Medicare is the government program that insures many of the nation’s retirees and Americans with disabilities. Coverage for prescription medicines filled at a pharmacy first became available in 2006 under the Medicare Part D program. Private health plans administer the program and compete for beneficiary enrollment. These plans also negotiate with manufacturers, without government interference, to secure savings on medicines. This market-based approach has been successful since the program’s beginning, but some in Washington now are considering fundamental change. The information that follows is based on the Part D benefit design and program rules in place at the end of 2021.

This chart pack contains information on prescription drug coverage under Part D in four subsections: 101, Choice and Competition, Improved Adherence and Outcomes, and A Prescription for the Future.
As Is Common With Commercial Insurance, Medicare Covers Medicines Under 2 Benefits

Medicare’s retail pharmacy benefit is called Part D, and Medicare’s medical benefit is called Part B.

<table>
<thead>
<tr>
<th>MEDICARE</th>
<th>COMMERCIAL INSURERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Part D</strong></td>
<td><strong>Retail Pharmacy Benefit</strong></td>
</tr>
<tr>
<td>Includes most drugs, which are either picked up by patients at a retail pharmacy or delivered via mail order/specialty pharmacy.</td>
<td></td>
</tr>
<tr>
<td><strong>Part B</strong></td>
<td><strong>Medical Benefit</strong></td>
</tr>
<tr>
<td>Includes a minority of drugs, which generally must be administered by a physician or other health care professional</td>
<td></td>
</tr>
</tbody>
</table>

Source: McDonald R¹
PART D operates with plans competitively bidding against one another. Plans aggressively negotiate with manufacturers to secure discounted prices from manufacturers. In some cases, these negotiated savings are over and above mandatory discounts from manufacturers.

**PART D**

**PLANS** compete to deliver comprehensive, affordable coverage for beneficiaries and value for taxpayers.

**MANUFACTURERS** provide significant negotiated rebates and mandatory coverage gap payments that help fund the program.

**BENEFICIARIES** choose the plan with the coverage and costs that best meet their needs.

**EXTRA HELP** is available for enrollees of limited means through the Low-Income Subsidy program.

**GOVERNMENT** sets standards/oversees competition.
Medicare Part D plans covered more than 47 million beneficiaries out of more than 60 million total Medicare enrollees in 2020, either through Medicare Advantage or stand-alone prescription drug plans.

Prescription Drug Coverage Among Part D Medicare Beneficiaries, 2020*

- Prescription drug plan (PDP): 25.1M
- Medicare Advantage—PDP: 21.9M
- Employer/union-only group waiver plan: 7.2M
- Retiree drug subsidy: 1.9M

*Excludes federal government and military retirees covered by either the Federal Employees Health Benefit Program or the TRICARE for Life program. Such programs qualify for the retiree drug subsidy, but the subsidy is paid since it would amount to the federal government subsidizing itself. Excludes those who had no drug coverage or had coverage less generous than Part D.

Source: MedPAC²
Part D Defined Standard Benefit

<table>
<thead>
<tr>
<th>INITIAL COVERAGE</th>
<th>COVERAGE GAP aka “Donut Hole”</th>
<th>CATASTROPHIC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td><strong>PAYMENT RESPONSIBILITY:</strong></td>
<td><strong>PAYMENT RESPONSIBILITY:</strong></td>
</tr>
<tr>
<td>Beneficiary pays: 25%</td>
<td>Plan pays: 75%</td>
<td>Beneficiary pays: 25%</td>
</tr>
<tr>
<td>Beneficiary pays: 100%</td>
<td>Manufacturer pays: 70%</td>
<td>Beneficiary pays: 5%</td>
</tr>
</tbody>
</table>

Each year, the standard benefit’s parameters change at the same rate as the annual change in beneficiaries’ average drug expenses. For 2021, discounts paid by brand manufacturers begin when a beneficiary without the Low-Income Subsidy has reached $4,130 in cumulative drug spending and continue until the individual reaches $6,550 in combined out-of-pocket spending and brand discounts.

Source: MedPAC³
Bipartisan Budget Act of 2018 Closed the Coverage Gap in 2019 and Beyond

Since 2010, nearly 12 million Medicare beneficiaries have saved over $26 billion on prescription drugs as a result of manufacturer coverage gap discounts—an average savings of about $2,272 per beneficiary.⁴

**STARTING IN 2019⁵:**

- **Manufacturers’ brand discount increased to 70%, plans’ liability decreased to 5%.
- **Beneficiaries** pay 25% cost sharing in the coverage gap, similar to the pre-coverage gap cost sharing in a standard plan.

Sources: CMS⁴; KFF⁵
Part D Share of Medicare Expenditures

Medicare Part D drug spending, including brand and generic drugs, made up 11% of Medicare spending in 2019.

Source: PhRMA calculation of Congressional Budget Office (CBO) data.

*Not including outlays for mandatory administration. Medicare Advantage (Part C) expenditures are apportioned among Parts A, B, and D according to type of service. Does not sum to 100% due to rounding.

Source: PhRMA calculation of Congressional Budget Office (CBO) data®
Medicare Part D Spending Growth per Enrollee Has Been Stable Over Time

Net Per Capita Spending in Medicare Part D

- **2010**: $2,620
- **2015**: $2,660

Average annual rate of increase: +0.3%

Source: CBO
Average Beneficiary Premiums Are Far Below Government’s Original Estimates

Average Monthly Part D Beneficiary Premium, 2010-2021

*All prior projection estimates are rounded to the nearest dollar.

Sources: CMS; Medicare Trustees
Part D Expanded Coverage, Improved Access to Medicines, and Reduced Out-of-Pocket Costs

As a result of Part D, nearly 90% of Medicare beneficiaries have comprehensive drug coverage. Peer-reviewed research confirms Medicare Part D substantially reduced out-of-pocket costs and increased access to medicines.

Sources: PhRMA analysis of data from The Lewin Group and CMS; Joyce GF et al; Duggan MG et al; Lichtenberg F et al; Yin W et al; Ketcham JD et al

Across several studies:

- 13.1%-24% decrease in out-of-pocket costs
- 4.7%-12.8% increase in use of prescription medicines

Sources: PhRMA analysis of data from The Lewin Group and CMS; Joyce GF et al; Duggan MG et al; Lichtenberg F et al; Yin W et al; Ketcham JD et al
Beneficiary Satisfaction With Part D

Several surveys show that more than 9 in 10 Part D enrollees are satisfied with their coverage and indicate that their coverage works well.\textsuperscript{18,19}

Source: MedPAC\textsuperscript{18,19}
Part D Enrollees’ Satisfaction Is High Across Several Dimensions

Beneficiaries report that their plans are affordable and work well.

August 2020 Ratings

<table>
<thead>
<tr>
<th>Feature</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having variety of plans to compare and choose from is important</td>
<td>80%</td>
</tr>
<tr>
<td>Total out-of-pocket costs are reasonable</td>
<td>81%</td>
</tr>
<tr>
<td>Monthly premiums are affordable</td>
<td>84%</td>
</tr>
<tr>
<td>Plan provides good value</td>
<td>87%</td>
</tr>
<tr>
<td>Plan works well</td>
<td>90%</td>
</tr>
<tr>
<td>Plan is convenient to use</td>
<td>93%</td>
</tr>
</tbody>
</table>

Source: Medicare Today
Satisfaction With Part D Is High Among the Most Vulnerable Beneficiaries

Dual eligibles and beneficiaries with limited incomes exhibit the highest satisfaction rate with their drug coverage.

Satisfaction of Selected Groups of Part D Enrollees, 2014*

<table>
<thead>
<tr>
<th>Category</th>
<th>Satisfied</th>
<th>Not satisfied</th>
</tr>
</thead>
<tbody>
<tr>
<td>All seniors with Medicare Rx</td>
<td>86%</td>
<td>13%</td>
</tr>
<tr>
<td>Dual eligibles†</td>
<td>95%</td>
<td>1%</td>
</tr>
<tr>
<td>Limited income‡</td>
<td>92%</td>
<td>8%</td>
</tr>
<tr>
<td>Individuals with disabilities</td>
<td>81%</td>
<td>19%</td>
</tr>
</tbody>
</table>

*Excludes nonrespondents
†Dual eligibles are those enrolled in both Medicare and Medicaid. Dual eligibles not choosing a Part D plan are autoenrolled in a plan.
‡Limited income is defined as less than $15,000.

Source: KRC Research21
Competition in Part D Promotes Access and Helps Control Costs

**Mechanisms to PROMOTE ACCESS**
- Plans compete for enrollees based on benefits, quality, and price.
- Beneficiaries have a choice among plans to best meet their needs.
- Enrollees can switch plans each year during open enrollment.
- Premium and cost-sharing subsidies assist low-income beneficiaries.
- There are no limits on the number of prescriptions.
- Defined standard benefit and formulary rules set minimum plan requirements.

**Mechanisms to CONTROL COSTS**
- Plans are paid based on competitive bids submitted each year.
- Plans and manufacturers negotiate discounts for covered medicines.
- Plans attract enrollment through lower premiums and quality of coverage.
- Plans use tiered formularies, tiered copays, and other utilization management tools.

Source: PhRMA analysis of data from MedPAC\(^2\)}
Beneficiaries Have Broad Choice of Plans

Part D beneficiaries have 24 to 32 stand-alone prescription drug plan options in each state. More than 80% of beneficiaries indicate that having a variety of plans to choose from is important to them.23

Number of Stand-Alone PDPs per State (2020)24

Sources: Medicare Today23; Avalere Health24
Medicare—Part D: Choice and Competition

Six Protected Classes Policy Ensures Access to Appropriate Medicines for Vulnerable Enrollees

Part D plans are required to cover “all or substantially all” medications within 6 classes and categories: anticonvulsants, antidepressants, antineoplastics, antipsychotics, antiretrovirals, and immunosuppressants.

THE SIX PROTECTED CLASSES POLICY PROTECTS PATIENTS

- Ensures enrollees with serious and debilitating conditions, including HIV, epilepsy, organ transplants, cancer, and mental health conditions, have access to appropriate treatments, as many medicines are not interchangeable.
- Ensures that Medicare enrollees reliant on these medicines would not be substantially discouraged from enrolling in Part D plans.

TOOLS ARE IN PLACE TO CONTROL UTILIZATION IN THE SIX PROTECTED CLASSES

- Plans use formulary tiers and cost sharing to spur competitive utilization of generics. The generic utilization rate in the six protected classes is as high as 84%.
- There is widespread evidence that plans have ample flexibility to manage utilization among Part D beneficiaries.

Plans apply prior authorization or step therapy policies for a majority of branded drugs (54%) in the protected classes.

Sources: CMS; SSA; The PEW Charitable Trusts; Partnership for Part D Access
Virtually All Brand Medicines Covered in Part D Have at Least 1 Competitor

Part D Medicine Spending by Type of Competition, 2019*

- Generics and brands that have generic equivalents: 29%
- Brands without generic equivalents but in classes that include generics: 63%
- Brands in class with competing brands (but no generics): 8%
- Brand medicines alone in their class: <0.001%

*Class analysis is based on United States Pharmacopeia (USP) classification system. Part D plans are generally required to cover 2 medicines per USP class, and Centers for Medicare & Medicaid Services (CMS) uses USP to review Part D plan formularies to ensure plans meet formulary standards.

Source: Avalere Health29
Enrollees Typically Do Not Benefit From Rebates and Discounts at the Pharmacy

Large, powerful Part D purchasers negotiate sizable discounts and rebates with drug manufacturers on behalf of Medicare beneficiaries. For the top-200 brand medicines ranked by total Part D spending, rebates and discounts nearly doubled from 2014 to 2016. According to the Medicare Trustees, Part D rebates have increased each year of the program.

Sources: GAO; Medicare Trustees

PART D PLANS negotiate discounts with manufacturers.

These savings are often used to help reduce premiums, not enrollees’ cost sharing.
The Gap Between List and Net Price Growth for Medicines Is Driven by Rebates and Discounts

Estimated Gross and Net Spending in Medicare Part D in Billions, 2011-2019

Source: Avalere Health

Gross brand spending
Net brand spending

Source: Avalere Health
Medicare Plan Finder Is a Tool for Beneficiaries to Help Make Part D Plan Selections Each Year

The Medicare Plan Finder, available on Medicare.gov, allows beneficiaries to enter their individual drug lists and find out which plans cover their medicines and their expected out-of-pocket costs for the year. Beneficiary choice of plans is a key feature of Part D’s competitive structure. *

OPEN ENROLLMENT

The annual open enrollment period is from October 15 to December 7 each year.

STAR RATINGS

Plans are rated overall using a 5-star rating system, and Plan Finder provides information on how plans are performing on specific dimensions, such as customer service and patient safety.

*It is important to know what is and is not reflected in Plan Finder drug prices to ensure the information is not interpreted in a misleading way. For example, Plan Finder drug prices typically do not reflect the rebates and discounts negotiated between Part D plans and biopharmaceutical manufacturers.

Source: Medicare.gov™
Illustrative Pharmaceutical Lifecycle

New prescription medicines typically face competition after a relatively short time on the market, first from brand competitors and eventually from generics.

*Brand medicines limited to small molecule drugs. Brand medicine market share typically declines rapidly after generic entry.
†For brand medicines with more than $250 million in annual sales in 2008 dollars, which account for 92% of sales of the brand medicines analyzed

Sources: PhRMA; DiMasi JA et al; Grabowski H et al

Medicare—Part D: Choice and Competition
The US Prescription Drug Lifecycle Promotes Innovation and Affordability

Daily Cost of Top-10 Therapeutic Classes* Most Commonly Used by Medicare Part D Enrollees

*The 10 therapeutic classes most commonly used by Part D enrollees in 2006 were: lipid regulators, angiotensin-converting-enzyme inhibitors, calcium channel blockers, beta blockers, proton pump inhibitors, thyroid hormone, angiotensin II, codeine and combination products, antidepressants, and seizure disorder medications.

Source: The IQVIA Institute
Nearly Nine out of Ten Part D Prescriptions Are Generic

Before Part D, seniors used generic drugs at low rates, with about 54% generic utilization in 2005. Since Part D’s inception, generic utilization has steadily increased to 88% in 2018.

Sources: PhRMA analysis of data from IMS Health Vector One; Medicare Trustees

*Part D went into effect on January 1, 2006.

Sources: PhRMA analysis of data from IMS Health Vector One; Medicare Trustees
Better Use of Medicines Yields Significant Health Gains by Avoiding the Need for Other Medical Services

Due to a growing body of evidence, in 2012 the Congressional Budget Office (CBO) began recognizing reductions in other medical expenditures associated with an increased use of medicines in Medicare.

Pharmaceuticals have the effect of improving or maintaining an individual’s health . . . adhering to a drug regimen for a chronic condition such as diabetes or high blood pressure may prevent complications . . . taking the medication may also avert hospital admissions and thus reduce the use of medical services [emphasis added].”

CBO41

Since the CBO announcement, the evidence has continued to develop, broadening the potential for cost offsets in the health care system.

CHRONIC DISEASES

Medicare savings due to better use of medicines may be 3 to 6 times greater than estimated by the CBO for seniors with common chronic conditions, including heart failure, diabetes, and hypertension.42

MEDICAID

Increased use of medicines is associated with reductions in Medicaid expenditures from avoided use of inpatient and outpatient services.43,44

Sources: CBO41; Roebuck MC42; Roebuck MC et al43,44
Seniors Experienced Beneficial Health Outcomes Following Part D Implementation

RESULTS OF GAINING PART D PRESCRIPTION DRUG COVERAGE

8.0% decrease in hospital admissions

18.3% decrease in non-emergency Emergency Department visits

2.2% reduced risk of mortality

1.6% increase in cognitive functioning, resulting in a 1.1-year delay in cognitive aging

Sources: Kaestner R et al\textsuperscript{45}; Huh J et al\textsuperscript{46}; Ayyagari P et al\textsuperscript{47}; Pak T et al\textsuperscript{48}
Cardiovascular-Related Mortality Dropped Significantly Following Part D Implementation

Mortality rates dropped, and years of life lost due to cardiovascular disease declined significantly following the implementation of Part D. The estimates suggest that as many as 27,000 more beneficiaries were alive mid-2007 as a result of Part D implementation.

Source: Dunn A et al49
Part D Implementation Increased Longevity and Reduced Mortality

FROM 2006 TO 2014, PART D IMPLEMENTATION RESULTED IN:

- **100,400** fewer deaths from **diabetes**
- **53,100** fewer deaths from **congestive heart failure**
- **40,000** fewer deaths from **stroke**
- **200,000** beneficiaries have lived at least **1 year longer**.

3.3 years average increase in longevity

Source: Semilla AP et al\(^6\)
Between 20% and 40% of Medicare beneficiaries with common chronic diseases are not adherent to their medicines. Improved medication adherence can result in billions of dollars in cost savings from avoidable hospital stays.

### Improved Outcomes With Better Adherence

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cost Savings From Avoided Hospital Stays</th>
<th>Avoidable Hospital Inpatient Days</th>
<th>Annual Medicare Savings per Person</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DIABETES</strong></td>
<td>$4.5B</td>
<td>2.9M</td>
<td>$5,170</td>
</tr>
<tr>
<td><strong>HYPERLIPIDEMIA</strong></td>
<td>$5.1B</td>
<td>5.2M</td>
<td>$1,847</td>
</tr>
<tr>
<td><strong>HEART FAILURE</strong></td>
<td>$5.6B</td>
<td>4.2M</td>
<td>$7,893</td>
</tr>
<tr>
<td><strong>HYPERTENSION</strong></td>
<td>$13.7B</td>
<td>7.3M</td>
<td>$5,824</td>
</tr>
</tbody>
</table>

Source: Lloyd JT et al[51]
Medicare Part D beneficiaries who are not eligible for Low-Income Subsidies (LIS) face multiple affordability challenges today due, in part, to the way the benefit is structured and how cost sharing is calculated.

The Part D benefit can be strengthened and improved for patients if changes address these affordability challenges:

- **High coinsurance** based on list prices
- **Lack of an out-of-pocket cap**
- **Uneven distribution** of out-of-pocket costs over the course of the year
Part D Plans Have Shifted Costs to Seniors Through Increased Use of Coinsurance

Five-Year Jump in Average Percentage of Drugs on Coinsurance Tiers Among PDPs*

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>44%</td>
</tr>
<tr>
<td>2020</td>
<td>58%</td>
</tr>
</tbody>
</table>

**IN 2020:**

- **Coinsurance is replacing copays.**
  >99% of PDPs have either 2 or 3 coinsurance tiers.

- **Increased use of complex, multi-tiered formularies:**
  Most PDPs (93%) use 5-tier formularies.

- **Among PDPs with 5-tier formularies,**
  enrollment-weighted average coinsurance ranges from 23% on the preferred brand tier to 39% on the non-preferred brand tier.

Source: Avalere Health\(^\text{52}\)
Abandonment Is Very High for Prescriptions With Cost Sharing Greater Than $250 No Matter How Critical the Medicine

Source: Amundsen Consulting

Abandonment rate for cost sharing greater than $250
Percentage of drug type with cost sharing greater than $250

Source: Amundsen Consulting

Medicare—Part D: A Prescription for the Future
Part D Plans Are Covering Fewer Medicines and Increasingly Restricting Access

Average Share of Medicines Covered on Part D Formularies

- 2010: 73%
- 2021: 55%
- Change: -18%

Average Number of Drugs Subject to Utilization Management

- 2010: 27%
- 2021: 47%
- Change: +20%

Source: Marsh T et al
Benefits are often pay cost sharing based on a medicine’s full price, even when their Part D plan receives a discount.

Most plan sponsors don't share rebates with patients at the pharmacy counter. Instead, patients pay cost sharing based on the medicine’s full list price, sometimes exceeding the Part D plan net price.

Across all phases of the benefit, out-of-pocket costs for patients using insulin have been increasing as a share of net plan costs, despite the increased generosity of the Part D benefit through filling in the coverage gap.

Source: Milliman®

**Cost Sharing for Non-LIS Insulin Users Over Time in the Deductible Phase**

<table>
<thead>
<tr>
<th>Year</th>
<th>2011</th>
<th>2014</th>
<th>2017</th>
<th>2020</th>
<th>2023</th>
<th>2026</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>108%</td>
<td>120%</td>
<td>149%</td>
<td>182%</td>
<td>192%</td>
<td>201%</td>
</tr>
</tbody>
</table>

In 2017, Part D patients using insulin paid 149% of the net plan costs in the deductible phase, and, assuming rebates continue to grow, patients are expected to pay more than double by 2026 relative to net allowed costs.
How Could Medicare Part D Work Better for Enrollees?

- **SHARE NEGOTIATED REBATES AT THE POINT OF SALE**
  - Share rebate savings directly with patients at the pharmacy counter

- **MODIFY THE BENEFIT DESIGN**
  - Reduce cost sharing and add an annual out-of-pocket limit

- **IMPROVE AFFORDABILITY**
  - Smoothing uneven distribution of out-of-pocket costs
Lowering Cost Sharing for Seniors at the Pharmacy Counter Can Generate Medicare Savings

Sharing a portion of negotiated manufacturer rebates directly with patients could improve medicine adherence and result in savings for seniors and Medicare Part D.

**BENEFITS OF SHARING NEGOTIATED REBATES:**

- Lower beneficiary out-of-pocket spending by an average of **$350 per year**
- Save Medicare nearly **$1,000 per year** for every senior taking diabetes medicine
- Reduce total health care spending by approximately **$20B over 10 years**

Source: IHS Markit
An Out-of-Pocket Limit Would Provide True Catastrophic Coverage for Enrollees With High Out-of-Pocket Spending and Align Medicare Part D With Other Markets

Source: KFF57

Average Out-of-Pocket Spending by Medicare Part D Enrollees Without Low-Income Subsidies in 2017

- Overall average: $486
- Spending below the coverage gap: $274
- Spending above the coverage gap but below the catastrophic threshold: $1,200
- Spending above the catastrophic threshold: $3,214

Part D non-LIS beneficiaries with high out-of-pocket drug costs spent more than $3,200 above the catastrophic phase in 2017, more than 6 times overall average out-of-pocket costs among non-LIS enrollees.
A smoothing policy would allow beneficiaries to spread their out-of-pocket costs over a longer period (e.g., over multiple months), rather than pay these costs up front.

Hypothetical Patient Facing High Out-of-Pocket (OOP) Costs at the Beginning of the Year

- 71 years old
- Lives in Memphis, TN
- Part D enrollee
- Takes 2 medicines:
  1. Brand TNF inhibitor for rheumatoid arthritis
  2. Generic beta blocker

Total annual OOP burden: $5,306

A smoothing policy would particularly benefit beneficiaries who incur high OOP in a short period.
Measured Improvements Could Strengthen the Medicare Part D Program for the Future

The Medicare Part D program works well for seniors and those with disabilities, but there are ways to make it work even better for those who are facing increasingly higher out-of-pocket costs at the pharmacy.

Policymakers need to **cap annual out-of-pocket costs** for seniors and patients with disabilities in Medicare Part D and allow them to **spread their cost sharing across the year** to give more predictability and peace of mind about what they’ll pay each month at the pharmacy.

**High and unpredictable cost sharing** is a problem for seniors and patients with disabilities, who shoulder a much higher share of the cost burden and who need targeted reforms that will improve affordability.

Plans should also **share the savings from negotiated rebates** directly with Part D beneficiaries at the pharmacy counter.

These reforms could lower out-of-pocket costs for millions of people, generate savings for the federal government, and strengthen the successful Part D program.
Notes and Sources


8 CMS. Actual average premium figures taken from annual CMS press releases. https://www.cms.gov/newsroom


