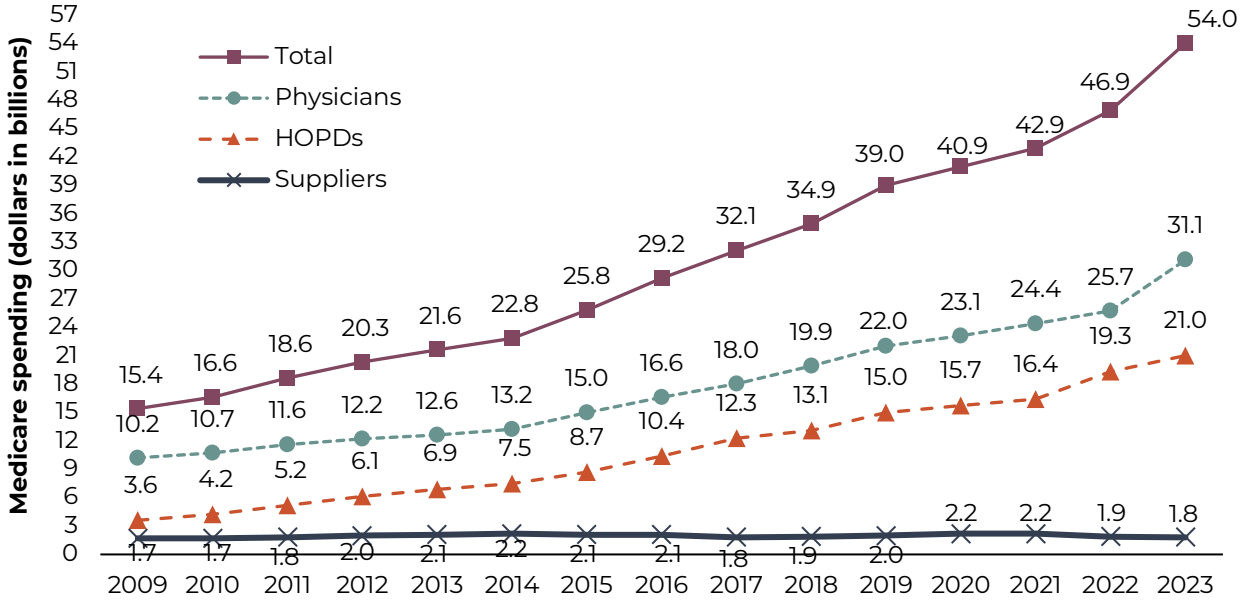
SECTION

10

Prescription drugs

Chart 10-1 Medicare spending for Part B drugs furnished by physicians, hospital outpatient departments, and suppliers, 2009–2023



Note: HOPD (hospital outpatient department). Data include Part B–covered drugs furnished by several provider types, including physicians, suppliers, and HOPDs, and exclude those furnished by critical access hospitals, Maryland hospitals, and dialysis facilities. "Medicare spending" includes program payments and beneficiary cost sharing. Data reflect all Part B drugs whether they were paid based on the average sales price or other methods. Data exclude blood and blood products (other than clotting factor). Dollar amounts are nominal, not adjusted for inflation.

Source: MedPAC and Acumen LLC analysis of Medicare claims data.

> Fee-for-service (FFS) Medicare and its beneficiaries spent about $54 billion on separately paid Part B drugs in 2023, with physician offices, HOPDs, and pharmacy suppliers accounting for 57 percent, 39 percent, and 3 percent of spending, respectively.

> Between 2009 and 2023, Part B drug spending grew 9.4 percent per year on average on a nominal basis, not adjusted for inflation. Spending grew more rapidly for HOPDs than for physicians and suppliers—at average annual rates of about 14 percent, 8 percent, and 1 percent, respectively.

> Between 2022 and 2023, FFS Part B drug spending increased 9.7 percent, with spending growing most rapidly (21.0 percent) in physician offices, largely due to a growth in payment for COVID-19 vaccines and skin substitutes. See Charts 10-2, 10-5, and 10-6 for more discussion on payments for COVID-19 vaccines and skin substitutes, respectively.

> Medicare generally pays providers for Part B drugs based on the average sales price (ASP) + 6 percent. Between 2018 and 2021, Medicare paid a reduced rate (ASP – 22.5 percent) for hospitals participating in the 340B Drug Pricing Program. In 2022, in response to a Supreme Court ruling, CMS increased the payment rate for 340B-acquired Part B drugs to ASP + 6 percent. (CMS will make separate lump-sum payments to 340B hospitals to compensate for reduced payments received in 2018 through 2021, but those amounts are not reflected in the chart).

> The data exclude Part B drugs furnished by critical access hospitals (CAHs) and Maryland hospitals, which are not paid under the general Part B drug ASP payment system. Medicare and beneficiaries spent about $1.5 billion in CAHs and $0.4 billion in Maryland hospitals for Part B drugs in 2023 (data not shown). Also, the data do not reflect Part B drugs paid as part of larger payment bundles (i.e., certain drugs furnished by HOPDs that are packaged into payment for other services and drugs furnished by dialysis facilities that are paid under the broader dialysis payment bundle).

Chart 10-2 Change in use of and Medicare payments for separately payable Part B drugs, 2009–2023

	2009	2023	Average annual growth 2009–2023
Total payments: Separately payable Part B drugs (in billions)	$11.3*	$47.8*	10.9%*
Total payments: All Part B drugs excluding vaccines (in billions)	$11.1	$45.4	10.6
Number of beneficiaries using a Part B drug (in millions)	2.5	3.7	2.9
Average number of Part B drugs per beneficiary	1.3	1.3	0.0
Average annual payment per Part B drug per beneficiary	$3,346	$9,243	7.5
Total payments: Part B preventive vaccines (in billions)	$0.2	$2.4	18.6
Number of beneficiaries using a Part B vaccine (in millions)	13.4	14.0	0.3
Average number of Part B vaccines per beneficiary	1.1	1.6	2.7
Average annual payment per Part B vaccine per beneficiary	$15	$109	15.1

Note: This analysis includes Part B drugs paid based on the average sales price as well as the small group of Part B drugs that are paid based on other methods. "Preventive vaccines" refers to four Part B–covered preventive vaccines: COVID-19, influenza, pneumococcal, and hepatitis B. Data include Part B drugs furnished by physicians, hospitals paid under the outpatient prospective payment system, and suppliers and exclude data for critical access hospitals, Maryland hospitals, and dialysis facilities. Yearly figures presented in the table are rounded; the average annual growth rate was calculated using unrounded data. Dollar amounts are nominal, not adjusted for inflation.
* For purposes of this analysis, spending on separately payable Part B drugs excludes any drug that was bundled in 2009 or 2023 (i.e., drugs that were packaged under the outpatient prospective payment system in 2009 or 2023 were excluded from both years of the analysis, regardless of the setting in which the drug was administered (e.g., skin substitutes are excluded from the analysis for this reason)), drugs billed under not-otherwise-classified billing codes, and blood and blood products (other than clotting factor). Without those exclusions, Part B drug spending was $15.4 billion in 2009 and $54.0 billion in 2023, as shown in Chart 10-1.

Source: MedPAC analysis of Medicare claims data for physicians, hospital outpatient departments, and suppliers.

> Total payments by the Medicare program and beneficiaries for separately payable Part B drugs increased 10.9 percent per year, on average, between 2009 and 2023 on a nominal basis.

> Medicare spending on separately payable Part B drugs excluding Part B–covered preventive vaccines grew at a similar rate (10.6 percent per year) between 2009 and 2023.

> Growth in the average price that Medicare Part B paid per drug was the largest factor contributing to increased spending for separately payable Part B drugs excluding vaccines between 2009 and 2023. During that period, the average annual payment per drug grew 7.5 percent per year on average, reflecting increases in the prices of existing drugs; the launch of new, higher-priced drugs; and shifts in the mix of drugs (data not shown). Growth in the number of beneficiaries using nonvaccine Part B drugs (about 2.9 percent per year on average) also contributed to increased spending. The number of Part B drugs received per user was stable.

> In 2023, Medicare and beneficiaries spent $2.4 billion on four Part B–covered preventive vaccines (COVID-19, influenza, pneumococcal, and hepatitis B) furnished by physicians, hospital outpatient departments, and pharmacy suppliers. Between 2009 and 2023, Part B vaccine spending grew by 2.2 billion (19 percent per year on average). A large portion of that growth was due to higher average payments per vaccine, which grew from $15 to $109 between 2009 and 2023, reflecting higher launch prices of COVID-19 vaccines and new pneumococcal and influenza vaccines. With the development of COVID-19 vaccines, the average number of vaccines per beneficiary who received a vaccine also increased over this period, contributing to spending growth. In 2023, the first year Medicare Part B was liable for the cost of COVID-19 vaccines, Medicare Part B spent over $900 million on COVID-19 vaccines. (Prior to that, COVID-19 vaccines were purchased directly by the federal government rather than paid for by providers and reimbursed by Medicare Part B).

Chart 10-3 Top 20 Part B drugs, 2023

		2023			Percent change, 2022–2023		
	Drug indication(s)	Total drug spending (billions)	Number of users	Average spending per user	Total drug spending	Number of users	Average spending per user
Keytruda	CA	$5.4	71,900	$75,500	10%	7%	3%
Eylea	MD	3.1	341,800	9,200	–11	0	–11
Darzalex*	CA	2.3	25,400	90,500	21	14	6
Prolia/Xgeva	CA SE, OS	2.2	677,400	3,200	9	3	5
Opdivo	CA	1.9	27,600	69,100	3	2	1
Dual Layer Impax	WC	1.4	5,100	278,500	N/A	N/A	N/A
Vabysmo	MD	1.3	112,600	11,500	N/A	N/A	N/A
Orencia	AR, AI	0.9	32,800	27,500	0	2	–2
Rituxan**	AR, AI, CA	0.8	59,000	14,100	–20	–2	–18
Tecentriq	CA	0.8	11,900	63,400	–3	–8	5
Gammagard	IMD, NE	0.7	25,100	29,500	17	15	2
Imfinzi	CA	0.7	13,300	55,600	31	26	4
Entyvio	IB	0.7	18,900	38,400	8	7	1
Ocrevus	MS	0.7	12,600	55,500	0	–1	2
Avastin**	CA, MD	0.6	161,500	3,700	–14	–10	–4
Prevnar 20	VA	0.6	2,054,300	300	66	64	1
Lucentis**	MD	0.5	91,600	5,900	–32	–11	–24
Remicade**	AR, IB	0.5	53,500	9,900	–14	–1	–13
Pluvicto	CA	0.5	3,900	133,700	N/A	N/A	N/A
Spikevax	VA	0.5	3,613,300	100	N/A	N/A	N/A
Top 10 drugs		20.2					
Top 20 drugs		26.3					
All Part B drugs		54.0					

Note: CA (cancer), MD (macular degeneration and other eye disorders), SE (side effect), OS (osteoporosis), WC (wound care), N/A (not applicable), AR (arthritis), AI (autoimmune disease), IMD (immune deficiency), NE (neuropathy), IB (inflammatory bowel disease), MS (multiple sclerosis), VA (vaccine). "Total drug spending" includes Medicare program payments and beneficiary cost sharing. The 20 drugs shown in the chart reflect the Part B drug billing codes with the highest Medicare expenditures in 2023. Percent change from 2022 to 2023 is not displayed for Dual Layer Impax, Vabysmo, Pluvicto, and Spikevax because there was little or no utilization in 2022 due to the product first receiving a billing code in mid-2022 or 2023. Data include Part B–covered drugs furnished by several provider types, including physicians, suppliers, and hospital outpatient departments, but exclude those furnished by critical access hospitals, Maryland hospitals, and dialysis facilities. Data exclude blood and blood products (other than clotting factor). Components do not always sum to totals due to rounding. Dollar amounts are nominal, not adjusted for inflation.
* Darzalex includes both intravenous and subcutaneous products.
** For originator biologics that have biosimilar competitors, data in the table reflect both the originator biologic and biosimilars.

Source: MedPAC and Acumen LLC analysis of Medicare claims data.

> Part B drugs are billed using over 1,000 billing codes, but spending is concentrated. In 2023, Medicare spending (including beneficiary cost sharing) on the top 10 products accounted for $20.2 billion, or 37 percent of total Part B drug spending. Spending on the top 20 products accounted for $26.3 billion, or about 49 percent of total Part B drug spending.

(Chart continued next page)

Chart 10-3 Top 20 Part B drugs, 2023 (continued)

> The top 20 Part B drugs are concentrated in certain therapeutic areas. Eight of the top 20 drugs treat cancer, and one treats cancer side effects. The top 20 also include 4 products for macular degeneration and 4 products for arthritis, autoimmune disease, or inflammatory bowel disease.

> Sixteen of the top 20 Part B products are biologics. One product is a nonbiologic radiopharmaceutical (Pluvicto), and two products are vaccines (Prevnar 20 and Spikevax). Dual Layer Impax is a skin substitute that is considered to be human cells, tissues, or cellular and tissue-based product.

> Among the top 20 highest-expenditure Part B drugs in 2023, average total spending per user varied. Excluding Avastin (which has costs that vary substantially depending on whether it is used for cancer or macular degeneration), the remaining 7 drugs in the top 20 that treat cancer had average spending per user ranging from $14,000 to $134,000. Average spending per user ranged from $10,000 to $38,000 for four drugs used to treat arthritis, autoimmune disease, or inflammatory bowel disease, and from $6,000 to $12,000 for three drugs used to treat macular degeneration (excluding Avastin). Dual Layer Impax, a skin-substitute product, had the highest average spending per user among the top 20, at $279,000.

> Between 2022 and 2023, total spending increased for 12 of the top 20 Part B drugs, decreased for 6 drugs, and was unchanged for 2 drugs on a nominal basis (not adjusted for inflation). Three products experienced spending growth of more than 20 percent (Darzalex, Imfinzi, and Prevnar 20) and four products (Dual Layer Impax, Vabysmo, Pluvicto, and Spikevax) had substantial spending in 2023 after first receiving a billing code mid-2022 or 2023. Among the products that experienced spending decreases in 2022, the most substantial decreases occurred among four products with biosimilar competition (Rituxan, Avastin, Lucentis, and Remicade), ranging from 14 percent to 32 percent.

Chart 10-4 Growth in manufacturer prices for the 20 highest-expenditure Part B drugs, 2015–2025

	Average annual percentage change in average sales price 2015–2023	Percentage change in average sales price 2023–2024	Percentage change in average sales price 2024–2025
Keytruda	2.4%[c]	3.4%	3.4%
Eylea	–1.1	–4.0	–7.1
Darzalex	3.9[c]	4.7	5.9
Prolia/Xgeva	5.8	9.2	9.8
Opdivo	2.4[c]	3.6	3.9
Dual Layer Impax	N/A[d]	N/A[d]	–74.2
Vabysmo	N/A[e]	–4.2	–2.3
Orencia	3.5	–0.8	1.5
Rituxan[a]	1.5	–3.1	–3.1
Tecentriq	1.3[c]	5.2	3.8
Gammagard	1.9	–3.1	5.2
Imfinzi	1.4[c]	2.3	3.9
Entyvio	3.5[c]	1.7	–1.8
Ocrevus	0.9[c]	0.2	–1.6
Avastin[a]	0.5	4.7	–1.2
Prevnar 20[b,c]	7.2	1.7	3.2
Lucentis[a]	–6.2	–20.9	–33.9
Remicade[a]	–9.0	–7.7	–5.1
Pluvicto	N/A[f]	N/A[f]	N/A[f]
Spikevax[b]	N/A[g]	N/A[g]	10.8
Consumer Price Index for All Urban Consumers	**3.1**	**3.1**	**3.0**

Note: N/A (not available). Growth rates are calculated for average sales price (ASP) from first quarter to first quarter of each year and for the Consumer Price Index for All Urban Consumers (CPI–U) from January to January of each year. For products that launched after 2015, the table displays average annual ASP growth between the earliest year that a first-quarter payment rate was available for the product and 2023. ASP at the billing-code level is calculated using the publicly available Part B drug payment-rate data on CMS's website. Price growth is nominal, not adjusted for inflation.
[a] Indicates the product is an originator biologic that has experienced biosimilar entry. ASP trends are for the originator product only.
[b] For Prevnar 20 and Spikevax, preventive vaccines paid at 95 percent of the average wholesale price, the table displays the percentage change in the actual payment rate, not ASP.
[c] Product was not available over the full time period, so average annual growth was calculated over a shorter period: from 2016 to 2023 (Keytruda, Opdivo, Entyvio), 2017 to 2023 (Darzalex), 2018 to 2023 (Tecentriq, Ocrevus), 2020 to 2023 (Imfinzi), or 2022 to 2023 (Prevnar 20).
[d] Dual Layer Impax first received a billing code in January 2023 and first had a published payment rate in October 2023.
[e] Vabysmo first received a billing code in October 2022.
[f] Pluvicto is a radiopharmaceutical that first received a billing code in October 2022 and that is not paid based on ASP in the physician office setting.
[g] Spikevax first received a billing code and published payment rate in September 2023.

Source: MedPAC analysis of CMS ASP payment-rate files publicly available on the CMS website, CPI–U data from the Bureau of Labor Statistics, and MedPAC and Acumen LLC analysis of Medicare claims data.

(Chart continued next page)

Chart 10-4 Growth in manufacturer prices for the 20 highest-expenditure Part B drugs, 2015–2025 (continued)

> Medicare pays for most Part B drugs at a rate of 106 percent of the average sales price. ASP is the average price realized by the manufacturer for sales to most U.S. purchasers, net of rebates, discounts, and price concessions, with certain exceptions. For biologics, biosimilars, and brand-name drugs with no generic competitors, Medicare Part B pays each product an ASP-based rate under the product's own billing code, essentially paying whatever price the manufacturer establishes. For brand drugs with generic competitors, Medicare Part B assigns both the brand product and its generic equivalents to the same billing code and pays 106 percent of a volume-weighted ASP.

> Beginning January 1, 2023, manufacturers of Part B single-source drugs, biologics, and biosimilars are required to pay Medicare a quarterly rebate if their product's ASP grows faster than inflation. Beginning April 2023, beneficiary cost sharing for products that incur a rebate is based on the lower, inflation-adjusted ASP. Certain types of products are excluded from the policy (e.g., low-cost drugs, preventive vaccines, drugs experiencing a shortage or supply-chain disruption, and biosimilars meeting certain criteria). Whether a product incurs an inflation rebate is determined based on cumulative growth in the payment rate between a base period (generally from July 1, 2021) and a given quarter and how that compares to growth in the CPI–U over a specified period. Data on trends in ASP and CPI–U in this chart do not replicate the CMS rebate calculation.

> In the most recent year, among the top 20 highest-expenditure drugs, 10 products experienced a price increase on a nominal basis, with 9 of those products' prices increasing faster than the CPI–U between January 2024 and 2025.

> Between January 2024 and 2025, Spikevax (a COVID-19 vaccine) and Prolia/Xgeva (a product for osteoporosis and cancer side effects) experienced the largest price growth, 11 percent and 10 percent, respectively. Between the second quarter of 2023 and the first quarter of 2025, Prolia/Xgeva was the only product among the top 20 to have reduced beneficiary cost sharing as a result of the ASP inflation rebate (data not shown).

> Between January 2024 and 2025, 9 of the top 20 products experienced a price decrease. Some of the price declines occurred among originator biologics facing biosimilar competition. Rituxan, Avastin, Lucentis, and Remicade all have biosimilar competitors. Prices for these originator biologics declined by 1 percent to 34 percent between 2024 and 2025.

Chart 10-5 Top 10 Part B therapeutic classes of drugs, 2023

	Total Medicare payments in 2023 (in billions)	Percentage change in total Medicare payments 2022–2023
Antineoplastics	$20.2	9%
Ophthalmic agents	5.3	11
Skin substitutes	4.4	184
Endocrine agents	4.3	9
Hematological agents	3.4	–2
Analgesics, anti-inflammatories, or antipyretics	2.8	–2
Immune globulin agents	2.5	11
Vaccines	2.5	74
Respiratory therapy agents	1.6	5
Neuromuscular and musculoskeletal therapy agents	1.4	3

Note: Therapeutic classes are ranked in order of 2023 total fee-for-service (FFS) Medicare spending. This analysis includes Part B drugs paid based on the average sales price as well as the small group of Part B drugs that are paid based on other methods. Drug spending includes Medicare program payments and beneficiary cost sharing. "Vaccines" includes both preventive vaccines (e.g., influenza) and other vaccines when used to treat an injury or direct exposure to a disease (e.g., hepatitis A). Dollar amounts are nominal, not adjusted for inflation.

Source: MedPAC analysis of Medicare claims data for physicians, hospital outpatient departments, and suppliers.

> In 2023, 10 drug therapeutic classes accounted for roughly 90 percent of total FFS Medicare spending for Part B drugs (calculation based on total Part B spending of $54.0 billion reported in Chart 10-1).

> Total spending by therapeutic class was somewhat concentrated. In 2023, antineoplastics (products used to treat cancer) accounted for 37 percent, and the top three classes—antineoplastics, ophthalmic agents, and skin substitutes—accounted for 56 percent of total Medicare spending.

> Between 2022 and 2023, the growth in total spending for four therapeutic classes—ophthalmic agents, skin substitutes, immune globulin agents, and vaccines—exceeded the average annual growth across all Part B products (which averaged 9.7 percent during this period on a nominal basis (shown in Chart 10-1)).

> Between 2022 and 2023, total spending for vaccines grew by 74 percent, largely due to the growth in payment for COVID-19 vaccines. Prior to 2023, COVID-19 vaccines were purchased directly by the federal government rather than purchased by providers and reimbursed by Medicare Part B.

> Total spending on separately payable skin substitutes has been growing rapidly. Between 2022 and 2023, Medicare spending on skin substitutes grew by 184 percent, from $1.6 billion (not shown) to $4.4 billion. This therapeutic class increased in rank by total Medicare spending from 10th in 2021, 7th in 2022, and 3rd in 2023. Preliminary claims data for calendar year 2024 (claims processed through week 20 of 2025) indicate that spending on skin substitutes was nearly $10.2 billion that year, more than double the prior year's level (see Chart 10-6) and that this therapeutic class ranked second in total 2024 spending (data not shown).

Chart 10-6 Change in spending for skin-substitute products, 2023–2024

	2024			2023		
	Total spending (billions)	Number of users	Average spending per user	Total spending (billions)	Number of users	Average spending per user
All skin-substitute products	$10.2	N/A	N/A	$4.4	N/A	N/A
Top 10 skin-substitute products, 2024						
Membrane Graft or Wrap	$1.5	10,500	$139,000	$0.3	3,200	$107,000
Complete FT	1.2	5,100	229,000	0.01	20	364,000
Esano ACA	0.9	1,900	493,000	*	*	*
Restorigin	0.7	5,300	140,000	0.002	40	56,000
Helicoll	0.6	2,400	266,000	0.1	600	93,000
Impax Dual Layer Membrane	0.3	1,700	190,000	1.4	5,100	279,000
Membrane Wrap-Hydro	0.3	1,800	173,000	N/A	N/A	N/A
AmnioCore Pro+	0.3	1,500	195,000	N/A	N/A	N/A
Neostim TL Membrane	0.3	1,200	230,000	N/A	N/A	N/A
Amnio Quad-core	0.3	1,400	179,000	N/A	N/A	N/A

Note: N/A (not available). Drug spending includes Medicare program payments and beneficiary cost sharing. Spending and utilization estimates for 2023 are based on claims with a 2023 date of service processed through week 26 of 2024. Spending and utilization estimates for 2024 are preliminary, based on claims with a 2024 date of service processed through week 20 of 2025. Yearly figures presented in the chart are rounded, but data for average spending per user were calculated using unrounded data. Per CMS, skin-substitute products include non-autologous human cellular or tissue products, nonhuman cellular and tissue products, or biological products that are used to treat chronic wounds (Centers for Medicare & Medicaid Services. 2024. LCD—Skin substitute grafts/cellular and tissue-based products for the treatment of diabetic foot ulcers and venous leg ulcers (L39828). Baltimore, MD: CMS.). Dollar amounts are nominal, not adjusted for inflation.
* Medicare use and spending data cannot be reported for Esano ACA in 2023 because the value is based on fewer than 11 observations in that year.

Source: MedPAC analysis of Medicare claims data for physicians, hospital outpatient departments, and suppliers.

> According to CMS, skin-substitute products are a heterogeneous group that includes non-autologous human cellular or tissue products, nonhuman cellular and tissue products, or biological products that are used to treat chronic wounds (e.g., venous leg ulcer and diabetic foot ulcers).

> Under the physician fee schedule, skin-substitute products are generally paid average sales price (ASP) + 6 percent. Under the outpatient prospective payment system, payment for skin-substitute products that do not qualify for pass-through status are packaged into the payment for the associated skin-substitute application procedure into two groups: (1) high-cost skin-substitute products and (2) low-cost skin-substitute products. The above spending data do not reflect skin-substitute products paid as part of larger payment bundles (i.e., skin-substitute products furnished by hospital outpatient departments that are packaged into payment with other services and products).

> Spending on skin-substitute products is growing rapidly. Between 2021 and 2024, total spending increased in aggregate by 890 percent from $1.0 billion to $10.2 billion on a nominal basis (not all data shown). Most recently, spending on skin-substitute products increased by 130 percent from $4.4 billion in 2023 to $10.2 billion in 2024. In 2024, skin-substitute products accounted for 16 percent of all Part B drug spending (data not shown).

(Chart continued next page)

Chart 10-6 Change in spending for skin-substitute products, 2023–2024 (continued)

> Spending on skin-substitute products per user is also substantial and growing. In 2024, average spending per user for the top 10 products ranged from $139,000 to $493,000, and average cost-sharing liability per user ranged from $28,000 to $100,000 (data not shown). By comparison, in 2023, average spending per user for these products ranged from $56,000 to $364,000, and average cost sharing per user ranged from $11,000 to $74,000 (data not shown).

> Adoption of some skin-substitute products by providers has occurred rapidly. For example, between 2023 and 2024 the number of users grew from about 20 beneficiaries to 5,100 beneficiaries for Complete FT and from about 40 beneficiaries to 5,300 beneficiaries for Restorigin.

> Use of and spending on skin-substitute products is shifting over time. For example, in 2023, the three leading products as measured by total spending were Impax Dual Layer Membrane ($1.4 billion), Carepatch ($0.5 billion), and Woundfix ($0.4 billion) (Carepatch and Woundfix data not shown). By contrast, total spending in 2024 declined for each product, to $0.3 million for Impax Dual Layer Membrane (ranked 6th in total spending), $0.1 billion for Carepatch (ranked 25th in total spending), and $0.01 billion for Woundfix (ranked 64th in total spending). Between 2023 and 2024, both the price and use of these three products declined. Between October 2023 and 2024, the ASP payment rate declined by 69 percent for Impax Dual Layer Membrane, 56 percent for Carepatch, and 52 percent for Woundfix while the annual number of beneficiaries furnished each product in 2023 and 2024 declined by 67 percent, 73 percent, and 95 percent, respectively (data not shown).

> The increase in spending on skin-substitute products is associated with an increase in unique billing codes—Healthcare Common Procedure Coding System Level II coding request applications—for newly developed skin-substitute products. The number of skin-substitute products (as identified by a unique billing code in Medicare claims data) increased from 93 in 2021 to 101 in 2022, 113 in 2023, and 138 in 2024 (data not shown).

Chart 10-7 Trends in Medicare Part B payment rates for originator biologics and their biosimilar products

	First biosimilar entry	Percentage change in originator biologic's payment rate		Biosimilar's payment rate as a percentage of originator biologic's payment rate (2025 Q1)	Biosimilar market share (2024 Q3)
		In 10 years before biosimilar entry	Since biosimilar entry (through 2025 Q1)		
Neupogen and biosimilars	2015 Q3	71%	–1%	29%–46%	88%
Remicade and biosimilars	2016 Q4	54	–63	38–86	27
Neulasta and biosimilars	2018 Q3	117	–95	124–1,493	58
Procrit/Epogen and biosimilars	2018 Q4	35	–47	10–116	47
Avastin and biosimilars	2019 Q3	42	–10	31–71	85
Herceptin and biosimilars	2019 Q3	69	–28	25–93	80
Rituxan and biosimilars	2019 Q4	68	–19	31–48	65
Lucentis and biosimilars	2022 Q3	–31	–55	136	60
Actemra and biosimilars	2024 Q2	63	–1	69–101	N/A

Note: Q1 (first quarter), Q3 (third quarter), Q4 (fourth quarter), Q2 (second quarter), N/A (not available). An originator biologic is a drug product derived from a living organism. A biosimilar product is a follow-on product that is approved by the Food and Drug Administration (FDA) based on the product being highly similar to the originator biologic. The biosimilars included in the analysis are Granix, Nivestym, Releuko, and Zarxio for originator Neupogen; Inflectra, Renflexis, and Avsola for originator Remicade; Fulphila, Fylnetra, Nyvepria, Stimufend, Udenyca, and Ziextenzo for originator Neulasta; Retacrit for originator Procrit/Epogen; Alymsys, Mvasi, Vegzelma, and Zirabev for originator Avastin; Ontruzant, Herzuma, Ogivri, Trazimera, and Kanjinti for originator Herceptin; Truxima, Ruxience, and Riabni for originator Rituxan; Byooviz and Cimerli for originator Lucentis; and Tyenne and Tofidence for Actemra. Although Granix is not a biosimilar in the U.S. (because it was approved under the standard FDA approval process for new biologics), we include it here because it was approved as a biosimilar to Neupogen in Europe and it functions as a competitor to Neupogen in the U.S. market. "First biosimilar entry" reflects the earliest market date for a product approved by the FDA as a biosimilar to the originator biologic. Growth in payment rates is nominal, not adjusted for inflation.

Source: MedPAC analysis of average sales price (ASP) payment-rate files publicly available on the CMS website and product market date information from CMS's database on drug products in the Medicaid Drug Rebate Program and Acumen LLC analysis of Medicare claims data.

> Under Part B, Medicare pays for an originator biologic at 106 percent of its own ASP. For biosimilars, Medicare pays 100 percent of the biosimilar's ASP + 6 percent or 8 percent of the originator product's ASP. Per the Inflation Reduction Act of 2022, for five years beginning October 2022, existing biosimilars and new biosimilars receive an 8 percent add-on as long as the biosimilar's ASP does not exceed the originator's ASP.

(Chart continued next page)

Chart 10-7 Trends in Medicare Part B payment rates for originator biologics and their biosimilar products (continued)

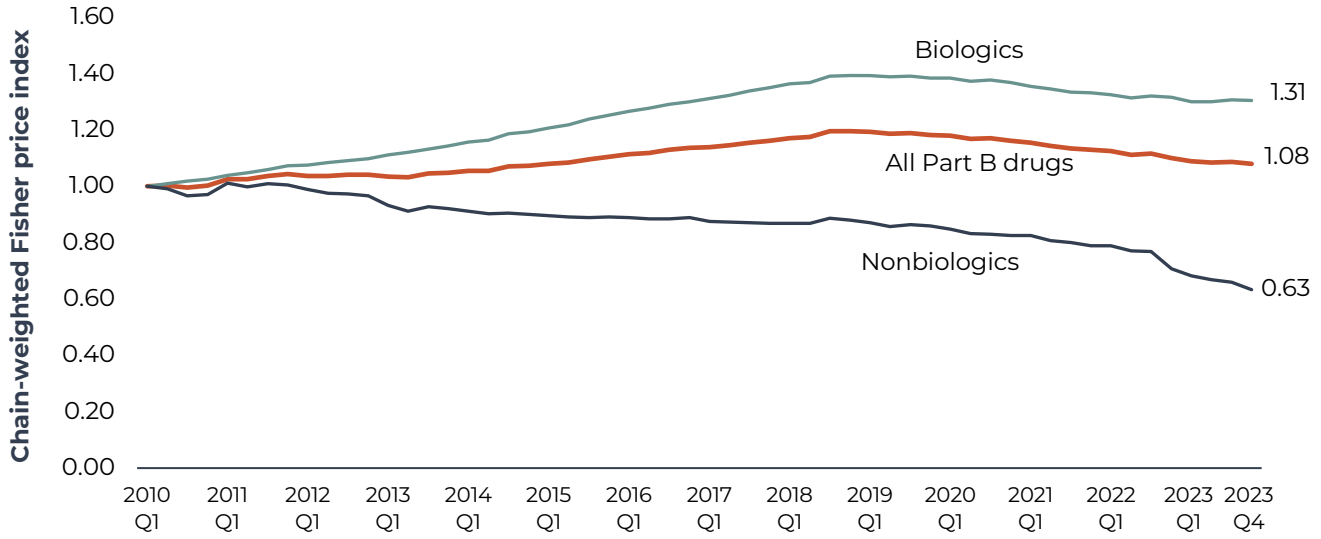
> Biosimilar entry has generated savings for Medicare. For the eight biologics that had biosimilars on the market in 2023, Medicare spending on Part B originator biologics and their biosimilars declined on a nominal basis by about 24 percent, from $4.3 billion in 2022 to $3.3. billion in 2023 (data not shown). Pricing patterns and biosimilar uptake vary across products.

> For some products, biosimilars are priced substantially below originators, and biosimilar uptake has driven savings. For example, lower-price biosimilars now account for 80 percent or more of the market share for Neupogen, Avastin, and Herceptin and 65 percent of the market share for Rituxan. These four originator products have reduced their prices only minimally or modestly (1 percent, 10 percent, 28 percent, and 19 percent, respectively) since biosimilar entry. Each of these products had at least one biosimilar on the market with a Medicare payment that was roughly 70 percent or 75 percent below the originator's payment rate.

> In a few cases, originator biologics have reduced their prices by more than 50 percent in response to biosimilar entry. Originator Remicade's payment rate has declined 63 percent, and originator Neulasta's payment rate has declined 95 percent since biosimilar entry. As of the first quarter of 2025, Remicade had some biosimilar competitors on the market that were priced lower (as much as 62 percent below the originator's payment rate). In contrast, originator Neulasta had a lower Medicare payment rate than all of its biosimilar competitors as of the first quarter of 2025. Originator Remicade continues to retain the majority of market share as of the third quarter of 2025.

> Although biosimilar competition has resulted in reduced prices for originator biologics relative to the products' prices at the time of biosimilar entry, nearly all of these originator biologics experienced substantial price increases prior to biosimilar entry. With the exception of Lucentis, the originator biologics' cumulative growth in payment rates over the 10 years prior to biosimilar entry ranged from 35 percent to 117 percent. In contrast, Lucentis's payment rate declined 31 percent in the 10 years before biosimilar entry.

Chart 10-8 Postlaunch price indexes for Medicare Part B drugs, 2010–2023



Note: Q1 (first quarter), Q4 (fourth quarter). The indexes are Fisher price indexes and reflect postlaunch price growth for individual Part B–covered drug products, measured in nominal terms (not adjusted for inflation). A product is defined as a Part B drug billing code (referred to as a Healthcare Common Procedure Coding System billing code). Each Part B single-source drug, biologic, and biosimilar receives its own Part B drug billing code, while brand drugs with generic competitors are grouped together in the same billing code. The price index is different from the change in the aggregate average annual payment per Part B drug (Chart 10-2), which reflects changes in the prices of existing products, rising launch prices of new products, and shifts in utilization across products.

Source: Acumen LLC analysis for MedPAC.

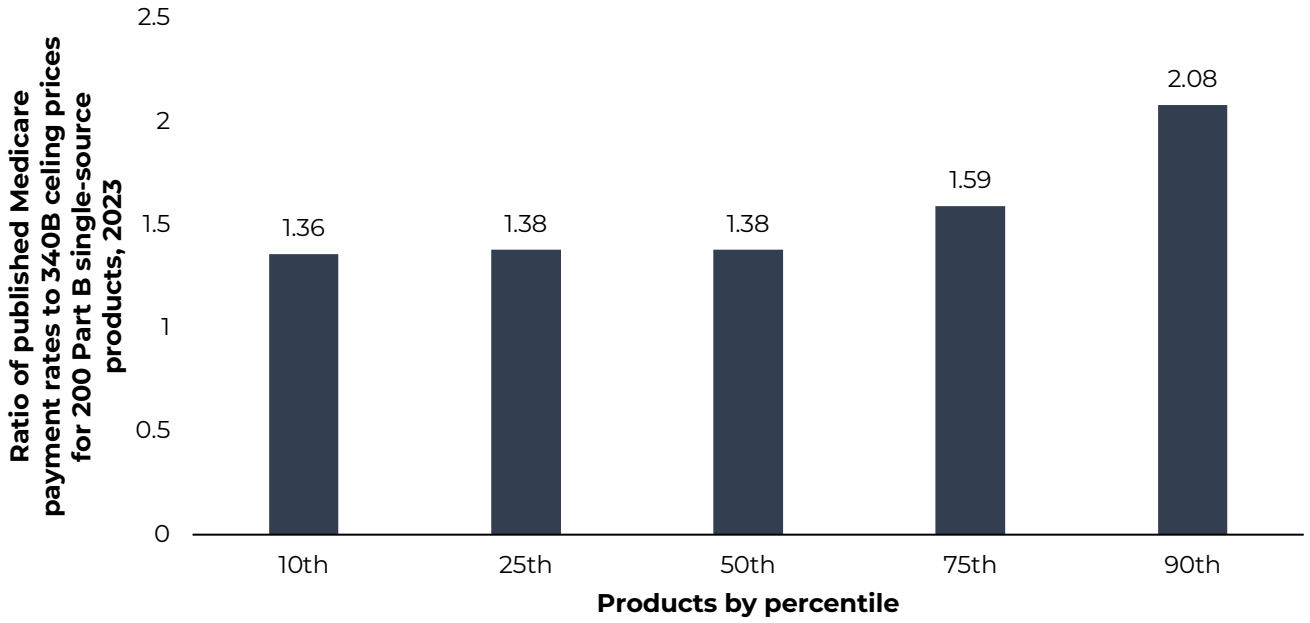
> The Part B price indexes reflect growth in the Medicare payment rate (generally the average sales price (ASP) + 6 percent) at the individual product level, which is a measure of average postlaunch price growth for Part B drugs. The price index is different from the change in the aggregate average annual payment per Part B drug (see Chart 10-2), which grew more than 7.5 percent per year on average between 2009 and 2023 and reflects a broader set of dynamics (including changes in the price of existing products, rising launch prices of new products compared with older products, and shifts in utilization across products).

> Measured by the change in the ASP of individual Part B–covered drugs, the prices of Part B–covered drugs rose by an average of 8 percent cumulatively between 2010 and 2023 (index of 1.08) on a nominal basis. Since the third quarter of 2019 through the end of 2023, the overall price index for Part B drugs has declined from 1.19 to 1.08, driven by a decline in the nonbiologics' price index, coupled with the continued decline in the biologics' price index.

> The price index for biologics increased cumulatively by 31 percent (index of 1.31) between 2010 and 2023, reaching a high of just over 1.38 in the third quarter of 2018 and the first quarter of 2020 and declining to 1.31 by the fourth quarter of 2023. Pricing trends differ for biologics that face biosimilar competition and biologics that do not. Between the first quarter of 2020 and the fourth quarter of 2023, the price index declined for biologics with recent biosimilar entry by about 42 percent and increased for biologics without biosimilar competition by about 6 percent (data not shown).

> The price index for nonbiologics declined 37 percent (index of 0.63) between 2010 and 2023, which in part reflects patent expiration and generic entry for some of these products. The design of the ASP payment system spurs price competition among generics and their associated brand products by paying them the same rate under a combined billing code.

Chart 10-9 Comparisons of Medicare payment rates and 340B ceiling prices for Part B single-source products, 2023



Note: Medicare payment rates reflect published presequester payment rates (which include the Medicare program payment and beneficiary cost sharing) posted on CMS's website. Ceiling prices in the 340B program are MedPAC estimates based on analysis of data from the Medicaid rebate program. For each Part B drug billing code (which we refer to as "product"), the ratio of the Medicare payment rate to 340B ceiling price reflects the median ratio across the four quarters of 2023. First, we estimate 340B ceiling prices at the national drug code (NDC) level. Next, to estimate the average 340B ceiling price for each Part B drug billing code, we weight the 340B ceiling prices for each NDC associated with a given billing code by the manufacturer's reported market-wide utilization for the NDC (which is reported as part of the manufacturer's submission of average sales price data to CMS and includes Medicare and non-Medicare use of the NDC). All data for this analysis are aggregated to ensure confidentiality. Estimates are for 200 single-source drugs, biologics, or biosimilars billed by 340B hospitals under Medicare Part B and exclude drugs with generic competition. Estimates include outpatient prospective payment system (OPPS) hospitals that bill Medicare Part B for drugs acquired under the 340B program. We exclude hospitals paid under alternate payment systems (e.g., critical access hospitals, cancer hospitals, Indian Health Service hospitals, and Maryland hospitals). The 200 Part B single-source products were identified by focusing on Part B single-source products with at least $2 million in Part B OPPS payments (Medicare program payments and beneficiary cost sharing) for drugs acquired under the 340B program in 2023 and for which we were able to estimate 340B ceiling prices. Estimates do not reflect subceiling discounts, if any.

Source: MedPAC analysis of Medicare claims data, Part B drug payment-rate files, manufacturer-reported average sales price (ASP) and associated data, and Medicaid Drug Rebate Program data.

> Under the 340B Drug Pricing Program, nonprofit hospitals with high shares of Medicaid and low-income Medicare patients who participate in the program receive substantial discounts on outpatient drugs. Fee-for-service Medicare pays all providers the same rate for Part B drugs (generally the ASP + 6 percent), including 340B hospitals that acquire drugs at substantial discounts.

> Drug manufacturers are required to sell outpatient drugs to 340B hospitals for discounted prices that are no higher than the 340B ceiling price. The 340B ceiling price is the drug's average manufacturer price (AMP) less a unit rebate amount. For brand drugs, the unit rebate is the greater of 23.1 percent of AMP or the difference between AMP and best price, plus an additional inflation rebate if the product's price rises faster than inflation.

(Chart continued next page)

Chart 10-9 Comparisons of Medicare payment rates and 340B ceiling prices for Part B single-source products, 2023 (continued)

> To provide a sense of how Medicare payment rates compare to costs for 340B-purchased drugs, we estimated 340B ceiling prices for 200 Part B–covered single-source drugs, biologics, and biosimilars. These 200 single-source products accounted for 97 percent of Medicare spending on separately payable Part B drugs acquired under the 340B program by OPPS hospitals in 2023.

> Across the 200 single-source Part B products, Medicare payments exceeded the 340B ceiling price by 38 percent for the median product in 2023. The Medicare payment rate exceeded the 340B ceiling price by between 38 percent and 59 percent for half of products (25th percentile to 75th percentile), and by 108 percent or more for 10 percent of products (90th percentile).

> In 2023, Medicare and beneficiaries paid $13.8 billion for the 200 Part B–covered single-source products acquired under the 340B program by OPPS hospitals, while the estimated cost of these products at 340B ceiling prices was $9.5 billion (data not shown). Thus, aggregate payments exceeded 340B ceiling prices by an estimated 45 percent ($4.3 billion) in 2023. Ceiling-price costs equated to approximately ASP – 27 percent for the 200 single-source products in aggregate that year.

> The results of our analysis comparing the 2023 Medicare payment rate and 340B ceiling price at the billing-code level are similar to results from our 2022 analysis (data not shown). For example, in 2022, across 185 single-source products, we find that (1) for the median product, the Medicare payment rate exceeded the 340B ceiling price by 38 percent; (2) for half of products, the Medicare payment rate exceeded the ceiling price by 38 percent to 60 percent (25th percentile to 75th percentile); and (3) 10 percent of products had a Medicare payment rate at least 145 percent above the 340B ceiling price (90th percentile). We estimate that in 2022 aggregate payments exceeded 340B ceiling prices by an estimated 48 percent ($3.8 billion).

> Drug manufacturers can choose to sell products to 340B entities for prices lower than 340B ceiling prices (referred to as “subceiling prices”). Data are not available to determine the frequency of covered entities obtaining subceiling prices and the magnitude of subceiling prices. If 340B providers receive subceiling discounts for some products, discounts could be larger than we estimated.

Chart 10-10 Part D enrollment by plan type, 2015–2024

	2015	2023	2024	Average annual growth rate 2015–2024
Total Medicare enrollment, in millions	55.6	66.7	68.0	2.3%
Part D enrollment, in millions				
Part D plans	39.2	51.5	54.1	3.6
Non-Medicare employer plans under the RDS*	2.3	0.9	0.8	–11.1
Total Part D	41.5	52.4	54.9	3.1
Share of Medicare enrollees with Part D	*75%*	*79%*	*81%*	
LIS enrollment				
PDPs	8.0	5.2	4.7	–5.8
MA–PDs	3.7	8.6	9.3	10.8
Total LIS	11.7	13.8	14.0	2.0
Share of LIS enrollees in MA–PDs	*32%*	*58%*	*67%*	
Share of Part D plan enrollees with LIS	*30%*	*27%*	*26%*	
EGWPs (PDPs and MA–PDs), in millions	6.6	7.7	8.9	3.4
EGWP share of total Part D enrollment	*17%*	*15%*	*17%*	
Non-EGWP Part D plans, in millions				
PDPs	19.3	18.4	18.1	–0.7
MA–PDs	13.4	25.4	27.1	8.1
Share of non-EGWP plan enrollees in MA–PDs	*41%*	*58%*	*60%*	

Note: RDS (retiree drug subsidy), LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), EGWP (employer group waiver plan). A beneficiary was classified as "LIS" if that individual received Part D's LIS in the month used for the analysis; similarly, while a beneficiary may be enrolled in both a PDP and an MA–PD during the year, that individual was classified into the type of plan in which they were enrolled during the month analyzed. Not all components sum to their respective totals due to rounding. The average annual growth rate is calculated on unrounded numbers. Enrollment counts exclude enrollees in U.S. territories.
* Excludes federal government and military retirees covered by either the Federal Employees Health Benefit Program or the TRICARE for Life program.

Source: MedPAC analysis of monthly Medicare enrollment files from CMS and the 2024 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2024, 81 percent of Medicare beneficiaries were enrolled in Part D plans in the month analyzed or had prescription drug coverage through employer-sponsored plans that received Medicare's RDS. That share is up from 75 percent in 2015. (The RDS is a tax-free subsidy paid to an employer who remains the primary payer of their retirees' creditable drug coverage when the enrollees' drug costs fall within a specified range of spending.)

> Between 2015 and 2024, the number of enrollees receiving the LIS grew modestly (2 percent per year, on average) compared with the number of non-LIS enrollees (about 4.3 percent per year, on average; data not shown). Faster enrollment growth among non-LIS enrollees has resulted in a decline in the share of Part D enrollees who receive the LIS. In 2024, 26 percent of Part D enrollees received the LIS, a decrease from 30 percent in 2015. Two-thirds of LIS beneficiaries were in MA–PDs.

> Employer and union health plans continue to be important sources of drug coverage for Medicare beneficiaries under Part D. In 2024, 8.9 million Medicare beneficiaries (17 percent of Part D plan enrollees) were in plans (including PDPs and MA–PDs) set up by employers or unions for their retirees. Under these EGWPs, Medicare is the primary payer for basic drug benefits, and typically the employer offers wraparound coverage.

> In 2024, among non-EGWP plans, 27.1 million enrollees (60 percent) were in MA–PDs and 18.1 million enrollees (40 percent) were in stand-alone PDPs. Over the 2015 to 2024 period, enrollment in PDPs declined slightly, while enrollment in MA–PDs rose by an annual average of 8.1 percent.

Chart 10-11 Characteristics of Part D plan enrollees, 2023

	All Medicare	Part D plans	Plan type		Subsidy status	
			PDP	MA–PD	LIS	Non-LIS
Beneficiaries* (in millions)	69.6	54.6	23.8	30.8	15.3	39.2
Percent of all Medicare	100%	78%	34%	44%	22%	56%
Gender						
Male	46%	44%	43%	44%	41%	44%
Female	54	56	57	56	58	56
Race/ethnicity						
White, non-Hispanic	72	72	80	66	52	80
Black, non-Hispanic	11	11	7	14	20	7
Hispanic	9	9	5	12	17	6
Asian	4	4	3	4	7	3
Other	4	4	4	4	5	4
Age (years)**						
<65	13	14	12	15	34	5
65–69	27	25	24	26	23	26
70–74	23	23	23	23	16	26
75–79	17	17	18	17	11	20
80+	20	21	23	19	17	23

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). Components may not sum to totals due to rounding.
* Figures for "All Medicare" and "Part D plans" include all beneficiaries with at least one month of enrollment in the respective program. A beneficiary was classified as "LIS" if that individual received Part D's LIS at some point during the year. For individuals who switched plan types during the year, classification into plan types was based on the greater number of enrollment months.
** Age as of July 2023.

Source: MedPAC analysis of the Common Medicare Environment file from CMS.

> In 2023, 54.6 million Medicare beneficiaries (78 percent) were enrolled in Part D plans at some point in the year. Less than half (23.8 million) were enrolled in stand-alone PDPs, and the rest were enrolled in MA–PDs (30.8 million). Just over 15 million enrollees received Part D's LIS.

> Demographic characteristics of Part D enrollees are generally similar to the overall Medicare population, though Part D enrollees are more likely to be female and less likely to fall in the 65–69 age bracket. MA–PD enrollees are more likely to be Hispanic or Black than PDP enrollees are; LIS enrollees are more likely to be female, non-White, and under age 65 (eligible for Medicare due to disability) compared with non-LIS enrollees.

Chart 10-12 Changes over time in the parameters of the Part D defined standard benefit, 2016–2025

	2016	2024	2025	Average annual change 2016–2025
Deductible	$360	$545	$590	5.6%
Initial coverage limit	3,310	5,030	N/A	N/A
Annual out-of-pocket threshold	4,850	8,000	2,000	–9.4
Total covered drug spending at annual out-of-pocket threshold:				
Enrollees eligible for manufacturers' coverage-gap discount	7,515	12,447	$6,230	–2.1
Other enrollees	7,063	11,477	$6,230	N/A
Cost sharing for LIS beneficiaries:				
Copay for generic/preferred multisource drugs	2.95	4.50	4.90	5.8
Copay for other prescription drugs	7.40	11.20	12.15	5.7

Note: LIS (low-income subsidy), N/A (not applicable). In 2025, under Part D's defined standard benefit, the enrollee pays the deductible and then 25 percent of covered drug spending until total covered drug spending reaches the out-of-pocket (OOP) coverage limit. The amounts shown of total covered drug spending at the spending thresholds are for individuals who have no source of supplemental coverage and an average mix of brand and generic spending. Cost sharing paid by most sources of supplemental coverage did not count toward these thresholds before 2025, but starting this year, the value of plans' supplemental coverage does count toward enrollees' OOP limit. Above the OOP limit, prior to 2024, non-LIS enrollees paid 5 percent coinsurance or copay amounts set in law, whichever was greater. As of 2025, the standard benefit has been redesigned such that there are now fewer benefit phases and a single coverage limit—the OOP cap—above the deductible. Dollar amounts are nominal figures, not adjusted for inflation.

Source: CMS Office of the Actuary.

> In 2025, Part D's defined standard benefit was redesigned, with two key changes for beneficiaries: the elimination of the coverage gap and the application of an OOP cap, such that beneficiaries now have a single benefit phase after the deductible and are no longer responsible for any cost sharing after reaching the catastrophic threshold. This year, the standard benefit has a $590 deductible, and enrollees pay 25 percent coinsurance on covered drugs until they reach the $2,000 threshold in annual OOP spending. (The total dollar amount of drug spending at which a beneficiary reaches the OOP threshold varies from person to person, depending on the mix of brand-name and generic prescriptions filled and whether they have supplemental coverage. CMS estimates that in 2025, a person who does not receive Part D's LIS and has no supplemental coverage would, on average, reach the threshold at $6,230 in total drug spending.) Beneficiaries who do not receive the LIS are eligible for a 10 percent manufacturers' discount on brand prescriptions in the initial coverage phase. Enrollees with drug spending that exceeds the annual OOP threshold no longer pay any cost sharing in the catastrophic phase. Manufacturers now must pay 20 percent of costs for brand-name drugs and biologics in the catastrophic phase, and Medicare pays 20 percent for such products and 40 percent for generics. Plan sponsors are now responsible for the remaining 60 percent. CMS updates most parameters of this defined standard benefit structure each year by the annual change in average total drug expenses of Medicare beneficiaries enrolled in Part D. (See MedPAC's March report 2025 for more details.)

> Within certain limits, sponsors may offer Part D plans that have the same actuarial value as the defined standard benefit but a different benefit structure. For example, a plan may use tiered copayments rather than 25 percent coinsurance or have no deductible but use cost-sharing requirements that are equivalent to a rate higher than 25 percent (see Chart 10-18). Defined standard benefit plans and plans that are actuarially equivalent to the defined standard benefit are both known as "basic benefits." Once a sponsoring organization offers one plan with basic benefits within a prescription drug plan region, it may also offer up to two plans with enhanced benefits—basic and supplemental coverage combined.

Chart 10-13 Characteristics of stand-alone Medicare PDPs, 2024–2025

	2024				2025			
	Plans		Enrollees as of February 2024		Plans		Enrollees as of February 2025	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	709	100%	18.1	100%	464	100%	18.2	100%
Type of plan								
Benchmark	126	18	4.7	26	90	19	5.7	31
Nonbenchmark	583	82	13.4	74	374	81	12.5	69
Type of benefit								
Defined standard	0	0	0.0	0	0	0	0.0	0
Actuarially equivalent	266	38	7.0	39	196	42	7.8	43
Enhanced	443	62	11.0	61	268	58	10.5	57
Type of deductible								
Zero	103	15	2.3	13	79	17	2.8	16
Reduced	200	28	3.6	20	76	16	1.4	8
Defined standard*	406	57	12.2	67	309	67	14.0	77
Some formulary tiers not subject to a deductible	360	51	9.0	50	197	42	7.8	43

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer-only plans and plans offered in U.S. territories. "Actuarially equivalent" includes both actuarially equivalent standard and basic alternative benefits. "Enhanced" refers to plans with basic plus supplemental coverage. Not all components sum to their respective totals or to 100 percent due to rounding.
* The deductible for the defined standard benefit was $545 in 2024 and is $590 in 2025. The count of plans for 2024 includes some that have been sanctioned and terminated by CMS, making them no longer eligible for new enrollment or LIS auto-enrollment. Terminated plans have been excluded from the plan count in 2025.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

> Plan sponsors are offering 464 stand-alone PDPs to fee-for-service enrollees in 2025 compared with 709 in 2024—a decrease of 35 percent. Total enrollment in PDPs increased slightly to 18.2 million beneficiaries in 2025 from 18.1 million in 2024, though PDP enrollment as a share of all Part D enrollment fell 1 percentage point to 42 percent as enrollment continues to shift to MA–PDs (see Chart 10-10).

> For 2025, 58 percent of PDP offerings include enhanced benefits (basic plus supplemental coverage); this share had been between 60 percent and 62 percent since 2019 (2019 data not shown). The share of PDP enrollees in enhanced plans similarly fell from 61 percent in 2024 to 57 percent in 2025.

> In 2025, the share of enrollees in plans with either no or a reduced deductible fell to 23 percent, down from 33 percent in 2024, as the share of plans (and enrollees in such plans) with a defined standard benefit increased from 67 percent to 77 percent. Similarly, in 2025, the share of plans designating certain formulary tiers not subject to the deductible fell from 51 percent in 2024 to 42 percent in 2025. If, for example, a PDP used such a designation for preferred generic drugs, an enrollee would pay just the plan's cost sharing for that tier rather than the full cost of the prescription up to the amount of the deductible. In 2025, 43 percent of PDP enrollees were in such plans, down from 63 percent in 2022 (latter data not shown).

Chart 10-14 Characteristics of conventional MA–PDs, 2024–2025

	2024				2025			
	Plans		Enrollees as of February 2024		Plans		Enrollees as of February 2025	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	3,507	100%	19.7	100%	3,246	100%	20.2	100%
Type of plan								
Local HMO	1,998	57	11.8	60	1,846	57	12.2	60
Local PPO	1,467	42	7.6	39	1,363	42	8.0	39
PFFS	14	0	0.0	0	12	0	0.0	0
Regional PPO	32	1	0.3	1	25	1	0.1	1
Type of drug benefit								
Defined standard	18	1	0.0	<0.5	27	1	0.1	<0.5
Actuarially equivalent	54	2	0.1	1	29	1	0.1	1
Enhanced	3,439	98	19.5	99	3,190	98	20.0	99
Type of drug deductible								
Zero	2,300	66	15.2	77	1,183	36	7.9	39
Reduced	1,017	29	4.0	20	1,362	42	9.9	49
Defined standard*	194	4	0.5	3	701	22	2.4	12
Some formulary tiers not subject to a deductible	1,161	33	4.4	22	2,027	62	12.2	61

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service). The MA–PDs and enrollment described here exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, special-needs plans, and Part B–only plans. Components may not sum to totals due to rounding. "Actuarially equivalent" includes both actuarially equivalent standard and basic alternative benefits. "Enhanced" refers to plans with basic plus supplemental coverage.
* The defined standard benefit's deductible was $545 in 2024 and is $590 in 2025.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

> Sponsors are offering 3,246 conventional MA–PDs in 2025 compared with 3,507 in 2024 (7.5 percent fewer plans). The vast majority of MA plans combine medical benefits with prescription drug benefits under Part D. Despite the reduction in the number of plans, enrollment in MA–PDs grew 2.8 percent from 19.7 million in 2024 to 20.2 million in 2025.

> For the second year in a row, the number of MA–PD plans offered as HMOs decreased modestly from 1,998 in 2024 to 1,846 in 2025, though HMO plans remain the dominant type of MA–PD, making up 57 percent of all offerings. Local PPOs continue to grow in popularity, with enrollment growing nearly 17 percent over the past two years to 8.0 million enrollees in 2025.

> In 2025, 98 percent of MA–PDs have enhanced benefits compared with 58 percent of PDPs (see Chart 10-13). In 2025, those MA–PDs enrolled 99 percent of all MA–PD beneficiaries.

> This year, the first for the new Part D benefit design, plan sponsors made significant changes to the structure of their plan offerings. In 2025, just 36 percent of MA–PDs have no deductible for their Part D benefits, down from 66 percent in 2024, and those plans attracted just 39 percent of MA–PD enrollees, down from 77 percent in 2024, though still far more than the 16 percent of PDP enrollees in such plans (see Chart 10-13). While far fewer MA–PD enrollees have a plan with no deductible at all, relative to recent years, the share in plans that have some cost-sharing tiers of their formularies not subject to a deductible increased significantly from 22 percent in 2024 to 61 percent in 2025.

Chart 10-15 Characteristics of SNPs, 2024–2025

	2024				2025			
	Plans		Enrollees as of February 2024		Plans		Enrollees as of February 2025	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	1,306	100%	6.3	100%	1,417	100%	7.0	100%
Type of SNP								
Chronic condition	310	24	0.6	10	373	26	1.1	15
Dual eligible	828	63	5.6	88	884	62	5.8	83
Institutionalized	173	13	0.1	2	160	11	0.1	2
Type of drug benefit								
Defined standard	852	65	5.1	81	890	63	5.1	73
Actuarially equivalent	7	1	<0.5	<0.5	23	2	<0.5	1
Enhanced	452	34	1.2	19	504	36	1.9	27
Type of drug deductible								
Zero	272	21	0.5	8	205	14	0.4	6
Reduced	47	4	0.1	2	182	13	0.8	12
Defined standard*	992	76	5.7	90	1033	73	5.7	82
Some formulary tiers not subject to a deductible	111	8	0.5	7	252	18	0.9	13

Note: SNP (special-needs plan). The plans and enrollment described here exclude plans offered in U.S. territories. Components may not sum to totals due to rounding. "Actuarially equivalent" includes both actuarially equivalent standard and basic alternative benefits. "Enhanced" refers to plans with basic plus supplemental coverage.
* The defined standard benefit's deductible was $545 in 2024 and is $590 in 2025.

Source: MedPAC analysis of CMS landscape, premium, and enrollment data.

> The number of SNPs (MA–PDs designed for certain groups of beneficiaries) has grown rapidly in recent years, increasing 70 percent since 2020 to 1,417 in 2025 (2020 data not shown). SNP enrollment reached 7 million in 2025, growing more than 10 percent from 6.3 million in 2024.

> SNPs for individuals who are dually eligible for Medicare and Medicaid (D–SNPs) have the greatest enrollment, though their share of SNP enrollees declined slightly as more enrollees chose a plan specifically designated for individuals with certain chronic conditions (C–SNPs). In 2025, 62 percent of SNPs were D–SNPs, and they enrolled 83 percent of all SNP enrollees. The number of C–SNPs reached 373 in 2025; these SNPs enroll 15 percent of SNP enrollees, up from 10 percent in 2024. The number of SNPs for institutionalized beneficiaries decreased for the second year in a row to 160 in 2025 and continued to enroll just 2 percent of all SNP enrollees.

> Compared with PDPs and MA–PDs, SNPs are much more likely to offer a defined standard benefit, with 63 percent of SNPs offering such coverage. In 2025, these plans enrolled 73 percent of SNP beneficiaries, though this figure is significantly less than the 81 percent of SNP enrollees in such plans in 2024. The number of SNPs providing enhanced coverage in 2025 grew modestly, though enrollment in such plans increased from 19 percent to 27 percent of all SNP enrollees.

> Dually eligible beneficiaries automatically receive Part D's low-income subsidy, which means that most recipients pay nominal copayments while Medicare pays the remainder of their plan's cost sharing. Thus, D–SNPs more frequently use Part D's defined standard benefit design (73 percent in 2025) and are less likely to have some formulary tiers that are not subject to a deductible.

Chart 10-16 Change in average Part D premiums, 2016–2025

	2016	2024	2025	Change in dollars, 2016–2025
Base beneficiary premium	34.10	34.70	36.78	2.68
All plans	$31	$27	$23	–$7
Basic plans	28	41	36	8
Enhanced plans				
Basic benefits	27	14	6	–21
Supplemental benefits	7	7	13	6
Total premium	33	21	18	–15
All basic coverage	27	22	14	–13
PDPs	39	43	39	0
Basic plans	29	44	35	5
Enhanced plans				
Basic benefits	41	23	17	–24
Supplemental benefits	12	19	26	14
Total premium	53	42	42	–11
All basic coverage	34	31	24	–10
MA–PDs, excluding SNPs	17	9	7	–10
Basic plans	18	33	31	13
Enhanced plans				
Basic benefits	15	8	1	–14
Supplemental benefits	2	1	6	4
Total premium	17	9	7	–10
All basic coverage	15	8	1	–14
SNPs	23	34	30	6
Basic plans	26	38	36	10
Enhanced plans				
Basic benefits	15	18	–2	–17
Supplemental benefits	0	2	14	14
Total premium	15	20	11	–4
All basic coverage	23	34	26	
Average MA–PD buy-down of basic premium	15	20	14	–1
Average MA–PD buy-down of supplemental benefits	14	27	23	9

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNP (special-needs plan). All calculations exclude employer-only groups and plans offered in U.S. territories. In addition, MA–PDs exclude Part B–only plans, demonstrations, and 1876 cost plans. The MA–PD data reflect the portion of Medicare Advantage plans' total monthly premium attributable to Part D benefits for plans that offer Part D coverage, after subtracting Part C rebate dollars that were used to offset Part D premium costs. All premiums are enrollment-weighted averages. "All basic coverage" is a weighted average of the premiums for basic plans and the portion of premiums attributed to basic benefits in enhanced plans, for each respective plan type, or across all plan types in the case of the data presented under "all plans." Changes were calculated on unrounded data. Components may not sum to totals due to rounding. Dollar amounts are nominal figures, not adjusted for inflation.

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

(Chart continued next page)

Chart 10-16 Change in average Part D premiums, 2016–2025 (continued)

> Part D enrollees can select between plans with basic or enhanced benefits (the latter combines basic and supplemental coverage). Medicare has traditionally aimed to subsidize 74.5 percent of the average cost of basic benefits, with enrollees paying premiums for the remaining 25.5 percent and all of the cost of any supplemental benefits. The Inflation Reduction Act of 2022 (IRA) imposed a 6 percent cap on annual increases in the base beneficiary premium (BBP), a share of the average total costs for basic Part D benefits. This cap has shifted the balance of subsidy and premiums: In 2025, Medicare is subsidizing an estimated 83 percent of the average cost of basic benefits. (For more about how plan premiums are determined and changes that were made by the IRA, see Part D *Payment Basics* at https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_24_PartD_FINAL_SEC.pdf.)

> The overall average premium paid by enrollees for any type of Part D coverage decreased in 2025 from $27 per month in 2024 to $23 per month, despite the increased plan liability under the IRA's redesigned benefit structure. Without the IRA's cap on annual increases, the BBP would have been $55.98 per month in 2025. CMS also implemented a demonstration this year for stand-alone PDPs (nearly all of which chose to participate) to reduce their enrollees' monthly premiums by up to $15 per month and limit the annual increase in the plan's total monthly premium to no more than $35. (For more information on the demonstration, see the Commission's 2025 March report to the Congress at https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch12_MedPAC_Report_To_Congress_SEC.pdf.)

> Across all plans, the average premium for basic benefits has fallen from $27 in 2016 to $14 per month in 2025, a decline of 48 percent (a decrease of $13), largely due to the $21 reduction in the portion of the premium attributed to basic coverage in enhanced plans. This decline occurred despite very rapid growth in spending for Part D's catastrophic phase of the benefit (see Chart 10-20). Average premiums for basic plans (not including the cost of basic coverage in enhanced plans), however, have increased over this period from $28 in 2016 to $36 in 2025.

> The average premium for a basic plan offered by a PDP decreased to $35 after peaking at $44 last year. The average enrollee premium for enhanced plans offered by PDPs remained steady at $42 for the second year, down from $53 in 2016. Of the $42 average premium in 2025 among enhanced PDPs, $17 was for basic benefits and $26 was for supplemental benefits.

> The average basic premium for conventional MA–PDs is now just slightly lower than for PDPs at $31 per month. Nearly all MA–PD enrollees, however, are in enhanced plans, where the average premium is just $7 in 2025, a decrease of 58 percent since 2016. MA–PD sponsors typically use a portion of payments under Medicare Advantage, referred to as Part C rebates, to "buy down" Part D premiums. Because of those rebates, in 2025, MA–PD enrollees avoided having to pay $14 per month in basic premiums and an additional $23 per month for supplemental coverage, on average.

> Average premiums for SNPs are significantly higher than those for conventional MA–PDs at $30 per month in 2025. While average premiums for enhanced plans offered by SNPs are just $11, most SNP enrollees are dually eligible for Medicaid and Medicare and face very little cost sharing, reducing the value of an enhanced benefit; thus, most SNPs offered are basic plans with an average premium of $36, most or all of which is paid by Medicare's low-income subsidy.

Chart 10-17 Part D benchmarks for LIS premiums and number of qualifying PDPs, by region

Region	State(s)	2016		2025		Cumulative change, 2016–2025	
		Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs
1	ME, NH	$33	9	$34	3	$1	–6
2	CT, MA, RI, VT	31	6	53	3	21	–3
3	NY	40	7	72	3	33	–4
4	NJ	40	8	57	4	17	–4
5	DC, DE, MD	33	10	46	2	13	–8
6	PA, WV	35	9	48	2	13	–7
7	VA	33	7	31	3	–2	–4
8	NC	31	5	51	3	20	–2
9	SC	27	4	47	2	20	–2
10	GA	26	5	40	2	14	–3
11	FL	28	3	20	1	–8	–2
12	AL, TN	31	7	40	2	9	–5
13	MI	33	7	27	4	–7	–3
14	OH	30	5	39	2	10	–3
15	IN, KY	32	7	50	2	18	–5
16	WI	38	7	44	5	6	–2
17	IL	30	9	23	1	–7	–8
18	MO	26	4	51	2	25	–2
19	AR	21	4	21	3	0	–1
20	MS	28	6	47	3	19	–3
21	LA	32	7	56	3	24	–4
22	TX	28	7	18	1	–10	–6
23	OK	31	6	50	4	19	–2
24	KS	31	4	52	4	21	0
25	IA, MN, MT, ND, NE, SD, WY	31	5	51	3	20	–2
26	NM	21	8	16	4	–5	–4
27	CO	30	6	37	3	7	–3
28	AZ	33	10	30	2	–3	–8
29	NV	25	4	21	1	–4	–3
30	OR, WA	34	9	26	3	–8	–6
31	ID, UT	40	9	55	3	15	–6
32	CA	31	6	30	2	–1	–4
33	HI	26	2	48	3	21	1
34	AK	36	6	39	2	2	–4
Average		31	6	40	3	9	–3
Minimum		21	2	16	1	–5	–1
Maximum		40	10	72	5	32	–5

Note: LIS (low-income subsidy), PDP (prescription drug plan). All calculations exclude plans offered in U.S. territories. Cumulative changes were calculated on unrounded data.

Source: MedPAC analysis of CMS benchmark amounts and plan landscape files.

(Chart continued next page)

Chart 10-17 Part D benchmarks for LIS premiums and number of qualifying PDPs, by region (continued)

> Part D's LIS covers most premiums and cost sharing for enrollees with low incomes and assets. The LIS's coverage of premiums has a dollar limit, known as the benchmark, that encourages beneficiaries to enroll in lower-cost PDPs. Beneficiaries who enroll in plans with premiums that are less than or equal to the benchmark do not pay a premium; those who enroll in plans with higher premiums pay the difference. The PDPs for which LIS beneficiaries do not pay a premium are known as benchmark plans. When LIS beneficiaries do not select a PDP, Medicare automatically enrolls them in benchmark plans.

> The LIS benchmark equals the average premium for basic coverage in a region. CMS calculates it using a weighted average of both PDP and MA–PD premiums. For plans that offer enhanced coverage, CMS uses the portion of the plan's premium that reflects the cost of basic coverage only. For MA–PDs, CMS uses the amount of the premium for basic coverage before the plan sponsor has used any Part C (Medicare Advantage) rebates to reduce or eliminate the premium. The weight for each plan equals its share of LIS enrollment. CMS calculates separate benchmarks for each Part D region and updates them annually.

> In 2025, the lowest benchmark premium was less than $16, in Region 26 (New Mexico), knocking Texas from this ranking after five consecutive years. Region 3 (New York) again had the highest benchmark premium in 2025 at $72 per month, significantly higher than the next highest benchmark of $57 in Region 4 (New Jersey).

> The average benchmark premium across regions (not weighted by numbers of enrollees) has risen slowly over the years, from $31 per month in 2016 to $40 in 2025 (on a nominal basis), an increase of 29 percent over 10 years. This change contrasts with the average overall premium across all plans, weighted by enrollment, which decreased by 23 percent over the same period (see Chart 10-16).

> In 2016, the average number of benchmark plans in a region was six; by 2025, that figure had dropped to three, a decline of 50 percent. The number of benchmark plans has declined in every region over the past decade except Region 24 (Kansas), which has the same number of plans (four) in 2025 as it did in 2016. There are four regions this year with just one benchmark plan (Region 1, Florida; Region 17, Illinois; Region 22, Texas; and Region 29, Nevada). The maximum number of benchmark plans in any region in 2025 is 5, compared with 10 in 2016.

Chart 10-18 In 2025, more enrollees are in plans that use coinsurance for brand-name and nonpreferred drug tiers

	Benchmark PDP enrollees	PDP enrollees	MA–PD enrollees
5-tier formulary structure* (in percent)	100%	100%	99%
Drugs on formulary as percentage of all Part D drugs	66%	70%	74%
Median cost-sharing amounts			
Tier 1: Generic drugs	$0	$0	$0
Tier 2: Other generic drugs	$5	$5	$5
Tier 3: Preferred brand-name drugs	21%	21%	$47
Tier 4: Nonpreferred drugs	35%	40%	41%
Tier 5: Specialty-tier drugs	25%	25%	30%
Drugs with any utilization management	53%	53%	55%

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). Figures exclude employer-only groups, plans under CMS sanction (or terminated plans), and plans offered in U.S. territories. In addition, MA–PDs in this table exclude demonstration programs, special-needs plans, and 1876 cost plans. For the analysis in this table, a drug was defined based on the unique products listed on CMS's formulary reference file for the 2025 benefit year. "Utilization management" includes prior authorization, step therapy, and quantity limits. "Prior authorization" means that the enrollee must get preapproval from the plan before coverage. "Step therapy" refers to a requirement that the enrollee try specified drugs before being prescribed other drugs in the same therapeutic category. "Quantity limits" means that plans limit the number of doses of a drug available to the enrollee in a given time period.
* Includes formularies with an additional (sixth) tier for certain types of drugs (e.g., vaccines).

Source: MedPAC analysis of formularies submitted to CMS.

> In 2025, nearly all Part D enrollees chose plans that have a five-tier structure: two generic, one preferred brand-name tier, one nonpreferred drug tier (which may include both brand-name and generic drugs), plus a specialty tier.

> The number of drugs listed on a plan's formulary affects a beneficiary's access to medications. In 2025, on average, PDP enrollees have access to 70 percent of all Part D–covered products, compared with 74 percent among MA–PD enrollees. That share was lower (66 percent) for beneficiaries enrolled in benchmark plans—basic PDPs for which enrollees with the low-income subsidy do not have to pay a premium.

> The median copay in 2025 is $0 for a generic drug on a lower tier and $5 for other generic drugs. Benchmark plans have formularies that are similar to other PDPs, with somewhat lower cost-sharing amounts for nonpreferred drugs. For 2025, most PDPs are continuing to use coinsurance (a percentage of the total payment) for preferred brand-name and nonpreferred drug tiers. While the majority of MA–PDs continue to use copayments (a fixed dollar amount per prescription) for preferred brand-name drug tier, an increasing share of MA–PDs are in plans that use coinsurance for preferred brand-name and nonpreferred drug tiers. In 2025, about 30 percent and 60 percent of MA–PD enrollees were in plans that use coinsurance for preferred brand-name and nonpreferred drug tiers, respectively, up from less than 5 percent in 2024 for both tiers (data not shown). Both PDPs and MA–PDs use coinsurance (with median coinsurance rates of 25 percent and 30 percent, respectively) for specialty-tier drugs.

> Plans' processes for nonformulary exceptions and use of utilization management tools—prior authorization (preapproval for coverage), quantity limits (limitations on the number of doses of a particular drug covered in a given period), and step-therapy requirements (enrollees being required to try specified drugs before being prescribed other drugs in the same therapeutic category)—can affect access to certain drugs. In 2025, both PDPs and MA–PDs typically use some form of utilization management for more than half of the drugs listed on a plan's formulary.

Chart 10-19 Components of Part D spending growth, 2014–2023

	2014	2023	Average annual growth 2014–2023
Total gross spending (in billions)	$121.4	$276.0	9.6%
High-cost beneficiaries	64.6	177.5	11.9
Lower-cost beneficiaries	56.7	98.4	6.3
Number of beneficiaries using a Part D drug (in millions)	37.1	50.8	3.5
High-cost beneficiaries	3.4	4.8	3.8
Lower-cost beneficiaries	33.7	46.0	3.5
Amount per beneficiary who used Part D drugs			
Gross drug spending per year	$3,267	$5,429	5.8
Average price per 30-day prescription	$60	$93	5.1
Number of 30-day prescriptions	54.5	58.1	0.7
Amount per high-cost beneficiary who used Part D drugs			
Gross drug spending per year	$18,845	$37,067	7.8
Average price per 30-day prescription	$166	$319	7.6
Number of 30-day prescriptions per month	9.6	9.8	0.2
Amount per lower-cost beneficiary who used Part D drugs			
Gross drug spending per year	$1,683	$2,137	2.7
Average price per 30-day prescription	$35	$41	1.9
Number of 30-day prescriptions per month	4.2	4.5	0.7

Note: "High-cost beneficiaries" refers to individuals who incur spending high enough to reach the catastrophic phase of the benefit. "Gross spending" reflects payments to pharmacies from all payers, including beneficiary cost sharing, but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the point of sale. Changes in the average price per prescription, measured by gross spending at the point of sale, reflect both price inflation and changes in the mix of drugs used, including the adoption of new, higher-priced drugs. Dollar amounts are nominal figures, not adjusted for inflation. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Part D prescription drug event data and Common Medicare Environment file from CMS.

> Between 2014 and 2023, gross spending on drugs under the Part D program, on a nominal basis, grew by an annual average rate of 9.6 percent. The annual growth in spending was considerably higher (11.9 percent) among high-cost beneficiaries (individuals who incurred spending high enough to reach the catastrophic phase of the benefit) than among lower-cost beneficiaries (6.3 percent).

> During the 2014 through 2023 period, the number of high-cost beneficiaries grew more rapidly (3.8 percent) compared with lower-cost beneficiaries (3.5 percent), driven by the uptick in the number of high-cost beneficiaries in 2023.

> The average price per 30-day prescription covered under Part D rose from $60 in 2014 to $93 in 2023. Overall, growth in price per prescription accounted for most (5.1 percentage points) of the 5.8 percent average annual growth in spending per beneficiary. Growth in prices per prescription reflects increases in the prices of existing drugs and changes in the mix of drugs.

> The average annual growth rate in overall spending per beneficiary reflects two distinct patterns of price and spending growth—one for high-cost beneficiaries and another for lower-cost beneficiaries. Among high-cost beneficiaries, annual growth in prices (7.6 percent) accounted for nearly all of the spending growth (7.8 percent) during this period. In contrast, among lower-cost beneficiaries, the increase in the number of prescriptions (0.7 percent) accounted for over a quarter of the spending growth (2.7 percent).

Chart 10-20 Part D spending and use per enrollee, 2023

	Part D	Plan type		LIS status	
		PDP	MA–PD	LIS	Non-LIS
Total gross spending (billions)*	$276.0	$123.9	$152.1	$131.0	$144.9
Above OOP threshold (billions)	118.5	54.5	64.0	70.3	48.2
Share above OOP threshold	*43%*	*44%*	*42%*	*54%*	*33%*
Total number of prescriptions (billions)	3.0	1.2	1.7	1.0	2.0
Average spending per prescription	$93	$100	$89	$131	$74
Share of beneficiaries with no drug use	6%	6%	6%	6%	6%
Per enrollee per month					
Total gross spending	$443	$458	$431	$765	$321
OOP spending	30	41	22	3	40
Manufacturer gap discount	32	38	27	N/A	44
Plan liability	294	295	293	527	206
Low-income cost-sharing subsidy	64	56	70	232	N/A
Number of prescriptions	4.7	4.6	4.9	5.8	4.3

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy), OOP (out-of-pocket), N/A (not applicable). "Total gross spending" reflects payments from all payers, including beneficiaries (cost sharing) but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. "Plan liability" includes plan payments for drugs covered by both basic and supplemental (enhanced) benefits. "Number of prescriptions" is standardized to a 30-day supply. Components may not sum to totals due to rounding.
* "Total gross spending" includes $16.4 billion in manufacturer discounts for brand-name drugs and biologics filled by non-LIS enrollees during the coverage gap.

Source: MedPAC analysis of Medicare Part D prescription drug event data and Common Medicare Environment file from CMS.

> In 2023, gross spending on drugs for the Part D program totaled $276 billion, with about 45 percent ($123.9 billion) accounted for by Medicare beneficiaries enrolled in stand-alone PDPs. The 27 percent of Part D enrollees who received the LIS accounted for about 47 percent ($131 billion) of the total.

> Overall, 43 percent of gross spending was incurred after a beneficiary reached the annual OOP threshold ($7,400 in 2023). That share was higher among those who received the LIS (54 percent) compared with other enrollees (33 percent).

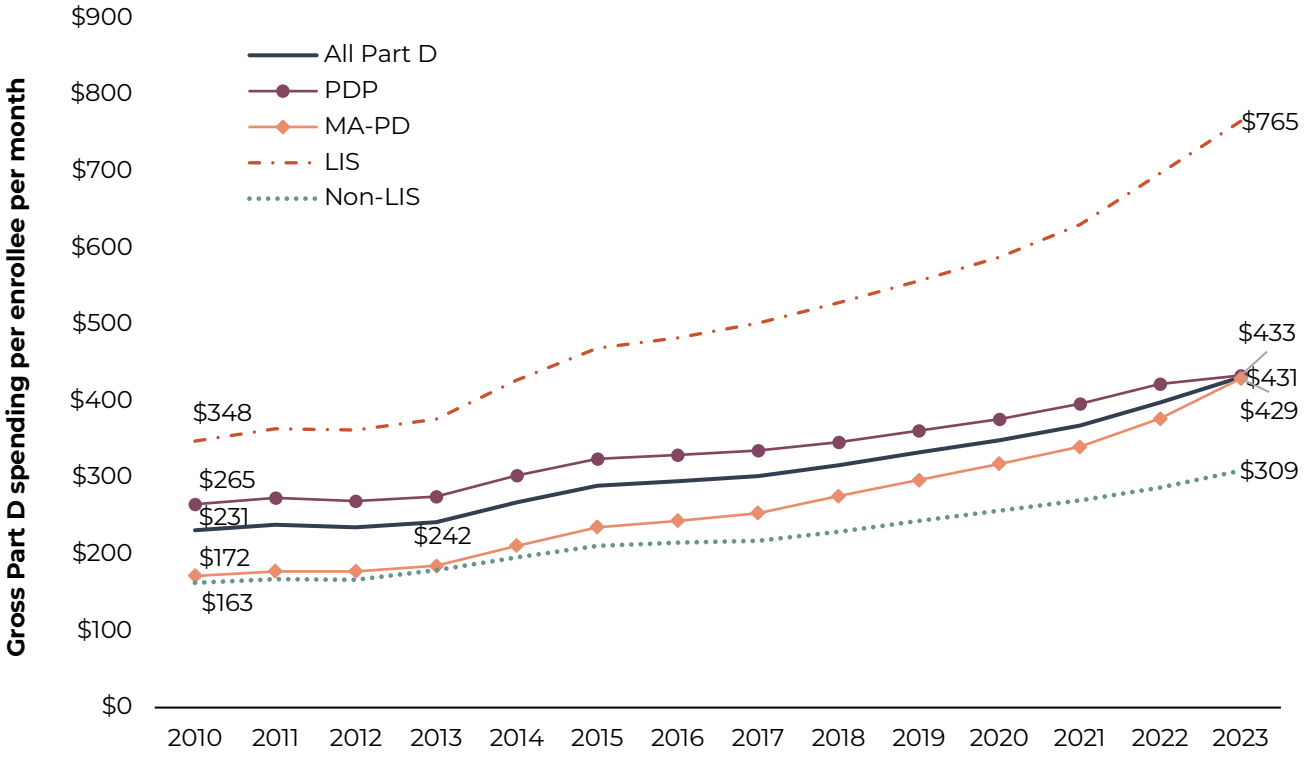
> The number of prescriptions filled by Part D enrollees totaled 3 billion, with 42 percent (1.2 billion) accounted for by PDP enrollees and about 34 percent (1 billion) accounted for by LIS enrollees. Overall, 6 percent of Part D enrollees did not fill any prescriptions during the year.

> In 2023, Part D enrollees filled 4.7 prescriptions at $443 per month on average, an increase from $398 per month (for 4.7 prescriptions) in 2022 (2022 data not shown). The average monthly plan liability for PDP enrollees ($295) was slightly higher than that of MA–PD enrollees ($293). The average monthly OOP spending for enrollees in PDPs ($41) was also higher than in MA–PDs ($22). Medicare's average monthly low-income cost-sharing subsidy was higher for MA–PD enrollees ($70) than for PDP enrollees ($56).

> Average monthly spending per LIS enrollee ($765) was more than double that of a non-LIS enrollee ($321), and the average number of prescriptions filled per month by an LIS enrollee was 5.8 compared with 4.3 for a non-LIS enrollee. LIS enrollees had much lower monthly OOP spending, on average, than non-LIS enrollees ($3 vs. $40, respectively). Part D's LIS pays for most of the cost sharing for LIS enrollees, averaging $232 per month in 2023.

> Manufacturer discounts for brand-name drugs filled by non-LIS enrollees while they were in the coverage gap accounted for, on average, 7.2 percent of the total gross spending, or nearly 13.7 percent of the average gross spending by non-LIS enrollees.

Chart 10-21 Trends in Part D spending per enrollee per month, 2010–2023



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), LIS (low-income subsidy). "Spending" (gross) reflects payments from all payers, including beneficiaries (cost sharing) but does not include rebates and fees from manufacturers and pharmacies that are not reflected in prices at the point of sale. Dollar amounts are nominal figures, not adjusted for inflation.

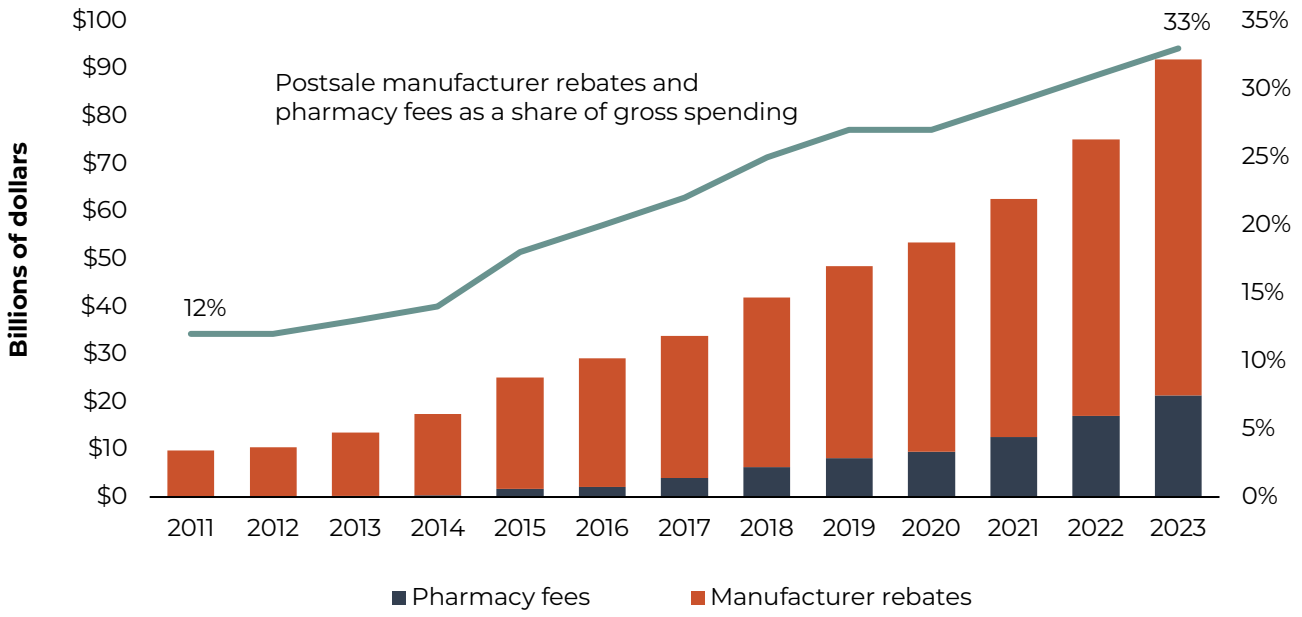
Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

> Between 2010 and 2023, average per capita spending per month for Part D–covered drugs grew from $231 to $431 on a nominal basis, an average growth rate of 4.9 percent annually, or about 86 percent cumulatively. The rate of growth in average per capita spending more than doubled after 2013, in part reflecting the introduction of new hepatitis C treatments in 2014 and other new expensive therapies in subsequent years.

> Between 2010 and 2023, monthly per capita spending for LIS enrollees grew faster than spending for non-LIS enrollees, increasing from $348 to $765 (cumulative growth of over 150 percent) compared with an increase from $163 to $309 for non-LIS enrollees (cumulative growth of about 90 percent). The number of standardized 30-day prescriptions filled by LIS and non-LIS enrollees grew by about 15 percent and 13 percent, respectively, during this period (data not shown).

> The growth in monthly per capita drug spending among MA–PD enrollees exceeded that of PDP enrollees during the 2010 to 2023 period (annual average growth of 7.3 percent and 3.8 percent, respectively). The average per capita spending for MA–PD enrollees continued to be lower than that of PDP enrollees. However, that difference has been declining since 2014. In 2023, the difference was $4 per month, down from $46 per month in 2022.

Chart 10-22 Postsale manufacturer rebates and pharmacy fees expanded rapidly in Part D, 2011–2023



Note: "Gross spending" includes enrollee cost sharing and plan (and any other) payments to the pharmacy at the point of sale for both brand and generic prescriptions. Pharmacy fees consist of net postsale payments from pharmacies to plan sponsors and their pharmacy benefit managers.

Source: MedPAC analysis of prescription drug event data and DIR data.

> The final amounts that Part D plans pay for their enrollees' prescriptions are often lower than prices at the pharmacy because plan sponsors and their pharmacy benefit managers (PBMs) negotiate postsale rebates and fees from drug manufacturers and pharmacies; CMS refers to those amounts as direct and indirect remuneration (DIR). Medicare keeps a portion of DIR to offset some of its reinsurance subsidies to plans. While large rebates help to constrain premium increases, using rebates primarily to lower premiums also means that beneficiaries who use such drugs (or the Medicare program, in the case of Part D's low-income subsidy (LIS) enrollees) sometimes pay cost sharing that is a significant portion of—and may even be higher than—the drug's cost to the plan. For enrollees without the LIS, high cost sharing can affect whether they fill their prescriptions.

> Between 2011 and 2023, DIR increased substantially from less than $10 billion to $92 billion. With manufacturer rebates accounting for roughly 25 percent of gross Part D spending in 2023 and pharmacy DIR accounting for another 8 percent, total DIR equaled about 33 percent, up from 12 percent in 2011.

> Multiple factors have contributed to growth in manufacturer rebates. For certain classes of drugs that lack generic competition but have considerable rivalry among competing brands, manufacturers have chosen to raise gross prices and compete using postsale rebates. Due to Part D's unusual benefit design and its emphasis on premium competition, sponsors have had incentives to try to maximize rebates and keep premiums low. Vertically integrated insurers with their own PBMs and specialty and mail-order pharmacies have large market shares of enrollment and dispensing, which tend to provide those plan sponsors with greater bargaining leverage for postsale price concessions from both manufacturers and pharmacies.

Chart 10-23 Incidence of Part D spending by type of product, 2023

			Share of gross spending paid					
			Medicare (at risk)			Pharmaceutical manufacturers		
	Total gross spending	Part D plans (at risk)	Reinsurance	Low-income subsidy	Beneficiary cost sharing	Coverage gap discount	Postsale rebates and discounts	Pharmacy fees
Brand-name drugs	$171.2	12%	24%	14%	6%	9%	29%	7%
Biologics	60.0	6	29	12	5	8	32	8
Generic drugs	42.5	38	11	20	18	N/A	<1	12
All products covered under Part D*	276.0	15	23	14	8	7	25	8

Note: "Total gross spending" reflects payment from all payers, including beneficiaries (through cost sharing) before accounting for postsale rebates, discounts, and fees from pharmacies and manufacturers. "Biologics" includes spending for insulins.
* Includes some products that could not be classified as one of the three drug types shown (e.g., nondrug products such as syringes used for insulins).

Source: MedPAC analysis of prescription drug event data and direct and indirect remuneration data.

> In 2023, 84 percent of total gross Part D spending was for brand-name drugs ($171.2 billion, or 62 percent) or biologics ($60 billion, or 22 percent). Generic drugs accounted for about 15 percent ($42.5 billion) of gross spending.

> The incidence of Part D spending varied by drug type, with Medicare's reinsurance accounting for a larger share of spending for brand-name drugs and biologics compared with generic drugs. For example, plans were at risk for 6 percent of spending on biologics (including biosimilars), while Medicare covered 29 percent through Part D's reinsurance. In contrast, for generic drugs, Medicare's reinsurance accounted for 11 percent of gross spending compared with 38 percent for plans. Medicare's low-income subsidy, on average, accounted for a higher share of gross spending for generic drugs (20 percent) compared with brand-name drugs (14 percent) or biologics (12 percent).

> On average, beneficiaries' cost sharing accounted for 18 percent of gross spending for generic drugs compared with 6 percent for brand-name drugs and 5 percent for biologics. Cost sharing as a share of gross spending tends to be lower for brand-name drugs and biologics because these products are more likely to be filled in the catastrophic phase of the benefit, where a lower coinsurance rate applied (5 percent of gross prices at the pharmacy before January 1, 2024) than for other phases of the benefit (typically averaging 25 percent of gross prices at the pharmacy). (See Chart 10-12 for changes in benefit parameters.) However, because prices of brand-name drugs and biologics are much higher than those of generic drugs, the lower coinsurance rate could still result in substantially higher cost-sharing liability than for generic drugs.

> Coverage-gap discounts and postsale rebates and fees paid by pharmaceutical manufacturers accounted for 7 percent and 25 percent of gross spending, respectively, across all Part D–covered products. Nearly all of those payments were for brand-name drugs and biologics. Pharmacy fees accounted for the remaining 8 percent of gross spending. On average, pharmacy fees accounted for a higher share of gross spending for generic drugs (12 percent) than for brand-name drugs and biologics (7 percent and 8 percent, respectively).

Chart 10-24 Top 15 therapeutic classes of drugs covered under Part D, by spending, 2023

	Gross spending		Negotiated rebates as a share of gross spending	Coverage-gap discount (billions)
	Billions	Percent		
Diabetic therapy	$60.7	22.0%	≥50%	$8.2
Antineoplastics	34.4	12.5	<10%	0.9
Anticoagulants	25.0	9.1	40% to 49%	4.0
Asthma/COPD therapy agents	17.9	6.5	40% to 49%	1.5
Disease-modifying anti-rheumatoid drugs	13.6	4.9	20% to 29%	0.5
Antihypertensive therapy agents	9.8	3.5	10% to 19%	0.6
Antiretrovirals	8.6	3.1	<10%	0.3
Antipsychotics (neuroleptics)	8.3	3.0	<10%	0.1
Dermatological (antipsoriatics)	7.0	2.5	10% to 19%	0.2
Ophthalmic agents	6.2	2.3	10% to 19%	0.4
Antihyperlipidemics	6.1	2.2	10% to 19%	0.4
Anticonvulsants	3.9	1.4	<10%	<0.1
Multiple sclerosis agents	3.5	1.3	10% to 19%	0.1
Urinary incontinence treatment agents	3.5	1.3	≥50%	0.3
Movement disorder drug therapy	3.0	1.1	40% to 49%	<0.1
Subtotal, top 15 drug classes	211.6	76.7	29%	17.6
Total, all drug classes	276.0	100.0	25%	19.8

Note: COPD (chronic obstructive pulmonary disease). "Gross spending" reflects payments from all payers, including beneficiaries (cost sharing) for both brand and generic drugs but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Part D prescription drug event and direct and indirect remuneration data from CMS.

> In 2023, the top 15 therapeutic classes by gross spending accounted for nearly 77 percent of the $276 billion spent on prescription drugs covered by Part D plans. Diabetic therapies continued to be at the top of the list, accounting for 22 percent of total gross Part D spending, up from 19.5 percent in 2022 (latter data not shown). The uptick in spending for diabetic therapies is likely due, in part, to the increase in the use of drugs called glucagon-like peptide-1 receptor agonists.

> In 2023, total manufacturer rebates as a share of gross spending ranged from less than 10 percent to more than 50 percent. Some of that variation reflects the degree of competition within each therapeutic class. Overall, rebates for the top 15 classes averaged 29 percent of gross spending, higher than the average of 25 percent for all Part D spending. Rebates were the highest (greater than or equal to 50 percent) for diabetic therapies and urinary incontinence treatment agents.

> In addition to negotiated rebates, before 2025, manufacturers were required to provide discounts for brand-name drugs and biologics filled by non-LIS enrollees when they filled prescriptions in the coverage-gap phase of the benefit. In 2023, these top 15 classes accounted for 89 percent ($17.6 billion) of all coverage-gap discounts. Diabetic therapies alone accounted for 42 percent of all coverage-gap discounts.

Chart 10-25 Despite high generic use, brand-name drugs accounted for the majority of spending in the top 15 therapeutic classes by spending, 2023

	Prescriptions*		Generic dispensing rate	Brand share of gross spending	LIS share of prescriptions
	Millions	Percent			
Diabetic therapy	219.8	7.4%	56%	98%	33%
Antineoplastics	16.1	0.5	87	90	22
Anticoagulants	58.9	2.0	19	99	28
Asthma/COPD therapy agents	88.4	3.0	58	91	43
Disease-modifying anti-rheumatoid drugs	3.1	0.1	35	100	49
Antihypertensive therapy agents	297.9	10.1	98	72	19
Antiretrovirals	3.1	0.1	18	98	67
Antipsychotics (neuroleptics)	36.2	1.2	91	80	68
Dermatological (antipsoriatics)	1.0	<0.1	24	99	54
Ophthalmic agents	65.1	2.2	84	75	26
Antihyperlipidemics	348.8	11.8	98	49	20
Anticonvulsants	110.4	3.7	99	41	44
Multiple sclerosis agents	0.7	<0.1	47	85	60
Urinary incontinence treatment agents	22.1	0.8	69	87	35
Movement disorder drug therapy	0.5	<0.1	6	98	76
Subtotal, top 15 drug classes	1,272.0	43.1	82	91	28
Total, all drug classes	2,952.0	100.0	89	84	28

Note: COPD (chronic obstructive pulmonary disease), LIS (low-income subsidy). "Gross spending" reflects payments from all payers, including beneficiaries (cost sharing) for both brand and generic drugs but does not include rebates and discounts from pharmacies and manufacturers that are not reflected in prices at the pharmacies. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System. Components may not sum to totals due to rounding.
* Prescriptions are standardized to a 30-day supply.

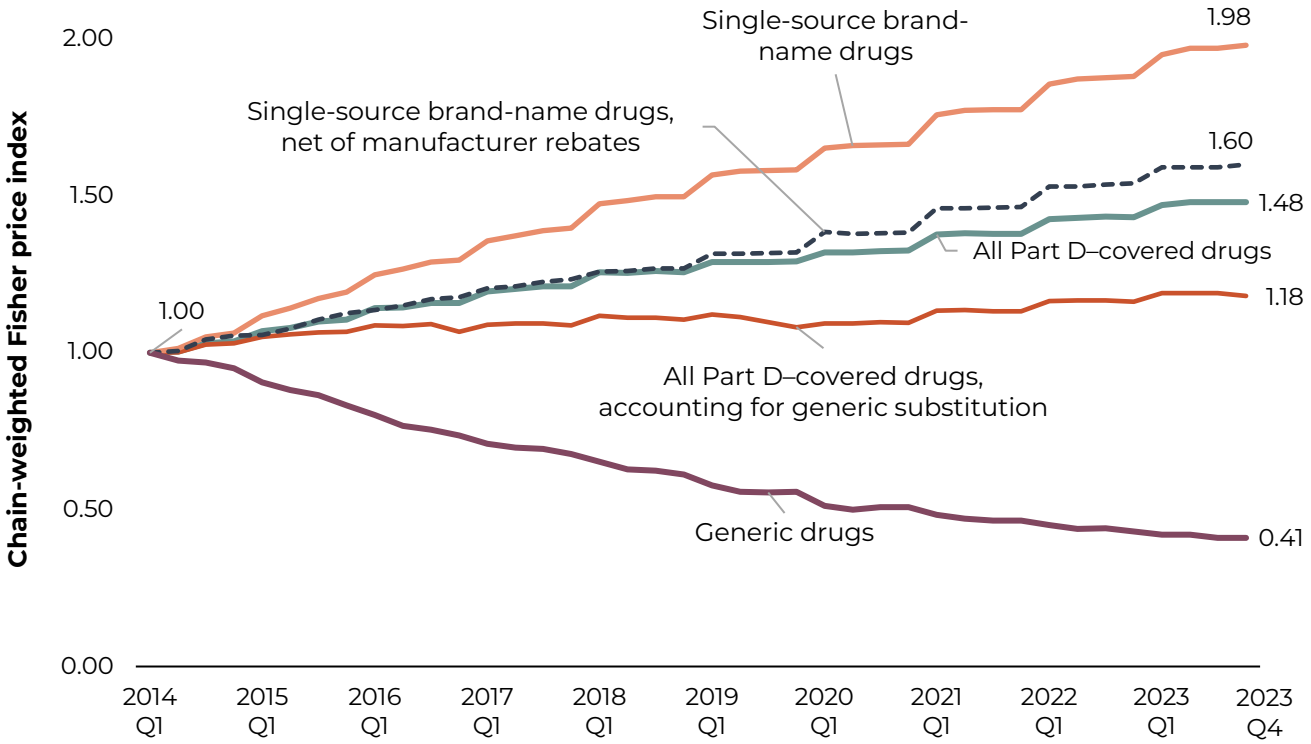
Source: MedPAC analysis of Medicare Part D prescription drug event and direct and indirect remuneration data from CMS.

> Filled prescriptions in the top 15 therapeutic classes by spending in 2023 (see Chart 10-24) totaled 1.27 billion prescriptions, accounting for 43 percent of all prescriptions filled under Part D. While 82 percent of these prescriptions were for generic drugs, brand-name products accounted for 91 percent of the gross spending for these products in 2023.

> In 2023, LIS beneficiaries filled 28 percent of total prescriptions for products in these 15 classes, which is identical to their share of prescriptions among all Part D drugs. Nevertheless, LIS enrollees accounted for a disproportionate share of prescriptions in a few classes such as antipsychotics (68 percent) and antiretrovirals (67 percent).

> Even when generic drugs are widely used by Part D beneficiaries, for some therapeutic classes, brand-name drugs may still account for the vast majority of spending. For example, in 2023, generic drugs accounted for 87 percent of prescriptions for antineoplastics, but brand-name drugs accounted for 90 percent of gross spending for that class.

Chart 10-26 Postlaunch price growth for Part D–covered drugs, 2014–2023



Note: Q1 (first quarter), Q4 (fourth quarter). Unless otherwise noted, Part D indexes reflect total amounts paid to pharmacies and do not reflect retrospective rebates or discounts from manufacturers and pharmacies, with the exception of the index for single-source brand-name drugs, net of manufacturer rebates. The price indexes are Fisher price indexes and reflect percentage changes in the average price of Part D–covered drugs measured at the product level in nominal terms, not adjusted for inflation. A product is defined at the individual national drug code (NDC) level with the exception of the index accounting for generic substitution, which groups NDCs with the same active ingredient(s), dosage form, route of administration, and strength. Indexes do not reflect the effects of launch prices of new products or changes in average price levels resulting from a shift in utilization across products. The price index is different from the change in the average price of drugs covered under Part D (see Chart 10-19), which reflects changes in the prices of existing products, the effects of launch prices of new products, and shifts in utilization across products.

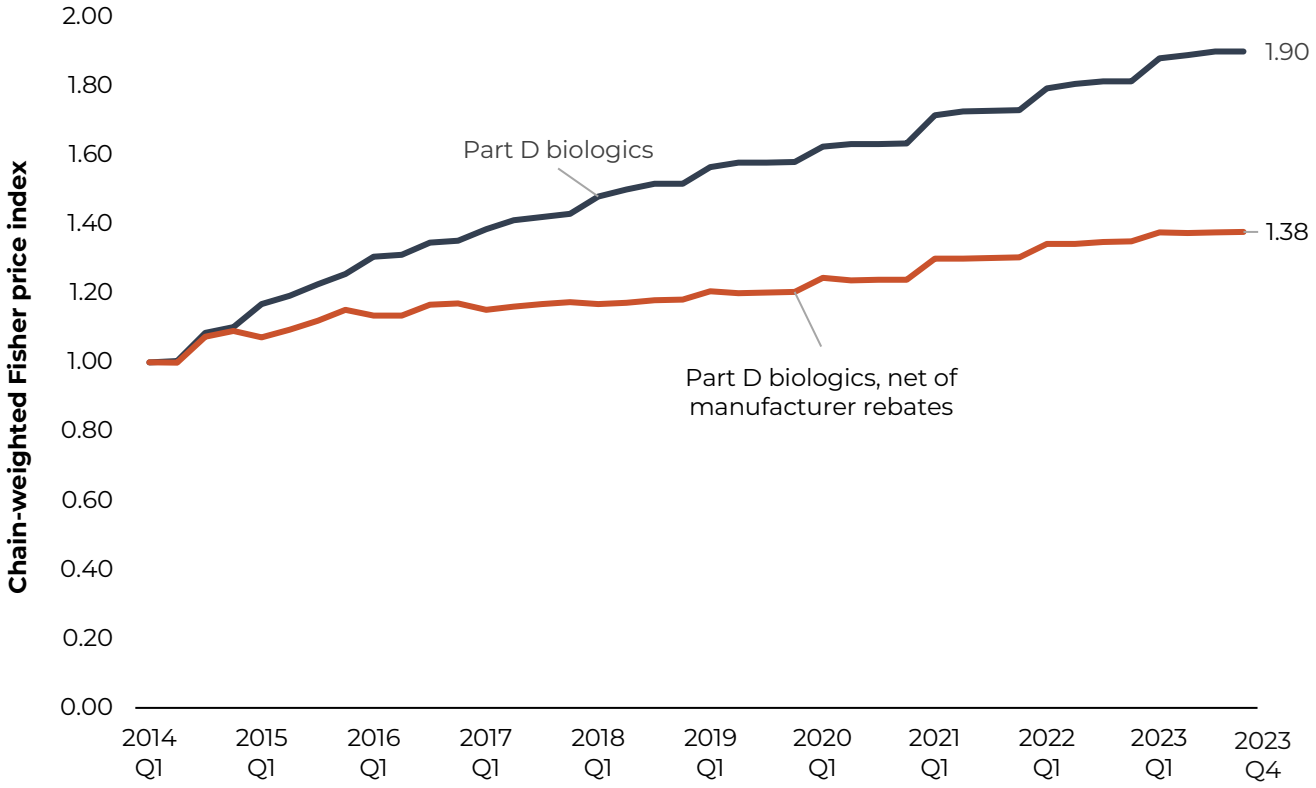
Source: Acumen LLC analysis for MedPAC.

> Measured by individual national drug codes, prices of drugs and biologics covered under Part D rose 48 percent cumulatively between 2014 and 2023 on a nominal basis (an index of 1.48). (Prices reflect total amounts paid to pharmacies and do not reflect retrospective rebates or discounts from manufacturers and pharmacies.)

> Overall, between 2014 and 2023, prices of generic drugs covered under Part D decreased to 41 percent of the average price observed at the beginning of 2014. As a result, when measured by a price index that takes generic substitution into account, Part D prices have remained relatively flat during this period, with a cumulative increase in prices at the end of 2023 at 18 percent above the prices at the beginning of 2014 (an index of 1.18). New and increased generic competition for selected therapeutic classes, such as anticonvulsants, antineoplastics, and drugs for multiple sclerosis, played a key role in slowing the growth in overall Part D prices during this period.

> Between 2014 and 2023, prices for all single-source, brand-name drugs (drugs with no generic substitutes) grew by a cumulative 98 percent (an index value of 1.98), compared with 60 percent (an index value of 1.60) for prices net of manufacturer rebates.

Chart 10-27 Postlaunch price growth for biologics covered under Part D, 2014–2023



Note: Q1 (first quarter), Q4 (fourth quarter). The price indexes are Fisher price indexes and reflect percentage changes in the average price of Part D–covered biologic products measured at the product level in nominal terms, not adjusted for inflation. A product is defined at the individual national drug code (NDC) level with the exception of the index accounting for substitution with biosimilar products, which groups NDCs with the same active ingredient(s), dosage form, route of administration, and strength. Indexes do not reflect the effects of launch prices of new products or changes in average price levels resulting from a shift in utilization across products. Biologics include insulins.

Source: Acumen LLC analysis for MedPAC.

> Measured by individual national drug codes, prices of biologics (without retrospective rebates, fees, or discounts) covered under Part D rose 90 percent cumulatively between 2014 and 2023 on a nominal basis (an index of 1.90). This increase is similar to the growth in prices for all single-source drugs and biologics (98 percent, or an index value of 1.98). (See Chart 10-26 for index measuring prices of all single-source drugs and biologics.)

> In comparison, between 2014 and 2023, prices of biologics net of retrospective rebates and discounts from manufacturers grew by a cumulative 38 percent (an index value of 1.38). The effect of manufacturer rebates on the prices of biologics was greater than that for all single-source drugs and biologics, which grew by a cumulative 60 percent (an index value of 1.60) for prices net of manufacturer rebates. (See Chart 10-26 for index measuring prices of all single-source drugs (including biologics) net of manufacturer rebates.)

> The prices of biologics are highly influenced by the prices of insulins. In 2023, insulins accounted for over a quarter of total gross spending on biologics. Insulins and other antidiabetic therapies had some of the highest rebates, totaling more than 50 percent of gross spending for therapies in that class (see Chart 10-24).