CHAPTER 12

# The Medicare prescription drug program (Part D): Status report

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## Chapter summary

In 2024, Part D paid for outpatient prescription drug coverage on behalf of more than 54 million Medicare beneficiaries. Medicare's payment system for Part D differs from Part A and Part B in that it does not pay for outpatient prescription drugs directly and instead pays private plans to administer the prescription drug benefit.

In 2023, Medicare and beneficiaries enrolled in Part D made payments to stand-alone Part D plans (known as PDPs) and Medicare Advantage–Prescription Drug plans (MA-PDs) totaling $128.2 billion (about 12 percent of total Medicare expenditures). Of that amount, Medicare paid $68.2 billion in subsidies for basic benefit costs and $43.9 billion in extra financial support for enrollees who receive the low-income subsidy (LIS), while Part D enrollees paid $16.1 billion in premiums for basic benefits. Not included in this total is an additional $18.8 billion in cost sharing paid by enrollees and $0.5 billion in retiree drug subsidies paid by Medicare to employers who provide drug coverage to their retirees. Surveys and focus-group findings suggest high overall satisfaction with Medicare Part D.

***Significant changes happening in 2025—***The passage of the Inflation Reduction Act of 2022 (IRA) changed many aspects of the Part D program. One of the most important changes, the redesign of the Part D's

## In this chapter

benefit structure, occurs in 2025. The redesign includes key elements of the Commission's 2020 recommendations intended to restore the plan incentives to manage drug spending that were in place at the start of the program. Notably, the redesign reduces the role of Medicare's reinsurance payments—the cost-based reimbursement that had paid for most of the costs incurred by enrollees with high spending—while increasing the role of capitated direct-subsidy payments.

By adding cost-sharing protections such as the $2,000 annual limit on out-of-pocket costs, the redesign also substantially shifts liability for drug spending from cost sharing paid by beneficiaries at the point of sale (POS) to plans (which increases both enrollee premiums and the premium subsidies paid by Medicare). By lowering POS costs and increasing premiums, the redesign spreads the cost of the prescription drug benefit more broadly among enrollees. Because the IRA also places a limit on the annual increase in average premiums paid by enrollees, Medicare's share of program spending has automatically increased to just over 83 percent (from the original 74.5 percent) in 2025.

The IRA also includes provisions that are expected to affect the broader pharmaceutical supply chain, such as requiring manufacturers to pay rebates when the price of their drug rises faster than inflation and the Medicare Drug Price Negotiation Program, which requires manufacturers of selected drugs to engage in negotiations with the Secretary of Health and Human Services over prices charged under Medicare Part B and Part D. The Commission has not made recommendations related to either of those new policies.

Changes taking place in 2025 and subsequent years are expected to have wide-ranging impacts on Part D plan sponsors and their enrollees as well as participants in the pharmaceutical supply chain. For 2025, the national average plan bid rose by nearly 180 percent. The redesign's increase in plan liability was expected to raise premiums and Medicare's upfront payments for capitated direct subsidies while decreasing the share of spending paid by Medicare's reinsurance and beneficiaries' costs at POS. However, greater variation in bids submitted by Part D plans for 2025 compared with previous years was likely driven by plans' uncertainty regarding the effects of the IRA on benefit costs, for which plans now bear a substantial portion of the insurance risk.

The Premium Stabilization Demonstration that CMS implemented for 2025 reduced some of the largest premium increases observed among PDPs, though premiums continue to vary widely. The demonstration will increase program spending by an estimated $5 billion in 2025. Over the coming years,

we expect plan sponsors to adjust to the redesigned benefit as they gain claims experience while adapting to the new market dynamics. At the same time, various IRA changes and subsequent policy changes (such as the premium demonstration) are likely to interact in ways that complicate our understanding of the impact of any given policy in isolation. As a result, we provide preliminary information to understand the effects of changes to date and emphasize the importance of continued monitoring as the program continues to respond to policy changes.

***Historical trends and concerns about the long-term stability of the PDP market—*** We also report on historical data that continue to show Part D enrollment shifting from PDPs to MA–PDs. In 2024, PDPs accounted for less than 43 percent of all Part D enrollees, down from 53 percent in 2020. Trends through 2024 also showed stable average premiums but significant differences between PDPs and MA–PDs, in part due to MA–PDs' ability to use Part C rebates to lower Part D premiums: The average PDP premium in 2025, weighted by 2024 enrollment, is estimated at $44, while the average MA–PD premium (including both special-needs plans and conventional plans) is $14. In 2023, Medicare's spending on cost-based reinsurance and the LIS continued to grow.

Some of the recent trends have raised concerns about the long-term stability of the PDP market, which provides drug coverage for FFS beneficiaries and, critically, ensures that premium-free plan options are available for individuals with low income and assets. The shift in Part D's enrollment from PDPs to MA–PDs is consistent with the shift in enrollment from fee-for-service (FFS) to MA in the broader Medicare program. At the same time, however, MA–PDs' ability to use Part C rebate dollars to offer more generous prescription drug coverage at lower premiums may affect insurers' willingness to participate in the PDP market. Misalignment between Medicare's payments to Part D plans and their enrollees' drug costs could also create disincentives for insurers to participate in the PDP market. Part D's risk adjustment has historically paid MA–PDs relatively more compared with their actual average costs, while paying relatively less to PDPs compared with their actual average costs. Those inaccuracies may result from differences in management of drug spending, differences in coding behavior, or some combination of the two. To try to address the inaccuracy in Part D's risk-adjustment model, for 2025 CMS is using a separate normalization factor for MA–PDs and PDPs. Despite a significant drop in PDP offerings across the country, in 2025 each beneficiary continues to have at least 12 PDPs from which to choose and roughly 30 MA-PDs. ■

## Background

In 2024, 54.1 million Medicare beneficiaries enrolled in the Part D program for outpatient prescription drug coverage. This coverage is provided by private-plan sponsors, which offer stand-alone prescription drug plans (PDPs) for fee-for-service (FFS) beneficiaries and Medicare Advantage–Prescription Drug plans (MA–PDs), which offer combined medical and prescription drug coverage, for beneficiaries choosing to enroll in Medicare Advantage (MA). (See text box, pp. 414–415, on the roles of plan sponsors and pharmacy benefit managers (PBMs)). In 2025, there are at least a dozen PDPs and roughly 30 MA–PDs available in every region (or county) of the country. In 2023, Part D spending by the Medicare program and enrolled beneficiaries totaled $128.7 billion, over 12 percent of total Medicare expenditures (Boards of Trustees 2024).

Medicare's payment system for Part D is different from payment systems under Part A and Part B because Medicare does not pay for outpatient prescription drugs directly. Instead, the Medicare program makes payments to PDP and MA–PD sponsors to provide coverage for each enrolled beneficiary. Medicare makes two payments on behalf of enrollees in their plans:

- ***Direct subsidy*—**For each enrollee, Medicare pays a monthly (capitated) prospective payment set as a share of the national average bid for Part D basic benefits, adjusted for the risk of the individual enrollee.
- ***Reinsurance*—**For enrollees in the catastrophic phase of the benefit—who have drug spending above an annual out-of-pocket (OOP) threshold—Medicare makes payments that cover a portion of spending above the threshold.[1]

Combined, the direct-subsidy and reinsurance payments aim to cover 74.5 percent of the expected cost of basic benefits. Beneficiary premiums are designed to cover the remaining 25.5 percent of the expected cost of basic benefits. (Some beneficiaries pay higher premiums for additional coverage beyond the basic benefit.) In addition to monthly premiums, Part D enrollees also pay any cost sharing required by plan sponsors. For enrollees who qualify for Part D's low-income subsidy (LIS), Medicare pays plans an additional amount on their behalf that covers most or all cost sharing and premium liabilities.

The Commission had long been concerned that past changes to Part D's benefit design combined with trends in prescription drug pricing and spending had weakened plan sponsors' incentives for cost control (Medicare Payment Advisory Commission 2022b, Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2016). Between 2007 and 2022, plan sponsors' overall financial risk for the basic-benefit spending for their enrollees declined markedly, from 75 percent to 30 percent.

The Commission has also voiced concerns about enrollee cost sharing under Part D. Because beneficiaries historically have paid an unlimited amount of cost sharing in the catastrophic phase, a small but significant share of enrollees had high OOP spending that could pose a financial burden and hinder adherence to treatment. At the same time, limits on cost sharing for LIS enrollees have blunted their incentives to use lower-cost drugs and have made it more difficult for plan sponsors to manage program spending.

In 2020, the Commission recommended major changes to the Part D program that would restructure its defined standard benefit and restore stronger financial incentives for plan sponsors and beneficiaries to use lower-cost medicines (Medicare Payment Advisory Commission 2020a). The Commission has consistently held that when plan sponsors bear more insurance risk, they should also be given tools to manage enrollee spending.[2]

The passage of the Budget Reconciliation Act of 2022 (commonly referred to as the Inflation Reduction Act (IRA)) changed many aspects of the Part D program, including a redesign of the Part D benefit structure that reflected some of the Commission's recommendations. The IRA included other provisions that are expected to affect the broader pharmaceutical supply chain, such as requiring manufacturers to pay rebates when the price of their drug rises faster than inflation and establishing the Medicare Drug Price Negotiation Program that requires manufacturers of selected

## Roles of plan sponsors and pharmacy benefit managers

When Part D was created, policymakers structured the program using private plans that compete to attract enrollees based on the prescription drugs they cover, pharmacy networks, premiums, cost sharing, and quality of services. One of the key premises behind Part D's competitive approach is that plan sponsors can negotiate for lower prices when there are competing drug therapies.

About 300 organizations operate Part D plans. Most plan sponsors offer Medicare Advantage–Prescription Drug plans (MA–PDs), but only about 50 operate stand-alone prescription drug plans (PDPs). As plan sponsors merged throughout the early years of the program, Part D enrollment grew more concentrated (Medicare Payment Advisory Commission 2019b). In 2023, the top five PDP sponsors ranked by enrollment accounted for 89 percent of all PDP enrollees, while the top five sponsors of MA–PDs accounted for 69 percent of enrollment in that market.[3] The largest organizations offering Part D coverage (UnitedHealth Group, CVS Health, and Humana Inc.) offer both stand-alone PDPs and MA–PDs, so there is considerable overlap among organizations participating in the two markets.

Plan sponsors use pharmacy benefit managers (PBMs) to reduce costs by negotiating rebates with pharmaceutical manufacturers, developing drug formularies, and establishing networks of pharmacies. Many of the largest plan sponsors have their own PBMs; other sponsors perform some PBM functions in-house but contract with outside PBMs for services such as rebate negotiations.[4] As a result, PBMs' market concentration is higher than that of plan sponsors. We estimate that in 2023, the top four PBMs (ranked by Part D–covered lives) negotiated rebates on behalf of roughly 90 percent of all Part D enrollees and prescriptions.

### Formulary management and manufacturer rebates

Formularies are a key tool used by plan sponsors to manage drug spending because they are one of the few ways in which plans can encourage patients to use specific drugs. Plan sponsors and PBMs decide which drugs to include on their formularies, which cost-sharing tier is appropriate for each drug, and whether a drug will be subject to utilization management—quantity limits, step therapy, and prior authorization. Those decisions require that plan sponsors strike a balance between providing access to medications and encouraging enrollees to use preferred therapies.

CMS reviews each plan's formulary as part of the process of deciding whether to approve a plan sponsor's bid. For most drug classes, plans must cover at least two distinct drugs that are not therapeutically equivalent or bioequivalent, as well as "all or substantially all" drugs in six protected classes—anticonvulsants, antidepressants, antipsychotics, immunosuppressants, antiretrovirals, and antineoplastics.

In drug classes that have competing therapies, PBMs negotiate with brand manufacturers for rebates that the manufacturers pay after the drug is dispensed. Generally, manufacturers pay larger rebates when a sponsor positions a drug on its formulary in a way that increases the likelihood of winning market share over competing drugs. Our previous analysis has found that plan sponsors with the most Part D enrollees obtain larger rebates, on average, than their smaller counterparts (Medicare Payment Advisory Commission 2023).

Increasing market concentration among the largest PBMs may have contributed to the rapid growth in aggregate manufacturer rebates negotiated by Part D sponsors. Between 2010 and 2023, the magnitude of aggregate rebates grew from $8.6 billion (11 percent

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## Roles of plan sponsors and pharmacy benefit managers (cont.)

of gross Part D spending) to just under $70 billion (25 percent).[5] By reducing costs for Part D sponsors, rebates can help reduce premiums for all enrollees. But because rebates generally are not used to reduce point-of-sale prices, a disproportionate share of benefit costs fall on Medicare's reinsurance and the low-income cost-sharing subsidy, as well as on patients who must pay a percentage coinsurance on a rebated drug.

Vertical integration of PBMs with insurers and pharmacies may increase efficiency—for example, by lowering transaction costs between the upstream and downstream entities. However, it also diminishes price transparency, which may further increase costs for enrollees and taxpayers who subsidize the program. The prices established between upstream and downstream entities ("transfer prices") of vertically integrated organizations are not visible to CMS, and profits accruing to wholly owned downstream entities may be reflected as higher costs for Part D plans (Herman 2022, Medicare Payment Advisory Commission 2023).

PBMs that own pharmacies may also face conflicting interests as a PBM that manages pharmacy benefits for payers and as an owner of a pharmacy with financial incentives to increase the volume of prescription drugs that their pharmacies dispense (Herman 2022). Vertical integration in a highly concentrated PBM market could also be associated with anticompetitive behavior. For example, a plan sponsor that is vertically integrated with a PBM may undermine competition by raising the costs for competing plans that contract with that PBM (Greaney 2019).

### Pharmacy networks

In Part D, plan sponsors must include in their networks any pharmacy that is willing to accept the sponsors' terms and conditions (known as the "any willing pharmacy" (AWP) provision). In addition to the AWP requirement, plan sponsors cannot require enrollees to fill their prescriptions at a particular pharmacy (e.g., at a mail-order or specialty pharmacy owned by its PBM). Sponsors must also demonstrate that their network meets Part D's pharmacy access standards. Sponsors can, however, designate a subset of network pharmacies that offer lower cost sharing as preferred cost-sharing pharmacies. For 2025, if enrollees remained in the same plan as in the previous year, about 75 percent of PDP enrollees (down from over 90 percent in 2024), 38 percent of general MA–PD enrollees, and less than 5 percent of enrollees in special-needs plans would be in plans that use preferred cost-sharing pharmacies.[6]

The strategy of designating certain pharmacies as preferred has the potential to reduce costs for Medicare and enrollees if it encourages enrollees to fill prescriptions at pharmacies that, for example, are more effective at encouraging generic drug use.[7] However, tiered pharmacy networks have been controversial because of concerns that some members have less access to preferred pharmacies or that tiering pharmacy networks could lead to higher low-income cost-sharing subsidies since enrollees with the low-income subsidy do not face any financial incentives to choose preferred pharmacies. ■

drugs to engage in negotiations with the Secretary of Health and Human Services over prices charged under Medicare Part B and Part D. The Commission has not made recommendations related to either of those new policies. The first of the IRA's Part D–related changes took effect in 2022, while others will not be effective until 2026 or later.

## Regulatory change affecting prices paid at the point of sale and its effects on pharmacies

Effective January 1, 2024, Part D plans' payments to their network pharmacies ("negotiated price") must include all possible pharmacy price concessions such that the price at the point of sale (POS) is the lowest possible reimbursement a network pharmacy may receive for a particular drug. Before this change, negotiated prices did not include price concessions that were performance based because they could not "reasonably be determined" at the POS.[8] As a result, pharmacies typically paid any price concessions to pharmacy benefit managers (PBMs) in lump sum at a later date (e.g., at the end of each quarter) and reported them to CMS as pharmacy direct and indirect remuneration (DIR). Similar to postsale rebates received from pharmaceutical manufacturers, 100 percent of pharmacy DIR must be passed on to Part D plans, which lowers benefit costs for plans and Medicare. At the same time, the higher prices paid at the POS increase costs for Medicare's low-income cost-sharing subsidy and for beneficiaries who pay coinsurance.

The aggregate amount of the net pharmacy DIR that plans received reached over $21 billion (just under 8 percent of total gross Part D spending) by 2023, up from less than $500 million in 2014, leading some independent pharmacies to report cash-flow challenges for their Part D business.

The change to the definition of "negotiated price" was expected to increase transparency of prices for beneficiaries and pharmacies and, in the long term, improve the predictability of revenues for pharmacies. However, in the initial months of the policy in 2024, there was an expectation that some pharmacies could experience cash-flow challenges as they simultaneously faced obligations to pay price concessions (pharmacy DIR) from 2023 while also receiving lower reimbursement for prescriptions filled in 2024 consistent with the new definition of negotiated price. Because of this concern, in December 2023, CMS issued a letter urging Part D sponsors and their PBMs "to make necessary cash flow arrangements with network pharmacies in preparations for these upcoming changes [to the pharmacy DIR]" (Centers for Medicare & Medicaid Services 2023d). According to the National Community Pharmacists Association (NCPA), however, the CMS letter was not effective in addressing the anticipated cash-flow issues for independent pharmacies (National Community Pharmacists Association 2024). In the letter to CMS, the NCPA noted that in their survey, nearly one-third of all respondents said they were considering closing because of the "cash crunch in Medicare" and that 93 percent reported that they may "drop out of Medicare Part D in 2025" if the situation did

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### Recent and ongoing changes to the Part D program

In addition to the benefit redesign effective this year, in recent years, numerous other policies related to drug pricing and the Part D program have been implemented, affecting plan sponsors, beneficiaries, and drug manufacturers.

The first effective change from the IRA pertaining to the Part D program was related to manufacturers' pricing of all Part D (and Part B) covered drugs: Beginning in 2022, manufacturers must now pay a rebate equal to any price increase above the rate of inflation for drugs dispensed to Medicare beneficiaries. Next were a series of beneficiary cost-sharing protections: limits on OOP costs applied to insulin products and vaccines, effective in 2023. Additional cost-sharing protections for beneficiaries were applied in 2024 when, for the first time since the program began, beneficiaries no longer faced any cost sharing once they reached the catastrophic phase of the benefit. Further, beneficiaries with income between 135

## Regulatory change affecting prices paid at the point of sale and its effects on pharmacies (cont.)

not improve (National Community Pharmacists Association 2024).

Pharmacy closures have been in the news for some time (Gregg and Peiser 2023, Span 2024). One study found that, between 2018 and 2021, there were more pharmacy closures than openings across the U.S., resulting in a 2.1 percent net reduction in the number of pharmacies over the period (Guadamuz et al. 2024). These closures predate the recent policy change. Reports suggest there could be a "surge" in pharmacy closures that are driven by business decisions made by major retailers such as CVS Health, Walgreens, and Rite Aid Corporation (Burris 2024, Higham 2024a).

Both chain and independent pharmacies have seen more closures than openings over the last several years (Guadamuz et al. 2024). Multiple factors may drive pharmacies to close, including low reimbursement rates from PBMs, changes in consumer habits that have affected both the pharmacy and retail side of the business, and increased competition from online retailers such as Amazon and Walmart, each of which has its own pharmacy (Burris 2024, Higham 2024b, Trygstad 2024). The increased demand on pharmacists' time (for example, to provide medication management or to administer vaccines), particularly after the COVID-19 pandemic, coupled with low payments from PBMs, may have led to burnout and staff shortages (Cheema 2024, Dee et al. 2023). These issues facing pharmacies are not new, and some have suggested that the challenges facing pharmacies may be a broader retail challenge—a reality that the retail pharmacy model "may be broken" (Becker 2024, Meara 2024).

Pharmacy closures could have negative consequences for beneficiaries, particularly if the closure affects their ability to obtain prescribed medicines. Pharmacy closures could also impede access to vaccinations (Guadamuz et al. 2024, Qato et al. 2019). To date, our focus groups and external surveys continue to indicate high satisfaction with the Part D program and do not suggest widespread issues with access to pharmacies or to their prescribed medicines (Morning Consult 2024, NORC at the University of Chicago 2024). But certain areas may be more at risk of closure than others. For example, nearly 10 percent of rural pharmacies closed between 2003 and 2021, while the number of retail pharmacies in metropolitan areas increased by 15 percent (Lazaro et al. 2022). However, not all metropolitan areas have seen equal growth: Other studies indicate that neighborhoods whose residents tend to be non-White may experience pharmacy closures that can result in beneficiaries no longer having convenient access to pharmacies (Guadamuz et al. 2024, Hunter 2024). ■

percent and 150 percent of the federal poverty level are now eligible for the full LIS rather than a less generous partial subsidy. Also beginning in 2024, the IRA imposed a limit on the annual increase in the base beneficiary premium (BBP) to no more than 6 percent (for more detail, see the section discussing the increase in the average national bid in 2025, p. 421).

A regulatory change (not part of the IRA) affecting pharmacy direct and indirect remuneration (DIR) also went into effect in 2024: This change required pharmacy DIR payment adjustments to be applied by plan sponsors and PBMs such that pharmacies' initial reimbursements are the lowest possible amount they could receive for a given drug dispensed (see text box on the recent regulatory change affecting prices paid at the POS and its effects on pharmacies).

Beginning in 2025, the IRA's redesign of the Part D benefit structure went into effect, the details of which are outlined below. Notably, liabilities for spending were shifted from beneficiaries and the Medicare

program to plans, significantly reducing the share of spending paid by beneficiaries in cost sharing (and Medicare's low-income cost-sharing subsidy (LICS)) and Medicare's reinsurance. Drug manufacturers' cost liability has also shifted, as discussed in the section below describing changes to Part D in 2025.

In 2026, for the first time, the prices of 10 single-source drugs with the highest total gross Part D spending will be set at the price negotiated by the government for all beneficiaries; additional drugs will be selected in subsequent years (see text box (pp. 437–439) on the Medicare Drug Price Negotiation Program for more details).

## Significant changes to Part D in 2025

The redesign of Part D's benefit structure, one of the most significant changes to the program, became effective with the 2025 plan year. The redesign and the IRA's broader impact on the pharmaceutical supply chain are expected to affect how Part D plans operate. These changes are shifting liability between the various stakeholders; in particular, beneficiary cost sharing will be reduced, while plan liability—and thus premiums—will increase. Medicare's liability, paid through a variety of subsidies, will also shift, with cost-based subsidies declining while capitated premium subsidies increase.

Plan sponsors have faced significant uncertainty as many of the IRA policies are implemented for the first time this year. For example, plan sponsors expected the IRA changes to increase the use of specialty drugs and other high-cost medicines, but those expectations differed based on assumptions that varied across plans (Cline and Liner 2024). The different assumptions, in turn, likely drove greater variation in plan bids and premiums for 2025, particularly among stand-alone PDPs, than those observed historically. The IRA capped the annual increase in the BBP to no more than 6 percent (for more detail, see the section discussing the increase in the average national bid in 2025, p. 421). Nevertheless, CMS stated that the level of increases in individual plan premiums for PDPs could result in "disruptive enrollment shifts" that could potentially destabilize the PDP market (Centers for Medicare & Medicaid Services 2024f). CMS thus implemented the Part D Premium Stabilization Demonstration, which lowered participating PDP premiums by up to $15 and required participating PDPs to limit the annual increase in their total monthly premiums (including both basic and supplemental premiums) to no more than $35. Under the demonstration, CMS will also provide more generous protection from losses under Part D's risk corridors.[9] While the lower premiums may have prevented large shifts in enrollment across plans, both within the PDP market and across the PDP and MA–PD markets, the additional subsidies that are paid to PDPs under the demonstration will increase Medicare spending. The Congressional Budget Office estimates that the additional subsidies paid to PDPs under the demonstration will increase federal spending for Part D by about $5 billion in 2025 (Swagel 2024). Even with virtually all PDPs participating in this demonstration, PDP premiums still vary widely in 2025 (Cubanski 2024). In contrast, most MA–PD enrollees continue to have access to many plans with $0 premiums, with the total average premium charged by MA–PDs projected to decrease in 2025 (Centers for Medicare & Medicaid Services 2024c).

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, Part D's enrollment has also shifted from PDPs to MA–PDs. MA–PDs increasingly offer more generous prescription drug coverage (for example, with fewer product exclusions and lower cost sharing) to enrollees at lower premiums (Ippolito and Vabson 2024, Joyce et al. 2024). At the same time, PDPs continue to play an important role since they provide drug coverage for FFS beneficiaries and, critically, they ensure that premium-free plan options ("benchmark" plans) are available for FFS beneficiaries with low income and assets.

However, recent work by the Commission has detailed diverging trends in the PDP and MA–PD markets that raise concerns about the long-term stability of the PDP market. Specifically, we found that (1) premiums charged by PDPs have tended to exceed those of MA–PDs; (2) the number of benchmark plans has continued to decline in certain areas of the country; (3) benefit costs, on average, are higher among PDP enrollees compared with MA–PD enrollees, but Part D's payment system may not adequately adjust for those higher costs; and (4) PDPs are more likely to incur losses in

Part D's risk corridors than MA–PDs. Plan offerings and premiums for 2025 show a continuing decrease in the number of PDPs and benchmark plans as well as continuing divergence in premiums charged by PDPs and MA–PDs.

Changes taking place this year are expected to have wide-ranging impacts on Part D plan sponsors and enrollees, as well as stakeholders in the pharmaceutical supply chain. As a result, some of the historical trends may no longer provide insights that will be useful in understanding trends going forward. However, we continue to provide historical data and describe trends since they could serve as baselines against which to measure the various effects of the policy changes that are implemented in 2025 and subsequent years.

## Beginning in 2025, Part D's benefit reflects key changes made by the IRA

Medicare law defines the standard Part D basic benefit that plan sponsors must offer (or coverage that is actuarially equivalent to that standard). The design and actuarial value of the standard basic benefit has changed numerous times over the years. The transition to the IRA's new benefit design for non-LIS beneficiaries is fully implemented in 2025, while the transition for LIS beneficiaries will occur gradually starting this year and continue through 2031. Since the last major reforms to the benefit design in 2010, LIS beneficiaries have had a different benefit design than non-LIS beneficiaries, but that will no longer be the case once the new benefit structure is fully implemented for LIS enrollees. (However, Medicare's LICS will continue to pay most of the cost-sharing liabilities on behalf of enrollees who receive the LIS.)

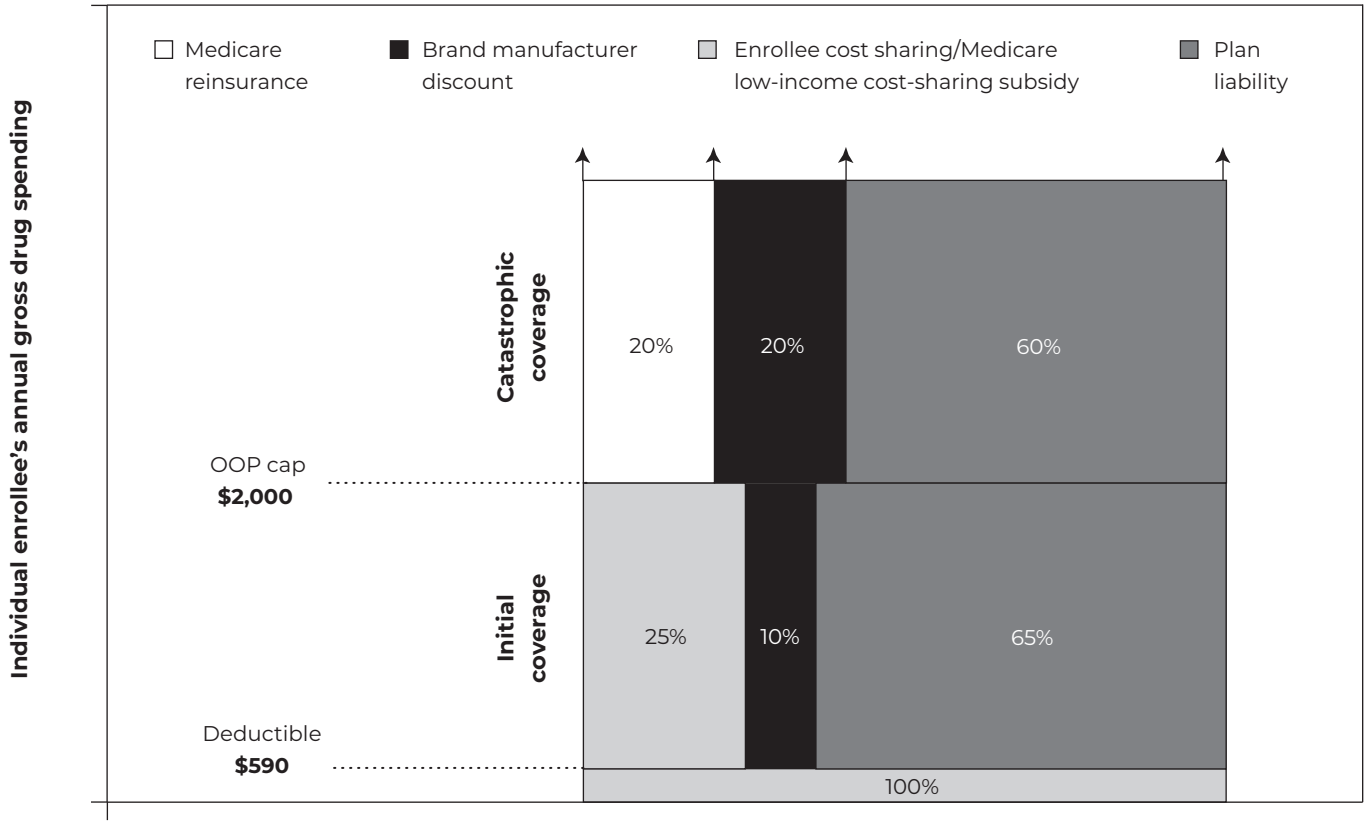
In 2025, Part D's defined standard benefit for enrollees without the LIS (74 percent of enrollees in 2024), includes a deductible; beneficiaries pay 100 percent of costs until the deductible is met. Next, in the initial coverage phase, beneficiaries are responsible for 25 percent of drug spending until reaching the catastrophic-coverage limit (Figure 12-1, p. 420). There is no longer a coverage gap (or "donut hole"), and beneficiaries now have a maximum OOP cap, which are two of the biggest changes from the historical design. Each year, the standard benefit's parameters change at the same rate as the annual change in beneficiaries' average drug expenses. For 2025, the deductible in Part D's standard benefit is $590 and the OOP threshold is $2,000, which is expected to be reached after a beneficiary incurs approximately $6,030 worth of drug spending (Centers for Medicare & Medicaid Services 2023b). That threshold is based on "true OOP" costs, referred to as "TrOOP." Before 2025, TrOOP spending excluded beneficiary cost sharing paid by most sources of supplemental coverage, such as employer-sponsored policies and more generous (supplemental) benefits from the beneficiary's Part D plan, but it included the 70 percent discount that manufacturers of brand-name drugs were required to pay in the coverage gap. Beginning in 2025, changes made by the IRA to the TrOOP calculation are expected to improve beneficiaries' access to drugs by limiting cost-sharing liabilities for many beneficiaries without the LIS. At the same time, the change is also expected to increase the number of enrollees who reach the OOP threshold and increase spending (see text box (pp. 422–423) on the new method for calculating TrOOP costs).

For beneficiaries with low incomes and assets, Medicare's LIS pays the difference between cost-sharing amounts set by each plan and nominal copayments set by law. In 2025, individuals receiving the LIS pay between $0 and $4.90 per prescription for generics and between $0 and $12.15 per prescription for brand-name drugs.[10] Above the OOP threshold, LIS enrollees have never paid cost sharing; Medicare's LICS subsidy paid the 5 percent coinsurance they previously would have owed if they did not receive the LIS. Beginning in 2024, no beneficiaries pay cost sharing above the OOP threshold. Since these costs had been covered for LIS enrollees by the LICS subsidy, this change has reduced Medicare's costs for the subsidy and increased plans' liability.

Another change included in the IRA affecting beneficiaries' cost sharing in 2025 is the new requirement for plan sponsors to allow enrollees to "smooth" their cost-sharing liabilities over the course of the year. At any time during the plan year, a beneficiary may opt in to a new Medicare Prescription Payment Plan. In addition to making all enrollees aware of the program, plan sponsors are required to specifically notify individuals who could benefit from this program of that likelihood. Enrollees who choose to opt in will pay nothing at the POS

**FIGURE 12–1**

**New defined standard benefit design, 2025**




Note: OOP (out of pocket). The "defined standard benefit" is depicted as it would apply to brand-name drugs and biologics. Beginning in 2024, beneficiaries have no liability in the catastrophic phase; plan liability will increase to cover the 5 percent that otherwise would have been paid by enrollees. For generic drugs, plan sponsors must pay 75 percent of covered benefits between the deductible and OOP cap. Medicare will pay 40 percent reinsurance above the OOP cap. Total spending at the $2,000 OOP cap is expected to be $6,230. For beneficiaries with the low-income subsidy (LIS) and for certain small manufacturers, the new manufacturer discount program will be phased in over time, reaching final levels by 2031. In addition, Medicare's low-income cost-sharing subsidy will continue to pay most of the cost-sharing liabilities on behalf of enrollees who receive the LIS.

Source: MedPAC depiction of Part D benefit structure for 2025.

(instead, plan sponsors will pay the pharmacy the full cost-sharing amount); enrollees will make their cost-sharing payments directly to the plan sponsor over the remainder of the year. The amount owed each month will be based on the total cost-sharing liability owed at the time of the opt-in, the amount of TrOOP already accumulated toward the annual limit, the number of months remaining in the year, and any new charges incurred in subsequent months for additional drugs. Because of all these factors, the formula may result in large fluctuations in payment amounts throughout the year that do not coincide with when individuals fill their prescriptions. This mismatch, in turn, may cause confusion for some beneficiaries. CMS thus notes that the program may be more helpful for some beneficiaries than others (Centers for Medicare & Medicaid Services 2024g). The Medicare Prescription Payment Plan may also require Part D plans to set up new infrastructure to bill patients and to notify the pharmacy staff in a way that fits with their workflow, a process which could be administratively complex (Dusetzina et al. 2024).

## In 2025, the national average plan bid increased by nearly 180 percent

The IRA shifted more of the insurance risk to plans while increasing the generosity of the basic benefit, meaning that Medicare's capitated direct subsidy would rise while the share of benefit costs paid based on actual spending (Medicare's reinsurance) would go down. Changes in the average bid amount, BBP, and the capitated and cost-based subsidies between 2024 and 2025 were all directionally consistent with the changes that were expected due to the IRA's redesign.[11] At the same time, the magnitude of the changes may have exceeded some expectations (BGR Group 2024, Cline et al. 2024). This effect likely results, in part, from higher-than-expected spending growth in 2023, which preceded the implementation of the benefit redesign (Congressional Budget Office 2024).[12]

In 2025, the national average bid rose from $64 to $179, an increase of nearly 180 percent, while the average expected reinsurance declined from $90 to $40 (Table 12-2, p. 424) (Centers for Medicare & Medicaid Services 2024b). The average bid is calculated as the enrollment-weighted average of plan bids that reflect their expectations about benefit costs and about administrative costs and profit margin.[13] The average bid is used to determine the level of Medicare's capitated direct subsidy for the Part D benefit and the BBP. (The BBP is an enrollee's share of the national average expected cost of basic benefits.)

By law, the BBP is set as 25.5 percent of the total expected benefit cost, unless the annual increase in the BBP is greater than 6 percent, which is the maximum annual increase allowed under the IRA. In 2030, the BBP will continue to be based on the lower of the prior year's BBP plus an increase of 6 percent or the BBP calculated based on the national average bid. However, the BBP cannot be less than 20 percent of the average basic benefit costs (i.e., Medicare's overall subsidy rate cannot exceed 80 percent). For subsequent years, the enrollees' share (percentage) of expected benefit costs will remain at the level set for 2030.

The 6 percent cap so far has had the effect of reducing enrollees' share of the total basic benefit costs from 25.5 percent to less than 20 percent in the two years in which the policy has been in effect. Without the cap, in 2025 the BBP would have risen to $55.98, an annual increase of over 60 percent (from $34.70 in 2024) (Table 12-2, p. 424).[14] Because of the cap, the BBP for 2025 rose to just $36.78.

To ensure that plans are paid the full amount of the national average bid, Medicare's direct subsidy is increased by the amount of premium growth above the 6 percent cap ($19.20), or from $123.47 (without the application of the 6 percent cap) to $142.67 (Table 12-2, p. 424). The higher direct subsidy increases Medicare's share of the expected total benefit costs (which includes both the direct-subsidy and reinsurance payments). Thus, instead of $163.55, Medicare's spending per enrollee will average $182.75 in 2025, an increase in Medicare's overall subsidy of about 12 percent. So, in 2025, Medicare's overall subsidy rate is expected to rise to 83.2 percent, from the 77.5 percent subsidy rate estimated for the 2024 benefit year. Enrollees' share of the expected total benefit cost, on the other hand, decreased to 17 percent from 22.5 percent in 2024.

CMS noted that it observed large increases as well as greater variation in bids submitted by PDP sponsors compared with bids submitted by MA–PD sponsors for 2025, which could result in premium changes that create "disruptive enrollment shifts in the PDP market during the initial implementation of the IRA benefit improvements" (Centers for Medicare & Medicaid Services 2024a). To mitigate the destabilizing effects that large premium changes may have on the PDP market, CMS implemented a new voluntary nationwide demonstration, the Part D Premium Stabilization Demonstration for 2025 (Centers for Medicare & Medicaid Services 2024e). (See p. 418 for more information on the Part D Premium Stabilization Demonstration.) The demonstration, which could be extended for two additional years, is expected to increase federal spending.

## Fewer plan offerings for 2025

Beneficiaries' enrollment choices are based on whether the individual receives their medical benefits under FFS Medicare or under the MA program, as well as the region or county in which they reside. FFS beneficiaries may choose from among PDPs offered in their states, while MA beneficiaries may choose from among MA–PDs offered in their county of residence. PDP sponsors must offer a plan that covers an entire PDP region (there are 34 PDP regions that consist of one or

## New method for calculating true OOP costs lowers cost sharing but raises concerns about higher costs and polypharmacy

The Inflation Reduction Act of 2022 (IRA) lowered the annual out-of-pocket (OOP) threshold to $2,000 in 2025 (from $8,000 in 2024) and changed the method used to calculate the true out-of-pocket (TrOOP) costs for the purpose of determining when a beneficiary reaches the annual OOP threshold.

Before the change in law, TrOOP consisted of cost sharing paid by enrollees as well as coverage-gap discounts paid by manufacturers of brand-name drugs and biological products. In addition, payments made by certain organizations (e.g., qualified State Pharmacy Assistance Programs, AIDS Drug Assistance Programs, and certain charitable organizations) also counted as TrOOP. Beginning in 2025, payments by manufacturers of brand-name drugs and biological products under the discount program will no longer count as TrOOP, but the value of supplemental benefits will. This change will have implications for how quickly enrollees reach the OOP threshold.

For example, a beneficiary on two medications, Eliquis and Jardiance, enrolled in an enhanced-benefit plan with a $47 copay for each drug (totaling

*(continued next page)*

**TABLE 12–1**

**A hypothetical example of how the new TrOOP calculation would work for an individual enrolled in an enhanced plan**

| | Gross drug cost | Enrollee cost sharing: Defined standard | Enrollee cost sharing: Enhanced plan | Estimated value of supplemental benefit | TrOOP | Cumulative TrOOP |
|---|---|---|---|---|---|---|
| January | $1,334 | $776 | $94 | $682 | $776 | $776 |
| February | 1,334 | 334 | 94 | 240 | 334 | 1,110 |
| March | 1,334 | 334 | 94 | 240 | 334 | 1,443 |
| April | 1,334 | 334 | 94 | 240 | 334 | 1,777 |
| May | 1,334 | 223 | 94 | 129 | 223 | 2,000 |
| June | 1,334 | 0 | 0 | 0 | 0 | 2,000 |
| July | 1,334 | 0 | 0 | 0 | 0 | 2,000 |
| August | 1,334 | 0 | 0 | 0 | 0 | 2,000 |
| September | 1,334 | 0 | 0 | 0 | 0 | 2,000 |
| October | 1,334 | 0 | 0 | 0 | 0 | 2,000 |
| November | 1,334 | 0 | 0 | 0 | 0 | 2,000 |
| December | 1,334 | 0 | 0 | 0 | 0 | 2,000 |
| Total | 16,010 | 2,000 | 470 | 1,530 | 2,000 | N/A |

Note: TrOOP (true out of pocket), N/A (not applicable). In this hypothetical example, we assumed that an individual is on two medications (Eliquis (5 mg tablet) and Jardiance (25 mg tablet)), which they fill every month, and that the individual is enrolled in an enhanced-benefit plan that charges a cost sharing of $47 for each 30-day prescription for each drug. The estimated value of the supplemental benefit is calculated as the difference between cost-sharing liability under the enhanced-benefit plan and the defined standard benefit plan, which has a deductible of $590 and a 25 percent coinsurance on spending above the deductible, until the individual has spent $2,000 in cost sharing. Components may not sum to totals due to rounding.

Source: MedPAC calculation based on Plan Finder data at www.Medicare.gov.

## New method for calculating true OOP costs lowers cost sharing but raises concerns about higher costs and polypharmacy (cont.)

$94 a month in cost sharing), would reach the OOP threshold in May with just under $500 in total OOP cost sharing ($94 × 5 months) (Table 12-1).[15] For this individual, CMS calculates the value of the supplemental benefits by taking the difference between cost sharing that would have applied under the defined standard benefit and the copay charged by the plan (in this case, $94 (2 × $47)) for the two drugs, which the individual pays each month. (This plan has no deductible.) Under this scenario, both the $94 paid OOP and the value of the supplemental benefit (estimated to be $682 in January, $240 in February through April, and $129 in May) would count as TrOOP. In May, the individual would have reached the annual OOP threshold of $2,000 by paying just $470 in cost sharing OOP.

In general, for beneficiaries who do not receive the low-income subsidy and are in an enhanced-benefit plan, the amount of cost sharing needed to reach the annual OOP threshold would depend on the plan's benefit design (e.g., use of coinsurance or copay) and the drug(s) an individual is on. Beneficiaries with more generous supplemental coverage for their medication(s) would have lower cost-sharing liability compared with beneficiaries with less generous supplemental coverage for their medications (e.g., nonpreferred brand-name drugs with high coinsurance) (Karcher 2024). As a result, some individuals on expensive medication(s) could reach the OOP threshold earlier in the year, with substantially lower cost-sharing amounts paid OOP than the amount set in law.

One study estimated that, in 2025, nearly 10 million beneficiaries would reach the OOP threshold (Assistant Secretary for Planning and Evaluation 2024). This amount is more than double the number of beneficiaries with spending above the annual OOP threshold in 2023 (4.8 million), the latest year for which we have data.

The new method for calculating TrOOP costs combined with the IRA change to eliminate cost sharing above the annual OOP threshold could pose a challenge for plans as they take on more insurance risk. With no cost sharing in the catastrophic phase of the benefit, plans will have limited ability to manage spending once a beneficiary has reached the OOP threshold. That could in turn result in higher subsidy costs for Medicare and premiums paid by all enrollees. Although CMS noted that it has not found any significant changes in plan formularies for 2025, some plans appear to have modified their formularies, for example, by increasing the use of coinsurance rather than copays or using narrower formularies (Centers for Medicare & Medicaid Services 2024c, Cubanski and Damico 2024, Friedman 2024, Knable et al. 2024).

Going forward, the new method for calculating TrOOP costs may have implications for the availability of plan offerings and the generosity of enhanced benefits offered (Karcher 2024). Some beneficiaries will reach the annual OOP threshold relatively early in the year yet incur OOP costs that are substantially below the annual OOP limit set in law. Plans then may need to explore new approaches to balance access to needed medications with the concerns about polypharmacy, higher benefit spending, and higher enrollee premiums. ■

more states), while MA–PD sponsors may choose their service area on a county-by-county basis.

The number of PDP offerings has fluctuated over the years but has declined steadily since 2023. In 2025, plan sponsors are offering a total of 464 PDPs, down from 709 plans in 2024.[16] The magnitude of the decrease (a 35 percent drop), driven in part by the declining number of sponsors participating in the PDP market, is notable (Cubanski and Damico 2024).

In 2025, there are 3,246 conventional MA–PDs available to MA enrollees, down from more than 3,500 plans in 2024 (a 7.4 percent decrease). At the same time, offerings of a specific type of MA–PD, special-needs plans (SNPs), continued to rise. (SNPs are limited to

**TABLE 12–2**

**Changes in Part D national average monthly bid amount, base premium, and average subsidies, 2024–2025**

| | 2024 | 2025 | Percent change |
|---|---|---|---|
| **Total expected basic benefit cost** | $154.31 | $219.53 | 42% |
| National average monthly bid amount | 64.28 | 179.45 | 179 |
| National average expected reinsurance | 90.03 | 40.08 | –55 |
| **Base beneficiary premium** | | | |
| Before the application of the 6% cap (25.5% of the total expected benefit cost) | 39.35 | 55.98 | 42 |
| After the application of the 6% cap | 34.70 | 36.78 | 6 |
| *Effect of the 6% cap* | *–4.65* | *–19.20* | |
| **Medicare's direct subsidy** | | | |
| Before the application of the 6% cap | 24.93 | 123.47 | 395 |
| After the application of the 6% cap | 29.58 | 142.67 | 382 |
| *Effect of the 6% cap* | *4.65* | *19.20* | |
| **Medicare's total subsidy costs** | | | |
| Before the application of the 6% cap | 114.96 | 163.55 | 42 |
| After the application of the 6% cap | 119.61 | 182.75 | 53 |
| *Effect of the 6% cap* | *4.65* | *19.20* | |
| **Medicare's subsidy rate** | | | |
| Before the application of the 6% cap | 74.5% | 74.5% | |
| After the application of the 6% cap | 77.5 | 83.2 | |

Note: The "national average monthly bid" is the enrollment-weighted average of plan bids, which include plan sponsors' expected benefit liability net of the plan's share of postsale rebates and discounts, administrative costs, and profit margin. The "national average expected reinsurance" is estimated based on the expected reinsurance costs, accounting for Medicare's share of postsale rebates and discounts, and is used to calculate the base beneficiary premium (BBP) before the application of the 6 percent cap. By law, the BBP is calculated as 25.5 percent of the total expected benefit cost per enrollee. Under the changes made by the Inflation Reduction Act of 2022, beginning in 2024, the annual increase in the BBP is limited to 6 percent through 2029. In 2030, the BBP increase will continue to be limited to 6 percent. However, the BBP cannot be less than 20 percent of the average basic benefit costs. For subsequent years, the BBP's share of the expected benefit costs will remain at the level set for 2030. Medicare's direct subsidy is computed as the difference between the national average bid and the BBP. Figures do not reflect the effects of the Part D Premium Stabilization Demonstration discussed on p. 418.

Source: CMS's annual release of Part D national average monthly bid amount and other Part C and Part D bid information.

enrollees who have a chronic condition, are dually eligible for Medicare and Medicaid, or live in an institution.) In 2025, there are 1,417 SNPs, up from about 1,300 plans in 2024 (an 8.5 percent increase).

Despite the decrease in the PDP and conventional MA–PD offerings, beneficiaries in every region continue to have a choice of at least a dozen PDPs, in addition to many MA–PDs. (The number of conventional MA plans—most of which also offer a Part D drug benefit—that are available to a beneficiary varies by the county of residence, with an average of 28 plans in each county.)

Benchmark plans, which are a subset of PDPs available to LIS enrollees at no premium, have decreased over the years, which generally follows the trend observed for the broader PDP market. Benchmark plans serve a unique role in the Part D program. To qualify as a

benchmark plan, the plan must be a basic-benefit plan and a stand-alone PDP with a premium at or below the regional LIS benchmark, which is calculated as an enrollment-weighted average of plan bids in a region, using LIS enrollment. Because Medicare's low-income premium subsidy covers LIS enrollees' premiums up to the regional benchmark, LIS enrollees in these plans pay $0 in premiums. In addition, LIS beneficiaries who do not choose their own plan are automatically enrolled in a benchmark PDP in their region.

In 2025, there are 90 benchmark plans, down from 126 in 2024. This year's decrease in the number of PDP offerings has given rise to concerns that a continued decrease could result in regions with no PDPs and thus no benchmark plans.[17] The number of regions with limited choice in benchmark plans grew in 2025: 4 regions have just one benchmark plan, and 11 regions have two, up from 8 regions having a minimum of two plans in 2024.[18] For 2025, CMS expects to reassign over 400,000 LIS enrollees who were in plans that were terminated or lost the benchmark status to a different plan that is premium free for LIS enrollees (Liu and Centers for Medicare & Medicaid Services 2024). (That figure is significantly lower than the 1.4 million LIS enrollees who were reassigned to a benchmark plan in 2024.)

In 2025, the benchmarks varied widely across regions, ranging from just under $16 in New Mexico to more than $72 in New York. This range is wider than the historical trend. For example, in 2024, benchmarks ranged from $28 in Texas to $49 in New York, a difference of about $20. The larger variation in the LIS benchmarks across regions is likely due, in part, to the greater variability in PDP bids for 2025 compared with prior years (Centers for Medicare & Medicaid Services 2024e).

### Policies helped to keep average premiums stable in 2025 despite the large increase and wide variation in bids for some plans

While the annual increase in the BBP has been limited to 6 percent, changes in individual plan premiums may increase by more (or less) than 6 percent because they reflect any difference between the sponsor's bid and the national average bid. In addition, enrollees choosing an enhanced plan must pay any supplemental premiums charged by their plans.

Overall, average premiums remain stable in 2025, likely due in large part to the implementation of policies that shift premium increases from beneficiaries to the Medicare program. First, the new limit on the annual increase in the BBP effectively limits the extent to which plan sponsors can cover the costs of IRA-required benefit expansions by raising enrollee premiums. Instead, as described above, most of the increase in benefit costs are shifted from enrollees to the Medicare program by automatically increasing Medicare's overall subsidy rate to cover a larger share of basic benefit costs than the 74.5 percent originally set in law. Second, for participating PDPs, the Premium Stabilization Demonstration lowered monthly premiums by up to $15 and limited their annual increases to no more than $35. Without these policies, premiums likely would have grown dramatically, with an even greater variation around the average, particularly among PDPs. However, these policies are expected to increase Medicare's subsidy by about 12 percent.

The average total premium for national PDPs in 2025 is about $44, weighted by 2024 enrollment (as is the case for all average premiums discussed in this section), an amount that is virtually unchanged from 2024. (Premiums reflect the lower BBP applied to all participating PDPs under the Premium Stabilization Demonstration.) However, there is wide variation around that average. For example, in California, among the 16 national PDPs offered in both 2024 and 2025, monthly enrollee premiums increased by $35 (the maximum total premium increase allowed under the Premium Stabilization Demonstration) for 8 PDPs, while premiums decreased for 6 (Cubanski 2024).

For 2025, most MA–PD enrollees continue to have access to many plans with $0 or low premiums. The total average Part D premium charged by MA–PDs is projected to decrease from over $15 in 2024 to $13.50 in 2025 (Centers for Medicare & Medicaid Services 2024c). (These amounts reflect any Part C rebates that plans applied to lower their basic and/or supplemental premiums.[19]) Among the conventional MA–PDs, the average premium for 2025 is estimated to be just over $7 per month. That premium reflects $44 of Part C rebates that plan sponsors used, on average, to lower total Part D premiums for their conventional MA–PD plans. The premiums for SNPs are estimated to average

$31 per month. That premium reflects $11 of the Part C rebates that plan sponsors apply to buy-down premiums. The majority of the SNPs are D-SNPs (SNPs for beneficiaries who are dually eligible for Medicare and Medicaid) that target the LIS benchmarks in order to remain premium free for their enrollees, all of whom receive the LIS. (These plans are almost exclusively basic plans; thus they do not have supplemental premiums and therefore do not use rebate dollars to buy down supplemental premiums.)

## Understanding the full impact of the IRA changes

Changes taking place this year are expected to have wide-ranging impacts on Part D plan sponsors and their enrollees as well as stakeholders in the pharmaceutical supply chain. The redesign of the Part D benefit is expected to improve plan incentives to manage prescription drug spending: Instead of payments relying primarily on cost-based reinsurance and LICS subsidies, payments will depend more on capitated direct subsidies in a way that better aligns with the incentives present at the start of the program. Further, several provisions improve Part D enrollees' access to and affordability of drugs covered under Part D, with savings estimated to be in the thousands of dollars for enrollees with the highest spending (Assistant Secretary for Planning and Evaluation 2024).

These benefits, however, have trade-offs. Lower cost sharing for patients at the point of sale makes medications more affordable but is likely to put upward pressure on overall drug utilization and benefit costs, which in turn increases premiums for beneficiaries and subsidy costs for Medicare. For 2025, many plan sponsors expected an increase in the use of specialty drugs and other high-cost brand medications "as a direct result of the new cost-sharing limits and flexibilities [i.e., M3P] created by the IRA" (Cline and Liner 2024). This significant uncertainty about how much utilization will increase has resulted in assumptions that likely drove the variation in 2025 bids (Cline and Liner 2024).

The changes adopted in the IRA are also likely to affect revenues of pharmaceutical manufacturers and may affect their future investment decisions regarding pharmaceutical research and development and strategies for new-product launches. However, estimates of possible effects have varied widely, with estimates regarding the number of drugs entering the market ranging from 1 fewer to more than 100 fewer over the next decade (Avalere 2022, Congressional Budget Office 2022, Gassull et al. 2023, Philipson et al. 2023).

As we discussed in our previous reports to the Congress, the price that Medicare and other entities pay for drugs is just one of many factors that influence investment in biopharmaceutical research and development (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2022a).[20] Some also expect that launch prices for new therapies may be higher than they otherwise would be as a result of the IRA's inflation rebate policies that limit manufacturers' ability to increase drug prices after launch (Congressional Budget Office 2023). The Commission has consistently stressed the importance of balancing a drug's net clinical benefit with an appropriate reward for innovation and affordability for beneficiaries and taxpayers, and we will continue to take into account the need for an appropriate balance as we evaluate the Part D program (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2022a, Medicare Payment Advisory Commission 2017).

Other changes mandated by the IRA are expected to affect how Part D plans operate through the law's impacts on the broader pharmaceutical supply chain. For example, the new mandatory manufacturer discount program may have financial impacts for pharmaceutical manufacturers that diverge from the impact of the coverage-gap discount program that it replaced (Upchurch and Saliba 2025). Prices negotiated by the Secretary under the new Medicare Drug Price Negotiation Program that will become effective next year may further drive changes in the pharmaceutical supply chain.

An early look at the 2025 plan offerings shows a mix of expected effects, such as an increase in plan bids and lower expected reinsurance costs, as well as some unexpected effects, such as the magnitude of the increase in the national average bid (an increase of nearly 180 percent) while average premiums remain stable. Understanding the full impact of the IRA will take time. Over the coming years, we expect plan sponsors to adjust to the redesigned benefit as they gain claims experience and adapt to the new market dynamics as pharmaceutical manufacturers and other supply-chain

**TABLE 12–3**

**Part D's enrollment has gradually shifted toward MA–PDs**

| | 2020 | 2021 | 2022 | 2023 | 2024 | Average annual change 2020–2024 |
|---|---|---|---|---|---|---|
| **Total Medicare enrollment (in millions)** | **62.9** | **63.8** | **65.0** | **66.3** | **68.0** | **1.8%** |
| **Total enrollment in Part D plans (in millions)** | **47.0** | **48.3** | **49.8** | **51.5** | **54.1** | **3.6** |
| *As a share of total Medicare enrollment* | *75%* | *76%* | *77%* | *78%* | *80%* | |
| **Part D plan enrollment by plan type (in millions)** | | | | | | |
| PDP | 25.1 | 24.0 | 23.3 | 22.5 | 23.0 | –2.1 |
| MA–PD | 21.9 | 24.3 | 26.5 | 29.1 | 31.0 | 9.1 |
| **Full LIS enrollment (in millions)** | | | | | | |
| PDP | 6.7 | 6.0 | 5.5 | 5.2 | 4.7 | –8.8 |
| MA–PD | 6.1 | 6.8 | 7.7 | 8.6 | 9.3 | 11.3 |
| Overall | 12.8 | 12.8 | 13.3 | 13.8 | 14.0 | 2.2 |

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), PDP (prescription drug plan), LIS (low-income subsidy). Part D enrollment figures do not include beneficiaries in employer-sponsored plans that receive the retiree drug subsidy but do include enrollees in employer group waiver plans. In addition to beneficiaries who receive full LIS assistance, a small number (0.2 million in 2023) receive partial assistance. Components may not sum to totals due to rounding, and percentage changes were calculated on unrounded data.

Source: MedPAC analysis based on the 2023 Medicare Trustees' report and CMS Part D enrollment data from February 2024.

participants evolve in response to the changes. At the same time, the IRA and subsequent policy changes (such as the Premium Stabilization Demonstration) are likely to interact in a way that complicates our understanding of the impact of any given policy in isolation (Congressional Budget Office 2024). We anticipate the initial year of data to provide an incomplete picture of the effects the IRA has had on the Part D program. The Commission plans to continue to monitor the IRA's effects on the program and its stakeholders beyond the initial years of the implementation.

## Recent trends in enrollment, premiums, and program spending

In this section, we discuss historical trends in enrollment, spending, and other aspects of the Part D program. The substantial changes affecting the Part D benefit will likely create departures from many of these trends, but this analysis will serve as important context and a baseline for measuring those changes as they are implemented.

In 2024, 54.1 million individuals—about 80 percent of all Medicare beneficiaries—were enrolled in Part D plans (Table 12-3). Another 1 percent of beneficiaries obtained drug coverage through their former employers that provided a prescription drug benefit that was at least as generous as Part D's defined standard benefit and received Medicare's retiree drug subsidy (data not shown). We estimate that just under 10 percent of eligible Medicare beneficiaries had creditable drug coverage from other sources. About 11 percent of eligible beneficiaries had no coverage or coverage less generous than Part D (data not shown).[21]

### More enrollees in MA–PDs and enhanced plans

Beginning in 2020, the number of enrollees in PDPs has declined as more beneficiaries opt to enroll in MA and accompanying MA–PDs. Enrollees in MA–PD plans

are more likely to be in enhanced plans that have more generous benefits than enrollees in PDPs. Beneficiaries with the LIS are more likely to be in basic-benefit plans.

### Enrollment has shifted toward MA–PDs

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, the distribution of Part D enrollment has moved gradually toward MA–PDs. The number of enrollees in PDPs began to decline in 2020, from 25.1 million to about 23.0 million by 2024 (Table 12-3, p. 427). In 2024, PDPs accounted for less than 43 percent of all Part D enrollees, down from 53 percent in 2020.

In 2024, 14.0 million beneficiaries (26 percent of Part D enrollees) received the LIS. Of these individuals, 9.7 million were eligible for both Medicare and full Medicaid benefits ("dually eligible") (data not shown) (Boards of Trustees 2024, Boards of Trustees 2023).[22] Between 2020 and 2024, LIS enrollment grew more slowly (an average rate of about 2 percent per year compared with 4 percent per year for other enrollees (latter data not shown)). As a result, the share of Part D enrollees who received the LIS declined from 27 percent to 26 percent during that period. At the same time, the share of LIS enrollees in MA–PDs grew from 48 percent in 2020 to 67 percent in 2024, while LIS enrollment in PDPs declined by nearly a third during this period. Much of the LIS enrollment growth in MA–PDs was in D-SNPs.

### Majority of beneficiaries without the LIS chose enhanced plans

While statute sets the parameters for the defined standard benefit, in practice, most sponsors use alternative benefit designs that include lower deductibles or tiered copayments for some formulary tiers rather than the uniform coinsurance under the defined standard benefit. Sponsors, however, must demonstrate that their basic benefits have the same average value as the defined standard benefit.

A PDP sponsor must offer a basic-benefit plan in a region before it can offer an enhanced-benefit plan (i.e., a plan that combines basic Part D benefits with supplemental drug coverage). MA–PDs do not have to offer a basic-benefit plan in order to offer an enhanced-benefit plan, which likely explains the difference in plan offerings between PDPs and conventional MA–PDs, with the latter offering nearly exclusively enhanced-benefit plans (Medicare Payment Advisory Commission 2024a). In 2024, 99 percent of enrollees in conventional MA–PDs were in enhanced plans compared with 61 percent for enrollees in PDPs (Table 12-4).

MA–PD plan sponsors can use a portion of their MA payments to supplement their Part D benefits or to lower Part D premiums. As a result, enrollees in conventional MA–PDs tend to have more generous benefits than enrollees in PDPs. For example, in 2024, 77 percent of conventional MA–PDs enrollees were in plans that had no deductible, compared with just 13 percent for PDPs (Table 12-4).

### Beneficiaries with the LIS were more likely to enroll in basic plans

In 2024, about 10 million beneficiaries were enrolled in a benchmark plan or other plans with premiums at or below the regional benchmarks. Just under half of these enrollees (4.7 million) were enrolled in benchmark PDPs, which are PDPs that offer basic benefits that qualify as premium-free to LIS beneficiaries (Table 12-4). In 2024, on average, 79 percent of the enrollees in benchmark PDPs received the LIS (compared with nonbenchmark PDPs, in which only 7 percent of enrollees received the LIS) (data not shown). Benchmark PDPs are the only plans in which LIS beneficiaries may be automatically enrolled.

Another 5.1 million beneficiaries were enrolled in SNPs (Table 12-4). Most SNP enrollees are in D-SNPs that serve dually eligible beneficiaries. Nearly all D-SNPs are basic-benefit plans that use Part D's defined standard-benefit structure, which requires an enrollee to pay a defined standard deductible and 25 percent coinsurance on all covered drugs. Because all dual-eligible beneficiaries receive the LIS, they themselves do not pay the deductible or cost sharing set by plans; they pay nominal copays set in law, and the LICS subsidy pays most of their cost-sharing liabilities. Also, any extra cost for supplemental coverage is not covered by Medicare. Thus, LIS beneficiaries do not typically gain the same value from an enhanced plan with lower cost sharing or no deductible as non-LIS beneficiaries. Further, plan sponsors' value of the low-income premium subsidy they receive for LIS enrollees is maximized when such beneficiaries enroll in a basic plan with a premium equal to the benchmark. These factors contribute to the increased likelihood of LIS

**TABLE 12–4** **Majority of PDP and conventional MA–PD enrollees chose enhanced coverage, 2024**

| | PDP | | Conventional MA–PD | | SNP | |
|---|---|---|---|---|---|---|
| | Number of enrollees (in millions) | Percent | Number of enrollees (in millions) | Percent | Number of enrollees (in millions) | Percent |
| Total | 18.1 | 100% | 19.7 | 100% | 6.3 | 100% |
| Type of coverage | | | | | | |
| Basic | 7.0 | 39 | 0.1 | <1 | 5.1 | 81 |
| Enhanced | 11.0 | 61 | 19.5 | 99 | 1.2 | 19 |
| Type of deductible | | | | | | |
| Zero | 2.3 | 13 | 15.2 | 77 | 0.5 | 8 |
| Reduced | 3.6 | 20 | 4.0 | 20 | 0.1 | 2 |
| Defined standard ($480) | 12.2 | 67 | 0.5 | 2 | 5.7 | 90 |
| Benchmark/premium-free | 4.7 | 26 | 0.1 | 1 | 5.1 | 81 |

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNP (special-needs plan). Enrollment excludes employer group waiver plans (EGWPs), plans offered in U.S. territories, 1876 cost plans, demonstrations, and Part B–only plans. "Defined standard" deductible category includes plans that are actuarily equivalent. Beneficiaries enrolled in EGWPs, a specific type of PDP or MA-PD in which an employer contracts with a Medicare Part D carrier to provide coverage for their Medicare-eligible retirees, totaled 8.9 million. Components may not sum to totals due to rounding.

Source: MedPAC analysis of CMS landscape, plan report, and February enrollment data.

beneficiaries being in a basic plan rather than an enhanced plan.

## In 2024, overall average premiums remained stable; MA–PDs' use of Part C rebates helped to lower their average premiums

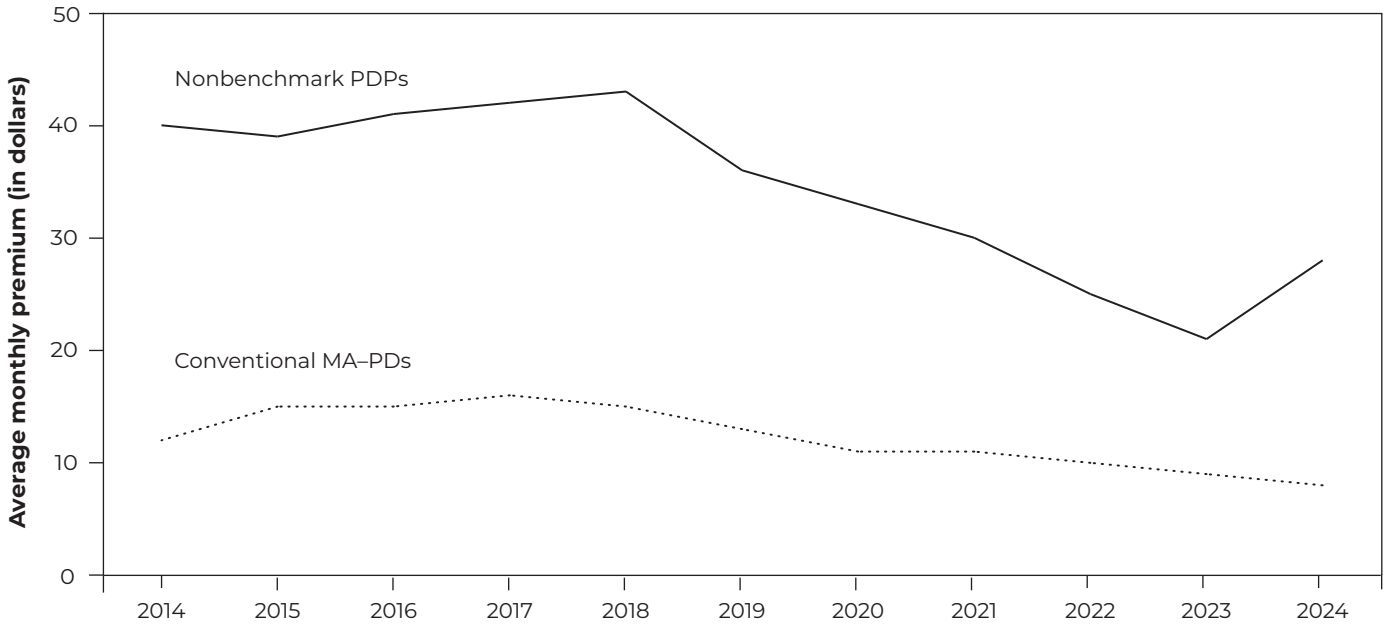
In 2024, monthly beneficiary premiums averaged about $27 across all types of plans (basic and enhanced, stand-alone PDP and MA–PD)—increasing slightly from the previous two years. However, premiums for specific plans varied widely around that average, from $0 for many MA–PDs and a small number of PDPs to $195 for the most expensive enhanced PDP.

The variation in premiums across plans reflects a multitude of factors that affect plans' bids, such as assumptions about drug pricing and utilization trends, product development and new market entries, costs, and enrollment. In addition, the ability of MA–PDs to use Part C rebates to lower their Part D premiums also contributes to the difference across plans.

The overall average MA–PD premium of $15 reflects the plan sponsors' use of Part C rebates to offset Part D premium costs. In 2024, premiums for enrollees in conventional MA–PDs averaged $9 per month compared with $34 per month for enrollees in SNPs (the majority of whom were in D-SNPs and receive the LIS and thus typically pay no premium) and $43 per month for enrollees in PDPs. Part C rebates used by MA–PD plans to buy down the Part D premiums for conventional MA–PDs averaged $58 per month. For SNPs, the amount of Part C rebates used for premium buydowns varied by the type of SNP. For D-SNPs, plan sponsors applied about $8 per month to lower the Part D premium, an amount substantially lower than the amount used by sponsors of conventional MA–PDs. Because most D-SNPs are basic-benefit plans, most do not have supplemental premiums to buy down. In

**FIGURE 12–2**

**Average premiums for basic benefits, nonbenchmark PDPs versus conventional MA–PDs, 2014–2024**




Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Excludes employer group plans. "Conventional MA–PDs" excludes special-needs plans. Figures are weighted by enrollment in the month of July of each year. Note that premiums are based on plans' expected costs. As a result, for any given year, there could be systematic over- or underestimation of benefit costs when there is an unexpected event—for example, an unexpected launch of a new drug, an addition of new indications for an existing drug that affects its uptake, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months before the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

addition, because they are bidding to be at or below the LIS benchmark in their region, the amount of Part C rebates used to buy down Part D premiums is typically set equal to the difference between their bids and the LIS benchmark (rather than competing to offer lower or $0 premiums).

Two other factors, not accounted for in the averages described above, can affect the premiums that enrollees pay. First, higher-income enrollees have a lower federal subsidy of their Part D benefits in 2024; such individuals paid between $12.90 and $81.00 in additional monthly premiums, depending on specified income thresholds.[23] In 2024, nearly 8 percent of enrollees were subject to the income-related premium, compared with less than 3 percent in 2011 (Liu and Centers for Medicare & Medicaid Services 2024). Second, individuals enrolling outside their initial enrollment period must have proof that they had drug coverage as generous as the standard benefit to avoid the late-enrollment penalty (LEP) that would be added to their premiums for the duration of their Part D enrollment.[24] In 2024, about 6 percent of Part D enrollees paid the LEP (Liu and Centers for Medicare & Medicaid Services 2024).

## Trends that raise concerns about the long-term stability of the PDP market

At our November 2024 meeting, the Commission discussed program trends related to beneficiary premiums, plan costs, and risk scores for MA–PDs and PDPs. Our discussion focused on differences in MA–PD and PDP trends that may affect competition within and between the two sectors and the benefits they offer to Medicare beneficiaries (Medicare Payment Advisory

Commission 2024d). MA–PDs increasingly offer more generous prescription drug coverage (e.g., lower deductibles) to enrollees at lower premiums. At the same time, PDPs continue to play an important role as they provide drug coverage for FFS beneficiaries and, critically, they ensure that premium-free plan options ("benchmark" plans) are available for FFS beneficiaries with low income and assets. However, there are trends that raise concerns about the long-term stability of the PDP market.

### Basic premiums charged by PDPs, on average, exceed MA–PD premiums

For both beneficiaries with and without the LIS, we found that basic premiums charged by PDPs tended to be higher than those of MA–PDs. Between 2014 and 2024, the average basic monthly premium for conventional MA–PDs averaged between $8 and $16, far below the average charged by PDPs excluding benchmark PDPs ("nonbenchmark PDPs"), which ranged between $26 and $36 during the same period (Figure 12-2). Both nonbenchmark PDPs and conventional MA–PDs primarily enroll beneficiaries without the LIS. As discussed above, some of the difference arises from the ability of MA–PD plans to use Part C rebates to lower Part D premiums. In 2024, Part C rebates used to lower basic Part D premiums for conventional MA–PDs averaged $24 per month.

Because premiums are one of the key price signals that beneficiaries compare when choosing a plan, this trend likely influences beneficiary enrollment decisions. In general, beneficiaries would be less likely to choose a plan that charges a higher premium without any obvious or perceived difference in benefits (e.g., generosity of drug coverage or breadth of pharmacy networks) relative to another plan with a lower premium. For some beneficiaries without the LIS, the higher premiums charged by PDPs may pose a barrier to remaining in FFS even if that is their preferred option for Medicare coverage.

### PDPs, on average, had higher gross costs but lower risk scores than MA–PDs

Risk scores assigned to each enrollee should reflect the expected costliness of that individual relative to the overall average, which would ensure that direct subsidies are adjusted to account for the effects of health status and demographics on the expected plan costs. Given that Part D's risk-adjustment model is based on gross plan costs (for basic benefits) for enrollees in both MA–PDs and PDPs, we would expect the trends for average risk scores for PDPs and MA–PDs to reflect the relative expected costs of enrollees in the respective markets. However, our analysis found diverging trends between average risk scores and average gross spending in the two markets that appear counterintuitive to how risk adjustment should work.

Between 2012 and 2023, PDP enrollees, on average, had higher gross costs than MA–PD enrollees (Figure 12-3, p. 432). However, since 2016, the average risk scores for MA–PD enrollees have exceeded that of PDP enrollees. The difference has grown over time, and by 2022, it had grown to nearly 15 percent. (The difference decreased to 13 percent (1.07 divided by 0.94) in 2023.) In contrast, the average gross costs for MA–PDs and PDPs narrowed from over $20 in 2012 to just $2 by 2023.

Taken together, these two trends imply that over this period, PDPs continued to have higher gross benefit costs than MA-PDs despite enrolling a population that had increasingly lower expected spending than MA–PDs based on their risk scores. This discrepancy could be explained by PDPs managing benefit costs relatively inefficiently compared with MA–PDs, by differences in diagnostic coding in FFS compared with MA, or by some combination of both.

Under Part D's payment system, a higher risk score would translate into a relatively higher risk-adjusted direct-subsidy payment. When risk scores, on average, are higher for plans with lower average costs, it raises a question about the accuracy of the risk scores in ensuring appropriate payment for the expected costliness of enrollees across plans.

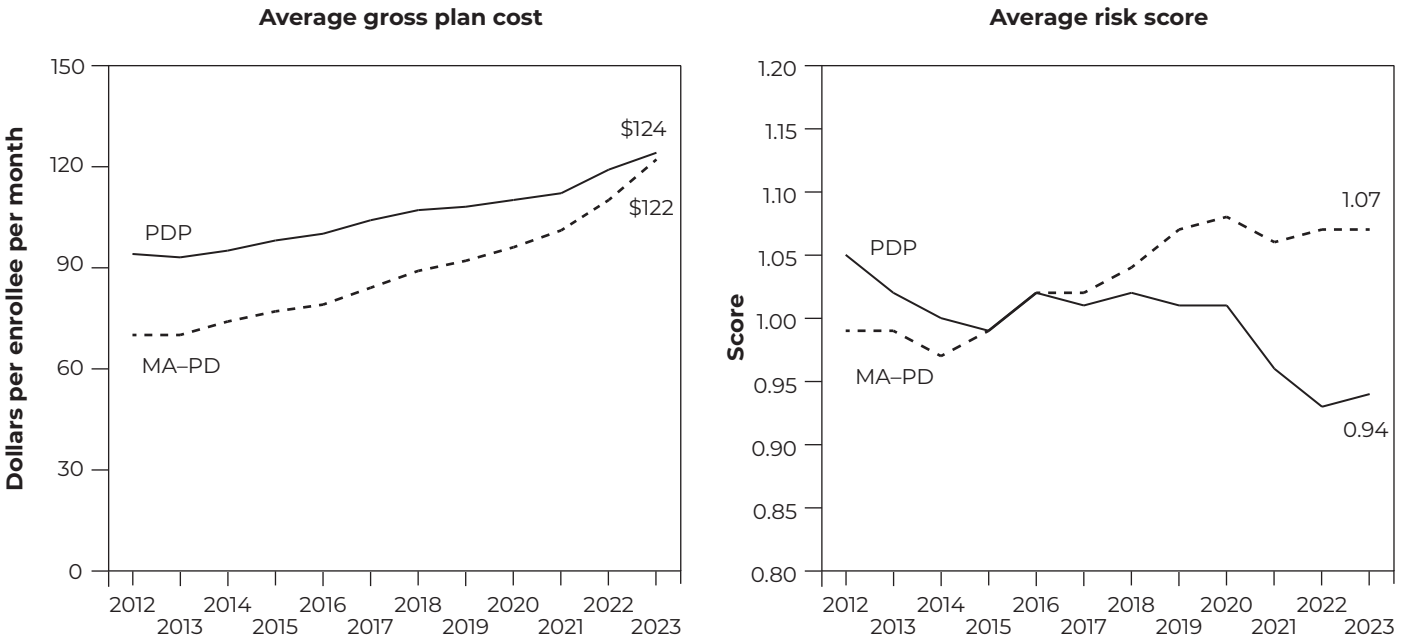
### The Commission's ongoing work examining structural differences between PDP and MA–PD markets

These program trends all suggest that PDPs may be facing challenges that are not generally present for MA–PDs. CMS's implementation of the Premium Stabilization Demonstration for PDPs in 2025 suggests that, without the demonstration, the PDP market could have experienced even greater premium increases and enrollment changes.

Even before the implementation of the IRA's benefit redesign, CMS noted that Part D's risk-adjustment model, the prescription drug–hierarchical condition

**FIGURE 12–3**

**Average gross plan cost and risk score by plan type, 2012–2023**




Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). "MA–PD" includes both conventional MA–PDs and special-needs plans.

Source: Part D risk-score file and enrollment files from CMS.

category (RxHCC) model, historically overpredicted costs for MA–PDs and underpredicted costs for PDPs (Centers for Medicare & Medicaid Services 2024f). One factor that may be contributing to the diverging risk scores between PDPs and MA–PDs is the ability of MA plans to submit more diagnoses for their enrollees, which increases payments that plans receive under MA (Medicare Payment Advisory Commission 2024c). While the RxHCC model is separate from the model used to risk adjust Part C payments to MA plans, there is substantial overlap in the diagnoses used in the two models.

Because of the systematic prediction errors CMS had observed across the two markets, in 2025, the agency is applying a separate normalization factor for MA–PDs and PDPs to "more accurately reflect Part D costs in each of these two sectors" (Centers for Medicare & Medicaid Services 2024f). The agency noted that the new normalization factors (0.955 for PDPs and 1.073 for MA–PDs) are expected to increase PDP risk scores and decrease MA–PD risk scores. However, to the extent that MA–PD risk scores grow at a faster rate than projected, risk scores for MA–PDs could still exceed PDP risk scores on average even after the separate normalization factors are applied.

## Prior to 2024, program spending increasingly shifted to cost-based payments

In 2023, Part D expenditures totaled $128.7 billion. Medicare made payments to Part D plans of $4.9 billion for the monthly capitated direct subsidy, $63.3 billion for reinsurance, and $43.9 billion for the LIS. Medicare also paid $0.5 billion in retiree drug subsidies to employers who provide drug coverage to their retirees.[25] Enrollees paid the remaining $16.1 billion in premiums for basic benefits (Table 12-5). Between 2019 and 2023, program spending rose from $88.3 billion to $112.6 billion, or an average of 6.3 percent per year.

**TABLE 12–5**

**Medicare spending and enrollee premiums for Part D**

| | Annual spending (in billions) | | | | | Average annual change, 2019–2023 |
|---|---|---|---|---|---|---|
| | 2019 | 2020 | 2021 | 2022 | 2023 | |
| Total Medicare spending on Part D | $88.3 | $93.0 | $94.8 | $101.6 | $112.6 | 6.3% |
| Capitated payments (direct subsidy) | 11.8 | 10.9 | 7.1 | 4.9 | 4.9 | –19.7 |
| Cost-based reinsurance payments | 46.1 | 48.5 | 52.1 | 56.7 | 63.3 | 8.2 |
| Subtotal, basic benefits | 57.9 | 59.4 | 59.2 | 61.6 | 68.2 | 4.2 |
| Low-income subsidy | 29.7 | 33.0 | 35.0 | 39.4 | 43.9 | 10.3 |
| Retiree drug subsidy* | 0.7 | 0.6 | 0.6 | 0.6 | 0.5 | –8.1 |
| Enrollee premiums for basic benefits** | 13.8 | 13.6 | 15.0 | 15.5 | 16.1 | 3.9 |

Note: Figures for capitated payments account for risk-sharing payments that plans make or receive under Part D's risk corridors. Figures for amounts that are paid prospectively (cost-based reinsurance and low-income subsidy) have been reconciled to actual spending amounts. Components may not sum to totals due to rounding.
* Subsidy for employers providing prescription drug coverage to their retirees that is comparable with or more generous than Part D's defined standard benefit.
** Excludes low-income premium subsidies.

Source: MedPAC analysis based on Table IV.B10 of the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

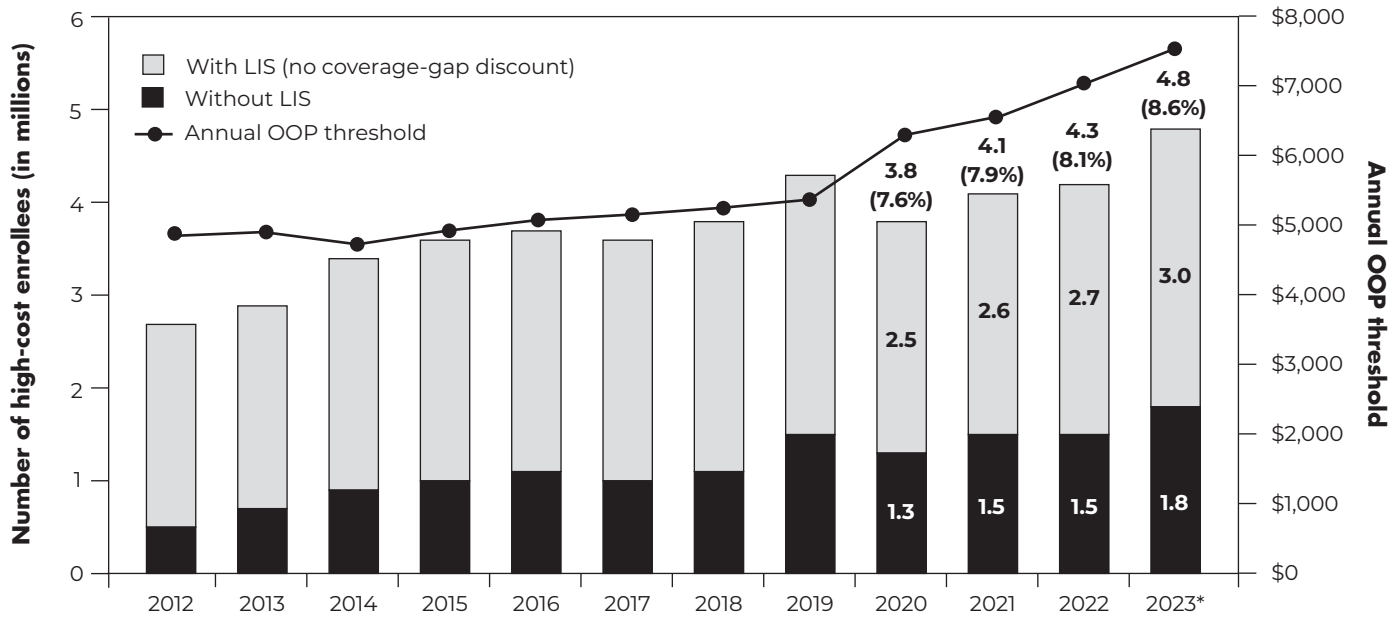
(Total Part D enrollment grew by about 3 percent per year on average during this period (data not shown).) Medicare's payments for the monthly capitated direct subsidy have declined sharply in recent years, falling by nearly 20 percent, on average, from 2019 to 2023 (Table 12-5). Multiple factors have contributed to this decline, including the increased use of generic drugs by Part D enrollees and the rapid growth in manufacturer rebates and pharmacy fees that disproportionately offset plans' basic benefit costs. Meanwhile, Medicare's cost-based reinsurance payments continued to climb, rising 8.2 percent per year, on average, over the period, as the number of enrollees reaching the catastrophic phase of the benefit increased. As a result, in recent years, over 90 percent of all Medicare's basic-benefit payments took the form of reinsurance (cost-based reimbursement) rather than monthly capitated direct-subsidy payments.

The Commission has been concerned about the misaligned plan incentives that arose from this shift in program spending, from relying primarily on capitated direct-subsidy payments to cost-based reinsurance. The growth in postsale rebates further undermined plans' incentives to manage spending by shifting more of the costs to Medicare's LICS subsidy and to beneficiaries who paid a percentage coinsurance on prices that did not reflect postsale rebates. In 2020, the Commission recommended changes to the Part D program to restructure its benefits in order to restore stronger financial incentives for plan sponsors to manage drug spending and to protect beneficiaries from unlimited cost-sharing liabilities (described on p. 413).

This trend toward greater reliance on cost-based reinsurance was reversed in 2024 as a combination of legislative and regulatory changes took effect. First, as discussed in our March 2024 report to the Congress, the new requirement to reflect all pharmacy price concessions at the point of sale, which began in 2024, is expected to have reduced POS prices and beneficiary cost sharing, on average. This change, in turn, would tend to slow the progression toward the OOP threshold and reduce the share of spending in the catastrophic phase of the benefit (in which Medicare makes reinsurance payments) (Medicare Payment

**FIGURE 12–4**

**Part D enrollees reaching the benefit's catastrophic phase, 2012–2023**




Note: LIS (low-income subsidy), OOP (out of pocket). Percentages shown in parentheses are high-cost enrollees as a share of all Part D enrollees. Components may not sum to totals due to rounding.
* Amounts are based on preliminary Part D prescription drug event data.

Source: Enrollee counts for 2012 to 2023 are based on MedPAC analysis of Part D prescription drug event data.

Advisory Commission 2024c). Second, the IRA change to limit the annual increase in the BBP to no more than 6 percent means that any increase in the expected average basic-benefit costs (including expected average reinsurance) in excess of that 6 percent would be paid in the form of a higher direct subsidy from the Medicare program.

In addition to reinsurance, Medicare shares financial risk with plan sponsors by limiting each plan's overall losses or profits through risk corridors if actual benefit spending, excluding reinsurance, is much higher or lower than the plan sponsor anticipated in its bid (Medicare Payment Advisory Commission 2024b). Aggregate amounts of net risk-corridor payments have fluctuated over the years but have been consistently positive in recent years—meaning that, in the aggregate, Medicare's payments to cover a portion of plans' losses have exceeded the amount it has received from plans to recoup a portion of plans' profits (Boards of Trustees 2024).

In 2023, total direct-subsidy payments included an adjustment for net risk-corridor payments and additional IRA-related subsidies. Some of the risk-corridor losses are likely related to a class of drugs called glucagon-like peptide-1 receptor agonists (GLP-1s).[26] GLP-1s have been used to treat patients with Type 2 diabetes for decades, but Part D could experience an uptick in use as they gain additional indications (see text box on GLP-1 drugs in the context chapter, pp. 14–15). In addition, Medicare paid subsidies to plans related to provisions in the IRA that limited cost sharing for insulins to no more than $35 and prohibited imposing cost sharing on Part D–covered vaccines (Liu and Centers for Medicare & Medicaid

Services 2024).[27] These subsidies accounted for the majority of the additional adjustment costs reported under this category of payments (Liu and Centers for Medicare & Medicaid Services 2024).

In 2023, 4.8 million beneficiaries had spending high enough to reach the catastrophic phase of the benefit ("high-cost enrollees"), an increase of nearly 18 percent from 4.3 million in 2022, following smaller increases in 2021 and 2022 (Figure 12-4).[28] In 2023, enrollees with the LIS continued to account for the majority (63 percent) of all high-cost enrollees. Beneficiaries with the LIS tend to use more medications and incur higher average spending compared with beneficiaries without the LIS (Medicare Payment Advisory Commission 2024a).

The annual OOP threshold is set each year based on a formula set in law. Between 2022 and 2023, the annual OOP threshold increased from $7,050 to $7,400 (Figure 12-4). For LIS enrollees, because Medicare's LIS pays for nearly all costs in the coverage gap (above any nominal copayments required by law), the effects of the increase in the OOP threshold fell almost entirely on Medicare (taxpayers) rather than beneficiaries themselves. For enrollees without the LIS, the financial impact of a higher OOP threshold differed depending on whether the prescription was for a generic or brand-name drug. For brand-name drugs, the manufacturer's coverage-gap discount was treated as though it were the enrollee's own OOP spending. An enrollee who filled only brand-name drugs in the coverage gap would be responsible for paying about a quarter of that increase. Meanwhile, beneficiaries who took only generic drugs would be responsible for the full increase. In 2023, coverage-gap discounts among high-cost enrollees without the LIS averaged more than $5,100, accounting for 69 percent of the OOP threshold amount ($7,400).

In 2023, the number of enrollees who used drugs with very high prices—where a single prescription was sufficiently expensive to meet the OOP threshold—rose by about 10 percent to over 532,000 enrollees—about 11 percent of high-cost enrollees—up from just 33,000 enrollees in 2010. High-cost enrollees without the LIS were more likely to have such claims compared with high-cost enrollees with the LIS (about 16 percent compared with just over 8 percent, respectively). This difference in the use of drugs by enrollees' LIS status reflects the underlying difference in the patterns of drug use between these two populations: In our analysis of the Part D data, we found that many LIS beneficiaries reach the catastrophic phase of the benefit using multiple medications for chronic or more prevalent conditions. High-cost enrollees without the LIS, on the other hand, were more likely to reach the catastrophic phase of the benefit because they used specialty drugs and biologics (Medicare Payment Advisory Commission 2016).

## Growth in overall Part D prices driven by single-source brand-name drugs and biologics

Growth in prices at the pharmacy counter—referred to here as "gross prices" or "POS prices"—continues to be an important metric for understanding how drug prices affect Part D program spending and costs faced by beneficiaries. POS prices paid at the pharmacy are an important indicator of Part D's costs because they affect beneficiary cost sharing and the rate at which enrollees reach Part D's catastrophic phase. While most Part D enrollees primarily use generic drugs, and many (but not all) generic prices remain low, enrollees without the LIS who use brand-name drugs often feel the effects of rising POS prices when they pay a deductible or coinsurance. These effects can be felt particularly acutely among the relatively small share of enrollees who use high-priced specialty drugs.

All levels of the drug supply chain include incentives that drive up POS prices of brand-name drugs and biologics, particularly when payments among the supply-chain participants are based on a percentage of prices (Fein 2018, Feldman 2018, Garthwaite and Morton 2017, Sood et al. 2021). Meanwhile, manufacturers' focus on developing drugs and biologics for smaller patient populations means that many products are launched at high prices and may not have direct therapeutic competitors. Over time, these factors combined with the consolidation of supply-chain participants have pushed POS prices higher (Sood et al. 2020).

To examine growth in prices, the Commission contracted with Acumen LLC to construct a series of volume-weighted price indexes that reflect total

**TABLE 12–6**

**Part D point-of-sale prices, after accounting for generic substitution, continued to rise in 2023**

| | 2019 | 2020 | 2021 | 2022 | 2023 |
|---|---|---|---|---|---|
| | Price index as of 4th quarter (1st quarter 2014 = 1.00) | | | | |
| All drugs and biologics | | | | | |
| Before accounting for generic substitution | 1.29 | 1.33 | 1.38 | 1.43 | 1.48 |
| After accounting for generic substitution | 1.08 | 1.10 | 1.13 | 1.16 | 1.18 |
| Generic drugs | 0.56 | 0.51 | 0.47 | 0.43 | 0.41 |
| Single-source brand-name drugs and biologics | 1.58 | 1.66 | 1.78 | 1.88 | 1.98 |
| Net of manufacturer rebates | 1.32 | 1.38 | 1.46 | 1.54 | 1.60 |
| | Annual percentage change* | | | | |
| All drugs and biologics | | | | | |
| Before accounting for generic substitution | 2.9% | 2.6% | 4.1% | 3.8% | 3.4% |
| After accounting for generic substitution | –2.1 | 1.3 | 3.4 | 2.6 | 1.9 |
| Generic drugs | –8.9 | –8.9 | –8.3 | –7.4 | –5.7 |
| Single-source brand-name drugs and biologics | 5.7 | 5.2 | 6.7 | 5.9 | 5.0 |
| Net of manufacturer rebates | 3.9 | 4.5 | 5.8 | 5.5 | 3.9 |

Note: Indexes are calculated using chain-weighted Fisher price indexes and are measured at the median of the distribution relative to prices as of the first quarter of 2014. Prices reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies with the exception of the price index for single-source brand-name drugs and biologics net of manufacturer rebates, which accounts for the effects of postsale manufacturer rebates and discounts negotiated by Part D plans. Indexes shown are rounded. Price indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They do not reflect the effect of launch prices of new products.
* Annual percentage changes reflect growth in the price index since the fourth quarter of the previous year, calculated on unrounded data.

Source: Acumen LLC analysis for MedPAC.

amounts paid to pharmacies for Part D prescriptions (i.e., POS prices) as well as prices for single-source brand-name drugs net of postsale manufacturer discounts. The indexes reflect prices (of existing products) measured at the median of the distribution for each grouping of products associated with a specific drug or biologic.[29]

## High generic penetration has helped moderate the growth in overall Part D prices at the point of sale

Between 2014 and 2023, prices for all drugs and biologics, measured by individual national drug codes (NDCs), grew by nearly 50 percent (an index value of 1.48) (Table 12-6).[30] Overall, growth in drug prices slowed in 2023 to an annual rate of 3.4 percent, down from 4.1 percent in 2021; however, it still exceeded price growth observed prior to 2021.

Because generic drugs account for 90 percent of all prescriptions, decreases in generic prices help moderate overall price growth. Our price index for generic drugs has declined consistently in the past and continued to do so in 2023 (Table 12-6). As a result, our overall price index that takes generic substitution into account has grown at a more moderate rate, growing by 1.9 percent in 2023 compared with 3.4 percent before accounting for generic substitution.[31]

## The Medicare Drug Price Negotiation Program and the drugs selected for 2026

The Inflation Reduction Act of 2022 (IRA) established the Medicare Drug Price Negotiation Program ("the negotiation program"), under which the Secretary of Health and Human Services has new authority to negotiate directly with manufacturers for the prices of drugs covered under Medicare Part B and Part D.

The law sets forth specific criteria for selecting products for the negotiation program (the "selected drugs"). For example, the product:

- must have been on the market for 7 years for a small-molecule drug and 11 years for a biological product,
- must be a single-source drug without therapeutically equivalent generic or biosimilar alternatives that are approved or licensed and marketed, and
- must be among the top-selling drugs in Medicare, based on total expenditures.

Certain single-source brand-name drugs and biologics ("single-source drugs") that would otherwise be selected drugs may be exempted from the negotiation program. For example, the law specifically excludes plasma-derived products or drugs that are approved and designated for only one rare disease or condition.[32] The Secretary may also exclude a drug if they determine that there is a "high likelihood" of imminent biosimilar competition. Manufacturers that fail to comply with the requirements of the negotiation program may be subject to an excise tax of up to 95 percent. Because manufacturers would be prohibited from deducting the excise tax payments in determining their income taxes, the combination of income taxes and excise taxes on sales in the U.S. could cause the drug manufacturer to lose money for those sales (Swagel 2019).

*(continued next page)*

### Going forward, take-up of biosimilars and the new Medicare Drug Price Negotiation Program will affect Part D prices

Generics' share of prescriptions has plateaued since 2017, driven primarily by the shift in the drug-development pipeline. Medicare now spends significant amounts on products for which generic versions are not available because they are brand-name drugs and biologics produced by a single manufacturer ("single-source drugs"). While the introduction of single-source drugs can be important advances in pharmacological therapy, their high prices can pose barriers to access.

In 2023, single-source drugs accounted for about 10 percent of the prescriptions but nearly 80 percent of gross Part D spending, up from 70 percent in 2014 (data not shown). Between 2019 and 2023, POS prices of single-source drugs have grown by between 5.0 percent and 6.7 percent per year (Table 12-6), down from an average growth rate of nearly 9 percent per year before 2018 (latter data not shown).

For many single-source drugs, plans negotiate postsale rebates and discounts from manufacturers that reduce prices after the POS transactions. Those "net prices" affect the premiums paid by Part D enrollees and subsidies paid by the Medicare program. Manufacturer rebates and discounts have grown from about $16 billion in 2014 to nearly $70 billion in 2023 (an average growth of 17 percent per year) (data not shown). Even with the rapid growth in postsale rebates and discounts, net prices of single-source drugs still grew by between 3.9 percent and 5.8 percent during this period (Table 12-6).

Pipeline shifts also mean that, going forward, restraining growth of drug prices in Part D will increasingly depend on successful launch and adoption of biosimilars by prescribers and beneficiaries. Several

## The Medicare Drug Price Negotiation Program and the drugs selected for 2026 (cont.)

The price negotiations for the first 10 drugs (all covered under Part D) began with the announcement of the selected drugs on August 29, 2023, and ended a year later with the publication of the negotiated prices that would be applicable in 2026. (The Secretary is required to select 15 Part D drugs for 2027; starting in 2028, selections must be made from among both Part D and Part B, beginning with 15 from either program in that year and 20 for 2029 and subsequent years.[33]) On January 17, 2025, CMS announced the selection of 15 additional Part D–covered drugs for the negotiation program (Centers for Medicare & Medicaid Services 2025). The selected drugs included glucagon-like peptide-1 receptor agonists (GLP-1s), used to treat Type 2 diabetes, obesity and overweight, and cardiovascular conditions, which have seen an uptick in use among Part D enrollees (see text box on GLP-1s in the context chapter, pp. 14–15).[34] Prices negotiated for these 15 drugs will become effective in 2027.

By law, the negotiated prices, referred to as the "maximum fair price" (MFP), for selected Part D drugs cannot be greater than the lower of:

- the average Part D price, net of all price concessions and rebates, weighted by plan enrolment;[35] or
- the applicable percentage of a drug's average nonfederal average manufacturer price, where the applicable percentage ranges from 40 percent for drugs that have been on the market for more than 16 years to 75 percent for drugs that have been on the market for 9 years to 12 years.

The Secretary may consider prices of therapeutic alternative(s), if available, as well as information submitted by the manufacturers of the selected drugs related to research and development costs, prior federal financial support, unit costs of production and distribution, revenue and sales data, and information on patents and market exclusivity granted by the Food and Drug Administration (Centers for Medicare & Medicaid Services 2024d). After the Secretary submits an initial offer, the negotiation process may involve counteroffer exchanges (by both the manufacturer and the Secretary) and multiple meetings with the manufacturers until an agreement is reached on the final offer.

Gross Part D spending for the first 10 selected drugs totaled $55.7 billion in 2023, accounting for about 20 percent of total gross Part D spending, or just over a quarter of gross spending for single-source drugs in that year (Table 12-7). (Note that gross spending reflects point-of-sale (POS) prices paid at the pharmacy. For brand-name drugs, POS prices are on average about 6 percent below a list price known as the wholesale acquisition cost (WAC) (Congressional Budget Office 2021a).)

The final negotiated prices that would apply to prescriptions filled under Part D in 2026 were published on August 15, 2024 (Table 12-7). CMS estimates that, relative to the WACs, the negotiated prices achieved discounts ranging from 38 percent for Imbruvica to 79 percent for Januvia. Beginning in 2026, these discounts are expected to have a material impact on the POS price trends for single-source drugs.

At the same time, there is uncertainty about the magnitude of savings achieved by the negotiation program because Medicare's program spending and enrollee premiums are affected by the prices net of all rebates and discounts. Because many of the drugs selected for the negotiation program are in classes with therapeutic alternatives, pharmacy benefit managers (PBMs) have been able to negotiate substantial rebates on some of the therapies (which are fully passed on to Part D plan sponsors and are shared with Medicare to lower program spending).

*(continued next page)*

## The Medicare Drug Price Negotiation Program and the drugs selected for 2026 (cont.)

As a result, for most products, net prices were lower than their gross prices and, in some cases, substantially so.

Savings from price reductions must be considered relative to net prices. In 2023, manufacturer rebates and discounts negotiated by PBMs for selected products achieved an overall discount of about 40 percent relative to gross prices (though average discounts varied across those products). When combined with other discounts (e.g., the coverage-gap-discount program that was in place in 2023), the net prices for some selected drugs in 2023 may not have differed substantially from the price reductions achieved under the negotiation program. At the same time, because net prices typically grow over time, the prices resulting from the negotiation program, effective in 2026, may achieve savings relative to the prices that would have prevailed absent the negotiation program. Further, there may be spillover effects for drugs with brand-name competitors in the therapeutic class; makers of a competing product may feel pressure to offer greater discounts to remain financially competitive with the selected product and maintain or improve its formulary status. ■

**TABLE 12–7** **Drugs selected for the Medicare Drug Price Negotiation Program, 2026**

| | | CMS announcement of negotiated prices published on August 15, 2024 (per 30-day supply) | | | |
|---|---|---|---|---|---|
| Drug name | Commonly treated conditions | Negotiated price | List price (WAC)* | Discount from the list price (in percent) | Total Part D gross spending in 2023 (in billions) |
| Eliquis | Prevention and treatment of blood clots | $231 | $521 | 56% | $18.3 |
| Jardiance | Diabetes, heart failure, chronic kidney disease | 197 | 573 | 66 | 8.8 |
| Xarelto | Prevention/treatment of blood clots, reduction of risk for patients with coronary or peripheral artery disease | 197 | 517 | 62 | 6.3 |
| Januvia | Diabetes | 113 | 527 | 79 | 4.1 |
| Farxiga | Diabetes, heart failure, chronic kidney disease | 179 | 556 | 68 | 4.3 |
| Entresto | Heart failure | 295 | 628 | 53 | 3.4 |
| Enbrel | Rheumatoid arthritis, psoriasis, psoriatic arthritis | 2,355 | 7,106 | 67 | 3.0 |
| Imbruvica | Blood cancers | 9,319 | 14,934 | 38 | 2.4 |
| Stelara | Psoriasis, psoriatic arthritis, Crohn's disease | 4,695 | 13,836 | 66 | 3.0 |
| Fiasp / Novolog | Diabetes | 119 | 495 | 76 | 2.6 |
| Total | | | | | 55.7 |

Note: WAC (wholesale acquisition cost). Components may not sum to totals due to rounding.
* List prices are WACs for the selected drugs based on a 30-day supply using prescription fills in Part D in 2022.

Source: Assistant Secretary for Planning and Evaluation 2023, Centers for Medicare and Medicaid Services 2024d, Centers for Medicare and Medicaid Services 2023c, and gross spending based on MedPAC analysis of the Part D prescription drug event data.

**TABLE 12–8**

**Relative contributions of price and quantity trends on the total expenditure growth, Medicare Drug Price Negotiation Program's selected drugs compared with single-source brand-name drugs and biologics, 2014–2023**

| | Single-source brand-name drugs and biologics | | | |
|---|---|---|---|---|
| | All | | Selected drugs* | |
| Aggregate gross spending in 2023 (billions) | $210.7 | | $55.7 | |
| | Index value | Average annual growth | Index value | Average annual growth |
| Indexes as of 4th quarter of 2023 (1st quarter of 2014 = 1.0) | | | | |
| Expenditure index | 3.54 | 13.9% | 10.30 | 27.0% |
| Price index | 1.98 | 7.2 | 2.21 | 8.5 |
| Quantity index | 1.79 | 6.2 | 4.66 | 17.1 |

Note: Indexes are calculated using chain-weighted Fisher indexes and are measured at the median of the distribution relative to prices as of the first quarter of 2014. Expenditure and price indexes reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies. Index values shown are rounded. The quantity index measures the percentage change in the number of units dispensed, weighted by prices (using chain weights). Price indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They do not reflect the effect of launch prices of new products.
* Drugs selected for 2026 price-applicability year under the Medicare Drug Price Negotiation Program.

Source: Acumen LLC analysis for MedPAC.

top-selling products for autoimmune conditions are now facing or are expected to face biosimilar competition in the next few years. In 2023, Humira, one of the top-selling products for the treatment of autoimmune conditions, began facing biosimilar competition. However, in 2024, nearly all plans continued to cover Humira products, with most plans placing the biosimilar product on the same cost-sharing tier as Humira (i.e., if a plan used a copay on that tier, enrollees would pay the same cost sharing for both Humira and its biosimilar product(s) (Medicare Payment Advisory Commission 2024c)). In 2025, some plans no longer include Humira products on their formularies.[36]

Beginning in 2026, Part D plans will pay no more at the POS for drugs selected for the Medicare Drug Price Negotiation Program than the prices negotiated by the Secretary of Health and Human Services (see text box on the Medicare Drug Price Negotiation Program and the drugs selected for 2026, pp. 437–439). Because the drugs are selected based on total gross spending, we constructed expenditure indexes that measure the percentage change in Part D gross spending relative to a reference period. (Gross prices at the POS are often used for determining beneficiary cost sharing for brand-name drugs and biologics with high prices.) The expenditure indexes allow us to examine the relative contributions of price and quantity trends to the growth in total expenditures.

Between 2014 and 2023, our expenditure indexes show that gross spending for the selected drugs grew much more rapidly compared with overall growth in single-source drugs, growing at an average annual rate of 27 percent (an index value of 10.30) compared with an average annual rate of about 14 percent (an index value of 3.54) for all single-source drugs (Table 12-8). During this period, prices of the selected drugs grew by 8.5 percent per year (an index value of 2.21), on average, compared with an average of 7.2 percent per year (an index value of 1.98) for single-source drugs.[37]

At the same time, we also found that, between 2014 and 2023, Part D enrollees' use of the selected drugs grew more rapidly, by about 17 percent per year, on average (an index value of 4.66) compared with an average growth of about 6 percent for all single-source drugs (an index value of 1.79) (Table 12-8). That is, on average, an increase in the use of the selected-drug therapies by Part D enrollees has had a greater impact on overall spending growth across the selected products during this period than the growth in prices. However, there was wide variation in the extent to which trends in prices or quantities consumed contributed to the overall growth in spending. For example, for four products (Januvia, Enbrel, Imbruvica, and Fiasp/Novolog), growth in prices had a larger impact on spending growth than did the quantity consumed.

Finally, the estimate of the effects of price increases on expenditure growth (both measured using gross prices at the POS) overstates the contribution of prices to program spending. Under Part D, any postsale rebates or discounts negotiated by the PBMs are passed on to Part D plans to lower benefit costs. For selected drugs, because many of the therapies were in highly competitive classes, postsale rebates and discounts have helped slow the growth in net prices. Between 2014 and 2023, prices net of postsale manufacturer rebates and discounts for the selected drugs grew at an average annual rate of just over 3 percent, which is lower than the 5 percent annual growth for all single-source drugs).[38]

## Most Part D enrollees are satisfied with drug coverage

Measuring the quality of the pharmacy benefit is critical for assessing the value of Part D plans. However, it is a task that requires nuance since there is no single metric to determine the quality of the pharmacy benefit for all enrollees. On the one hand, effective treatment for many conditions may hinge primarily on access and adherence to prescription drugs. On the other hand, Medicare beneficiaries are likely to have multiple chronic conditions and may be on multiple medications, which tends to increase the risk of adverse drug events associated with polypharmacy.

To promote access, CMS reviews each plan's formulary to check that it includes medicines in a wide range of therapeutic classes used by the Medicare population and that plans apply utilization-management tools in appropriate ways. Further, Part D law requires sponsors to have a transition process to ensure that new enrollees, as well as current members whose drugs are no longer covered or are subject to new restrictions, have access to the medicines they have already been taking.[39] CMS has also established network-adequacy requirements to ensure that beneficiaries have a sufficient number of pharmacies in-network within the plan's geographic area. In addition, Medicare requires plan sponsors to establish a process for coverage determination and appeals.[40] If an enrollee is dissatisfied with a plan's final coverage decision, the enrollee may appeal the decision to an independent review entity and then, if necessary, to higher levels of appeal.

CMS collects quality and performance data to monitor plan sponsors' operations and evaluate access to medicines, enrollee experience, and patient safety. A subset of these data are used in the 5-star-rating system made available through Medicare's Plan Finder at Medicare.gov to help beneficiaries evaluate their plan options. The agency also uses star ratings that are based in part on prescription drug benefits to determine MA quality-bonus payments. (Although both MA–PDs and stand-alone PDPs are evaluated with star ratings, only MA–PDs are eligible for quality-bonus payments through the Part C payment system.) The agency displays other Part D quality measures on the CMS website, including some metrics that are either being removed from or evaluated for addition to the star-rating system. In addition, by law, Part D plans are required to carry out medication therapy management programs and programs to manage opioid use.

Plans offered in 2025 have lower average overall star ratings for the third straight year, though some plans have had their ratings adjusted since the official release of ratings from CMS, following lawsuits filed that accused CMS of inaccurately scoring some metrics (Centers for Medicare & Medicaid Services 2024b, Pifer 2024). Eleven percent of PDPs offered in 2025 received 4 or more stars, and these plans enrolled 5 percent of PDP beneficiaries in 2024. MA–PDs, on the other hand, enrolled 76 percent of MA–PD beneficiaries in the 40 percent of such plans that earned 4 or more stars, reflecting high enrollment concentration in high-performing plans (before ratings adjustments

**TABLE 12–9**

**MA–PD and PDP enrollee experience with the drug-plan CAHPS performance scores, 2023**

| CAHPS measure | MA–PD | PDP |
|---|---|---|
| Rating of drug plan | 88% | 82% |
| Getting needed prescription drugs | 90 | 88 |

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), PDP (prescription drug plan), CAHPS (Consumer Assessment of Healthcare Providers and Systems). "Rating of drug plan" is a global rating measure in which a survey question has a response of 1 to 10, which CMS converts to a national linear mean score on a 0 to 100 scale. "Getting needed prescription drugs" is a composite measure of multiple survey questions with "never," "sometimes," "usually," and "always" responses. CMS converts these to a national linear mean score on a 0 to 100 scale. The MA–PD–CAHPS response rate was 33 percent, and the PDP–CAHPS response rate was 38 percent in 2023.

Source: MA–PD and PDP–CAHPS mean scores published by CMS, 2023.

were made; it is estimated that after adjustments, another 7 percent of enrollees were in plans with 4 or more stars). The number of MA–PDs receiving 5 stars declined significantly, with just 7 MA–PDs earning the highest rating, down from 31 in 2024 (2 additional plans received 5 stars after ratings were adjusted). The number of PDPs earning 5 stars remained at two. All but one plan that received a 5-star rating in 2025 also received 5 stars in 2024, showing consistency among the high performers, while the overall rating decreased for the majority of plans.

MA–PD and PDP star-rating calculations include performance on two measures of enrollee experience with the plan ("rating of drug plan" and "getting needed prescription drugs"). These scores are based on Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses from a random sample of each contract's enrollees.[41] Table 12-9 presents national CAHPS measures of drug-plan experience for both MA–PD and PDP contracts in 2023.

Enrollees in both MA–PD and PDP contracts rated their coverage and experiences favorably overall in 2023 (Table 12-9). The 2023 MA–PD CAHPS score for "rating of drug plan" was 88 (scored on a scale of 0 to 100), which is higher than the 82 for stand-alone PDPs. The 2023 MA–PD CAHPS score for "getting needed prescription drugs" was 90, which is similar to the PDP score of 88. These results have been relatively stable over the past few years.

Consistent with CAHPS results, in focus groups convened for the Commission, Medicare beneficiaries generally rated their prescription drug coverage highly and reported being able to access their prescriptions when needed (NORC at the University of Chicago 2023). Beneficiaries who rated their drug coverage below "excellent" commonly cited the costs of prescriptions as the reason. This information coincides with findings that the satisfaction rate pertaining to the affordability of cost sharing for brand-name medicines is lower (76 percent) than for generic medicines (84 percent) (Morning Consult 2024). Nevertheless, because the majority of prescriptions are for inexpensive generic drugs and a relatively small number of beneficiaries use brand-name or high-cost specialty drugs, overall satisfaction remains high. ■

# Endnotes

1 Plans receive prospective payments for reinsurance that are reconciled with actual spending (net of postsale rebates and discounts) after the end of the benefit year for each enrollee who reached the OOP threshold.

2 The Commission has also recommended establishing higher copayment amounts for nonpreferred and nonformulary drugs under the LIS benefit and giving plans greater flexibility regarding coverage of drugs in the protected classes, though these proposals have not yet been adopted (Medicare Payment Advisory Commission 2020a, Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2016).

3 While market concentration at the national level among MA–PDs is lower than that of PDPs, local (county-level) competition is more relevant for MA–PD enrollees. Our analysis of MA enrollment at the county level suggests that the MA market is more concentrated at this level than at the national level (see Table 11-6 (p. 367)). For example, in 2024, enrollment in the top three organizations in each county accounted for 81 percent of all MA enrollment compared with 58 percent at the national level. Because nearly all MA plan enrollees are in plans that also offer Part D drug coverage, the patterns of market concentration for MA–PDs would be nearly identical to those of MA plans (Freed et al. 2024).

4 Some PBMs that are vertically integrated with plan sponsors operate exclusively for the plan sponsor that owns them. Humana Pharmacy Solutions (Humana), IngenioRx (Anthem/Elevance), and Kaiser Pharmacy (Kaiser) are examples. Other PBMs serve the sponsor that owns them as well as other clients, e.g., CVS/Caremark (CVS Health), OptumRx (UnitedHealth Group), and Express Scripts (Cigna) (Guardado 2022).

5 The Commission's calculation is based on data from CMS on Part D prescription drug events and direct and indirect remuneration.

6 Among plans that have them in 2025, preferred pharmacies make up an average of 42 percent, 48 percent, and 44 percent of all network pharmacies for PDPs, MA-PDs, and special-needs plans, respectively.

7 Researchers found that over the period from 2011 to 2014, Part D enrollees without the LIS were highly sensitive to preferred cost sharing, and the approach reduced overall drug spending by about 2 percent (Starc and Swanson 2021a, Starc and Swanson 2021b).

8 Examples of pharmacy performance measures that have been used by Part D plan sponsors and their pharmacy benefit managers to determine the amount of postsale price concessions include generic dispensing rates, patient adherence rates, and/or generic effective rate contracting that requires retroactive adjustments to ensure the achievement of pricing targets across all or most generic drugs dispensed over a given period of time.

9 The demonstration made no change to the risk corridors for profit sharing.

10 Previously, a small share of LIS enrollees with slightly higher levels of income or assets received a partial subsidy; beginning in 2024, all beneficiaries who previously would have been eligible for a full or partial LIS receive full subsidy benefits.

11 Before the 2025 bids were submitted, CMS estimated that the IRA changes would roughly double gross plan liability, and many, including CMS, expect Part D's risk adjustment to take on much greater importance (Centers for Medicare & Medicaid Services 2023a, Robb et al. 2024).

12 Several factors contributed to the higher-than-expected spending in 2023, including an uptick in the use of glucagon-like peptide-1 receptor agonists and IRA provisions related to the coverage of insulins and vaccines. See pp. 434–435 for more discussion.

13 Sponsors of all types of plans (stand-alone PDPs, MA–PDs, and special-needs plans) that are generally available for individual purchase must submit bids in order to participate in Part D. Plans sponsored by employers and unions and plans in the Program of All-Inclusive Care for the Elderly are exempt from bidding.

14 The 60 percent increase reflects the cumulative effects of the IRA's change to limit the annual increase in the BBP to no more than 6 percent in 2024 and 2025. Had the 6 percent cap not been in effect in 2024, the BBP would have been $39.35, and the annual increase in the BBP (without the 6 percent cap) would have been 42 percent (which is the increase in the total expected basic benefit cost as reflected in plan bids and the expected average reinsurance amount).

15 In this hypothetical example, we assumed that an individual is on two medications (Eliquis (5 mg tablet) and Jardiance (25 mg tablet)), which they fill every month, and that the individual is enrolled in an enhanced-benefit plan that charges a cost sharing of $47 for each 30-day prescription for both drugs.

16 The number of plan offerings for 2025 excludes 60 plans offered by Clear Spring Health that were included in the 2025 landscape files but have been terminated by CMS due to consistently low star ratings disqualifying them from the program.

17 When the Part D program was created, the Congress contemplated such a scenario and included in the legislation a contingency plan to ensure beneficiaries would always have a minimum of two options for prescription drug coverage. If that minimum requirement is not met, the law allows the Secretary to approve plan(s) that administer Part D's prescription drug benefit without taking insurance risk (or only assuming limited insurance risk). In 2025, however, all regions continued to meet the minimum number of required plans, with all enrollees having at least five qualifying PDPs.

18 The four regions with just one benchmark plan available in 2025 include Florida, Illinois, Nevada, and Texas.

19 Under Part C, MA plans that bid below the MA benchmark receive a portion of the difference between the benchmark and the plan bids as rebates. MA plans must use these rebates to provide supplemental benefits, which may include reduced Part D premiums (Medicare Payment Advisory Commission 2024c).

20 Other factors that affect investment in biopharmaceutical research and development include federal regulatory policies related to drug approval, patents, and intellectual property; federal tax policy; payment policies of other payers in the U.S. and internationally; the cost of drug development, including capital availability and costs; and collaboration between pharmaceutical manufacturers and academic institutions (Congressional Budget Office 2021b). In addition, the federal government contributes to innovation both directly and indirectly through its funding for basic science research and drug development research for some products (Galkina Cleary et al. 2018, Sampat and Lichtenberg 2011).

21 Examples of creditable drug coverage from sources other than Part D include the Federal Employees Health Benefits Program, TRICARE, and coverage from the Department of Veterans Affairs.

22 The remainder qualified either because they received benefits through the Medicare Savings Program or Supplemental Security Income program or because they were eligible after they applied directly to the Social Security Administration.

23 As with the income-related premium for Part B, higher Part D premiums apply to individuals with an annual adjusted gross income greater than $103,000 and to couples with an adjusted gross income greater than $206,000 in 2024; these thresholds are updated annually.

24 The LEP amount depends on the length of time an individual goes without coverage as generous as Part D and is calculated by multiplying 1 percent of the base beneficiary premium by the number of full uncovered months an individual was eligible but was not enrolled in a Part D plan and went without other creditable coverage.

25 The retiree drug subsidy is paid to employers that provide prescription drug coverage to their retirees that is comparable with or more generous than Part D's defined standard benefit.

26 The Medicare Trustees' report noted that, in 2023, Part D experienced faster-than-expected growth in spending due to "unanticipated rapid growth in the use of antidiabetic drugs," which accounted for a 4.4 percent increase in drug spending that year (Boards of Trustees 2024).

27 Because the IRA, enacted after Part D plans had submitted bids for 2023, expanded Part D's benefit beginning in 2023 to cover certain vaccines at no cost and limit cost sharing for insulins to no more than $35 per month, CMS provided additional subsidies to cover the higher benefit costs that plans incurred due to the IRA changes that were not reflected in the bids.

28 The Affordable Care Act of 2010 required Medicare to temporarily apply slower growth rates to the OOP threshold between 2014 and 2019. However, for 2020 and thereafter, the OOP threshold reverted to the levels that would have been in place had the slower growth rates never applied. As a result, in 2020, there was an unusually large increase in the OOP threshold from its 2019 level, which likely contributed to the slower growth in the number of Part D enrollees reaching the OOP threshold in 2021 and 2022.

29 The price index measures changes in the prices of products that existed in both the measurement period and the preceding period. It does not reflect the effect of launch prices of new products.

30 An individual NDC uniquely identifies the drug, its labeler, dosage form, strength, and package size.

31 For this index, Acumen groups NDCs that are pharmaceutically identical, aggregating prices across drug trade names, manufacturers, and package sizes. As a result, brand-name drugs are grouped with their generics if they exist, and this price index more closely reflects the degree to which market share has moved across products.

32 Under the IRA, certain drugs used for the treatment of a rare disease, referred to as "orphan drugs," are exempted from price negotiation if that orphan drug treats exactly one rare disease.

33 Part B drugs will be eligible for selection beginning in 2028.

34 Selected drugs also include other drugs used to treat Type 2 diabetes (Janumet/Janumet XR and Tradjenta), asthma and chronic obstructive pulmonary disease (Trelegy Ellipta and Breo Ellipta), and several types of cancer (e.g., Xtandi used for the treatment of prostate cancer). Under Part D's protected class policy, plans must cover all or substantially all drugs in six protected classes, which includes antineoplastics (cancer drugs). This coverage requirement has limited Part D plans' ability to negotiate lower prices or rebates for drugs used for cancer treatment. Because the Medicare Drug Price Negotiation Program sets a ceiling price that requires mandatory discounts based on the number of years the drug has been on the market, prices negotiated under the program could provide substantial discounts relative to the prices obtained by Part D plans.

35 For Part B drugs, the MFP cannot be greater than the lower of average sales price or the applicable percentage of a drug's average nonfederal average manufacturer price.

36 Plans that no longer include Humira products on their formularies accounted for just under 30 percent of all Part D enrollment in 2024. About 90 percent of those enrollees were in PDPs.

37 Annual growth was calculated based on price index values as of the fourth quarter of 2023.

38 The growth rate does not include the effects of postsale discounts and fees that Part D plans negotiated with their network pharmacies or the mandatory coverage-gap discounts paid by pharmaceutical manufacturers.

39 The transition fill is a temporary one-month supply provided within the first 90 days of coverage in a new plan or the new contract year for existing enrollees.

40 Plan sponsors must make coverage-determination and exception decisions within 72 hours of a request or within 24 hours for expedited requests. If the initial request for an exception does not include the necessary supporting documentation, the plan has up to 14 calendar days to obtain the information. See our March 2020 report to the Congress for more details (Medicare Payment Advisory Commission 2020b).

41 CAHPS surveys generate standardized and validated measures of patient experience. MA organizations and Part D plan sponsors are required to contract with a third-party survey vendor to collect CAHPS survey responses from a random sample of each contract's enrollees.

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