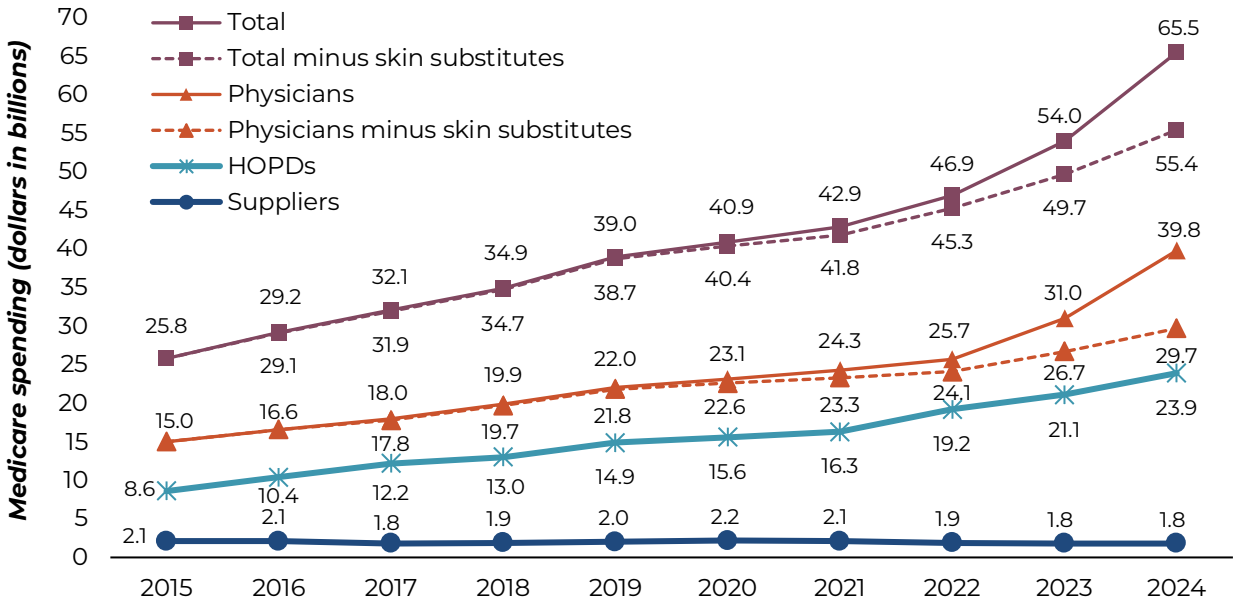
SECTION

10

Prescription drugs

Chart 10-1 FFS Medicare spending for Part B drugs, biologics, and other products furnished by physicians, hospital outpatient departments, and suppliers, 2015–2024



Note: FFS (fee-for-service), 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 for FFS beneficiaries. 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. The "HOPDs" spending line includes modest spending on skin substitutes; the "Suppliers" spending line does not include any spending on skin substitutes.

Source: MedPAC and Acumen analysis of Medicare claims data.

> FFS Medicare and its beneficiaries spent about $66 billion on separately paid Part B drugs, biologics, and other products paid under the Part B drug payment systems in 2024, with physician offices, HOPDs, and pharmacy suppliers accounting for 61 percent, 36 percent, and 3 percent of spending, respectively.

> Between 2023 and 2024, Part B drug spending increased 21.3 percent, with spending growing most rapidly (28.4 percent) in physician offices, largely due to growth in payment for skin substitutes. Excluding Medicare spending for skin substitutes, total Part B drug spending increased 11.5 percent between 2023 and 2024, and spending growth in physician offices was similar (11.2 percent). (See Charts 10-3, 10-5, and 10-6 for more discussion on payments for skin substitutes.)

> Between 2015 and 2024, Part B drug spending grew 10.9 percent per year on average on a nominal basis, not adjusted for inflation. Spending grew for HOPDs and physicians—at average annual rates of about 12 percent and 11 percent, respectively—while spending fell for suppliers at an average annual rate of about 2 percent. Excluding Medicare spending for skin substitutes, total Part B drug spending and spending for physicians grew at average annual rates of about 9 percent and 8 percent, respectively.

(Chart continued next page)

Chart 10-1 FFS Medicare spending for Part B drugs, biologics, and other products furnished by physicians, hospital outpatient departments, and suppliers, 2015–2024 (continued)

> According to CMS, skin-substitute products are a heterogeneous group that includes nonautologous human cellular or tissue products, nonhuman cellular and tissue products, or biological products that are used to treat chronic wounds (e.g., venous leg ulcers and diabetic foot ulcers). In the nonfacility setting, CMS has historically paid for most skin substitutes under Medicare's Part B drug payment system based on each product's average sales price plus 6 percent (ASP + 6 percent). Beginning in 2026, CMS will no longer pay for skin substitutes that are not drugs or biologics based on ASP. Instead, CMS will pay for skin substitutes that are not drugs or biologicals as incident to supplies under the physician fee schedule and the outpatient prospective payment system by grouping them into three Food and Drug Administration (FDA) regulatory categories (premarket approval applications; 510(k)s; and 361 human cells, tissues, and cellular and tissue-based products HCT/Ps) to set payment rates. CMS will continue to pay for any skin-substitute products that are approved by the FDA under Section 351 of the Public Health Service Act as biological products based on each product's ASP + 6 percent.

> Medicare generally pays providers for Part B drugs based on the 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 later made 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 $1.7 billion in CAHs and $0.4 billion in Maryland hospitals for Part B drugs in 2024 (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 FFS Medicare payments for separately payable Part B drugs, 2015–2024

	2015	2024	Average annual growth 2015–2024
Total payments: Separately payable Part B drugs (in billions)	$23.0*	$53.9*	9.9%*
Total payments: All Part B drugs excluding vaccines (in billions)	$21.6	$51.2	10.0
Number of beneficiaries using a Part B drug (in millions)	3.3	4.0	2.4
Average number of Part B drugs per user	1.3	1.4	0.5
Average annual payment per Part B drug	$5,108	$9,365	7.0
Total payments: Part B preventive vaccines (in billions)	$1.4	$2.7	7.6
Number of beneficiaries using a Part B vaccine (in millions)	16.2	13.2	–2.2
Average number of Part B vaccines per user	1.3	1.6	2.4
Average annual payment per Part B vaccine	$63	$126	8.0

Note: FFS (fee-for-service). 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 2015 or 2024 (i.e., drugs that were packaged under the outpatient prospective payment system in 2015 or 2024 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 $25.8 billion in 2015 and $65.5 billion in 2024, as shown in Chart 10-1.

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

> Total payments by the FFS Medicare program and beneficiaries for separately payable Part B drugs increased 9.9 percent per year, on average, between 2015 and 2024 on a nominal basis.

> Medicare spending on separately payable Part B drugs excluding Part B–covered preventive vaccines grew at a similar rate (10.0 percent per year) between 2015 and 2024.

> 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 2015 and 2024. During that period, the average annual payment per drug grew 7.0 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 2.4 percent per year on average) and the average number of Part B drugs per user (about 0.5 percent per year on average) also contributed to increased spending.

> In 2024, Medicare and beneficiaries spent $2.7 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 2015 and 2024, Part B vaccine spending grew 7.6 percent per year on average. A large portion of that growth was due to higher average payments per vaccine, which grew at an average annual rate of 8 percent per year, partly reflecting higher launch prices of COVID-19 vaccines and new pneumococcal and influenza vaccines. Growth in the average number of Part B vaccines per user (2.4 percent per year on average) also contributed to vaccine spending growth. A decline in the number of FFS beneficiaries receiving Part B vaccines (2.2 percent per year on average) offset some of the spending growth, largely reflecting the decline in the FFS beneficiary population. The number FFS beneficiaries enrolled in Part B declined on average 1.9 percent per year from 2015 to 2024, based on our analysis of the 2025 Medicare Trustees' report data.

Chart 10-3 Top 20 Part B drugs, biologics, and other products paid under Part B drug payment systems, 2024

		2024			Percent change, 2023–2024		
	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	$6.0	75,900	$78,900	10%	6%	4%
Eylea[a]	MD	3.0	329,500	9,200	–4	–4	0
Darzalex[b]	CA	2.7	28,600	93,600	17	13	3
Prolia/Xgeva	CA SE, OS	2.4	698,000	3,500	11	3	8
Opdivo	CA	1.9	27,200	71,100	1	–2	3
Vabysmo	MD	1.9	173,300	11,100	48	54	–4
Membrane Graft or Wrap	SS	1.4	10,500	137,800	325	229	29
Complete FT	SS	1.2	5,100	229,500	N/A	N/A	N/A
Orencia	AR, AI	0.9	33,500	27,800	3	2	1
Esano ACA	SS	0.9	1,900	484,400	N/A	N/A	N/A
Imfinzi	CA	0.8	14,900	56,500	14	12	2
Rituxan[c]	AR, AI, CA	0.8	60,100	13,100	–11	0	–11
Entyvio	IB	.8	19,900	38,600	6	5	0
Gammagard	IMD, NE	0.8	26,400	29,000	3	5	–1
Reblozyl	CA SE	0.8	6,500	116,400	68	58	6
Restorigin	SS	0.7	5,300	139,100	N/A	N/A	N/A
Comirnaty	VA	0.7	4,278,900	163	58	23	29
Tecentriq	CA	0.7	10,300	65,800	–10	–13	4
Ocrevus	MS	0.7	12,100	55,200	–4	–4	0
Padcev	CA	0.6	5,900	109,000	106	79	15
Top 10 drugs		22.4					
Top 20 drugs		29.7					
All Part B drugs		65.5					

Note: CA (cancer), MD (macular degeneration and other eye disorders), CA SE (cancer side effects), OS (osteoporosis), SS (skin substitutes used in wound care), N/A (not applicable), AR (arthritis), AI (autoimmune disease), IB (inflammatory bowel disease), IMD (immune deficiency), NE (neuropathy), VA (vaccine), MS (multiple sclerosis). "Total drug spending" includes Medicare program payments and beneficiary cost sharing for fee-for-service (FFS) beneficiaries. The 20 products shown in the chart reflect the Part B drug billing codes with the highest FFS Medicare expenditures in 2024. Percent change from 2023 to 2024 is not displayed for three skin substitute products - Complete FT, Esano ACA, and Restorigin - because there was little utilization in 2023 and thus the percent change in total spending between 2023 and 2024 is extremely large (i.e., greater than 1,000 percent). 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.

[a] Eylea includes both Eylea and Eylea HD.

[b] Darzalex includes both Darzalex and Darzalex Faspro.

[c] Rituxan includes Rituxan and its biosimilars and Rituxan Hycela.

Source: MedPAC and Acumen analysis of Medicare claims data.

(Chart continued next page)

Chart 10-3 Top 20 Part B drugs, biologics, and other products paid under Part B drug payment systems, 2024 (continued)

> In 2024, Part B–covered drugs, biologics, and other products paid under Medicare's Part B drug payment systems were billed using over 1,000 billing codes, but spending is concentrated. FFS Medicare spending (including beneficiary cost sharing) on the top 10 products accounted for $22.4 billion, or 34 percent of total Part B drug spending. Spending on the top 20 products accounted for $29.7 billion, or about 45 percent of total Part B drug spending.

> The top 20 Part B drugs are concentrated in certain therapeutic areas. Seven of the top 20 drugs treat cancer, and two treat cancer side effects. The top 20 also include 3 products for arthritis, autoimmune disease, or inflammatory bowel disease and 2 products for macular degeneration.

> Fifteen of the top 20 Part B products are biologics. One product is a vaccine (Comirnaty for COVID-19). Four products are skin substitutes (human cells, tissues, or cellular and tissue-based products) used in wound care, which Medicare paid for under the Part B drug payment systems in 2024.

> Among the top 20 highest-expenditure Part B drugs in 2024, average total spending per user varied. The 7 drugs in the top 20 that treat cancer had average spending per user ranging from $13,000 to $109,000. Average spending per user ranged from $13,000 to $39,000 for three drugs used to treat arthritis, autoimmune disease, or inflammatory bowel disease, and from $9,000 to $11,000 for two drugs used to treat macular degeneration. The four skin-substitute products had the highest average spending per user among the top 20, ranging from $138,000 to $484,000.

> Between 2023 and 2024, total spending increased for 16 of the top 20 Part B products and decreased for 4 products on a nominal basis (not adjusted for inflation). Five products experienced spending growth of more than 40 percent (Vabysmo, Membrane Graft or Wrap, Reblozyl, Comirnaty, and Padcev), and three products (Membrane Graft or Wrap, Complete FT, Restorigin) had substantial spending in 2024 after having little spending in 2023 (data not shown). Among the 4 products in the top 20 that experienced spending decreases in 2024, 3 products experienced a decline in the number of users and 1 product (Rituxan), which faced biosimilar competition, experienced a decline in the average payment per user.

Chart 10-4 Growth in manufacturer prices for the 20 highest-expenditure Part B drugs, biologics, and other products, 2015–2026

Top 20 products as of 2024	Average annual percentage change in average sales price, 2015–2024	Percentage change in average sales price, 2024–2025	Percentage change in average sales price, 2025–2026
Keytruda	2.5%[a]	3.4%	3.7%
Eylea[b]	–1.4	–7.1	–4.6
Darzalex[c]	4.0[a]	5.9	8.4
Prolia/Xgeva[b]	6.2	9.8	6.5
Opdivo[c]	2.6[a]	3.9	4.0
Vabysmo	–4.2[a]	–2.3	–6.7
Membrane Graft or Wrap	N/A[d]	–20.8	N/A[e]
Complete FT	N/A[d]	N/A[d]	N/A[e]
Orencia	3.0	1.5	2.2
Esano ACA	N/A[d]	N/A[d]	N/A[e]
Imfinzi	1.7[a]	3.9	2.8
Rituxan[b]	1.0	–3.1	–2.6
Entyvio[a]	3.3[a]	–1.8	–1.4
Gammagard	1.3	5.2	1.8
Reblozyl	3.3[a]	3.3	3.6
Restorigin	N/A[d]	–33.9	N/A[e]
Comirnaty[f]	N/A[d]	18.9	8.0
Tecentriq	1.9[a]	3.8	6.4
Ocrevus	0.8[a]	–1.6	0.9
Padcev	7.8[a]	4.6	0.2
Consumer Price Index for All Urban Consumers	***3.1***	***3.0***	***2.4***

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. 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] Payment-rate data were not available over the full time period, so average annual growth was calculated over a shorter period: from 2016 to 2024 (Keytruda, Opdivo, Entyvio); 2017 to 2024 (Darzalex); 2018 to 2024 (Tecentriq, Ocrevus); 2020 to 2024 (Imfinzi); 2021 to 2024 (Reblozyl, Padcev); or 2023 to 2024 (Vabysmo).

[b] Indicates that the product is an originator biologic that has experienced biosimilar entry by the first quarter of 2026. ASP trends are for the originator product only.

[c] For Darzalex and Opdivo, ASP trend displayed is for the intravenous product.

[d] Published payment rate was not available for the period. First published payment rate was the fourth quarter of 2023 (Membrane Graft or Wrap, Comirnaty); first quarter of 2024 (Restorigin); second quarter of 2024 (Complete FT); and second quarter of 2025 (Esano ACA).

[e] Effective the first quarter of 2026, skin substitutes are no longer paid under the Part B drug payment system (unless the product is approved as a biologic by the Food and Drug Administration under Section 351 of the Public Health Service Act).

[f] For Comirnaty, a preventive COVID-19 vaccine paid at 95 percent of the average wholesale price, the table displays the percentage change in the actual payment rate, not ASP.

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 analysis of Medicare claims data.

(Chart continued next page)

Chart 10-4 Growth in manufacturer prices for the 20 highest-expenditure Part B drugs, biologics, and other products, 2015–2026 (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 with 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.

> Among the top 20 highest-expenditure products as of 2024, 16 products had a published payment rate under Medicare's Part B drug payment systems in the first quarter of 2026. Among those 16 products, 12 products experienced a price increase on a nominal basis between 2025 and 2026, with 8 of those products' prices increasing faster than the CPI–U over that period.

> Between January 2025 and 2026, Darzalex (a product for multiple myeloma), Comirnaty (a COVID-19 vaccine), Prolia/Xgeva (a product for osteoporosis and cancer side effects), and Tecentriq (a product for several cancers) experienced the largest price growth, 8.4 percent, 8.0 percent, 6.5 percent, and 6.4 percent, respectively.

>Between the second quarter of 2023 and the first quarter of 2026, 3 of the top 20 products—Padcev (from the second quarter of 2023 through the first quarter of 2026), Prolia/Xgeva (from the third quarter of 2023 through the first quarter of 2026) and Darzalex (in the fourth quarter of 2025)—had reduced beneficiary cost sharing as a result of the ASP inflation rebate (data not shown).

> Between January 2025 and 2026, four products experienced a price decrease: Eylea, Vabysmo, Rituxan, and Entyvio. Two of these products have biosimilar competitors available as of 2026 (Eylea and Rituxan), and the other two products (Vabysmo and Entyvio) treat conditions for which other reference biologics with biosimilars are available.

Chart 10-5 Top 10 Part B therapeutic classes of drugs, biologics, and other products, 2024

	Total FFS Medicare payments in 2024 (in billions)	Percentage change in total FFS Medicare payments 2023–2024
Antineoplastics	$22.7	12%
Skin substitutes	10.1	128
Ophthalmic agents	6.2	17
Endocrine agents	4.7	9
Hematological agents	3.8	13
Immune globulin agents	2.9	12
Vaccines	2.8	15
Analgesics, anti-inflammatories, or antipyretics	2.7	–0.4
Neuromuscular and musculoskeletal therapy agents	1.7	22
Respiratory therapy agents	1.6	5

Note: FFS (fee-for-service). Therapeutic classes are ranked in order of 2024 total fee-for-service (FFS) Medicare spending. This analysis includes Part B drugs, biologics, and other products paid based on the average sales price as well as the small group of Part B drugs that are paid based on other methods. "Total FFS Medicare payments" includes Medicare program payments and beneficiary cost sharing for FFS beneficiaries. "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 2024, 10 drug therapeutic classes accounted for roughly 90 percent of total FFS Medicare spending for Part B drugs, biologics, and other products (calculation based on total Part B spending of $65.5 billion reported in Chart 10-1).

> Total spending by therapeutic class was somewhat concentrated. In 2024, antineoplastics (products used to treat cancer) accounted for 35 percent, and the top three classes—antineoplastics, ophthalmic agents, and skin substitutes—accounted for 60 percent of total Medicare spending.

> Between 2023 and 2024, the growth in total spending for six therapeutic classes—antineoplastics, ophthalmic agents, hematological agents, immune globulin agents, vaccines, and neuromuscular and musculoskeletal therapy agents—exceeded the average annual growth across all Part B products excluding Medicare spending for skin substitutes (which averaged 11.5 percent during this period on a nominal basis (shown in Chart 10-1)).

> Total spending on separately payable skin substitutes has been growing rapidly. Between 2023 and 2024, Medicare spending on skin substitutes grew by 128 percent, from $4.4 billion (not shown) to $10.1 billion. This therapeutic class increased in rank by total Medicare spending from 10th in 2021, 7th in 2022, 3rd in 2023, and 2nd in 2024. Preliminary claims data for calendar year 2025 (claims processed through Week 20 of 2026) indicate that spending on skin substitutes was $18.4 billion that year, an 82 percent increase compared with the prior year's level (see Chart 10-6) and that this therapeutic class ranked second in total 2025 spending (data not shown).

Chart 10-6 Change in FFS Medicare spending for skin-substitute products, 2024–2025

	2025			2024		
	Total spending (billions)	Number of users	Average spending per user	Total spending (billions)	Number of users	Average spending per user
All skin-substitute products	$18.4	68,400	$270,000	$10.1	67,700	$150,000
Top 10 skin-substitute products, 2025						
Amchoplast	$3.0	4,400	$681,000	$0.1	100	$501,000
Tri membrane wrap	1.8	4,100	451,000	*	*	*
Simplimax	1.6	3,500	455,000	*	*	*
Xcell amnio matrix	1.5	5,300	276,000	0.03	200	127,000
AmnioAMP-MP	1.1	2,900	395,000	0.2	1,300	132,000
Complete FT	0.8	4,700	167,000	1.2	5,100	230,000
Neostim TL	0.6	4,000	156,000	0.3	1,200	228,000
Membrane Graft or Wrap	0.6	3,800	153,000	1.4	10,500	138,000
Acapatch	0.6	2,200	261,000	N/A	N/A	N/A
Amnio burgeon xplus membrane and xplus hydromembrane	0.4	800	564,000	N/A	N/A	N/A

Note: FFS (fee-for-service), N/A (not available). "Total spending" includes Medicare program payments and beneficiary cost sharing for FFS beneficiaries. Spending and utilization estimates for 2024 are based on claims with a 2024 date of service processed through Week 26 of 2025. Spending and utilization estimates for 2025 are preliminary, based on claims with a 2025 date of service processed through Week 20 of 2026. 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 nonautologous 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 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 nonautologous human cellular or tissue products, nonhuman cellular and tissue products, or biological products that are used to treat chronic wounds (e.g., venous leg ulcers and diabetic foot ulcers).

> Before 2026, under the physician fee schedule, skin-substitute products were generally paid average sales price (ASP) + 6 percent. Under the outpatient prospective payment system before 2026, 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 2025, total spending increased in aggregate by roughly 1,690 percent from $1.0 billion to $18.4 billion on a nominal basis (not all data shown). Most recently, spending on skin-substitute products increased by nearly 82 percent from $10.1 billion in 2024 to an estimated $18.4 billion in 2025 (spending based on preliminary claims with a 2025 date of service processed through Week 20 of 2026). In 2025, skin-substitute products accounted for 23 percent of all Part B drug spending (data not shown).

(Chart continued next page)

Chart 10-6 Change in FFS Medicare spending for skin-substitute products, 2024–2025 (continued)

> Spending on skin-substitute products per user is also substantial and growing. In 2025, estimated average spending per user for the top 10 products ranged from $153,000 to $681,000, and estimated average cost-sharing liability per user ranged from $31,000 to $138,000 (data not shown) (2025 estimates based on preliminary claims data for calendar year 2025 (claims processed through Week 20 of 2026)). By comparison, in 2024, average spending per user for these products ranged from $127,000 to $501,000, and average cost sharing per user ranged from $26,000 to $102,000 (data not shown). Across all skin-substitute products, average spending per user increased from $150,000 in 2024 to an estimated $270,000 in 2025.

> Providers' adoption of some skin-substitute products has occurred rapidly. For example, between 2024 and 2025, the number of users grew from fewer than 11 beneficiaries to 3,500 beneficiaries for Simplimax and from fewer than 11 beneficiaries to about 4,100 beneficiaries for Tri membrane wrap.

> Use of and spending on skin-substitute products is shifting over time. For example, in 2024, the three leading products as measured by total spending were Membrane Graft or Wrap ($1.4 billion), Complete FT ($1.2 billion), and Esano ACA ($0.9 billion). In 2025, spending for these three products declined to $0.6 billion, $0.8 billion, and $0.4 billion, respectively (spending data for Esano ACA not shown). Between 2024 and 2025, both the price and use of these three products declined. Between October 2024 and 2025, the ASP payment rate declined by 6 percent for Membrane Graft or Wrap and 28 percent for Complete FT (ASP data are not available for Esano ACA in 2024), while the annual number of beneficiaries who were furnished each product in 2024 and 2025 declined by 63 percent, 8 percent, and 22 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). In 2025, the number of products declined slightly to 125 (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 (2026 Q1)	Biosimilar market share (2025 Q3)
		In 10 years before biosimilar entry	Since biosimilar entry (through 2026 Q1)		
Neupogen and biosimilars	2015 Q3	71%	0%	25%–100%	89%
Remicade and biosimilars	2016 Q4	54	–61	73–86	28
Neulasta and biosimilars	2018 Q3	117	–69	80–132	66
Procrit/Epogen and biosimilars	2018 Q4	35	–37	98	49
Avastin and biosimilars	2019 Q3	42	–9	32–52	88
Herceptin and biosimilars	2019 Q3	69	–31	11–75	84
Rituxan and biosimilars	2019 Q4	68	–21	18–40	63
Lucentis and biosimilars	2022 Q3	–31	–76	92–127	7
Actemra and biosimilars	2024 Q2	63	–7	75–100	8
Eylea and biosimilars	2024 Q4	–16	–7	113	31
Stelara and biosimilars	2025 Q1	N/A	–2	66–346	16
Soliris and biosimilars	2025 Q2	6	0	70–94	1
Prolia and biosimilars	2025 Q3	93	1	96	2

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, Zarxio, and Nypozi 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, Kanjinti, and Hercessi for originator Herceptin; Truxima, Ruxience, and Riabni for originator Rituxan; Byooviz and Cimerli for originator Lucentis; Tyenne and Tofidence for originator Actemra; Pavblu for originator Eylea; Steqeyma, Yesintek, Wezlana, Pyzchiva, Selarsdi, and Otulfi for originator Stelara; Epysqli and Bkemv for originator Soliris; and Jubbonti/Wyost for originator Prolia. 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. We do not include Herceptin Hylecta and Rituxan Hycela (subcutaneous forms of the products) because these products do not currently have FDA-approved biosimilars. "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 analysis of Medicare claims data.

(Chart continued next page)

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

> 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 (IRA), 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.

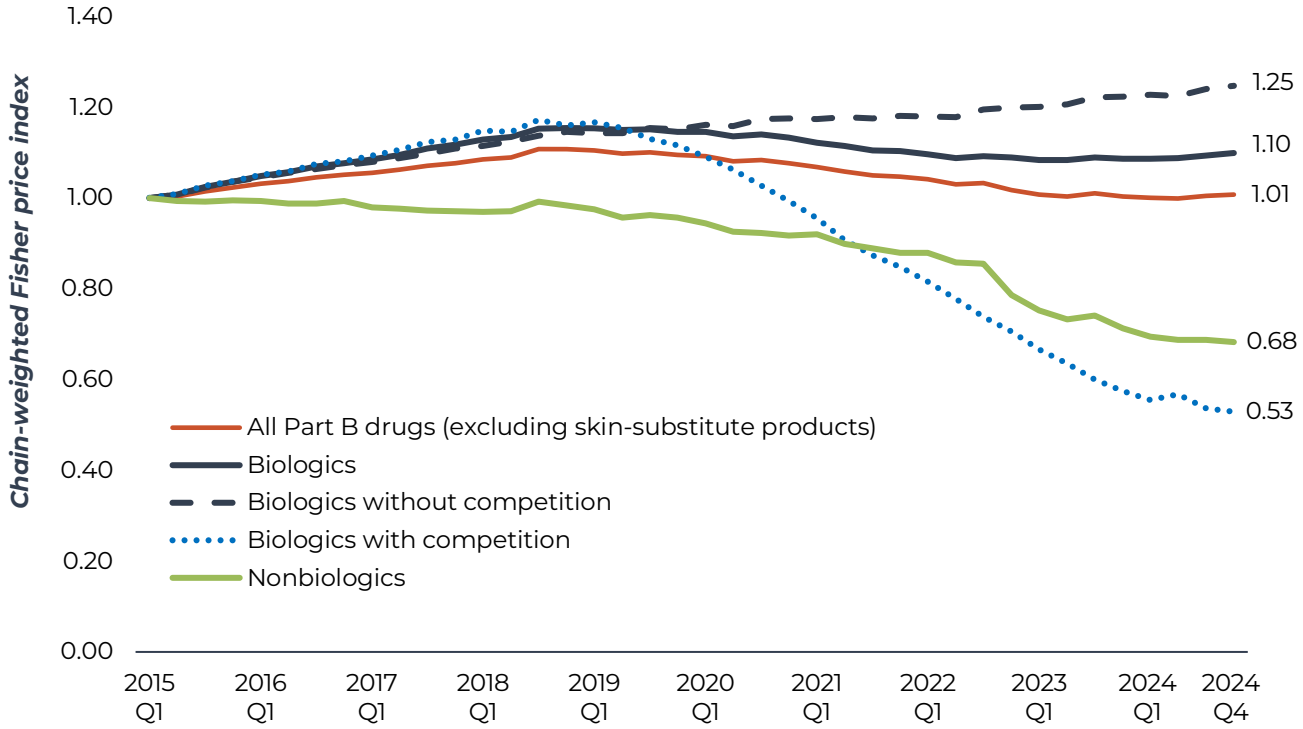
> Biosimilar entry has generated savings for Medicare. Pricing patterns and biosimilar uptake vary across products. For the nine biologics that had biosimilars on the market in 2024 (excluding Eylea because its biosimilar did not have a billing code until the second quarter of 2025), Medicare spending on Part B originator biologics and their biosimilars declined on a nominal basis by about 9 percent, from $3.7 billion in 2023 to $3.4 billion in 2024 (data not shown). The decline in spending between 2023 and 2024 reflects a mix of dynamics including a reduction in the number of users (by about 4 percent to 18 percent across the nine products and their biosimilars except Neupogen, Rituxan, and Actemra) and in average payments per user (by about 1 percent to 15 percent across these products except Avastin, Neulasta, and Actemra) (data not shown).

> For some products, biosimilars are priced substantially below originators, and biosimilar uptake has driven savings. For example, lower-priced biosimilars now account for 84 percent or more of the market share for Neupogen, Avastin, and Herceptin and 63 percent of the market share for Rituxan. These four originator products have reduced their prices only minimally or modestly (0 percent, 9 percent, 31 percent, and 21 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 90 percent below the originator's payment rate.

> In a few cases, originator biologics have reduced their prices by more than 60 percent in response to biosimilar entry. Originator Remicade's payment rate has declined 61 percent, originator Neulasta's payment rate has declined 69 percent, and originator Lucentis's payment rate has declined 76 percent since biosimilar entry. As of the first quarter of 2026, Remicade had some biosimilar competitors on the market that were priced modestly lower (roughly 27 percent below the originator's payment rate). In contrast, originators Neulasta and Lucentis had lower Medicare payment rates than some of their biosimilar competitors as of the first quarter of 2026. Originators Remicade and Lucentis had 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 before biosimilar entry. With the exception of Lucentis and Eylea, the originator biologics' cumulative growth in payment rates over the 10 years before biosimilar entry ranged from 6 percent to 117 percent. In contrast, Lucentis and Eylea's payment rates declined 31 percent and 16 percent, respectively, in the 10 years before biosimilar entry.

Chart 10-8 Postlaunch price indexes for Medicare Part B drugs, 2015–2024



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, higher launch prices of new products, and shifts in utilization across products. The "biologics with competition" line represents originator biologics that faced biosimilar entry by the fourth quarter of 2024 (including the period before biosimilar entry that falls between 2015 and 2024) and their biosimilars. Skin-substitute products are excluded from this analysis.

Source: Acumen 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 7.0 percent per year on average between 2015 and 2024 and reflects a broader set of dynamics (including changes in the price of existing products, higher launch prices of new products compared with older products, and shifts in utilization across products).

> Measured by the change in the ASP within individual Part B–covered drugs, the prices of Part B–covered drugs (excluding skin-substitute products) rose by an average of 1 percent cumulatively between 2015 and 2024 (index of 1.01) on a nominal basis. The overall price index for Part B drugs rose between 2015 and the first quarter of 2019 from 1.00 to 1.11, before declining through the end of 2024 to 1.01, driven by a decline in the nonbiologics' price index, coupled with the decline in the price index for biologics with biosimilar competition.

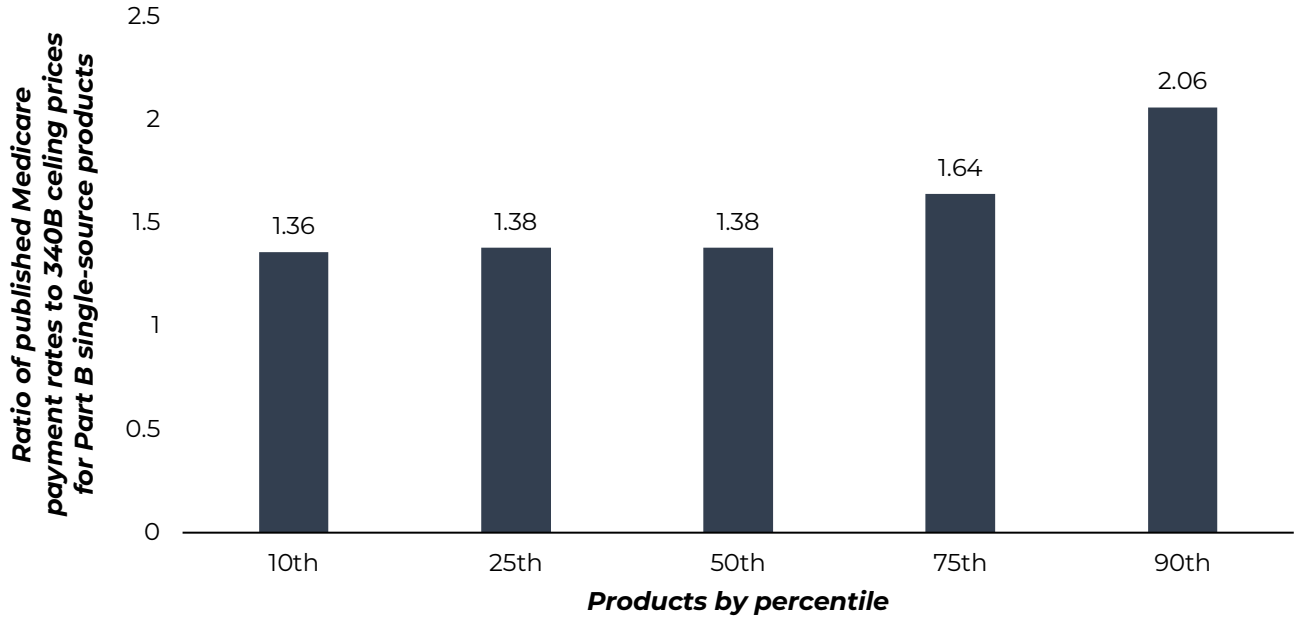
(Chart continued next page)

Chart 10-8 Postlaunch price indexes for Medicare Part B drugs, 2015–2024 (continued)

> The price index for biologics increased cumulatively by 10 percent (index of 1.10) between 2015 and 2024, reaching a high of just over 1.15 in the third quarter of 2018 through the first quarter of 2020 and declining to 1.08 by the first quarter of 2023 before rising again to 1.10 by the fourth quarter of 2024. Pricing trends differ for biologics that face biosimilar competition and biologics that do not. While the price index for biologics without biosimilar competition increased continuously between 2015 and 2024 (reaching 1.25 by the fourth quarter of 2024), the price index for biologics with biosimilar competition increased between 2015 and the third quarter of 2018 (price index of 1.17), then subsequently declined to 0.53 by the fourth quarter of 2024. The decline in the price index for biologics that face biosimilar competition may be, in part, attributable to the first entry of biosimilar products for several originator biologics in 2018 and 2019 (Chart 10-7).

> The price index for nonbiologics declined 32 percent (index of 0.68) between 2015 and 2024, which in part reflects patent expiration and generic entry for some of these products (e.g., pemetrexed). 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, 2024



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 2024. 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 (ASP) 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 211 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 211 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 2024 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 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 from manufacturers. Fee-for-service Medicare pays all providers the same rate for Part B drugs (generally 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 (best price is defined in statute as the lowest price available from the manufacturer to any purchaser, net of price concessions, and subject to specified exclusions), 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, 2024 (continued)

> To provide a sense of how Medicare payment rates compare with costs for 340B-purchased drugs, we estimated 340B ceiling prices for 211 Part B–covered single-source drugs, biologics, and biosimilars. These 211 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 2024.

> Across the 211 single-source Part B products, Medicare payments exceeded the 340B ceiling price by 38 percent for the median product in 2024. The Medicare payment rate exceeded the 340B ceiling price by between 38 percent and 64 percent for half of products (25th percentile to 75th percentile) and by 106 percent or more for 10 percent of products (90th percentile).

> In 2024, fee-for-service Medicare and beneficiaries paid $15.9 billion for the 205 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 $11.0 billion (data not shown). Thus, aggregate payments exceeded 340B ceiling prices by an estimated 44 percent ($4.9 billion) in 2024. Ceiling-price costs equated to approximately ASP – 28 percent for the 211 single-source products in aggregate that year.

> The results of our analysis comparing the 2024 Medicare payment rate and 340B ceiling price at the billing-code level are similar to results from our 2023 analysis (data not shown). For example, in 2023, across 200 single-source products, we found 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 59 percent (25th percentile to 75th percentile); and (3) 10 percent of products had a Medicare payment rate at least 108 percent above the 340B ceiling price (90th percentile). We estimated that in 2023 aggregate payments exceeded 340B ceiling prices by an estimated 45 percent ($4.3 billion). Ceiling price costs equated to approximately ASP – 28 percent across the 200 products.

> 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, 2016–2025

	2016	2024	2025	Average annual growth rate 2016–2025
Total Medicare enrollment, in millions	57.1	68.0	69.5	2.2%
Part D enrollment, in millions				
Part D plans	41.0	54.1	55.8	3.5
Non-Medicare employer plans under the RDS*	1.9	0.8	0.7	–10.5
Total Part D	42.9	54.9	56.5	3.1
Share of Medicare enrollees with Part D	*75%*	*81%*	*82%*	
LIS enrollment				
PDPs	8.0	4.7	4.3	–6.6
MA–PDs	4.0	9.4	9.3	9.8
Total LIS	12.0	14.0	13.6	1.4
Share of LIS enrollees in MA–PDs	*34%*	*67%*	*68%*	
Share of Part D plan enrollees with LIS	*29%*	*26%*	*24%*	
EGWPs (PDPs and MA–PDs)	6.6	8.9	9.2	3.7
EGWP share of total Part D enrollment	*16%*	*17%*	*16%*	
Non-EGWP Part D plans, in millions				
PDPs	20.1	18.1	18.2	–1.1
MA–PDs	14.3	27.1	28.4	8.0
Share of non-EGWP plan enrollees in MA–PDs	*42%*	*60%*	*61%*	

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.

Source: MedPAC analysis of monthly Medicare enrollment files from CMS and the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

> In 2025, 82 percent of Medicare beneficiaries were enrolled in Part D plans or had prescription drug coverage through employer-sponsored plans that received Medicare's RDS. That share is up from 75 percent in 2016. (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 2016 and 2025, the number of enrollees receiving the LIS grew modestly (1.4 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 2025, 24 percent of Part D enrollees received the LIS, a decrease from 29 percent in 2016. More than two-thirds of LIS beneficiaries are now in MA–PDs, a reversal from 2016 when two-thirds were in PDPs.

> Employer and union health plans continue to be important sources of drug coverage for Medicare beneficiaries under Part D. In 2025, 9.2 million Medicare beneficiaries (16 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 2025, among non-EGWP plans, 28.4 million enrollees (61 percent) were in MA–PDs and 18.2 million enrollees (39 percent) were in stand-alone PDPs. Over the 2016 to 2025 period, enrollment in PDPs declined slightly, while enrollment in MA–PDs rose by an annual average of 8.0 percent.

Chart 10-11 Characteristics of Part D plan enrollees, 2024

	All Medicare	Part D plans	Plan type		Subsidy status	
			PDP	MA–PD	LIS	Non-LIS
Beneficiaries* (in millions)	67.8	54.1	23.1	31.1	14.5	39.7
Percent of all Medicare	100%	80%	34%	46%	21%	59%
Sex						
Male	46%	44%	43%	44%	41%	44%
Female	54	56	57	56	59	56
Race/ethnicity						
White, non-Hispanic	72	72	81	66	51	80
Black, non-Hispanic	11	11	7	14	21	7
Hispanic	9	9	5	12	17	6
Asian	4	4	3	5	7	3
Other	4	4	4	3	4	3
Age (years)**						
<65	11	11	9	13	32	4
65–69	27	25	24	26	24	26
70–74	23	24	24	23	17	27
75–79	18	18	19	17	12	21
80+	21	21	23	20	16	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 are based on enrollment as of April 2024.
** Age as of April 2024.

Source: MedPAC analysis of enrollment data from CMS.

> In 2024, 54.1 million Medicare beneficiaries (80 percent) were enrolled in Part D plans. Less than half (23.1 million) were enrolled in stand-alone PDPs, and the rest were enrolled in MA–PDs (31.1 million). About 14.5 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, Black, or Asian 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, 2017–2026

	2017	2025	2026	Average annual change 2017–2026
Deductible	$400	$590	$615	4.9%
Initial coverage limit	3,700	N/A	N/A	N/A
Annual out-of-pocket threshold	4,950	2,000	2,100	–9.1
Total covered drug spending at annual out-of-pocket threshold:				
Enrollees eligible for manufacturers' coverage-gap discount	8,071	$6,230	$6,555	–2.3
Other enrollees	7,425	$6,230	$6,555	–1.4
Cost sharing for LIS beneficiaries*:				
Copay for generic/preferred multisource drugs	3.30	4.90	5.10	5.0
Copay for other prescription drugs	8.25	12.15	12.65	4.9

Note: N/A (not applicable), LIS (low-income subsidy). In 2026, 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 that year, the value of plans' supplemental coverage does count toward enrollees' OOP limit. Above the OOP limit, before 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. Cost-sharing amounts shown for LIS beneficiaries are for individuals with income between 100 percent and 150 percent of the federal poverty level (FPL). Cost-sharing for full-benefit beneficiaries with income at or below 100 percent of the FPL is capped at $4.90.

Source: CMS Office of the Actuary.

> In 2026, Part D's defined standard benefit has a $615 deductible, and enrollees pay 25 percent coinsurance on covered drugs until they reach the $2,100 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 2026, a person who does not receive Part D's LIS and has no supplemental coverage would, on average, reach the threshold at $6,555 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 2026 report 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 available for general enrollment, 2025–2026

	2025				2026			
	Plans		Enrollees as of April 2025		Plans		Enrollees as of April 2026	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	464	100%	18.2	100%	360	100%	18.6	100%
Type of plan								
Benchmark	90	19	5.7	31	88	24	5.7	31
Nonbenchmark	374	81	12.5	69	272	76	12.9	69
Type of benefit								
Defined standard	0	0	0.0	0	1	<0.5	<0.1	<0.05
Actuarially equivalent	196	42	7.8	43	182	51	7.8	42
Enhanced	268	58	10.5	57	177	49	10.8	58
Type of deductible								
Zero	79	17	2.8	16	40	11	0.7	4
Reduced	76	16	1.4	8	71	20	3.4	18
Defined standard*	309	67	14.0	77	249	69	14.5	78
Some formulary tiers not subject to a deductible	197	42	7.8	43	142	39	10.4	56

Note: PDP (prescription drug plan). The PDPs and enrollment described here exclude employer group waiver 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 $590 in 2025 and is $615 in 2026.

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

> Plan sponsors are offering 360 stand-alone PDPs that are available to all fee-for-service enrollees in 2026 compared with 464 in 2025—a decrease of 22 percent, after a decrease of 35 percent the year prior. Total enrollment in PDPs increased for the second year in a row to 18.6 million beneficiaries in 2026 from 18.2 million in 2025, after five prior years of decline, though PDP enrollment as a share of all Part D enrollment remained at an historical low of 40 percent as non–employer group waiver plan (EGWP) enrollment continues to shift to MA–PDs (see Charts 10-10 and 10-11). (Enrollment among EGWP beneficiaries, on the other hand, increased significantly among PDPs in 2026, but their enrollment is not included here.)

> For 2026, for the first time since 2012, the share of PDP offerings including enhanced benefits (basic plus supplemental coverage) is less than half (49 percent); this share had been between 60 percent and 62 percent from 2019 to 2024 and fell slightly in 2025 (2019 to 2024 data not shown). The share of PDP enrollees in enhanced plans, however, increased slightly from 57 percent in 2025 to 58 percent in 2026.

> In 2026, the share of enrollees in plans with no deductible fell to 4 percent, down from 16 percent in 2025, as the share of plans (and enrollees in such plans) with a reduced deductible increased and the share of enrollees with a defined standard benefit remained relatively flat at 78 percent. The share of enrollees in plans designating certain formulary tiers not subject to the deductible increased significantly from 43 percent in 2025 to 56 percent in 2026. 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.

Chart 10-14 Characteristics of conventional MA–PDs, 2025–2026

	2025				2026			
	Plans		Enrollees as of April 2025		Plans		Enrollees as of April 2026	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	3,246	100%	20.2	100%	2,967	100%	20.4	100%
Type of plan								
Local HMO	1,846	57	12.2	60	1,730	58	12.3	61
Local PPO	1,363	42	8.0	39	1,205	41	7.9	39
PFFS	12	0	0.0	0	11	0	0.0	0
Regional PPO	25	1	0.1	1	21	1	0.1	0.5
Type of drug benefit								
Defined standard	27	1	0.1	<0.5	27	1	<0.1	<0.5
Actuarially equivalent	29	1	0.1	1	39	1	0.2	1
Enhanced	3,190	98	20.0	99	2,901	98	20.1	98
Type of drug deductible								
Zero	1,183	36	7.9	39	440	15	3.5	17
Reduced	1,362	42	9.9	49	1,519	51	11.7	57
Defined standard*	701	22	2.4	12	1,008	34	5.2	25
Some formulary tiers not subject to a deductible	2,027	62	12.2	61	2,497	84	16.8	82

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 group waiver 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 $590 in 2025 and is $615 in 2026.

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

> Sponsors are offering 2,967 conventional MA–PDs in 2026 compared with 3,246 in 2025 (8.6 percent fewer plans), the third straight year of declines. The vast majority of MA plans combine medical benefits with prescription drug benefits under Part D. Enrollment in conventional MA–PDs grew slightly from 20.2 million in 2025 to 20.4 million in 2026 but declined as a share of all Part D enrollees, from 45 percent in 2025 to 43 percent in 2026 (latter data not shown).

> For the second year in a row, the number of MA–PD plans offered as HMOs decreased modestly, from 1,846 in 2025 to 1,730 in 2026, though HMO plans remain the dominant type of MA–PD, making up 58 percent of all offerings and enrolling 61 percent of MA–PD beneficiaries. Local PPO offerings and enrollment remained relatively flat from 2025.

> In 2026, 98 percent of conventional MA–PDs have enhanced benefits compared with 49 percent of PDPs (see Chart 10-13). In 2026, those MA–PDs enroll 98 percent of all conventional MA–PD beneficiaries.

> This year, the second for the new Part D benefit design, plan sponsors again made significant changes to the structure of their plan offerings. In 2026, just 15 percent of conventional MA–PDs have no deductible for their Part D benefits, down from 36 percent in 2025 and 66 percent in 2024, and those plans attracted just 17 percent of conventional MA–PD enrollees, down from 77 percent in 2024, though still far more than the 4 percent of PDP enrollees in such plans (2024 data not shown) (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 again increased significantly from 61 percent in 2025 to 82 percent in 2026.

Chart 10-15 Characteristics of SNPs, 2025–2026

	2025				2026			
	Plans		Enrollees as of April 2025		Plans		Enrollees as of April 2026	
	Number	Percent	Number (in millions)	Percent	Number	Percent	Number (in millions)	Percent
Total	1,417	100%	7.0	100%	1,701	100%	7.9	100%
Type of SNP								
Chronic condition	373	26	1.1	15	544	32	1.6	21
Dual eligible	884	62	5.8	83	1,003	59	6.1	78
Institutionalized	160	11	0.1	2	154	9	0.1	2
Type of drug benefit								
Defined standard	890	63	5.1	73	242	14	0.7	8
Actuarially equivalent	23	2	<0.5	1	226	13	0.5	6
Enhanced	504	36	1.9	27	1,233	72	6.7	85
Type of drug deductible								
Zero	205	14	0.4	6	164	10	0.6	7
Reduced	182	13	0.8	12	296	17	1.6	20
Defined standard*	1,033	73	5.7	82	1,241	73	5.7	73
Some formulary tiers not subject to a deductible	252	18	0.9	13	1,271	75	6.6	83

Note: SNP (special-needs plan). The plans and enrollment described here exclude employer group waiver plans and 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 $590 in 2025 and $615 in 2026.

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, more than doubling since 2020 to 1,701 in 2026 (2020 data not shown). SNP enrollment has grown similarly, reaching 7.9 million in 2026, accounting for 17 percent of all Part D enrollees, up from 8 percent in 2020 (latter data not shown).

> SNPs for individuals who are dually eligible for Medicare and Medicaid (D–SNPs) continue to have the greatest enrollment, though their share of SNP enrollees declined again as more enrollees chose a plan specifically designated for individuals with certain chronic conditions (C–SNPs). In 2026, 59 percent of SNPs were D–SNPs, and they enrolled 78 percent of all SNP enrollees, down from 83 percent last year. The number of C–SNPs grew again to 544 in 2026; these SNPs now enroll 21 percent of SNP enrollees, up from 10 percent in 2024 (2024 data not shown). The number of SNPs for institutionalized beneficiaries decreased for the third year in a row to 154 in 2026 and continued to enroll just 2 percent of all SNP enrollees.

> While SNPs were historically much more likely than PDPs and conventional MA–PDs to offer a defined standard benefit, that is no longer true: In 2026, 72 percent of SNPs now offer enhanced coverage, up from 36 percent in 2025. In 2025, 73 percent of SNP beneficiaries were enrolled in a defined standard plan; in 2026, just 8 percent of SNP enrollees are in a defined standard plan and another 6 percent are in plans actuarially equivalent to the standard benefit, reversing a long-standing trend of SNP enrollees primarily being in basic plans.

> 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, historically, D–SNPs have more frequently used Part D's defined standard benefit design (73 percent in 2025) and were less likely to have some formulary tiers that are not subject to a deductible. Following the end of the value-based insurance design demonstration in 2025, which allowed basic plans to include supplemental benefits, most basic SNPs have converted to enhanced plans to continue offering such benefits. This change can be seen in the increase in the share of SNP enrollees with some formulary tiers not subject to the deductible, growing from just 13 percent in 2025 to 83 percent in 2026.

Chart 10-16 Change in average Part D premiums, 2017–2026

	2017	2025	2026	Change in dollars, 2017–2026
Base beneficiary premium	$35.63	$36.78	$38.99	4.89
All plans	$32	$23	$21	–$11
Basic plans	30	35	30	–0.5
Enhanced plans				
Basic benefits	27	5	7	–20
Supplemental benefits	6	13	11	6
Total premium	33	18	18	–15
All basic coverage	29	14	11	–17
PDPs	40	39	36	–5
Basic plans	31	35	31	0
Enhanced plans				
Basic benefits	42	16	15	–28
Supplemental benefits	11	25	25	13
Total premium	54	42	39	–14
All basic coverage	36	24	21	–14
MA–PDs, excluding SNPs	19	7	8	–10
Basic plans	25	32	16	–8
Enhanced plans				
Basic benefits	16	0	2	–13
Supplemental benefits	2	6	6	4
Total premium	17	7	8	–9
All basic coverage	17	1	3	–14
Average buy-down of basic premium	16	15	30	13
Average buy-down of supplemental premium	15	28	21	7
SNPs	25	30	16	–9
Basic plans	29	37	27	–2
Enhanced plans				
Basic benefits	17	–2	8	–9
Supplemental benefits	0	13	7	7
Total premium	17	11	14	–2
All basic coverage	25	26	11	–15
Average buy-down of basic premium	13	12	11	–2
Average buy-down of supplemental premium	8	9	13	6

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), SNP (special-needs plan). Calculations include PDPs and MA–PDs that are open to individual enrollment offered in the 50 states and Washington, DC. We exclude employer group waiver plans, Part B–only plans, demonstrations, and 1876 cost plans. The MA–PD data reflect the portion of MA 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. The average dollar values of the Part C rebates used to reduce Part D premiums are shown in the rows labeled "Average buy-down of basic/supplemental premiums." Average premiums are weighted by enrollment as of April 2026. "All basic coverage" reflects an average of the premiums for basic plans and the portion of premiums attributed to basic benefits in enhanced 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. Figures differ from those reported in the March 2026 report to the Congress on Medicare payment policy (Chapter 13) because that analysis used 2025 enrollment for 2026 plan premiums due to data availability.

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

(Chart continued from previous page)

Chart 10-16 Change in average Part D premiums, 2017–2026 (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 2026, Medicare is subsidizing an estimated 87 percent of the average cost of basic benefits. (For more about how plan premiums are determined and about changes that were made by the IRA, see the March 2026 report to the Congress at https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch13_MedPAC_Report_To_Congress_SEC.pdf.)

> The overall average premium paid by enrollees for any type of Part D coverage decreased in 2026 from $23 per month in 2025 to $21 per month. Without the IRA's cap on annual increases, the BBP would have been $75.38 per month in 2026 (instead of $38.99). CMS also continued a demonstration, first implemented in 2025, for stand-alone PDPs (nearly all of which chose to participate) to reduce their enrollees' monthly premiums by up to $10 per month this year and limit the annual increase in the plan's total monthly premium to no more than $50. (For more information on the demonstration, see the Commission's 2026 March report to the Congress at https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch13_MedPAC_Report_To_Congress_SEC.pdf.)

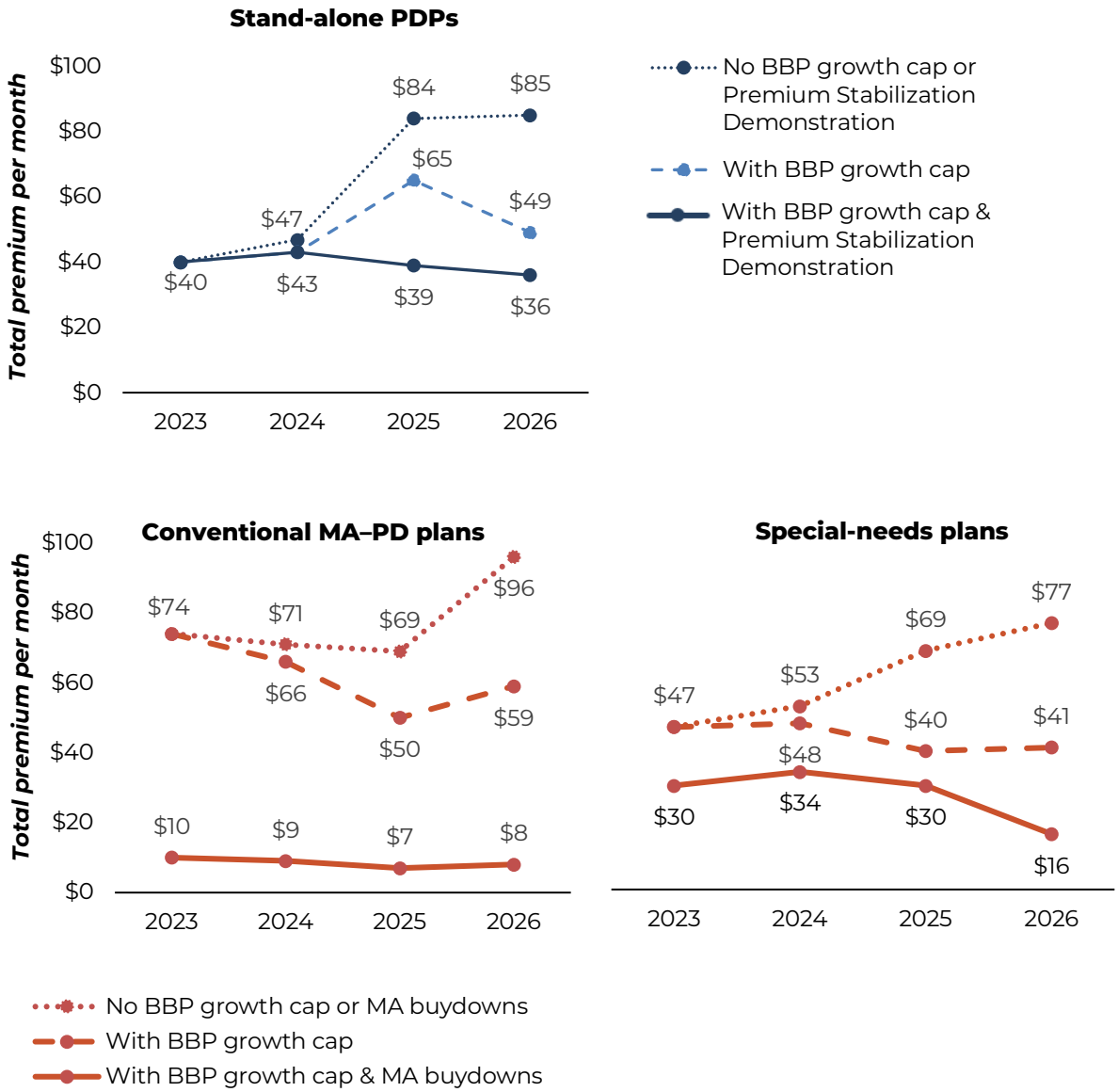
> Across all plans, the average premium for basic benefits has fallen from $29 in 2017 to $11 per month in 2026, a decline of about 60 percent, largely due to the $20 reduction in the portion of the premium attributed to basic coverage in enhanced plans. This decline occurred despite very rapid growth in spending for Part D's catastrophic phase of the benefit (see Chart 10-21). Average premiums for basic plans (not including the cost of basic coverage in enhanced plans) had increased over much of this period, but in 2026 returned to $30, the same as the 2017 premium.

> The average premium for a basic plan offered by a PDP decreased to $31 after peaking at $44 in 2024 (data not shown). The average enrollee premium for enhanced plans offered by PDPs declined from $42 in 2025 to $39, with $15 attributed to basic benefits and $25 for supplemental benefits.

> The average premium for a basic conventional MA–PD plan is now roughly half that of PDPs at $16 per month. Nearly all MA–PD enrollees, however, are in enhanced plans, for which the average premium is just $8 in 2026, a decrease of about 50 percent since 2017. MA–PD sponsors typically use a portion of payments under MA, referred to as Part C rebates, to "buy down" Part D premiums. Because of those rebates, in 2026, MA–PD enrollees avoided having to pay $30 per month in basic premiums and an additional $21 per month for supplemental coverage, on average.

> Average premiums for SNPs are higher than those for conventional MA–PDs at $16 per month in 2026, but they are still below PDP premiums. Average premiums for enhanced plans offered by SNPs are just $14. While most SNP enrollees are dually eligible for Medicaid and Medicare and have historically primarily enrolled in basic plans, that changed in 2026 (see Chart 10-15); basic plan premiums this year average $27, most or all of which is paid by Medicare's low-income subsidy. Average buy-downs among SNPs were $11 for basic benefits and $13 for supplemental coverage.

Chart 10-17 Part D premiums have been substantially lowered by Medicare policies, 2023–2026



Note: PDP (prescription drug plan), BBP (base beneficiary premium), MA–PD (Medicare Advantage Prescription Drug [plan]), MA (Medicare Advantage). Calculations include PDPs and MA–PDs that are open to individual enrollment offered in the 50 states and Washington, DC. We exclude employer group waiver plans, Part B–only plans, demonstrations, and 1876 cost plans. The "BBP growth cap" is a provision in the Inflation Reduction Act of 2022 (IRA) that limits annual growth in the BBP to no more than 6 percent, starting in 2024. The "Premium Stabilization Demonstration" refers to the Part D Premium Stabilization Demonstration that began in 2025 for PDPs whereby CMS provides additional subsidies to participating PDPs to decrease total premiums and caps year-over-year premium growth. For MA–PD plans, the "Total premium per month" refers to the Part D portion of the MA–PD premiums. Beneficiaries enrolled in MA–PDs may pay a separate premium for their MA benefits. "MA buydown" refers to MA plans' use of Part C rebates to lower Part D premiums for their enrollees. Dollar amounts are nominal figures, not adjusted for inflation. Figures differ from those reported in the March 2026 report to the Congress on Medicare payment policy (Chapter 13) because that analysis used 2025 enrollment for 2026 plan premiums due to data availability.

Source: Part D and MA bid pricing tool data, Part D landscape files, and Part D enrollment data from CMS.

(Chart continued next page)

Chart 10-17 Part D premiums have been substantially lowered by Medicare policies, 2023–2026 (continued)

> Multiple policies play a role in lowering enrollees' premiums. As the IRA redesign was expected to increase benefit costs and therefore premiums, the law specified a limit in the annual growth of the average basic Part D premium (or BBP) to 6 percent. Historically, the BBP was set to be 25.5 percent of basic benefit costs. Since the cap was implemented in 2024, it has been binding each year. Absent the cap, average premiums would have risen sharply, as illustrated by the upper dotted lines in each chart.

> CMS implemented the Part D Premium Stabilization Demonstration in 2025 in response to large increases and variation in PDP bids. The demonstration reduced participating PDPs' total premiums by up to $15 per member per month and limited annual premium increases to $35. It also narrowed risk corridors to provide more generous protection against losses. In 2026, the second year of the demonstration, CMS reduced participating PDPs' premiums by up to $10, capped annual increases in their total monthly premiums at $50, and returned risk corridors to their original parameters. As shown by comparing the top and middle lines of the top graph, the demonstration materially lowered premiums. In 2026, absent the demonstration, the average PDP premium would have been $49, but instead it averaged $36.

> MA–PDs have long reduced Part D premiums for their enrollees through "MA buydowns" financed by MA rebates. As the bottom-left chart shows, the average conventional MA–PD premium in 2026 would have been $59 in the absence of buydowns, but buydowns reduced it to $8. Special-needs plans make less use of MA buydowns to reduce Part D premiums, reflecting their high share of beneficiaries receiving the low-income subsidy, under which Medicare pays most of the Part D premium through the low-income premium subsidy amount.

Chart 10-18 Part D benchmarks for LIS premiums and number of qualifying PDPs, by region

Region	State(s)	2017		2026		Cumulative change, 2017–2026	
		Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs	Benchmark amount	Number of PDPs
1	ME, NH	$33	8	$22	3	–$11	–5
2	CT, MA, RI, VT	35	7	36	4	1	–3
3	NY	41	8	59	2	18	–6
4	NJ	41	8	54	2	13	–6
5	DC, DE, MD	33	10	31	2	–2	–8
6	PA, WV	39	9	33	3	–7	–6
7	VA	33	7	25	2	–8	–5
8	NC	31	7	36	2	5	–5
9	SC	26	6	36	2	10	–4
10	GA	26	4	25	2	–1	–2
11	FL	29	3	5	1	–24	–2
12	AL, TN	32	7	28	2	–4	–5
13	MI	34	8	9	3	–251	–5
14	OH	32	6	31	2	–1	–4
15	IN, KY	32	7	38	3	6	–4
16	WI	40	7	21	4	–19	–3
17	IL	29	9	15	2	–13	–7
18	MO	30	4	43	2	13	–2
19	AR	23	5	9	3	–14	–2
20	MS	27	7	24	2	–3	–5
21	LA	33	7	33	2	0	–5
22	TX	27	6	5	1	–23	–5
23	OK	31	7	28	3	–3	–4
24	KS	30	5	55	4	25	–1
25	IA, MN, MT, ND, NE, SD, WY	34	6	41	4	7	–2
26	NM	23	9	0	4	–23	–5
27	CO	32	7	35	2	3	–5
28	AZ	35	10	17	3	–18	–7
29	NV	27	4	9	2	–18	–2
30	OR, WA	35	8	10	3	–24	–5
31	ID, UT	40	9	38	3	–2	–6
32	CA	36	6	12	2	–24	–4
33	HI	27	5	46	4	–19	–1
34	AK	34	5	0	3	–34	–2
Average		32	7	27	3	–5	–4
Minimum		23	3	0	1	–23	–2
Maximum		41	10	59	4	18	–6

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. Dollar amounts are nominal figures, not adjusted for inflation.

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

(Chart continued next page)

Chart 10-18 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 low-income premium subsidy amount (LIPSA), that encourages beneficiaries to enroll in lower-cost PDPs. Beneficiaries who enroll in plans with premiums that are less than or equal to the LIPSA 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 LIS enrollment-weighted 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. If there is no basic PDP in a region with a premium below the benchmark, the LIPSA will equal that of the lowest-premium basic PDP; if there is a basic PDP with a premium below the benchmark, the LIPSA will equal the benchmark.

> In 2026, the lowest LIPSA was $0, in Region 26 (New Mexico) and Region 34 (Alaska), the first time a LIPSA has been $0. Region 3 (New York) again had the highest benchmark premium in 2026 at $59 per month.

> The average benchmark premium across regions (not weighted by numbers of enrollees) had risen slowly over the years, from $32 per month in 2017 to $40 in 2025 (on a nominal basis, data not shown), but fell significantly in 2026 to $27.

> In 2017, the average number of benchmark plans in a region was seven; by 2026, that figure had dropped to three, a decline of more than 50 percent. The number of benchmark plans has declined in every region over the past decade. This year, there are two regions with just one benchmark plan (Region 11, Florida, and Region 22, Texas), both of which also had just one benchmark plan in 2025. The maximum number of benchmark plans in any region in 2026 is 4, compared with 10 in 2017.

Chart 10-19 In 2026, 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	63%	66%	72%
Median cost-sharing amounts			
Tier 1: Generic drugs	$0	$0	$0
Tier 2: Other generic drugs	$10	$3	$5
Tier 3: Preferred brand-name drugs	25%	25%	21%
Tier 4: Nonpreferred drugs	31%	34%	38%
Tier 5: Specialty-tier drugs	25%	25%	28%
Drugs with any utilization management	53%	53%	55%

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]). Figures exclude employer group waiver plans, plans under CMS sanction, and plans offered in U.S. territories. In addition, MA–PDs exclude demonstration programs, special-needs plans, and 1876 cost plans. A drug was defined based on the unique products listed on CMS's formulary reference file for the 2026 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 another drug in the same therapeutic class. "Quantity limit" means that plans limit the number of doses of a drug available to the enrollee in a given time period. Results are weighted by plan enrollment.
* Includes formularies with an additional (sixth) tier for specific medications (e.g., generic drugs for certain chronic conditions) offered at $0 or low cost sharing.

Source: MedPAC analysis of formularies submitted to CMS.

> In 2026, 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 2026, on average, PDP enrollees have access to 66 percent of all Part D–covered products, compared with 72 percent among MA–PD enrollees. That share was lower (63 percent) for beneficiaries enrolled in benchmark plans—a subset of basic PDPs for which enrollees with the low-income subsidy do not have to pay a premium. This difference likely reflects the fact that nearly all MA–PD enrollees are in enhanced plans that offer more generous benefits than basic plans compared with just 57 percent of PDP enrollees (see Chart 10-13 and Chart 10-14).

> The median copay in 2026 is $0 for a generic drug on a lower tier and between $3 and $10 for other generic drugs. The use of coinsurance (a percentage of the total payment) for the preferred brand-name drug tier has risen in recent years, with nearly all PDP enrollees and 57 percent of MA–PD enrollees in such plans in 2026, up from 84 percent and about 30 percent in 2025, respectively (data not shown). For PDP enrollees, the median coinsurance rate for the preferred brand-name drug tier rose to 25 percent, up from 21 percent in 2025, while the median coinsurance rates for nonpreferred drugs declined by 6 percentage points and 3 percentage points for PDPs and MA–PDs, respectively, in 2026 (2025 data not shown). The median coinsurance rates for specialty-tier drugs averaged 25 percent and 28 percent for PDPs and MA–PDs, respectively.

> 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 2026, both PDPs and MA–PDs typically use some form of utilization management for more than half of plans' formulary drugs, averaging 53 percent and 55 percent, respectively.

Chart 10-20 Components of Part D spending growth, 2015–2024

	2015	2024	Average annual growth 2015–2024
Total gross spending (in billions)	$137.4	$288.9	8.6%
High-cost beneficiaries	78.9	184.3	9.9
Lower-cost beneficiaries	58.5	104.5	6.7
Number of beneficiaries using a Part D drug (in millions)	38.9	53.3	3.6
High-cost beneficiaries	3.6	4.4	2.1
Lower-cost beneficiaries	35.3	48.9	3.7
Amount per beneficiary who used Part D drugs			
Gross drug spending per year	$3,531	$5,422	4.9
Average price per 30-day prescription	$66	$92	3.8
Number of 30-day prescriptions	53.7	59.0	1.1
Amount per high-cost beneficiary who used Part D drugs			
Gross drug spending per year	$21,642	$41,949	7.6
Average price per 30-day prescription	$193	$356	7.0
Number of 30-day prescriptions per month	9.5	10.0	0.6
Amount per lower-cost beneficiary who used Part D drugs			
Gross drug spending per year	$1,658	$2,139	2.9
Average price per 30-day prescription	$34	$40	1.7
Number of 30-day prescriptions per month	4.3	4.7	1.1

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 (POS). Changes in the average price per prescription, measured by gross spending at the POS, 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 enrollment data from CMS.

> Between 2015 and 2024, gross spending on drugs covered under the Part D program grew by an annual average rate of 8.6 percent on a nominal basis. The annual growth in spending was considerably higher (9.9 percent) among high-cost beneficiaries (individuals who incurred spending high enough to reach the catastrophic phase of the benefit) than among lower-cost beneficiaries (6.7 percent).

> Between 2023 and 2024, the number of high-cost beneficiaries declined, reversing the trends of faster growth among high-cost beneficiaries through 2023. As a result, for the 2015 to 2024 period, the number of high-cost beneficiaries grew more slowly (2.1 percent) than lower-cost beneficiaries (3.7 percent). This shift likely reflects implementation of the policy to reflect pharmacy fees at the POS beginning in 2024, which slowed progression to the catastrophic phase of the benefit.

> The average price per 30-day prescription covered under Part D rose from $66 in 2015 to $92 in 2024. Overall, growth in price per prescription accounted for most (3.8 percentage points) of the 4.9 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 (7.0 percent) accounted for nearly all of the spending growth (7.6 percent). In contrast, among lower-cost beneficiaries, the increase in the number of prescriptions (1.1 percent) accounted for over a third of the spending growth (2.9 percent).

Chart 10-21 Part D spending and use per enrollee, 2024

	Part D	Plan type		LIS status	
		PDP	MA–PD	LIS	Non-LIS
Total gross spending (billions)	$288.9	$124.5	$164.4	$129.3	$159.5
Above OOP threshold (billions)	125.3	55.2	70.2	66.8	58.5
Share above OOP threshold	*43%*	*44%*	*43%*	*52%*	*37%*
Total number of prescriptions (billions)	3.1	1.3	1.9	1.1	2.1
Average spending per prescription	$92	$97	$88	$122	$76
Share of beneficiaries with no drug use	6%	6%	6%	8%	5%
Per enrollee per month					
Total gross spending*	$442	$448	$438	$723	$337
OOP spending	27	37	20	3	36
Manufacturer gap discount	32	39	27	N/A	44
Plan liability	307	303	310	515	228
Low-income cost-sharing subsidy	55	42	65	201	N/A
Number of prescriptions	4.8	4.6	5.0	5.9	4.4

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 and the exclusion of the Patient Liability Reduction Due to Other Payer (PLRO) amount. LIS status is based on receipt of the LIS at any point during the year.
* Total gross spending includes the portion of prescription drug costs covered by secondary, non-Medicare payers, referred to as the PLRO. The average PLRO amount was about $22 in 2024.

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

> In 2024, gross spending on drugs covered under the Part D program totaled about $289 billion, with 43 percent ($124.5 billion) accounted for by Medicare beneficiaries enrolled in PDPs. Beneficiaries who receive the LIS (about 27 percent) accounted for about 45 percent ($129 billion) of the total. About 43 percent of gross spending was incurred after a beneficiary reached the annual OOP threshold ($8,000 in 2024). This share was higher among LIS enrollees (52 percent) compared with other enrollees (37 percent).

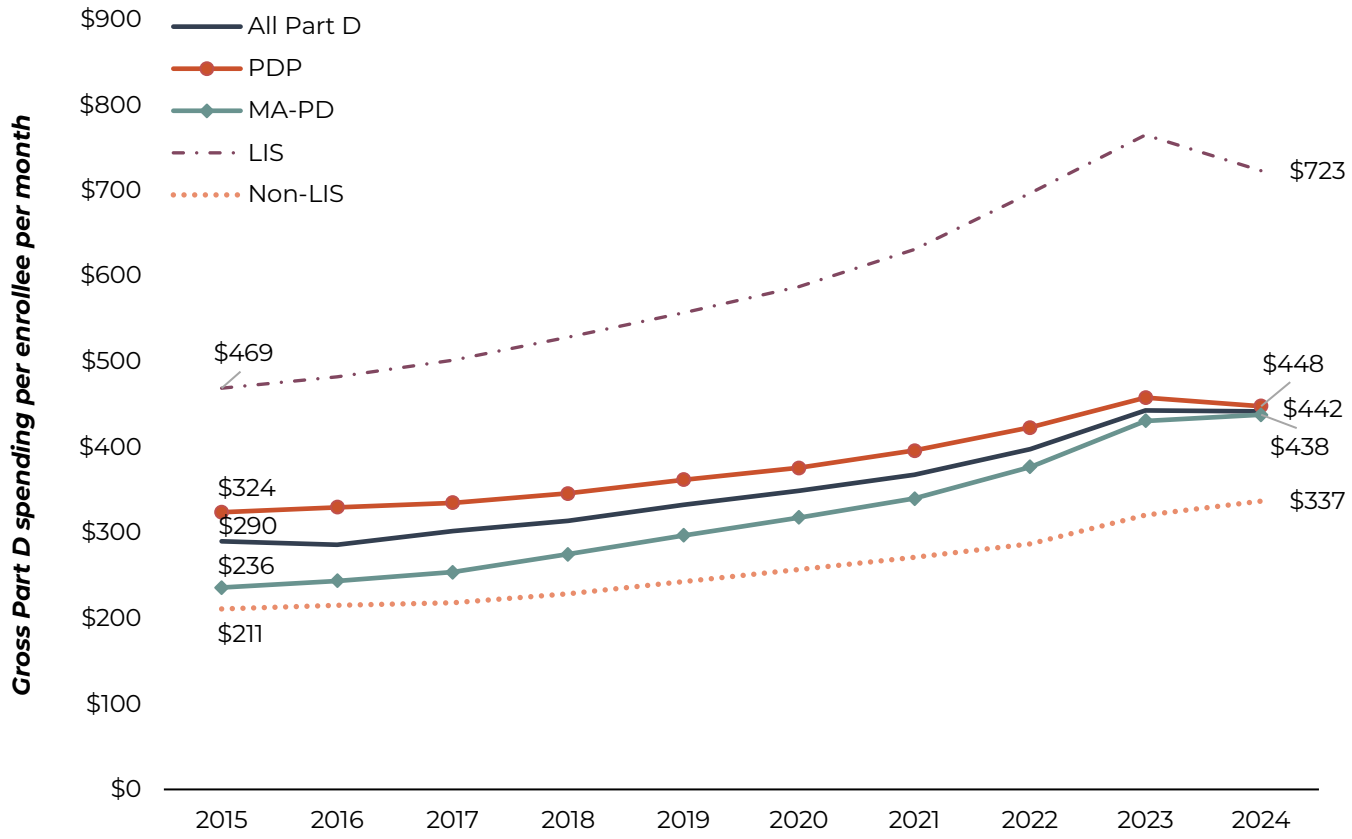
> The number of prescriptions filled by Part D enrollees totaled 3.1 billion, with 41 percent (1.3 billion) accounted for by PDP enrollees and about 34 percent (1.1 billion) accounted for by LIS enrollees. Overall, 6 percent of Part D enrollees did not fill any prescriptions during the year.

> In 2024, Part D enrollees filled 4.8 prescriptions at $442 per month on average, a slight decrease from $443 per month (for 4.7 prescriptions) in 2023 (2023 data not shown). The average monthly plan liability for PDP enrollees ($303) was lower than that of MA–PD enrollees ($310), reversing the pattern observed since the program began in 2006. The average monthly OOP spending for enrollees in PDPs ($37) was higher than in MA–PDs ($20), likely reflecting the fact that most MA–PDs offer supplemental benefits that reduce enrollee cost sharing. Medicare's monthly low-income cost-sharing subsidy per enrollee was higher for MA–PDs ($65) than for PDPs ($42), reflecting the greater share of MA–PD enrollees receiving the LIS.

> Average monthly spending per LIS enrollee ($723) was more than double that of a non-LIS enrollee ($337), and the average number of prescriptions filled per month by an LIS enrollee was 5.9 compared with 4.4 for a non-LIS enrollee. LIS enrollees had much lower monthly OOP spending, on average, than non-LIS enrollees ($3 vs. $36, respectively). Part D's LIS pays for most of the cost sharing for LIS enrollees, averaging $201 per month in 2024, down from $232 in 2023 (2023 data not shown).

> 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 total gross spending ($32 per enrollee per month), or nearly 13 percent of the average gross spending by non-LIS enrollees.

Chart 10-22 Trends in Part D spending per enrollee per month, 2015–2024



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.

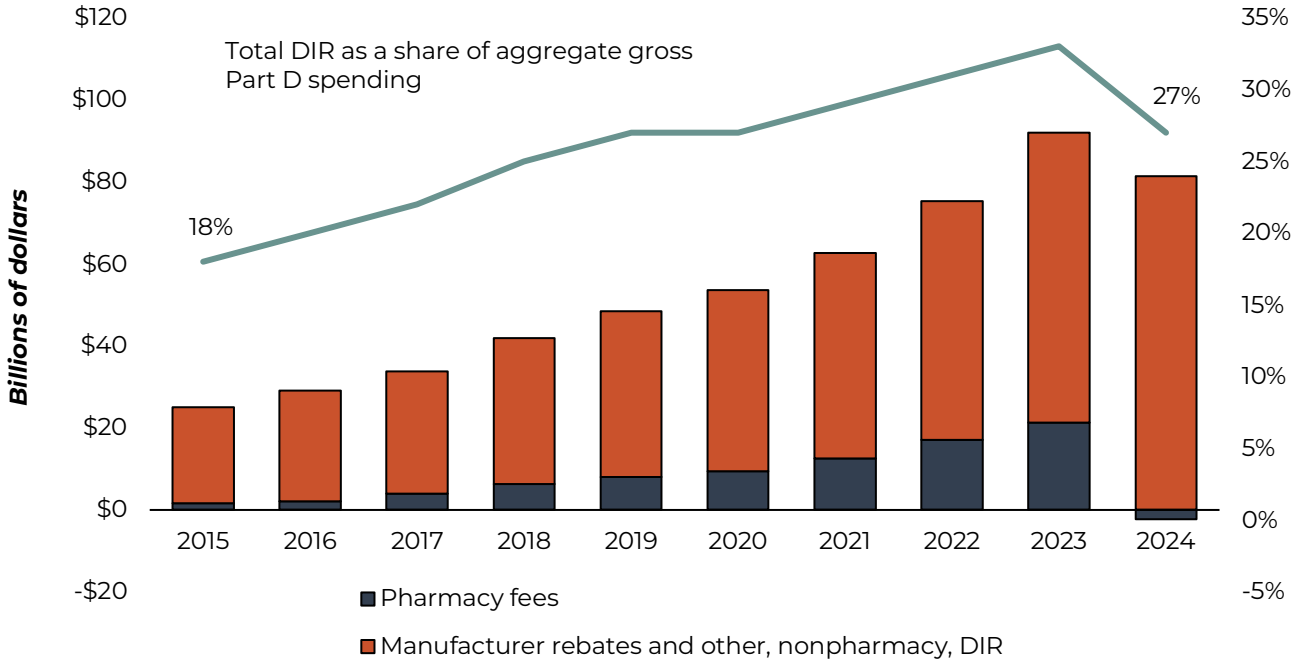
Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

> Between 2015 and 2024, per capita spending per month for Part D–covered drugs grew from $290 to $442 on a nominal basis, an average growth rate of 4.8 percent annually, or about 53 percent cumulatively.

> The flattening of growth between 2023 and 2024 reflects divergent spending trends between LIS and non-LIS enrollees. Monthly per capita spending for LIS enrollees declined from $765 in 2023 to $723 in 2024. In contrast, spending for non-LIS enrollees continued to increase to $337 in 2024. These differences reflect 2024 policies that lowered prices by applying pharmacy fees at the point of sale and eliminated cost sharing in the catastrophic phase of the benefit. The latter affected only non-LIS enrollees who, before 2024, paid 5 percent coinsurance for prescriptions filled in the catastrophic phase of the benefit. The net effect of these two policies was per capita spending growth of about 5 percent among non-LIS enrollees, compared with a decline of over 5 percent for LIS enrollees. The number of standardized 30-day prescriptions filled by LIS and non-LIS enrollees grew by about 8 percent and 9 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 2015 to 2024 period (annual average growth of 7.1 percent and 3.7 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 2024, the difference was $10 per month, down from $27 per month in 2023.

Chart 10-23 Postsale manufacturer rebates and pharmacy fees expanded rapidly in Part D, 2015–2024



Note: DIR (direct and indirect remuneration). "Gross Part D 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. Dollar amounts are nominal figures, not adjusted for inflation.

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." Medicare keeps a portion of DIR to offset some of its reinsurance subsidies to plans. While large rebates help to constrain premium increases, using DIR 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 2015 and 2024, DIR increased substantially from about $25 billion to $92 billion in 2023, before declining to about $79 billion in 2024. This decline reflects the new requirement to reflect pharmacy DIR at the point of sale beginning in 2024. As a result of this policy change, plans, on net, paid pharmacies about $2.2 billion as part of the postsale adjustments, resulting in total DIR accounting for about 27 percent of gross Part D spending, down from 33 percent in 2023.

> 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 10-24 Incidence of Part D spending by type of product, 2024

			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	Retroactive pharmacy fees*
Brand-name drugs	$195.6	18%	24%	12%	5%	9%	31%	1%
Biologics	54.4	16	37	9	3	7	28	<1
Generic drugs	36.1	49	15	18	19	N/A	<1	-1
All products covered under Part D**	288.9	21	25	12	6	7	27	1

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.
* Beginning in 2024, payments to pharmacies must reflect the lowest possible negotiated rates, requiring Part D plans to apply the maximum possible pharmacy fees at the point of sale. Accordingly, retroactive pharmacy fees are expected to be near zero or negative, though they were positive for brand-name drugs and biologics. One possibility is that the positive amounts reflect pharmacy fees collected for prior-year claims.
** 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 2024, over 86 percent of total gross Part D spending was for brand-name drugs ($195.6 billion, or nearly 68 percent) or biologics ($54.4 billion, or about 19 percent). Generic drugs accounted for 12.5 percent ($36.1 billion) of gross spending. The requirement to apply pharmacy fees at the point of sale (POS) beginning in 2024 put downward pressure on gross prices and eliminated nearly all retroactive pharmacy fees, which totaled just under 1 percent of gross spending at the POS, down from 8 percent in 2023 (2023 data not shown). However, the impact of this policy change differed across drug types. For example, in 2023, pharmacy fees accounted for a larger share of gross spending for generic drugs (12 percent) compared with brand-name drugs (7 percent) (data not shown).

> 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 16 percent of spending on biologics (including biosimilars), while Medicare covered 37 percent through Part D's reinsurance. In contrast, for generic drugs, Medicare's reinsurance accounted for 15 percent of gross spending compared with 49 percent for plans. Medicare's low-income subsidy, on average, accounted for a higher share of gross spending for generic drugs (18 percent) compared with brand-name drugs (12 percent) or biologics (9 percent).

> On average, beneficiaries' cost sharing accounted for 19 percent of gross spending for generic drugs compared with 5 percent for brand-name drugs and 3 percent for biologics. Cost sharing as a share of gross spending was substantially lower for brand-name drugs and biologics in part because these products are more likely to be filled in the catastrophic phase of the benefit, in which, beginning in 2024, beneficiaries pay no cost sharing. (See Chart 10-12 for changes in benefit parameters.)

> Coverage-gap discounts and postsale rebates and fees paid by pharmaceutical manufacturers accounted for 7 percent and 27 percent of gross spending, respectively, across all Part D–covered products. Nearly all of those payments were for brand-name drugs and biologics.

Chart 10-25 Top 15 therapeutic classes of drugs covered under Part D, by gross spending, 2024

	Gross spending		Negotiated rebates as a share of gross spending	Coverage-gap discount (billions)
	Billions	Percent		
Antineoplastics	$42.8	14.8%	<10%	$1.3
Antidiabetic agents—injectable	34.9	12.1	40–49	5.4
Anticoagulants	27.4	9.5	40–49	3.9
Antidiabetic agents—oral	25.4	8.8	≥50	3.2
Asthma/COPD therapy agents	16.4	5.7	40–49	1.3
Disease-modifying anti-rheumatoid drugs	14.6	5.0	30–40	0.6
Antihypertensive therapy agents	10.8	3.7	10–19	0.8
Antiretrovirals	8.7	3.0	<10	0.3
Dermatological (antipsoriatics)	8.6	3.0	20–29	0.2
Antipsychotics (neuroleptics)	8.2	2.9	<10	0.1
Ophthalmic agents	6.1	2.1	30–40	0.4
Antihyperlipidemics	5.7	2.0	20–29	0.5
Movement-disorder drug therapy	3.7	1.3	<10	0.1
Urinary incontinence treatment agents	3.7	1.3	≥50	0.3
Anticonvulsants	3.4	1.2	<10	<0.1
Subtotal, top 15 drug classes	220.2	76.2	30%	18.4
Total, all drug classes	288.9	100.0	27%	20.9

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 2024, the top 15 therapeutic classes by gross spending accounted for about 76 percent of the $289 billion spent on prescription drugs covered by Part D plans. Antineoplastics topped the list, with spending totaling $42.8 billion, up 24 percent from $34.4 billion in 2023 (latter data not shown). Diabetic therapies—which include injectable antidiabetic agents (12.1 percent), such as insulins and glucagon-like peptide-1 receptor agonists, and oral antidiabetic agents (8.8 percent)—continued to dominate the list, accounting for just over 20 percent of total gross Part D spending.

> In 2024, 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 30 percent of gross spending, higher than the average of 27 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 2024, these top 15 classes accounted for 88 percent ($18.4 billion) of all coverage-gap discounts. Diabetic therapies alone accounted for 41 percent of all coverage-gap discounts.

Chart 10-26 Despite high generic use, brand-name drugs accounted for the majority of spending in the top 15 therapeutic classes by spending, 2024

	Prescriptions*		Generic dispensing rate	Brand share of gross spending	LIS share of prescriptions
	Millions	Percent			
Antineoplastics	17.7	0.6%	84%	91%	24%
Antidiabetic agents—injectable	68.9	2.2	5	99	46
Anticoagulants	63.3	2.0	17	99	30
Antidiabetic agents—oral	170.0	5.4	73	97	36
Asthma/COPD therapy agents	93.4	3.0	63	89	45
Disease-modifying anti-rheumatoid drugs	3.5	0.1	35	100	47
Antihypertensive therapy agents	315.2	10.0	97	81	27
Antiretrovirals	3.2	0.1	19	98	66
Dermatological (antipsoriatics)	1.2	<0.1	21	99	51
Antipsychotics (neuroleptics)	38.1	1.2	91	85	71
Ophthalmic agents	69.9	2.2	86	78	30
Antihyperlipidemics	378.4	12.0	98	60	26
Movement-disorder drug therapy	0.6	<0.1	5	99	76
Urinary incontinence treatment agents	24.3	0.8	69	88	37
Anticonvulsants	116.6	3.7	99	46	48
Subtotal, top 15 drug classes	1,364.2	43.4	82	92	34
Total, all drug classes	3,145.6	100.0	90	87	34

Note: LIS (low-income subsidy), 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. The calculation of the overall generic dispensing rate excludes non–prescription drug items (e.g., insulin needles). Components may not sum to totals due to rounding.
* Prescriptions are standardized to a 30-day supply.

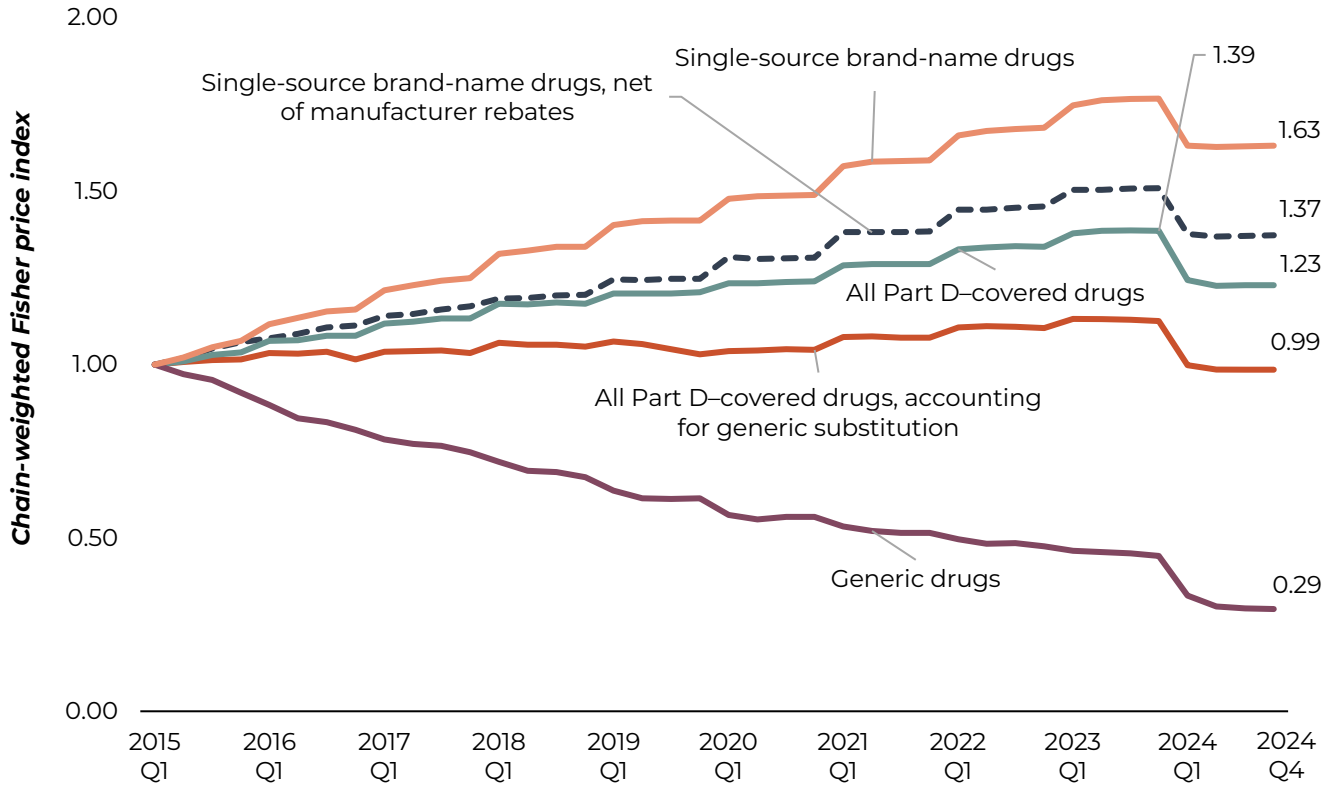
Source: MedPAC analysis of Medicare Part D prescription drug event and direct and indirect remuneration data from CMS.

> Filled prescriptions in the top 15 therapeutic classes by spending in 2024 (see Chart 10-25) totaled 1.36 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 92 percent of the gross spending for these products in 2024.

> In 2024, LIS beneficiaries filled 34 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 antiretrovirals (66 percent), antipsychotics (71 percent), and movement-disorder drug therapy (76 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 2024, generic drugs accounted for 84 percent of prescriptions for antineoplastics, but brand-name drugs accounted for 91 percent of gross spending for that class.

Chart 10-27 Postlaunch price growth for Part D–covered drugs, 2015–2024



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 10-20), 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 analysis for MedPAC.

> Measured by individual NDCs, prices of drugs and biologics covered under Part D rose 39 percent cumulatively between 2015 and 2023 on a nominal basis (an index of 1.39) before declining by 16 percentage points, from 1.39 to 1.23 in 2024. Much of this decline likely reflects the implementation of the requirements to reflect pharmacy fees at the point of sale beginning in 2024. (Prices reflect total amounts paid to pharmacies and do not reflect retrospective rebates or discounts from manufacturers or postsale pharmacy fee adjustments.)

> Overall, between 2015 and 2024, prices of generic drugs covered under Part D fell to 29 percent of the average price observed at the beginning of 2015. While generic prices have historically declined over time, the magnitude of the decrease between 2023 and 2024 represented a departure from recent trends, likely owing to the implementation of the policy related to pharmacy fees.

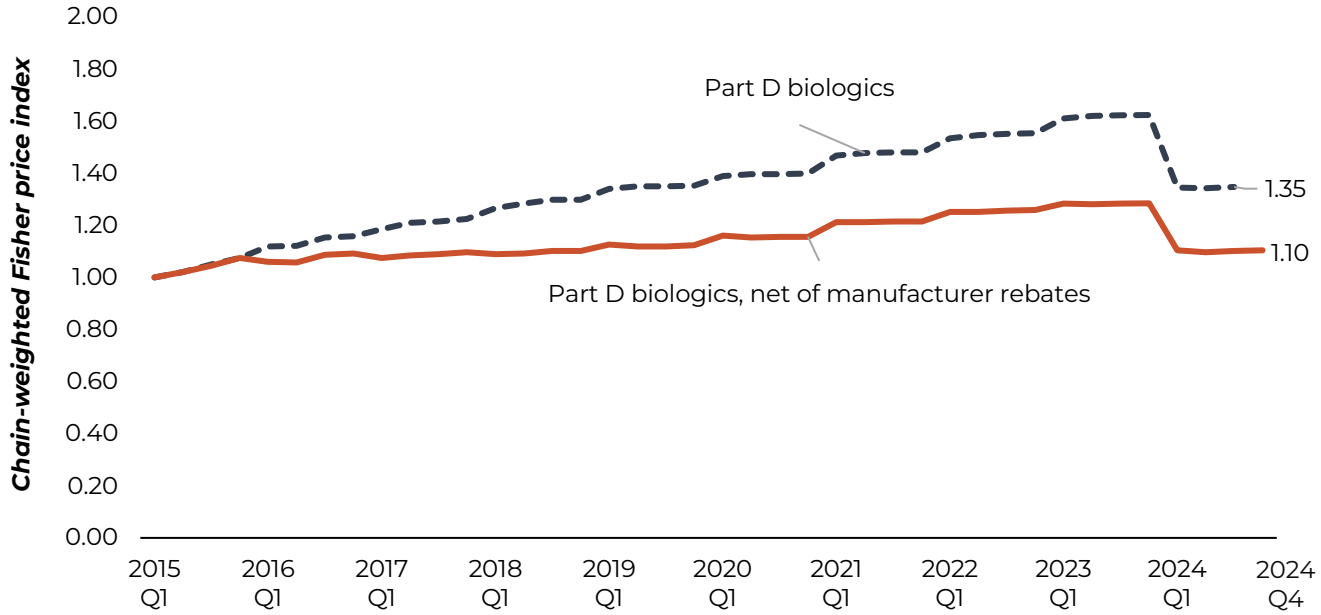
(Chart continued next page)

Chart 10-27 Postlaunch price growth for Part D–covered drugs, 2015–2024 (continued)

> When measured by a price index that takes generic substitution into account, Part D prices have remained relatively flat during this period, with prices at the end of 2024 about 1 percent below the prices at the beginning of 2015 (an index of 0.99). New and increased generic competition for selected therapeutic classes—such as anticonvulsants, antineoplastics, and drugs for multiple sclerosis—as well as this policy related to pharmacy fees played a key role in slowing the growth in overall Part D prices during this period.

> Between 2015 and 2024, prices for all single-source, brand-name drugs (drugs with no generic substitutes) grew by a cumulative 63 percent (an index value of 1.63), compared with 37 percent (an index value of 1.37) for prices net of manufacturer rebates.

Chart 10-28 Postlaunch price growth for biologics covered under Part D, 2015–2024



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. 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 analysis for MedPAC.

> Measured by individual NDCs, prices of biologics (without retrospective rebates, fees, or discounts) covered under Part D rose 62 percent cumulatively between 2015 and 2023 on a nominal basis (an index of 1.62), before declining by 27 percentage points, from 1.62 to 1.35 in 2024. In comparison, between 2015 and 2023, prices of biologics net of retrospective rebates and discounts from manufacturers grew by a cumulative 28 percent (an index value of 1.28), before declining by 18 percentage points, from 1.28 to 1.10 in 2024. These declines likely reflect the effects of a policy related to pharmacy fees (see Chart 10-27) as well as a substantial drop in insulin prices at the point of sale between 2023 and 2024 (from an index of 1.60 to 0.73) (data not shown).

> 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. In 2024, that share declined to about 14 percent, primarily as a result of lower point-of-sale prices for insulins (data not shown).