EXECUTIVE SUMMARY

The cost of the Medicare Part D prescription drug benefit has been of interest since the program was enacted into law as the centerpiece of the Medicare Modernization Act of 2003 (MMA). The most recent numbers show that actual net Part D spending has been about 30 percent lower than the initial projections made by the Congressional Budget Office (CBO) in 2003 during legislative consideration of the MMA. CBO spending projections may by higher or lower than actual spending levels for many reasons, including changes in economic and demographic factors from the original CBO assumptions, and the policy community has engaged in a robust debate over the reasons for the lower-than-expected spending in Part D. Some attribute lower-than-expected program spending to the success of competition among multiple Part D plans, while others attribute lower spending to lower than anticipated growth in the overall rate of drug spending, higher use of generic drugs, and lower-than-expected Part D enrollment. This brief uses available evidence to examine drug spending trends within Medicare Part D and the factors that have played a role in lower-than-expected spending, and to consider the future spending outlook.

Several factors have contributed to the gap between original projections and actual spending.

- **Enrollment in Medicare Part D has been significantly below projected levels.** CBO projected that about 87 percent of all beneficiaries would enroll in Part D, but actual participation is estimated to be only 73 percent in 2012. Lower enrollment results in lower spending, although the impact on the long-term drug spending trend is not substantial.

- **The growth of total public and private spending on prescription drugs has slowed considerably since projections were made by CBO in 2003.** Based on data available at the time, CBO assumed 12 percent average per capita growth in drug spending until 2006 and 9 percent thereafter, while actual growth was 10 percent and 4 percent, respectively. This lower growth trend in the health system as a whole has meant lower spending for Part D.

- **Although retail prices for the same drugs continue to rise, prices that take into account substitution of generic drugs for brand-name drugs have grown slowly, if at all.** In other words, lower prices due to generic substitution have balanced out higher prices for the brand drugs that remain on patent. This flat price trend has helped prevent a more rapid increase in Part D spending.

- **Manufacturer drug rebates are an important part of pricing, but remain mostly invisible to outside analysis.** Some evidence, cited in the annual Medicare Trustees reports, shows that drug rebates have exceeded expectations, which would tend to have a downward effect on spending. Nonetheless, drug rebates negotiated by Part D plans remain lower than the mandated drug rebates obtained by Medicaid.

- **Fewer drugs have been approved since the start of Part D, compared to previous decades, contributing to lower Part D spending because of fewer new patented brand-name drugs.**

- **Use of generic drugs has increased.** The introduction of the Part D benefit coincided with patent expirations for many of the most commonly prescribed drugs. As a result, the share of generic drugs used by Part D enrollees, similar to people with other coverage, grew from 61 percent in 2007 to 75
percent in 2010, with almost certain higher levels by 2012. This trend has been a major factor in lower Part D spending growth.

- **There is some evidence of increased average drug utilization per person since the start of Part D, but the increase is probably in line with projections.**

Based on the available evidence, the claim that Part D spending is lower than originally projected due to competing private plans seems overstated, given the multiple factors that influence drug spending trends. While the marketplace is active and Medicare drug plans have taken steps to manage the benefit for their enrollees, it is not possible to know whether a different approach might have achieved at least the same level of price discounting and utilization management. The fact that spending is lower than projected is more likely a product of estimating difficulties and forecasting imprecision.

Compared to projections, the combination of more patent expirations and few new breakthrough drugs has kept overall growth in national drug spending growth low. The growth rate of Medicare Part D spending has been affected by both of these trends, as well as lower-than-expected enrollment. Policymakers should interpret with caution the implications of the Medicare Part D experience for future Medicare reform.

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This paper was commissioned by the Kaiser Family Foundation. Conclusions or opinions expressed in this report are those of the author and do not necessarily reflect the views of the Kaiser Family Foundation.
INTRODUCTION

The beginning of 2012 was the start of the seventh year of operation for the Medicare Part D prescription drug benefit, which has affected access to drug coverage and overall quality of health care for Medicare beneficiaries in various ways. But the program’s cost has been a source of ongoing debate and discussion, as it was before the program was enacted into law as part of the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). Enactment occurred in the context of an agreement that a new program would not exceed a ten-year cost of $400 billion, and the Congressional Budget Office (CBO) verified that the legislation met this target. Although even this level of spending was too high for some policymakers, the willingness to invest this amount in a new Medicare benefit was critical to the support of others. Adding to the political turmoil, the ten-year price tag of the drug benefit was one-third higher in the Bush Administration’s 2005 budget estimates — released just two months after the law was signed — than the estimates prepared prior to the law’s passage. This new higher cost estimate for Part D triggered a new round of debate over the program’s long-term costs.

More recent accounting by the Centers for Medicare & Medicaid Services (CMS) indicates that actual Part D spending has been considerably lower than the initial projections made in 2003 — about 30 percent lower, on net. CBO spending projections may by higher or lower than actual spending levels for many reasons, including changes in economic and demographic factors from the original CBO assumptions, and the policy community has engaged in a robust debate over the reasons for the lower-than-expected spending in Part D. Some attribute lower program spending to the success of competition, with multiple plans competing to drive down costs to offer better value to enrollees. Others have downplayed the role of competition, arguing that program spending has been lower than anticipated due to slow growth in drug spending trend generally, higher use of generic drugs, and lower enrollment than expected. The Medicare Trustees have cited both types of factors for lower-than-expected Part D spending trends, those that might relate to competition (higher-than-expected rebates and other price discounts) and those pointing more to underlying trends in the pharmaceutical marketplace (higher penetration of generics and fewer new drug products). This brief uses available evidence to examine drug spending trends within Medicare Part D and the factors that have played a role in lower-than-expected spending, and to consider the future spending outlook.

BACKGROUND

On December 8, 2003, President George W. Bush signed the MMA into law. A key element of the law was creation of Medicare Part D, a voluntary outpatient prescription drug benefit available to all Medicare beneficiaries, to be implemented in 2006. President Bush hailed the new program saying that “Medicine has changed [since 1965] but Medicare has not. Until today.”

Although the need for a drug benefit in Medicare had long been acknowledged, the path to enactment of this specific piece of legislation was contentious. Final passage in the House of Representatives occurred with a five-vote margin after the longest roll call in House history, and a final Senate procedural vote had only one vote more than the 60-vote requirement. One of the numerous points of debate was over how to deliver the benefit. The Part D benefit was the first element of Medicare to be made available exclusively through competing private health plans, rather than being added to the existing menu of fee-for-service benefits. And yet even those who designed the Part D program were not entirely convinced that private plans would choose to enter a new market for a stand-alone prescription drug benefit for seniors and people with disabilities. As a result, the law included provisions for a backup option offered directly through the government in the event that two plans were not available in any particular region. Initial concerns about lack of interest proved to be unfounded, however, as plan participation has been robust from the program’s beginning.
Availability of drug coverage for several million beneficiaries without any previous source of coverage might be the most important result of creating Medicare Part D. By the end of the program’s first year, over half of Medicare beneficiaries had enrolled in Medicare Part D plans, many of whom had a previous source of coverage. But nearly two-thirds of those with no coverage in 2005 gained coverage through enrolling in Part D plans in 2006.7 Despite the availability of the Medicare drug benefit, however, about 4 million Medicare beneficiaries remain without drug coverage today.

Without a source of coverage for prescription drugs, research shows that people skip some necessary drugs and take others less frequently than prescribed.8 For those gaining coverage from Part D, use of drugs increased considerably.9 Research also indicates that beneficiaries who were paying for their drugs out of pocket have experienced considerable savings as a result of the new benefit. Researchers are beginning to study whether increased adherence to medications under Part D may yield savings elsewhere in Medicare as a result of fewer hospitalizations and other services.10

Medicare is now a significant part of the total U.S. retail prescription drug market.11 About 23 percent of all dispensed prescriptions were for Medicare Part D in 2010, up from 2 percent before the program began and 18 percent in the program’s first year.12 While the Medicare drug benefit is influenced by underlying trends in prescription drug costs, its large number of covered individuals also has the ability to influence these trends.

PART D SPENDING PROJECTIONS FROM 2003

Despite the importance of new coverage, the current national focus on budgets and the economy has drawn even more attention to the cost of Part D. The program is often highlighted as a rare case of a program that has been less expensive in practice than was projected by CBO. CBO’s final estimates, made in 2003, set the ten-year budget impact of the drug benefit at $407 billion for fiscal years 2004 to 2013 (Exhibit 1).13 This estimate reflects several components. The total estimated cost of the program was about $770 billion, or $551 billion with offsets from beneficiary premium payments and state payments to account for the transfer of drug benefits for beneficiaries dually eligible for Medicare and Medicaid from state Medicaid programs to Medicare. States are required to make so-called “clawback” payments in lieu of the spending they would have incurred in Medicaid; in addition, federal spending for these beneficiaries is in effect transferred from Medicaid accounts to Medicare.

These numbers were used by the Congress in passing the MMA and creating the new drug benefit. But, in its budget baseline for the new fiscal year, released just a short time after the law’s passage, the Bush Administration set its estimated cost for the MMA’s drug benefit at $510.7 billion over the same ten-year budget window (2004 to 2013), 25 percent above CBO’s estimate of $407.5 billion. Several factors account for the differences, with the Administration estimating: (1) a higher participation rate, by 3 percent to 4 percent (2) higher per capita drug costs by about 4 percent, with slightly lower benefit costs and slightly higher administrative costs, and (3) lower Medicaid savings than CBO (Exhibit 2). In general, the Administration’s cost components were larger and the offsetting revenues were smaller.14 For
example, the Administration estimated that low-income subsidies would cost $238.8 billion over 10 years, about $50 billion more than the CBO projection for the same time period.

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NOTE: Numbers may not add up to totals, because of rounding. SOURCE: CBO, “A Detailed Description of CBO’s Cost Estimate for the Medicare Drug Benefit,” Table 1, July 2004; “Comparison of the Office of the Actuary’s original Title I MMA cost estimates to those underlying the CY 2011 Trustees Report” (2011).

A revised estimate by CBO in 2005 also showed higher estimated costs than the original 2003 estimates. As result of updated baseline projections, technical changes in estimating assumptions or methodology, and estimates of the implications of regulatory decisions made by CMS, CBO increased the estimate of costs for 2004-2013 by 7 percent to $593 billion ($42 billion added to the net Part D costs of $551 billion, excluding the offsetting Medicaid savings).

Estimating the financial impact of a large new program comes with considerable challenges. Analysts at CBO and CMS had no good model for projecting costs in Part D since the approach in the legislation of using stand-alone drug plans had no precedent. Therefore, one challenge in estimating Part D costs related to the level of participation of plan sponsors and Medicare beneficiaries. At the time, many were skeptical that potential sponsors would indeed offer plans, as recalled by the comment by Thomas Scully, then administrator of CMS, that “stand-alone drug coverage ‘does not exist in nature’ and would probably not work in practice.” CBO assumed that nearly one in five Part D participants initially would be enrolled in either government fallback plans or special reduced-risk plans and that 5 percent would remain in such plans even in 2013. Many observers found this a reasonable assumption in 2003, but the reality proved to be different. The need for fallback plans was never triggered because of the robust participation by private plans.

The other large challenge was projecting a long-term growth rate for prescription drug spending. In 2003, prescription drugs were among the highest-growth health sectors, with annual growth rates in that period of around 12 percent. Growth was a combination of increases in both prices and utilization. The annual rise in retail prices at the time was around 4 percent; increased utilization accounted for the remainder of the growth. CBO estimates typically rely heavily on past and current trends, and there was no reason to assume that past drug spending growth trends were not reliable indicators for the future. As of February 2003, the CMS Office of the Actuary expected growth to remain in double digits (11.1 percent). The forecast in February 2004 was similar, although predicting some degree of deceleration. But, as described below, actual drug spending under Part D was substantially lower than projections made by CBO or the Office of the Actuary.
HOW DO 2003 PROJECTIONS OF OVERALL PART D SPENDING TRENDS COMPARE TO EXPERIENCE TO DATE?

Over the program’s first several years, Part D program spending has been considerably lower than the original projections, using the most recent spending numbers from the CMS Office of the Actuary, published in the annual Medicare Trustees Report (Exhibit 3).¹⁹,²⁰,²¹

Total spending on Part D benefits and administration, including the employer subsidy program, was about 74 percent of projected levels in 2006, the program’s first year, and about 68 percent over the program’s first six years (2006-2011). Although most of the difference was evident from the first year, the trend in 2010 and going forward also incorporates some effects from recent legislative changes.²²

The discrepancies between projected and actual costs vary considerably across different components of overall spending (Exhibit 4). The smallest gap is for the subsidy costs of low-income beneficiaries qualifying for the Low-Income Subsidy (LIS).²³ Actual LIS subsidy costs were 85 percent of projected costs for the first five years of the Part D benefit. There was a much larger discrepancy for subsidies for employer-sponsored coverage (41 percent of projected costs over five years).

EXPLAINING THE DIFFERENCES BETWEEN PROJECTED AND ACTUAL PART D SPENDING

The next section of the paper offers explanations for the differences between original projections and actual Part D program spending. Several factors have contributed to this gap: lower enrollment, the overall drug spending trend, trends in retail drug prices, higher rebates, more generic drug penetration, and fewer new brand drugs. After considering these various factors, the paper assesses the potential role played by competition in driving the differences.
**Factor 1: Lower Part D Enrollment**

*Enrollment in Medicare Part D has been significantly below projected levels, resulting in lower spending, but the impact on the long-term drug spending trend is not substantial.*

CBO originally estimated that nearly all Medicare beneficiaries would have prescription drug coverage after the Part D benefit became available. The agency projected that about 87 percent of all Medicare beneficiaries would enroll in Part D – either by enrolling in a Part D plan or by getting drug benefits through a former employer’s subsidized retiree coverage.24 Most of those not obtaining Part D coverage were thought to be active workers with coverage through their jobs, retired federal workers with coverage through civilian or military plans, and those not enrolled in Medicare Part B. The actual share covered has been considerably lower. According to the Medicare Trustees, participation rates for enrollment either in Part D plans or a former employer’s subsidized coverage have grown slowly but steadily from 71 percent in 2007 to an estimated 73 percent in 2012.25 Thus, even current enrollment levels are about 14 percentage points (about 5 million beneficiaries) below the CBO 2003 projection.

Fewer participants in the program translate directly to less program spending. In the 2007 report, the Medicare Trustees cited significantly lower enrollment, compared to original estimates, as a key factor in the first year’s lower spending. The effect was exaggerated in 2006 because more than one-third of those who ultimately enrolled for 2006 delayed signing up until after January 1 (the initial open enrollment season ran until May 15, 2006), and thus participated for less than a full year. The impact of lower enrollment on spending was tempered, however, by higher average per-person Part D drug costs than projected.26 Those who enrolled were probably in poorer health and needed more drugs than the average participant. The enrollees included 6 million dual eligibles who were automatically enrolled and who are sicker and use more drugs on average than other beneficiaries.

In subsequent annual reports, the Medicare Trustees did not again cite this factor when explaining lower-than-expected drug spending, presumably because ongoing enrollment patterns (while remaining lower than initial projections) did not fluctuate significantly after the first year. Thus it seems reasonable to conclude that lower enrollment reduced the level of total program costs from original projections, but has not had a large effect on the spending growth rate after that first year.

**Understanding Lower Enrollment Rates**

There is no simple explanation for why total Part D enrollment has been about 15 percent below the CBO projected enrollment rate. Those remaining outside the program include both people with another source of coverage and those who remain with no coverage.

- **Other sources of coverage.** CMS estimates that about 17 percent of Medicare beneficiaries currently obtain drug coverage from a source other than Part D, whereas CBO projected about 13 percent. Beneficiaries who are active workers are generally not eligible for Part D, and CBO also expected that federal retirees would not participate in the retiree subsidy program. The most recent CMS estimate of those with other sources of coverage includes those with coverage through the VA or other private coverage.

- **No source of coverage.** CBO projected that most beneficiaries without an alternate source of coverage would enroll in Part D. Although generous subsidies and a penalty for late enrollment created a strong incentive to enroll in the voluntary Part D program, some have opted not to enroll. According to several sources, about 10 percent of beneficiaries currently have no drug coverage.27 Some beneficiaries may have decided not to enroll in Part D because they incur low drug costs and do not want or need drug coverage. In addition, the requirement for active enrollment in Part D (opting in rather than opting out) and the perceived complexity of enrolling and choosing a plan may
have discouraged some from enrolling. And some beneficiaries may never have learned about the program or do not understand its benefits – and thus have remained outside the program.28

CBO also projected that plan participation would not be uniform across the country and that about 18 percent of Part D plan enrollees in 2006 and 5 percent in 2013 would be enrolled in reduced-risk or fallback drug plans. These two types of plans would only have been offered if the minimum of two drug plans was not achieved in a particular region. Robust participation by plans has meant that these special plans have never been offered. Because CBO assumed that fall-back and reduced risk plans would not achieve the same level of savings as full-risk Part D plans, and assumed 18 percent enrollment in these higher cost plans initially, the absence of reduced-risk and fallback plans may be a small factor in overall costs falling below expectations.

Enrollment in Employer-Sponsored Retiree Coverage: The MMA attempted to preserve employer-sponsored retiree coverage by providing a subsidy to the firms offering such coverage, as long as that coverage was at least as generous as the Medicare coverage. CBO estimated that about 30 percent of beneficiaries had such coverage (excluding federal retirees) and projected that the share would remain the same, estimating that 8.2 million beneficiaries would receive the retiree drug subsidy in 2006, rising to 9.5 million in 2013. Actual levels were lower, starting at 7.2 million and going down to 6.2 million by 2011.29 Lower enrollment in employer coverage means lower spending on the retiree drug subsidy component of the program, but could lead to higher overall costs. Spending per enrollee is higher in Part D plans than in subsidized employer plans (although total federal costs would also account for changes in tax receipts).

LIS Enrollment: Total participation in the Part D Low-Income Subsidy (LIS) program has been fairly close to CBO’s projections. The agency estimated that all beneficiaries dually eligible for Medicare and Medicaid would receive the LIS because enrollment is automatic, but only 45 percent of the others eligible for the LIS would ultimately enroll. Actual experience has been close to these expectations.30 Currently, about one-third of all enrollees in Part D plans receive the LIS. As a result, spending on LIS subsidy costs (including both premium and cost-sharing subsidies) is closer to projected levels for this category than for any other category (Exhibit 4). Spending is still below projected levels, because average drug costs are lower for all enrollees (as detailed below).

Medicare Advantage versus PDP Enrollment: CBO did not anticipate any difference in cost efficiency between stand-alone drug plans and Medicare Advantage drug plans. The share of Part D enrollment in MA prescription drug plans has increased from about one-fourth in 2006 to 37 percent in 2012. Average Part D premiums in MA drug plans are well below stand-alone drug plan premiums in part because MA plans are permitted to use savings achieved on the medical side to reduce Part D premiums (among other allowed uses). But premiums for MA drug plans are lower than premiums for stand-alone drug plans, even after adjusting for use of these savings.31 This may be because MA plans attract healthier beneficiaries (beyond the differences accounted for by risk adjustment), use relationships with prescribing physicians to manage drug use more effectively, or have a greater financial incentive to manage drug use because they accrue resulting savings on the medical side.32

Factor 2: Slower Overall Drug Spending Growth

The growth of prescription drug spending across all payers has slowed considerably compared to projections at the time of the MMA’s enactment in 2003, contributing to lower Part D spending.

At the time that CBO was making cost estimates for the drug benefit, the average annual growth in total national drug spending was a little more than 10 percent, as it had been much of the time since about 1980 (Exhibit 5). Although it was not anticipated in the early 2000s, drug spending growth was about to slow considerably.
As of January 2003, estimates from CMS projected that spending growth would slow over the next decade, but relatively high growth rates were still expected, from more than 12 percent in 2004 to about 9.5 percent by 2010 (Exhibit 6). In its cost estimates for the new drug benefit, CBO used this information to assume 12 percent average growth, on a per capita basis for the years prior to 2006, and 9 percent average per capita growth for 2006 to 2012. The rate of growth before the start of Part D matters as much as the later years, because the increase in spending from 2003 until the start of 2006 set the baseline spending level for the benefit’s first year.

The reality proved to be quite different. The rate of growth in drug spending was modest over the second half of the decade, reaching a historically low rate of 1.2 percent in 2010. Actual growth in 2002 and 2003 was about 1 percentage point lower than projected, and growth from 2004 to 2008 was 4.5 percentage points lower.

Whereas CBO used a projected 12 percent growth rate per capita for years before 2006 and 9 percent per capita starting in 2006, actual growth per capita has been 10 percent and 4 percent, respectively. Spending growth into the future is also expected to be slower than the original projections made back in 2003 (actual growth is only available through 2010).

One question is whether the Medicare Part D spending trend is significantly different than the overall trend for prescription drugs in the United States. This question is important for understanding whether slower growth is at all attributable to the steps taken by Part D plans in a competitive marketplace to manage costs and utilization or whether Part D spending is following larger trends in drug spending nationwide. Although many factors, including relative rates of population growth, affect the trend lines, overall drug spending growth has been higher for Medicare than for private health insurance in each year since the start of Part D. For the first four years, average annual growth for drugs paid by Medicare has been 10.7 percent, whereas the average for drugs paid by private health insurance has been 3.0 percent. During the same period, average annual growth for drugs paid by Medicaid, where market

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**Exhibit 5**

Average Annual Growth Rates in U.S. Prescription Drug Spending, 1966-2020

![Graph showing average annual growth rates in U.S. prescription drug spending from 1966 to 2020.](image)

**Exhibit 6**

Comparison of 2003 Projections vs. 2012 Actual Average Annual Growth Rates in U.S. Prescription Drug Spending, 2002-2010

![Graph comparing projected and actual growth rates in U.S. prescription drug spending from 2002 to 2010.](image)
competition plans the least role, has been 1.3 percent. Spending growth in all three sectors has been well below the projections made in 2003.

Together, these growth rates support the idea that Medicare Part D has generally tracked drug spending trends across the health system. To the extent that Medicare’s private drug plans have diverged from the trend, spending growth has exceeded rates in private health insurance and Medicaid.

**Factor 3: Slow Growth in Retail Drug Prices, Accounting for Generic Substitution**

Although retail drug prices for the same products continue to rise, substitution of generic drugs for brand-name drugs means that the effective prices have grown slowly, if at all; therefore trends in prices have had a downward effect on spending.

Drug prices are one of the important factors in examining the Part D spending trend. We look first at retail prices and then at price discounting through manufacturer rebates. The growing availability of generic drugs and the limited pipeline for new brand-name drugs are discussed separately.

Prices are both an external and internal influence. Externally, prices paid within Medicare plans are driven by broader global factors – some specific to pharmaceuticals and some around the broader economy – that affect both price inflation and the launch prices for new products. Prices are also driven by changes in product availability, including both the launch of new drugs and the market entry of new generic alternatives as brand-name drugs go off patent and lose their market exclusivity. Internally, Medicare drug plans have tools that may influence both prices and product selection. Plans may bring prices down through both negotiated retail prices and rebates they obtain from manufacturers. A plan may also influence product selection by using its benefit design and formulary to encourage or require enrollees to use generics or less expensive brand alternatives.

An analysis of retail price data by Acumen for the Medicare Payment Advisory Commission (MedPAC) shows two sides to the price story. At the product level (making no adjustment for generic substitution), prices paid by Part D enrollees rose by 18 percent over the first four years of the Medicare benefit (2006 through 2009). For this analysis, Acumen considered the prices of a particular product (at the level of the national drug code or NDC, which identifies a particular form, strength, and manufacturer) at the point of sale, but without any consideration of rebate payments.

Price trends vary across different categories of drugs. For example, an annual analysis of prices conducted by the AARP Public Policy Institute found that the retail prices for commonly prescribed generic drugs fell by an average of 7.8 percent in 2009, whereas brand-drug prices rose by 8.3 percent in the same year. MedPAC’s analysis also shows considerable variation by drug class – from a drop of 10 percent for anticonvulsants to an increase of 46 percent for cancer drugs.

The other side of the price story takes generic substitution into account by examining prices at the level of the chemical entity. In other words, when a patient uses a $100 brand-name drug one month and a $20 generic version of the same drug the next month, it counts as a drop in price. Over the same period from 2006 to 2009, prices accounting for generic substitution have been almost flat (up by 1 percent cumulatively over four years). Thus, the availability of more generic drugs has nearly completely offset the impact of higher drug prices for drugs still on patent.

Since the start of Medicare Part D, drug plan enrollees have paid higher prices for brand drugs, but have taken advantage of the availability of newly available generic drug substitutes for many popular brand drugs. After accounting for more use of generics, net prices are nearly unchanged. Medicare, like other segments of the health system, has thus benefited from the net price stability generated by patent expirations.
Factor 4: Larger Manufacturer Rebates and Other Discounts

Manufacturer rebates are an important part of pricing, but remain mostly invisible to outside analysis. There is some evidence that rebates have been higher than expectations, which would tend to have a downward effect on spending.

Pricing for prescription drugs is a mix of retail pricing and discounts in the form of rebates paid by pharmaceutical manufacturers to plans or pharmacy benefit managers (PBMs). Plans or PBMs negotiate rebates in exchange for favorable treatment of a particular manufacturer’s drugs, such as placing those drugs (but not others) on a preferred formulary tier or omitting competitors entirely from the plan’s formulary. Rebates are not typically available once patent protection lapses since the choice of drug can be made by the pharmacist and cannot easily be influenced by the plan (although recent stories about deals between Pfizer and some plans or PBMs to continue use of Lipitor over its generic competitors offer a counterexample). Retail discounts may also be obtained from some pharmacies through negotiations for inclusion in the plan’s pharmacy network or (for some plans) designation of preferred and non-preferred pharmacies with differential copayment rates. The latter discounts became more visible in 2011 with the partnership of Humana and Wal-Mart in a plan with considerably lower cost sharing when enrollees use Wal-Mart pharmacies.

In contrast to Medicaid, where discounts are achieved through a mandatory minimum rebate and additional rebates to ensure that the government gets a best price, Medicare Part D puts the negotiation of rebates and other discounts solely in the hands of the private plans. Discounts achieved through manufacturer rebates are considered proprietary information, so measuring their magnitude is difficult. Each year’s Medicare Trustees Report includes estimated rebate levels, averaged across all plans and all drugs, and the Trustees have consistently indicated that rebates have exceeded expectations, which would offer some evidence that competition has brought net pricing downward. In earlier reports, the Trustees estimated average rebates in the range of 4 percent to 5 percent, but in 2011 the Trustees said that rebates had peaked at 11.3 percent, although rebates were estimated to trend back down to about 10.3 percent as the share of brand-name drugs declines in the future.

Analysis by CBO found that rebates paid to Part D plans for single-source brand-name drugs totaled $6 billion in 2007, thus about 14 percent of these drugs. Since there are essentially no rebates for generic drugs, this discount rate is comparable to the estimate in the Trustees Report. A report by the DHHS Inspector General found that rebates reduced Part D expenditures by 19 percent in 2009 for 100 top-selling brand-name drugs. These drugs should have the highest rebates, because a high market share increases the incentive for manufacturers to offer large discounts, especially for drugs in classes with significant competition. The OIG report also found that Medicaid rebates for these same drugs were considerably higher – averaging about three times the size of the Part D rebates.

Although the absence of public data on rebates limits the ability to examine this pricing component, evidence from government researchers shows some success by Medicare drug plans in negotiating rebates that may be larger than originally anticipated – and thus may be a factor in lower spending trends. But rebates negotiated by private plans apparently remain lower than the mandated rebates obtained for Medicaid.

Factor 5: A Slow Pipeline for New Drugs

The number of newly approved drugs has been low compared to previous decades, thus contributing to lower Part D spending.

In the 1980s and 1990s, the large number of newly approved drugs was a significant factor in the rapid increase in U.S. drug spending. Many of the new products represented new drug classes and thus new approaches to treatment for chronic diseases that affected large segments of the population. In the 2000s, by contrast, few newly approved drugs have joined the list of the most-used drugs. According to
industry analysts, the total number of new brand products on the market was down each year from 2006 to 2010, and average spending per new brand product was also down from $114 million per product in 2006 to $62 million in 2010, although up again in 2011.45 Another industry analyst labeled the period from 2005 to 2010 as the “era of scarcity” with 22 new molecular entities approved annually, compared to 36 per year in the “era of abundance” from 1996 to 2004.46

The drug pipeline has been dominated by a shift in the product mix toward treatments for relatively uncommon medical conditions and drugs with the same mechanism of action as existing products (sometimes called “me too” drugs). Drugs for uncommon conditions are unlikely to have added substantially to overall Medicare Part D spending, because they are appropriate for few patients. The “me too” drugs are also unlikely to generate much new spending because plans tend to excluded them from formularies or place them on high cost-sharing tiers.

**Factor 6: Average Utilization per Person**

*There is modest evidence of increased average drug utilization per person since the start of Part D, but the increase is probably in line with projections.*

There is no easy means of disaggregating the lower-than-expected spending growth between price and quantity factors. CBO, in its projections, did not explicitly estimate the influence of price versus quantity, although its discussion of cost management by plans mostly emphasizes price effects. CBO also projected an induced demand effect based on enrollees experiencing lower out-of-pocket costs on average. Several studies, looking at these effects for the first years of the benefit, found increases in drug use generally between 6 percent and 13 percent.47 But it remains unclear how much of the increase is for those with no previous coverage versus changes in management for those with different insurance arrangements before and after the Part D benefit was implemented.

There is evidence that the quantity of drugs used by the average Part D enrollee is increasing over time. Between 2007 and 2009, there was a 5.1 percent increase in the number of prescriptions (30-day equivalents) dispensed to the average Medicare Part D enrollee, together with a 1.9 percent increase in spending per prescription. These increases combined to generate a 7.5 percent rise in per person spending over the two years.48 By contrast, total prescriptions per person across all populations were relatively steady from 2007 to 2011.49

**Factor 7: More Use of Generic Drugs**

*The introduction of the Part D benefit has coincided with patent expirations for many of the most commonly prescribed drugs, leading to a rapid increase in the use of generic drugs and lower Part D spending.*

A big piece of the pharmaceutical landscape since the beginning of Part D has been the growing role of generic drugs resulting from both the large number of drugs losing patent protection and the slowdown of the pipeline for new drugs. These factors have been cited by the Medicare Trustees each year since 2006 as a key explanation for spending growth that has been slower than expected.

According to industry analysts, the number of brand-name drugs going off patent and gaining exposure to generic competition each year from 2006 to 2011 has represented between 4 percent and 7 percent of prior-year spending, or a cumulative total of more than one-fourth of drug spending over five years.50 Looked at another way, of the top 75 brand-name drugs used by Part D enrollees in 2006 (based on Part D spending), more than half will have generic alternatives by the end of 2012.51 The result is that the generic share of the overall market, by prescription volume, reached 80 percent in 2011, up from 63 percent in 2006 – and the share should be even higher by the end of 2012.52 The trend for Medicare Part D enrollees has been similar, rising from 60 percent to 75 percent from 2006 to 2010.53 According
The price of a typical generic drug is well below that of other drugs in the same drug class; CBO reports that the average retail price for a generic drug in Medicare Part D was 25 percent of the price of the chemically equivalent brand-name drug. About one-fourth of states require generic substitution by the pharmacist for the same chemical entity if the physician does not specify “brand only,” while the others allow substitution (some states require patient consent before doing so). As a result, most patients shift rapidly after the first generic version of a drug enters the market. Although the price may take several months to stabilize, the conversion from brand to generic soon results in a substantial savings for both the patient and the payer.

The complex effect of greater generic availability on drug spending is illustrated in an analysis of national drug spending (without consideration of any discounts or manufacturer rebates not reflected in retail prices). By this calculation, total drug spending experienced net growth between 2009 and 2010 of about $7 billion or 2.4 percent. Three factors increased spending: higher prices for on-patent brands already on the market ($16.6 billion); spending on brand-name drugs new to the market ($4.0 billion); and higher spending on generics, including both higher volume and price increases ($7.6 billion). These increases were offset by three types of reductions: reduced spending on brand drugs, due to loss of patent protection ($12.6 billion); reduced volume for on-patent brands, including the effect of therapeutic substitution ($8.3 billion); and other factors ($0.2 billion). The net effect is that the combination of direct generic substitution and therapeutic substitution across alternatives in the same drug class has mostly counteracted the inflationary pressures from higher prices for drugs still on patent and the cost of innovation from new drugs that have made it to the market.

The influx of patent expirations for commonly prescribed brand drugs over the last several years thus created an opportunity for substantially lower rates of drug spending growth across the health system, including Medicare Part D. The arrival of new competing generic drugs on the market reduces Medicare drug spending without any intervention from plans, although it also creates opportunities for plans to encourage additional substitution for the remaining brand drugs in some drug classes.

**SUMMING UP THE EVIDENCE ON THE INFLUENCE OF PLAN COMPETITION ON PART D SPENDING**

The question of great interest in the policy community is whether Part D’s lower-than-expected costs can be credited to plan competition or whether underlying trends are the real story. In this section, we assess some of the arguments on each side. Competition advocates point to an active and competitive market and contend that vigorous plan competition has been the key to lower prices and better management of spending. Those more skeptical of the influence of competition suggest that lower prices and total spending have resulted from underlying trends, especially the much greater availability of generic drugs, and that Part D trends are no better than those achieved elsewhere in Medicare or the larger health system.

**Evidence in Support of Competition**

The evidence that plan competition has been a key influence starts with the presence of an active market. Contrary to many predictions, the Part D marketplace has attracted multiple participants. About ten plan sponsors compete nationally, alongside other regional sponsors. Although premiums for some plan sponsors have gone up consistently, other sponsors have avoided large increases across the life of the program. Furthermore, although there has been some consolidation among sponsors since the first two years, competing sponsors continue to see opportunities for new, innovative plan offerings. In 2011 and 2012, three national sponsors have collaborated with pharmacy chains to offer a preferred pharmacy network at lower premium levels. Humana’s plan, offered in partnership with Walmart pharmacies, has become the third largest stand-alone drug plan nationally in its second year on the
market. Although its premium is currently the lowest in the nation, it will be important to see whether discounting prices through a limited pharmacy network will have a long-term impact on the Part D program’s spending trends.

A second factor pointing toward the effective role of competition is the level of plan discounts and rebates negotiated by plans. As described above, the Medicare Trustees have consistently cited higher-than-expected rebate levels. This has been a critical argument for many advocates of competition – that private plans could use their tools to extract deeper discounts than would be possible from a government-run plan. Yet it is impossible to know whether a single national plan or a small set of larger competitors would have achieved the same or deeper discounts. Furthermore, the accounts of success are tempered by the findings of the Inspector General that Part D rebates have lagged considerably behind the mandated rebates in Medicaid.

A third factor is that plans have contributed to the low spending trend through effective management of drug use by their enrollees. As with prices, it is hard to disentangle overlapping influences. Use of generic drugs is up relative to the start of the program, and overall spending growth has moderated considerably. Some shift to generic drugs occurred relatively automatically with substitution by pharmacists, but plan benefit designs (such as tiered copayments, prior authorization and step therapy) may have encouraged more rapid generic substitution and a higher level of therapeutic substitution.

Some competition advocates suggest that Part D drug plans have been more successful on these dimensions than health plans elsewhere in the marketplace. One analyst attempts to make this case by showing that per capita Part D spending growth lags well behind the growth in spending for medical benefits under Medicare Parts A and B, estimating 1.8 percent growth for Part D for 2006 to 2009, well below the 4.9 percent growth for Parts A and B, whereas the similar comparison for the overall health market is much closer: 2.8 percent versus 3.4 percent. This comparison, however, is flawed by the artificially high Part D spending level for 2006 that led to reconciliation payments from Part D plans back to Medicare over the next two years. If the reconciliation payments are restored to the year that spending actually occurred, the Medicare comparison is 3.7 percent growth for Part D (instead of 1.8 percent) versus the 4.9 percent growth for Parts A and B. This shows almost the same relationship as for the overall health market, undercutting the argument that Part D plans have been more successful than other payers in slowing drug spending growth.

**Evidence in Support of Factors Other than Competition**

There is compelling evidence that factors other than competition offer the best explanations for the lower-than-expected spending trend. The evidence begins with the absence of extensive informed consumer shopping. Whereas advocates of competition point to the active Part D marketplace, skeptics point to a program where consumers face too many choices, are reluctant to switch plans, and do not make optimal choices. For competition to work well, consumers must take an active role in reviewing their plan choices and making a change if the value of their chosen plan declines. Yet a rapidly growing behavioral economics literature supports the idea that too many choices can lead to poor decision-making, and Medicare Part D seems to fit this model. Several recent studies show evidence that Medicare beneficiaries do not select plans that would minimize their costs, although such decisions can result from well-reasoned consideration of other factors such as customer service, plan reputation, or existing relationships.

Related evidence is that Part D enrollees have shown a reluctance to switch plans, sometimes in the face of premium increases well above market averages. Evidence from focus group discussions suggests that the reluctance to consider plan switching may stem in part from satisfaction with the current plan, but also reflects the large number of plan choices available combined with the costs in terms of time and energy of doing research and of actually making a switch. The more that enrollees stick with their
plans when they would benefit substantially from a switch, the more plan incentives to keep costs down are weakened.

This “stickiness” has contributed to a persistent concentration of enrollment in plans offered by just a few plan sponsors. In 2011, market concentration, as measured by the Herfindahl index, averaged 1,474 across the 34 regions in which Part D plans are offered, an increase from the 2010 level of 909. Market concentration is seen as an index value between 1,500 and 2,500 is considered by the Department of Justice (DOJ) and Federal Trade Commission (FTC) to be moderately concentrated. Because some LIS beneficiaries are assigned or re-assigned randomly to plans, a test would limit consideration to non-LIS beneficiaries. Within this subset of enrollees, the average index value across the 34 regions is 2,002 (up from 1,435 in 2010), a level considered to be moderately concentrated. Based on the DOJ/FTC guidelines, 20 of 34 regions are moderately concentrated for non-LIS enrollees and another 7 regions are highly concentrated. Only 7 regions would qualify as unconcentrated.

An additional factor is the evidence that lower spending is likely attributable to broad trends that are not exclusive to Part D. On the price side, competition skeptics point to the evidence that even higher-than-expected Part D rebates and other discounts fail to match the mandated rebates in the Medicaid program. But more important is the role played by generic drugs in holding down average annual increases in the price of prescription drugs. Unfortunately, evidence is not available to compare directly price trends for Medicare plans versus plans elsewhere in the marketplace, let alone to price discounts that might have been achieved under a different Part D design. But the evidence does indicate that although prices of single-source brand-name drugs have risen steadily over the past several years, average prices that take into account generic substitution have been essentially flat. The growing role of generic drugs — and the absence of significant new brand drugs in the market — has been a major driver of cost trends in recent years and is likely to be the main story over the next several years. Furthermore, as shown above, the overall spending trend for Medicare drug plans matches — but does not exceed — recent trends for other Medicare spending and drug spending elsewhere in the health system.

Furthermore, there is only limited evidence that active management of drug utilization by Medicare drug plans has been a primary driver of spending trends. There is evidence that active management by drug plans can influence use of generics, choice of drugs, and other aspects of utilization. Some Part D plans have achieved much higher rates of generic utilization than others, for example. But there is insufficient evidence to conclude that plans’ implementation of required medication therapy management programs has increased the quality of care for participants or adequately addressed polypharmacy or other issues for high drug spenders.

Finally, competing private plans are not well positioned to address the growing role of high-cost biologics and other specialty drugs that could play a greater role in driving drug spending trends in the future. Plans have the most leverage in drug classes where they can use cost sharing and other tools to encourage greater use of generics or in classes where they can obtain discounts among a set of competing brand-name drugs with similar therapeutic effects. But in a class dominated by a unique drug with little or no competition, plans have few tools to obtain discounts. Biologics and specialty drugs often fit this description, and these drugs are likely to play a growing role in pharmaceutical care in the future, and thus be a key factor in Part D drug spending.

**FUTURE OUTLOOK**

Looking to the future, the Medicare Trustees anticipate significant spending growth for Part D over the next decade, projecting an annual growth rate of about 8 percent (but lower than its projection from May 2011). If the projected trends occur, Part D costs will increase from $60 billion in 2011 to $131 billion in 2021. But the higher growth projection incorporates several factors that represent changes from the reality of the program’s early years. These projections incorporate the certain enrollment growth associated with much of the baby boom generation reaching age 65. On a per capita basis,
spending would increase from $1,667 to $2,726, or about 5 percent per year. The projected growth rate assumes the less certain end to the growth of generic utilization and a restored pipeline of new breakthrough drugs. The projected trend also assumes the impact of several changes enacted in the Affordable Care Act, including the phase-out of the coverage gap, higher premiums for higher-income beneficiaries, and changes to the tax treatment of employer-provided retiree drug benefits.

Part D projections included in the annual CBO baseline, released in March 2012, are similar to those in the 2012 Medicare Trustees report. CBO projects an overall growth rate for 2011 to 2021 of 9 percent and per capita growth of 5 percent. CBO lowered its projections, compared to the 2011 baseline, mostly due to the availability of generic substitutes for more high-volume drugs and other changes in drug utilization, but also because of a modest increase in projected Part D enrollment.

On top of the demographic trends and changes in law, two factors are probably the most significant ongoing sources of pressures on Part D drug spending. One is the costs of treating the highest-cost Medicare beneficiaries. The second is management of costs for LIS beneficiaries.

The Part D reinsurance system makes payment to plans to subsidize spending for plan enrollees who exceed the annual out-of-pocket spending limit ($4,700 in 2012). Medicare pays 80 percent of spending above the threshold as one means of reducing risk for Part D sponsors. Reinsurance payments on behalf of the highest-cost beneficiaries have grown faster than other components of Part D spending, growing 12.5 percent annually compared to a 6.1 percent overall increase. According to MedPAC’s analysis, about 8 percent of Part D enrollees had spending above the threshold in 2009. They have more prescriptions than other beneficiaries, and their prescriptions are more expensive on average. But their spending is not especially driven by use of expensive biologics and other specialty drugs. Combined with the program’s risk-sharing system that protects a plan with costs well above revenues, the reinsurance system considerably limits plan exposure to the costs for their most expensive enrollees. As a result, plans’ incentives to manage these enrollees actively are greatly reduced. If a plan chooses not to take active steps to manage drug use for patients who take many drugs or use high-priced drugs, the higher costs are mostly the responsibility of the federal government, not the plans.

A second source of spending growth has been spending by low-income enrollees who receive the government’s additional subsidies. The average LIS beneficiary has more spending ($339 versus $163 per person per month) and uses more drugs (5.0 versus 3.6 per month) than the average non-LIS beneficiary. Furthermore, LIS beneficiaries are far more likely to exceed the high-spending threshold. Because most cost sharing for LIS enrollees is paid by the federal government, LIS beneficiaries do not face the full force of the cost-sharing incentives used by most plans to encourage more use of generics and to manage drug use more generally. Under current policies, the program gives plans the responsibility for managing drug use for these enrollees, but without facing financial consequences.

**Conclusion and Implications**

Spending for Medicare Part D has fallen well below projections. But based on available evidence, claims that spending is lower because the program was designed around competing private plans seem overstated, given the multiple factors that influence spending trends. While the marketplace is active and Medicare drug plans have taken steps to manage the benefit for their enrollees, it is not possible to know whether a different approach – such as a government-operated benefit, similar to other parts of Medicare – might have been able to achieve at least the same level of price discounting and utilization management.

To a substantial degree, the lower spending trajectory for Medicare Part D is a product of estimating difficulties and imprecision. Estimating the initial cost of delivering the benefit was partly guesswork, based on assumptions and historical trends, and estimators’ guesses turned out to be higher than the reality. Lower-than-projected enrollment also produced spending levels lower than were expected,
although it remains unclear whether costs for those beneficiaries who apparently have no drug coverage show up elsewhere as higher Medicare costs. Finally, estimators considerably understated the impact of patent expirations for many of the most used drugs and the absence of new breakthrough brand-name drugs. Due largely to higher generic use, overall national drug spending in 2010 grew at a “historically low rate.”\textsuperscript{71}\\n\\n
Policymakers should interpret with caution the implications of the Medicare Part D experience for future Medicare reform. The model of using competitive plans has succeeded in the sense that an active market exists and fallback plans proved unnecessary. Many beneficiaries are enrolled in plans and, after some initial issues, receive their benefits mostly without problems. But the favorable spending trajectory may not be solely or even mainly attributable to the effects of competition as much as to larger trends in the pharmaceutical marketplace. Furthermore, caution is warranted in making claims about consumer behavior in a competitive environment, at least if based on the experience with Part D. Most Part D enrollees appear to prefer the comfort of staying with a known plan, even when facing substantial premium increases or formulary changes, over the effort of shopping for a better plan in a complex market with what may appear to be too many options.
ENDNOTES

5 Medicare Trustees Reports, 2007 through 2012.
11 Retail prescription drugs include drugs dispensed through mail order, but exclude drugs provided in physician’s offices, hospitals, nursing home, and other outpatient settings.
15 CBO, Letter from Douglas Holtz-Eakin, Director, to the Honorable Joe Barton, March 4, 2005. Offsetting savings for Medicaid and other federal programs were not “readily identifiable” in the new CBO baseline, so are excluded. Thus there is no total to compare with the $407 billion net spending estimate.
19 Medicare Trustees Report, 2012. Two adjustments were made for the analysis in this paper. First, the numbers in the Trustees Report have been adjusted, so that reconciliation payments between the government and the plans are reflected in the year when the costs were incurred. For example, the Trustees state that plans owed Medicare over $4 billion because 2006 was below plan bid amounts; these payments were made in 2007 and 2008. By contrast, actual spending exceeded bids by more than $2 billion in 2008, and reconciliation payments were incurred in 2009. In each case, the analysis in this paper displays spending in the year when benefit costs were incurred. Actual spending from the U.S. Treasury is less uniform over time. Second, CBO shows data by fiscal year, whereas the Trustees Reports display spending by calendar year. For the comparisons in this paper, the CBO spending is adjusted to calendar years.
A table produced by the CMS Office of the Actuary compares actual spending, as reported in the 2011 Medicare Trustees report, to the March 2004 Administration baseline (described in the previous section of this report).

"Comparison of the Office of the Actuary’s original Title I MMA cost estimates to those underlying the CY 2011 Trustees Report" (2011). Although specific numbers vary because of the different baseline used and some differences in spending categories, the spending differences are comparable to those presented here.

According to the Center on Budget and Policy Priorities, an updated version of the original CBO estimate for 2004 to 2013 is $385 billion, compared to the original $552 billion for total costs (with offsets for premiums and state payments, but not adjusting for savings in federal Medicare and other spending). CBPP notes that it could not identify a comparable figure for offsetting savings, nor did it attempt to break out sources of savings. This estimate also excluded projected effects of health reform in closing the coverage gap. Kathy A. Ruffing and James R. Horney, “Critics Still Wrong on What’s Driving Deficits in Coming Years,” Center on Budget and Policy Priorities, June 28, 2010.

These include reduced state clawback payments in 2010, as a result of the American Recovery and Reinvestment Act of 2009, and adjustments for increased coverage of drug costs incurred in the benefit’s coverage gap, as a result of the Affordable Care Act.

Beneficiaries qualify for the LIS based on Medicaid enrollment or on income and assets criteria. Depending on specific circumstances, LIS beneficiaries have premiums and cost sharing reduced or eliminated.

The law includes a retiree drug subsidy program, whereby Medicare subsidizes employer-sponsored plans offering a drug benefit at least as generous as the Medicare benefit. Changes in the tax treatment relating to employer drug costs (enacted in the Affordable Care Act) are expected to reduce participation in the subsidy program and cause some beneficiaries to transfer to enrollment in Part D plans.

In 2006, the share of Medicare beneficiaries enrolled in Part D was 64 percent, but this does not include a full 12 months of coverage since the initial open enrollment period ended in May of 2006. In 2010, 19 percent of Part D enrollees had subsidized employer coverage, 29 percent were in Medicare Advantage drug plans, and 52 percent were in stand-alone Part D plans. Enrollment numbers vary by month and how different types of plans are counted.


The Trustees project a further decline to 2.7 million by 2013. This projected drop is based on the anticipated response to changes made in the Affordable Care Act – likely in large part from shifting retirees from subsidized employer-run coverage to employer-only Part D plans.


Neither amounts for the premium offsets, nor the original MA plan bid amounts, are released by CMS. Estimates by MedPAC suggest that average monthly premium offsets are in the $7 to $8 range, whereas the average difference between basic-benefit monthly premiums for MA drug plans and for stand-alone drug plans has ranged from $15 to $25.

In some cases, however, plans may find that they need to encourage more use of drugs (better adherence) to accomplish medical savings.


Anne Martin et al., “Growth In US Health Spending Remained Slow In 2010; Health Share Of Gross Domestic Product Was Unchanged From 2009,” Health Affairs 31(1): 208-291, January 2012. Drugs provided as part of a hospital stay or administered by a physician (e.g., chemotherapy infusions) are excluded from these estimates.

Because the Part D population increases each year, per capita growth rates for drug spending are about 1 percentage point below the absolute spending growth rates described elsewhere in this section.


MedPAC, Report to the Congress: Medicare Payment Policy, March 2011 and March 2012. See also Acumen, “Growth of Drug Prices in the Part D Program,” presentation at the 2010 Part D Symposium, CMS. Rebates are not available for this analysis.

http://www.aarp.org/health/drugs-supplements/info-08-2010/rx_price_watch.html Acumen also found much higher price growth for brands than for generics.

The high price growth for cancer drugs illustrates the role of biologics and other specialty drugs as a force in pushing prices higher. But biologics, although expensive, are a small piece of total program spending. Shinobu Suzuki and Joan Sokolovsky, “Beneficiaries with High Drug Spending under Part D,” staff presentation to MedPAC meeting, September 16, 2011; MedPAC, Report to the Congress: Medicare Payment Policy, March 2012.


Medicare Trustees Reports, 2007-2012. In between, in 2008 the Trustees estimated an average of about 9 percent, revised upward in the next two years to 9.5 percent and 9.6 percent (peaking at 10.4 percent before falling to that level).


About 25 were available in generic versions by 2010, while another 16 will be available as generics by the end of 2012. IMS Institute for Healthcare Informatics, “The Use of Medicines in the United States: Review of 2011,” April 2012.

Another industry analysis shows a modestly lower generic dispensing rate (73 percent in 2010), but expects a rise of 4 to 8 percentage points by the end of 2012 – Anna A. Theodorou et al., “Generic Drug Trends in the United States,” *American Journal of Pharmacy Benefits* 3(2): 118-126, March/April 2011. The latter analysis also identifies some factors (e.g., the introduction of new formulations for drug now off patent, new indications for brand-name drugs in competitive classes, and new FDA approaches to drugs that reached the market prior to the current FDA approval process).


Office of the Assistant Secretary for Planning and Evaluation, “Expanding the Use of Generic Drugs,” ASPE Issue Brief, DHHS, December 1, 2010.


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