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Advising the Congress on Medicare issues

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

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Presentation roadmap

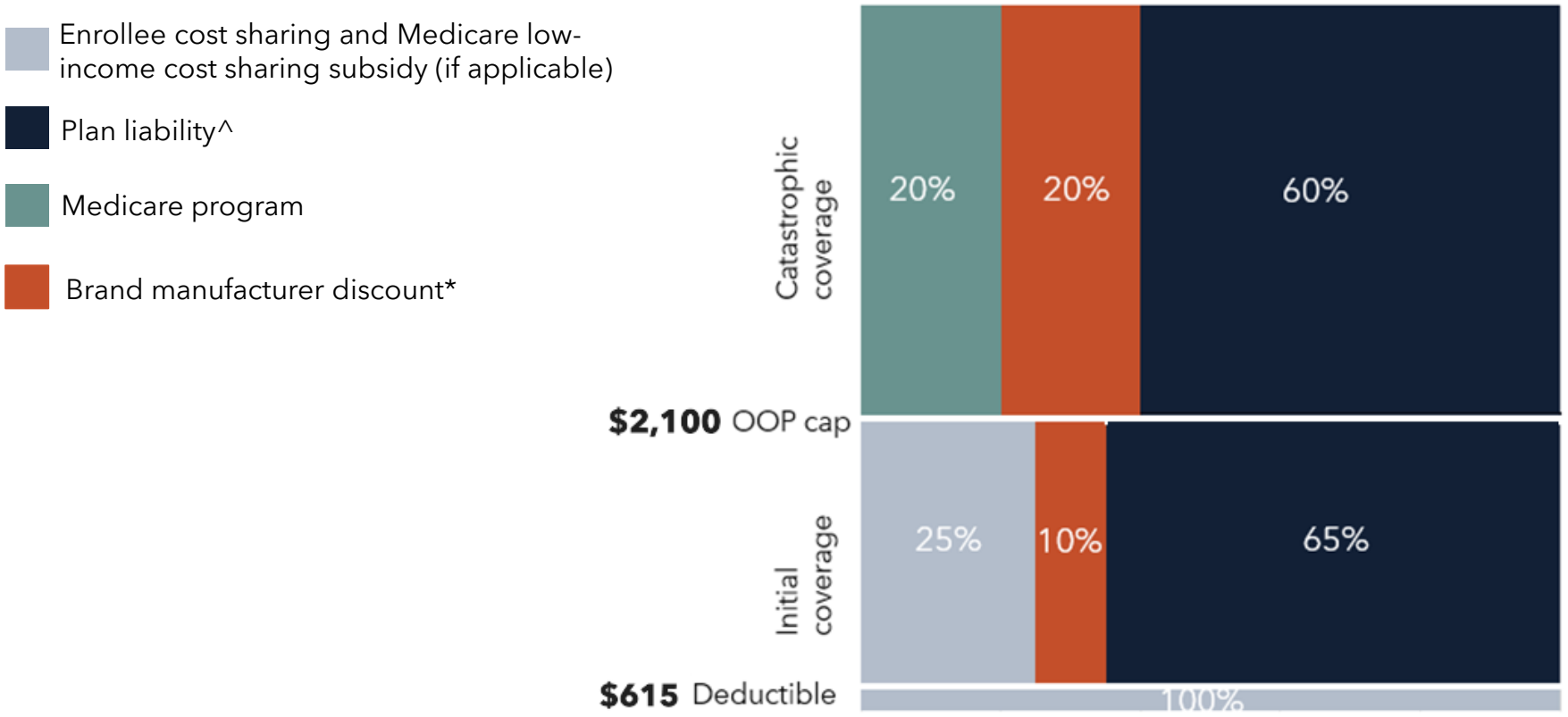
1. Part D program background
2. Enrollment, plan offerings, and spending
3. Medicare Part D prices
4. Beneficiary access and Plan Finder analysis
5. Discussion

In Part D, private insurers compete to deliver outpatient pharmacy benefits to enrollees

- Plans accept insurance risk and provide PBM services
  - PDPs: Stand-alone prescription drug plans for FFS beneficiaries
  - MA–PDs: Combined medical and prescription drug coverage for MA enrollees
- Plans and PBMs negotiate with:
  - Pharmacies for payments for dispensed prescriptions
  - Pharmaceutical manufacturers for rebates on brand-name drugs
- Medicare's payments to plans cover a substantial portion of basic benefit costs
- Enrollees pay premiums and cost-sharing
- Plans benefit from various risk mitigation measures, including cost-based reinsurance, risk corridors, and risk adjustment

Note: PBM (pharmacy benefit manager), PDP (prescription drug plan), FFS (fee-for-service), MA (Medicare Advantage), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNP (special needs plan).

Part D benefit structure for all enrollees, 2026



Note: OOP (out-of-pocket). The standard benefit is depicted as it would apply to brand-name drugs and biologics. For generics, plan sponsors must pay 75% of covered benefits between the deductible and OOP cap; Medicare will pay 40% reinsurance above the OOP cap.
^ Plan liability is financed by capitated payments, which are composed of Medicare's direct subsidy and beneficiary premiums.
* For beneficiaries receiving the low-income subsidy and for certain small manufacturers, the new manufacturer-discount program will be phased in over time, reaching final levels by 2031.

Part D program snapshot

Enrollment remained strong

- 56 million (80% of all beneficiaries)
- 13.6 M LIS beneficiaries

- PDP: 23M
- Conv. MA-PD: 25M
- SNP: 7M

2025

Available plans declined, in total

- 5,030 plans (down 2% from prior year)

- PDPs: 360
- Conv. MA-PDs: 2,970
- SNPs: 1,700

2026

Medicare spending increased; enrollee spending stable

- $132B: Medicare program spending (up 18% from prior year)
- $34B: beneficiary premium + OOP
- Bids in 2025 and 2026 suggest upward trend likely to continue

2024

Quality remained high

- High CAHPS rating on enrollee satisfaction and value/use
- Decline in star ratings

2024

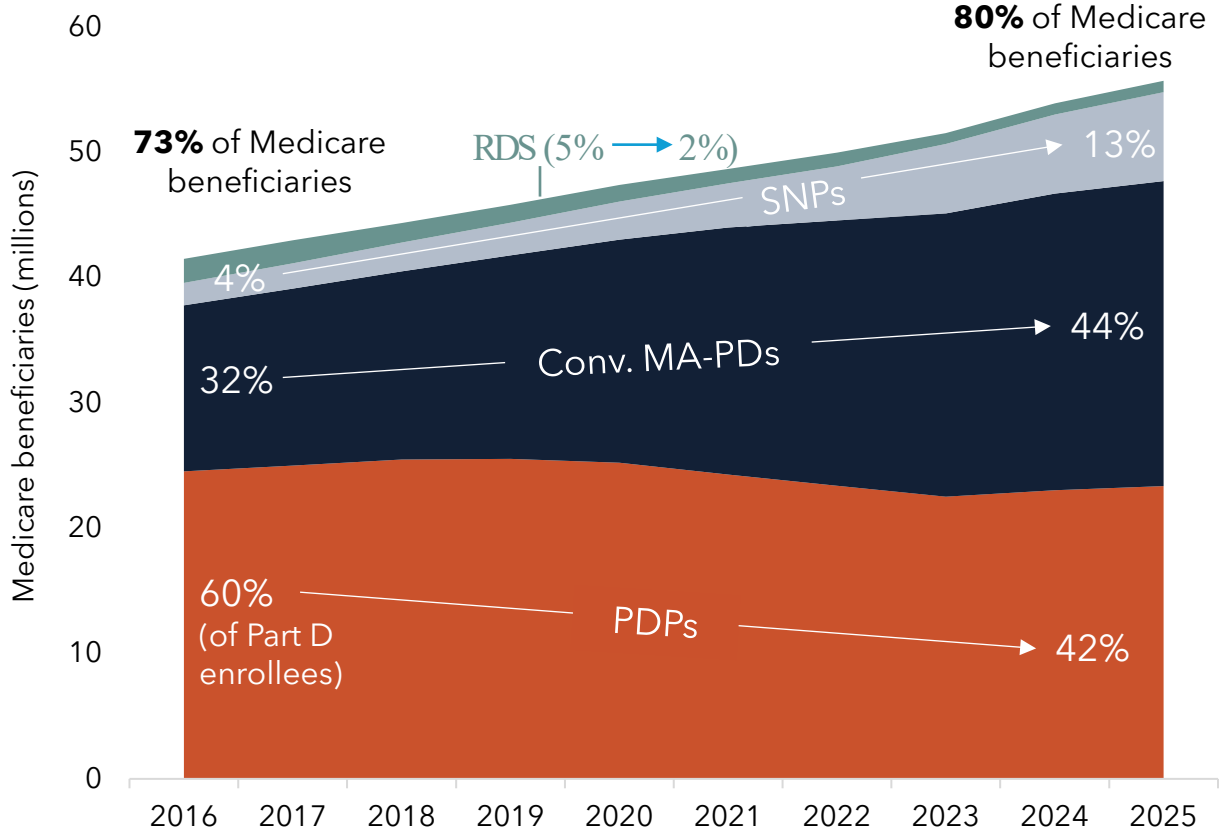
Note: PDP (prescription drug plan), Conv. MA-PD (conventional Medicare Advantage–Prescription Drug [plan]), SNP (special needs plan), CAHPS (Consumer Assessment of Healthcare Providers and Systems).

Source: MedPAC analysis of CMS landscape files and April enrollment data. MedPAC analysis based on Table IV.B10 of the 2025 annual report of the Boards of Trustees of the Medicare trust funds. MA and PDP CAHPS mean scores published by CMS, 2024.

Enrollment, plan offerings, and spending

Enrollment continues to shift to MA–PDs, with recent growth among SNPs, 2016-2025

- Over the past decade, Part D enrollment grew from 73% to 80% of Medicare beneficiaries
- PDP enrollment fell to 42% of Part D enrollees in 2025
  - Slight increase the past two years after a period of decline
- MA-PD enrollment grew steadily
  - Recent growth driven by SNPs
  - C-SNPs are growing, driven by enrollment by non-LIS beneficiaries



Note: PDP (Prescription Drug Plan), Conv. MA–PD (conventional Medicare Advantage Prescription Drug [plan]), SNP (Special Needs Plan), RDS (Retiree Drug Subsidy).

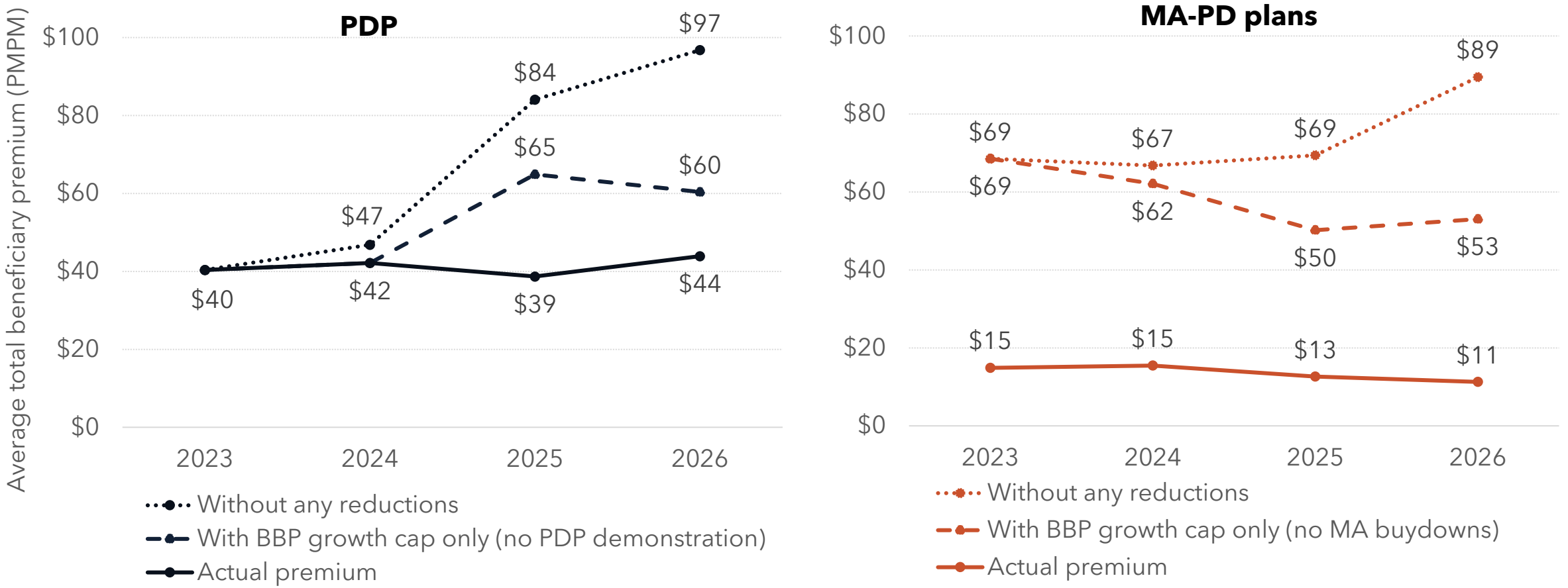
Source: Part D enrollment data from CMS.

Beneficiary choice of plans is evolving

- PDP offerings declined again in 2026 (22%), mostly due to a 34% reduction in the number of enhanced plans
- Conventional MA-PDs declined slightly after a decade of growth
- SNP offerings continued to grow (20%), particularly C–SNPs
  - Nearly 75% are now in enhanced plans, a reversal from the historical trend
- Beneficiaries in every region have access to an average of 11 PDPs and 32 MA–PDs in 2026
  - Every region has at least 1 premium-free benchmark PDP; most enrollees have access to zero-premium MA–PDs

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNP (Special Needs (MA) Plan), C–SNP (SNP for individuals with certain chronic conditions).

Average premiums differ for PDP and MA-PD plans after buydowns, 2026



Note: PDP (standalone prescription drug plan), MA-PD (Medicare Advantage Prescription Drug), BBP (base beneficiary premium), PMPM (per member per month). "Average total beneficiary premium" is the enrollment-weighted sum of basic and supplemental premiums. For 2026, we averaged premiums using plans' April 2025 enrollment. The "BBP growth cap" is an Inflation Reduction Act of 2022 provision limiting annual growth in the BBP to no more than 6 percent, starting in 2024. "PDP demonstration" refers to the PDP premium stabilization demonstration effective 2024. "MA buydown" refers to MA plans' use of Part C rebates to lower Part D premiums for their enrollees as a supplemental benefit for MA–PD plans.

Source: Part D and MA Bid Pricing Tool data, Part D landscape files, and Part D enrollment data from CMS.

In June 2025, the Commission noted concerning trends in the PDP market

- Average premiums for PDPs exceed those of MA–PDs
  - PDP premium stabilization demonstration ends in 2027
  - Base beneficiary growth cap ends in 2029
- Number of PDPs, particularly benchmark plans, has declined in recent years
- PDPs, on average, have higher gross costs but lower risk scores than MA–PDs
  - In 2025, CMS began applying separate normalization factors for PDPs and MA–PDs to account for the divergent risk score trends
- PDPs are more likely to incur losses compared with MA–PDs

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]).

In 2024, Medicare's Part D program spending grew by 18%

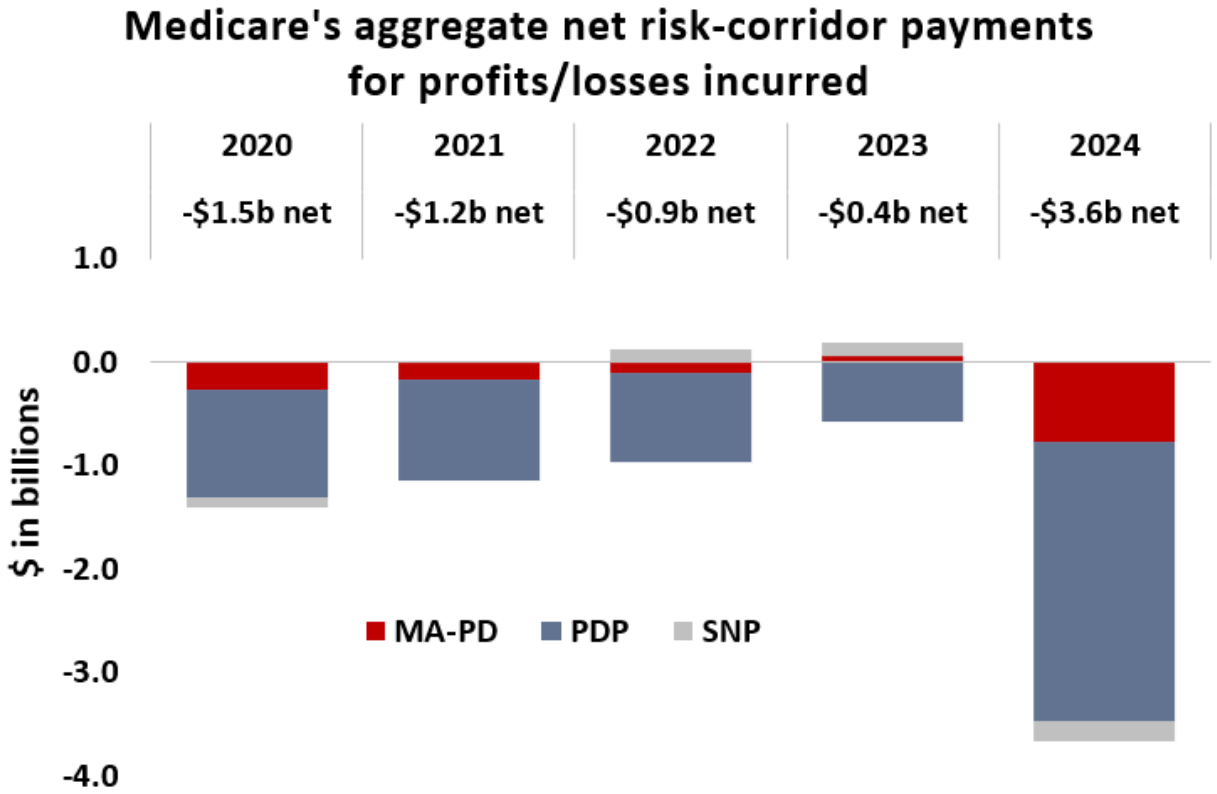
- Driven by 389% increase in capitated direct subsidy
  - Increase in catastrophic plan liability
  - Cap on basic premium increase
- Medicare's basic benefit costs grew by 34%; premiums grew by 6%
- Catastrophic spending trends:
  - Lower POS prices, reflecting pharmacy fees, resulted in fewer "high-cost" enrollees
  - Catastrophic spending for non-LIS enrollees rose sharply, in part, due to the elimination of cost sharing

	2023	2024	Change (%)
Medicare's total Part D program spending (billions)	**$112.3**	**$132.1**	**18%**
Capitated direct subsidy	4.5	22.0	389
Cost-based reinsurance	63.1	68.3	8
Subtotal, basic benefits	*67.6*	*90.3*	*34*
Low-income subsidy	44.2	41.3	-7
Retiree drug subsidy	0.5	0.5	0
Enrollee spending	**34.5**	**34.4**	**<0**
Basic premiums*	15.7	16.7	6
Cost sharing	18.8	17.7	-6

Note: POS (point of sale), LIS (low-income subsidy). Figures for capitated direct subsidy payments account for risk-sharing payments under Part D's risk corridors. Figures do not reflect the effects of the Premium Stabilization Demonstration. Components may not sum to totals due to rounding. *Low-income premium subsidies are included under Medicare's program spending.

Source: MedPAC analysis based on Table IV B10 of the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

High risk-corridor payments in 2024 suggest higher-than-expected utilization among non-LIS enrollees



Negative amount = net loss

Medicare's risk-corridor payments to plans > payments from plans

Profit margins included in bids are *excluded* from risk-corridors.

- Part D's risk corridors protect plans from large losses (and limit excess profits)
- Higher-than-expected catastrophic spending contributes to plan losses when actual plan cost > bid
- In 2024, Medicare's net risk-corridor payments to plans totaled $3.6 billion
  - Largest net payments to plans since 2006
  - About 75% of payments were to PDPs

Note: LIS (low-income subsidy), MA-PD (Medicare Advantage-Prescription Drug [plan]), PDP (prescription drug plan), SNP (special needs plan). Positive amounts reflect payments from plans to Medicare (for a portion of the profits beyond the amounts assumed in bids); negative amounts reflect Medicare payments to plans to cover a portion of their losses in risk corridors. Excludes employer group waiver plans, Program of All-Inclusive Care for the Elderly, and demonstration plans. CMS determines whether any risk-corridor payments are due by comparing plan bids for basic benefits with actual spending.

Source: Plan reconciliation data from CMS.

Medicare Part D prices

Single-source drugs increasingly affect overall Part D prices and costs

- Generic drugs account for 90% of all prescriptions
- In 2024, single-source drugs accounted for ~10% of prescriptions but over 83% of gross Part D spending, up from 70% in 2014
- Since 2019, POS prices for single-source drugs have increased by an average of 5% to 7%
  - Exception in 2024, when POS prices decreased due to new policy requiring pharmacy fees to be reflected at the POS
- Between 2014 and 2024, postsale manufacturer rebates for single-source drugs increased from about $16 billion to $77 billion
  - Average growth of about 17% per year
  - Prices net of rebates grew by 4% per year

Note: POS (point-of-sale). Single-source drugs are brand-name drugs or biologics with no direct generic or biosimilar alternatives.
Source: Acumen LLC analysis for MedPAC.

Medicare Drug Price Negotiation Program

- Beginning this year, Maximum Fair Price applies to single-source drugs selected under the negotiation program
- In 2024, selected drugs accounted for large shares of spending and rebates for single-source drugs:
  - For 2026 drugs (10) : $61B in spending (26%) and $28B in rebates (41%)
  - For 2027 drugs (15) : $42B in spending (18%) and $14B in rebates (21%)
- Nearly all selected drugs have high POS prices, often $500 or more, with some in the tens of thousands of dollars

Note: POS (point-of-sale). Single-source drugs are brand-name drugs or biologics with no direct generic or biosimilar alternatives.
Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Medicare Drug Price Negotiation program: Negotiated prices for initial price applicability year 2026. Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025. Medicare Drug Price Negotiation Program: Negotiated prices for initial price applicability year 2027.

Measuring changes in Medicare spending resulting from applying Maximum Fair Prices

- CMS estimated MFP discounts for applicable year 2026 and 2027 drugs to be:
  - Low to mid-60% relative to list prices in both years
  - 22% and 36% relative to net prices, respectively
- Discount relative to net prices driven primarily by rebates; the 2027 cohort included more protected-class and specialty drugs, where rebates tend to be limited
- Considerable uncertainty in estimating impact on Medicare spending
  - Prices and utilization of selected drugs may change
  - Higher reinsurance and subsidy costs for selected drugs
  - Shift from rebates to lower POS prices creates both downward and upward pressure on premiums and costs

Note: MFP (maximum fair price). CMS used WAC. Net prices reflects retrospective manufacturer rebates, discounts, and discounts paid by manufacturers.
Source: Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024. Medicare Drug Price Negotiation program: Negotiated prices for initial price applicability year 2026. Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025. Medicare Drug Price Negotiation Program: Negotiated prices for initial price applicability year 2027.

Beneficiary access and Plan Finder analysis

Beneficiary access to drugs is shaped by plan design

- Part D plans use different levers to manage benefit spending
  - E.g., formularies, cost-sharing, pharmacy networks
- Plan sponsors contract with pharmacies to create plan-specific networks
  - Direct beneficiaries to higher-value pharmacies
  - Offer lower cost sharing
- Medicare beneficiaries can use the Medicare Plan Finder tool to compare and select available Part D plans

Beneficiary access to drugs may be affected by pharmacy availability

- Part D plan networks must meet standards for convenient access to network pharmacies
- Reported pharmacy closures could make it difficult for plans to meet the standards
- Closures may be driven by lower reimbursement, PBM pressure, rising operating costs, and staffing shortages
- We plan to analyze how evolving incentives are influencing pharmacy participation and beneficiary access

Note: PBM (pharmacy benefit manager).
Sources: Guadamuz, J. S., G. C. Alexander, G. P. Kanter, et al. 2024. More U.S. pharmacies closed than opened in 2018–21; Independent pharmacies, those in Black, Latinx communities most at risk. *Health Affairs* 43, no. 12 (December): 1703–1711.; Berenbrok, L. A., M. Murphy, and S. Herbert. 2025. Community pharmacies are closing. Here's what to do if your neighborhood location does too. *PBS News*, February 22.

Medicare Plan Finder: Accuracy of displayed drug prices

- Displays drug prices and estimates of OOP costs, which may be personalized based on a beneficiary's drug regimen and pharmacies of choice
- Beneficiaries' plan selection often driven by expected OOP costs
- Accurate Plan Finder prices are essential for beneficiaries to be able to make informed decisions
- In 2024, CMS raised concerns that some plans may be engaging in "pricing tactics" during the AEP by submitting artificially high or low prices

Note: OOP (out-of-pocket), CMS (Centers for Medicare & Medicaid Services), AEP (Annual Enrollment Period).
Source: Stults, C. D., A. S. Baskin, M. K. Bundorf, et al. 2018. Patient experiences in selecting a Medicare Part D prescription drug plan. *Journal of Patient Experience* 5, no. 2 (June): 147–152.; CMS Calendar Year 2025 Advance Notice of Methodological Changes for Medicare Advantage Capitation Rates and Part C and Part D Payment Policies.

Medicare Plan Finder: Analysis of drug price accuracy

- Used Medicare Plan Finder data to compare drug prices for the 2024 benefit year at the AEP (October 2023), January 2024, and August 2024
  - Analysis limited to solid oral drugs at the NDC level
  - Prices averaged across pharmacies for each contract/NDC combination
  - Results weighted by enrollment and prescription volume (standardized to a 30-day supply)
- Analysis included just under 800 contracts and about 3,700 NDCs
- Price (unit cost) at the AEP averaged $5* ($0.06 to $12 at the 10th to 90th percentile)

Note: AEP (Annual Enrollment Period), NDC (National Drug Code). An NDC is a unique 10-digit or 11-digit number that serves as a pharmaceutical product identifier.
*Equivalent to $150 per month for an oral medicine taken once daily.

Sources: MedPAC analysis of Medicare Plan Finder data, July 2024 Part D monthly enrollment data, and 2024 Medicare Part D Prescription Drug Event data

Medicare Plan Finder: Prices during AEP generally aligned with those at the start of the 2024 benefit year

- Between the AEP and January 2024, most solid oral drug products experienced very small price changes
  - Just under half increased in price (by $0.14, or about 3%) and a comparable share decreased (by -$0.03)
  - E.g., in January, 90% of oral drug products with price increases changed by $0.10 or less
- Price increases were more common and slightly larger in August
- A small number of oral drug products with large price changes may warrant further analysis

Note: AEP (Annual Enrollment Period).
Sources: MedPAC analysis of Medicare Plan Finder data, July 2024 Part D monthly enrollment data, and 2024 Medicare Part D Prescription Drug Event data

Discussion

- Questions or comments?
- Feedback on draft chapter for the March 2026 report to the Congress
- More work planned on LIS benchmarks and pharmacy networks

Note: LIS (low-income subsidy).

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