small, resulting in administrative costs that may be considerably higher than for marketplace Part D plans.

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 \$893.17, in contrast to the national average premium of \$42.05 for stand-alone Part D plans in 2020.

Need for Action

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 the PACE Part D plan is prohibitive for many prospective Medicare-only participants. 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. 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

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boomers turn 65 each day and become eligible for Medicare, leading to a 50 percent increase in beneficiaries that will result in over 80 million in 2030.ⁱ While individual care needs will vary, people age 65 and over have a 68 percent probability, on average, of either 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 53,000 Americans who have complex, chronic medical conditions and need long-term services and supports (LTSS). Of these, the vast majority are Medicaid-eligible, either dual-eligible or Medicaid-only. Just under 200 PACE participants have only Medicare coverage. Part D plan choice would increase affordability and access to PACE for these participants and potentially for future Medicare beneficiaries.

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 also found to experience lower mortality rates than comparable individuals either in nursing facilities or receiving home and community based waiver services. Additionally, PACE incorporates many of the reforms the Medicare program seeks to promote, including: person-centered care, delivered and coordinated by a provider-based, comprehensive system, with financial incentives aligned to promote quality and cost effectiveness through capitated financing.

ⁱ MedPAC. (2015). *Report to the Congress: Medicare and the Health Care Delivery System*. June, p. 37. Retrieved from medpac.gov.

ⁱⁱ Gibson, M.J. (2003). *Beyond 50.03: A Report to the Nation on Independent Living and Disability: Executive Summary*. AARP Public Policy Institute. April. Retrieved from aarp.org.

ⁱⁱⁱ Swanson, E., Benz, J., Titus, J., et al. (2015). *Long-Term Care in America: Expectations and Preferences for Care and Caregiving*. The Associated Press-NORC Center for Public Affairs Research, May. Retrieved from longtermcarepoll.org.

^{iv} Ghosh, A., Schmitz, R., Brown, R. (2015). *Effect of PACE on Costs, Nursing Home Admissions, and Mortality: 2006-2011*. Mathematica Policy Research, p. 15. Retrieved from aspe.hhs.gov.

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