

PART D PAYMENT SYSTEM

payment**basics**

Revised:
November 2025

In 2023, Medicare spent \$112.6 billion in subsidies for the Part D program. A combination of stand-alone prescription drug plans (PDPs) and Medicare Advantage (MA) prescription drug plans (MA-PDs) delivers Medicare's voluntary outpatient drug benefit. In each of 34 geographic regions, plans compete for enrollees on the basis of annual premiums, benefit structures, specific drug therapies covered, pharmacy networks, and quality of services. Medicare aims to subsidize premiums by about 75 percent and provides additional subsidies for beneficiaries who have low income and assets.¹ Medicare's payments to plans are determined through a competitive bidding process, and enrollee premiums are tied to plan bids. Part D has several mechanisms for risk sharing so that plans do not take all the insurance risk for their enrollees' drug spending.

The drug benefit

A number of changes in law have revised the structure of the Part D benefit over time, most recently under the Inflation Reduction Act of 2022 (IRA). Most of the IRA's changes to Part D's standard benefit began in 2025, including a single standard benefit design for all enrollees, whether receiving the low-income subsidy or not. For 2026, the standard benefit will include:²

- a \$615 deductible;
- coverage for 75 percent of allowable drug expenses in the initial coverage phase; and
- a \$2,100 limit on true out-of-pocket (OOP) spending.³

CMS updates these benefit parameters each year to reflect estimated changes in average annual drug spending.

Figure 1 details each stakeholder's liability in each phase of the reformed standard benefit.

Beginning in 2025, after reaching their deductible, beneficiaries pay 25 percent cost sharing until they reach the annual

OOP limit. The IRA eliminated cost sharing above the OOP limit; in 2026, beneficiaries will have no cost sharing once they have spent \$2,100 out of pocket.

Under Part D, individuals with low income and limited assets have lower cost-sharing liability and receive an additional premium subsidy (these individuals receive the low-income subsidy (LIS)). Beneficiaries dually eligible for Medicare and Medicaid with incomes up to 100 percent of the federal poverty level have no deductibles, nominal copays, and receive full premium subsidies. Beneficiaries who do not qualify for full Medicaid benefits but whose incomes are below 150 percent of the poverty level and who meet an asset test have no deductibles and receive full premium subsidies, but their copayments are higher than those that apply to beneficiaries who qualify for full Medicaid benefits.⁴

Plans can and often do offer alternative coverage structures to provide the basic Part D benefit. For example, a plan can offer a deductible lower than \$615, or use tiered copayments rather than coinsurance—provided that the alternative benefit meets certain tests of actuarial equivalence. Also, plans may offer additional drug coverage through an enhanced plan that supplements the standard benefit. Medicare's payments to plans do not subsidize such supplemental coverage, and enrollees in those plans may have to pay additional premiums.⁵

Medicare's subsidy components

For each enrollee in a plan (either a stand-alone PDP or MA-PD), Medicare provides plans with a subsidy that aims to average 74.5 percent of basic benefit costs for all types of beneficiaries.⁶ That average subsidy takes two forms:

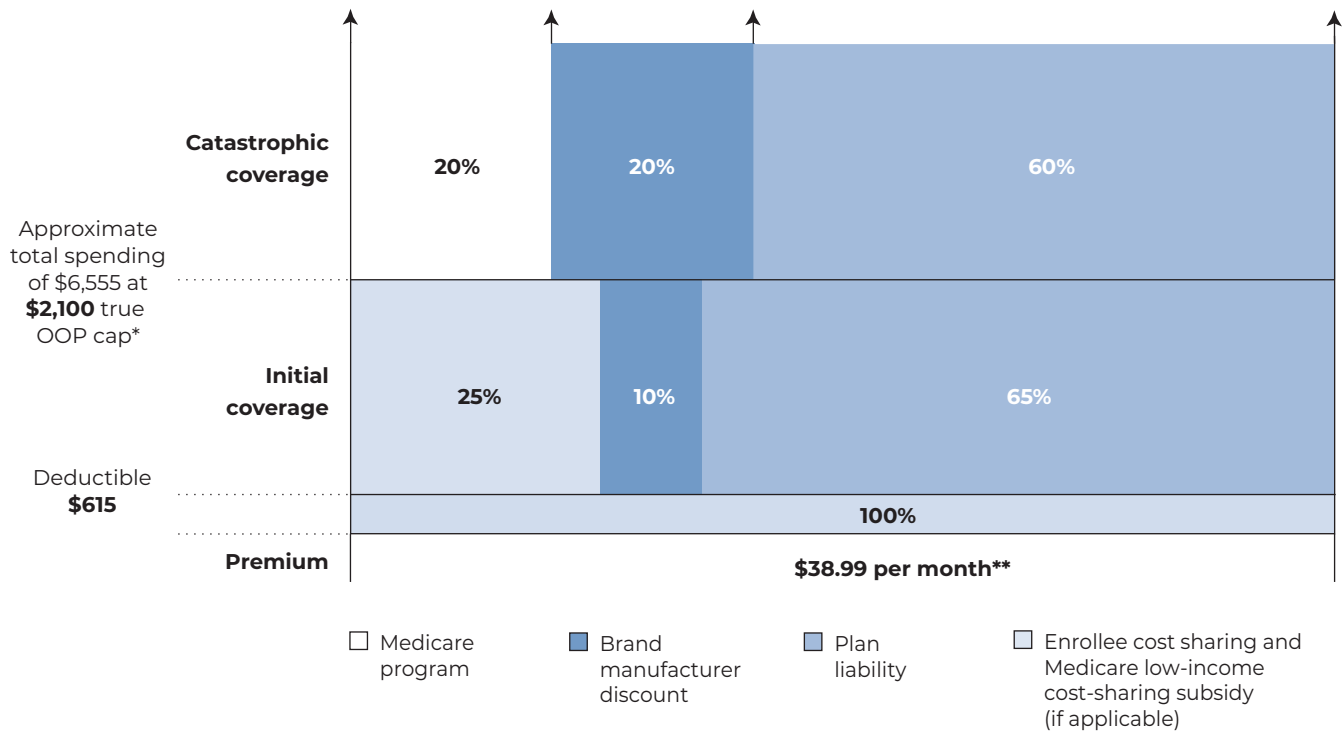
- **Direct subsidy**—a capitated payment to plans calculated as a share of the national average of plan bids adjusted for risk.

The policies discussed in this document were current as of September 30, 2025. This document does not reflect proposed legislation or regulatory actions.

MEDPAC

425 I Street, NW
Suite 701
Washington, DC 20001
ph: 202-220-3700
www.medpac.gov

Figure 1 Standard drug benefit in 2026



Note: OOP (out-of-pocket). This benefit structure is applicable to an enrollee who has no supplementary drug coverage and is taking an "applicable drug" (i.e., a brand-name drug, biologic, or biosimilar) for which a manufacturer will owe a discount under the manufacturer discount program. For generic drugs, plan sponsors must cover 75 percent of enrollee spending between the deductible and OOP cap (with enrollees paying the remaining 25 percent), and Medicare's reinsurance will pay for 40 percent of spending in the catastrophic phase. For low-income subsidy (LIS) enrollees, Medicare's LIS pays for all cost sharing except nominal copayments.

* Equivalent to \$2,100 in OOP spending: \$615 (deductible) + \$1,485 (25 percent cost sharing on \$5,940). Total spending at the annual OOP limit would depend on the mix of drugs used and whether the individual was enrolled in an enhanced plan with supplemental benefits.

** There is a base beneficiary premium of \$38.99 (about \$468 per year), which is less than 15 percent of expected Medicare Part D benefits per person, but the actual premiums that beneficiaries pay vary by plan. Federal subsidies pay for the remainder of covered Part D benefits.

- **Individual reinsurance**—Medicare subsidizes a portion of drug spending above the annual OOP limit on an incurred cost basis. (Beginning in 2025, Medicare reduced its reinsurance and increased capitated payments.) Reinsurance acts as a form of risk adjustment by providing greater federal subsidies for the highest-cost enrollees.

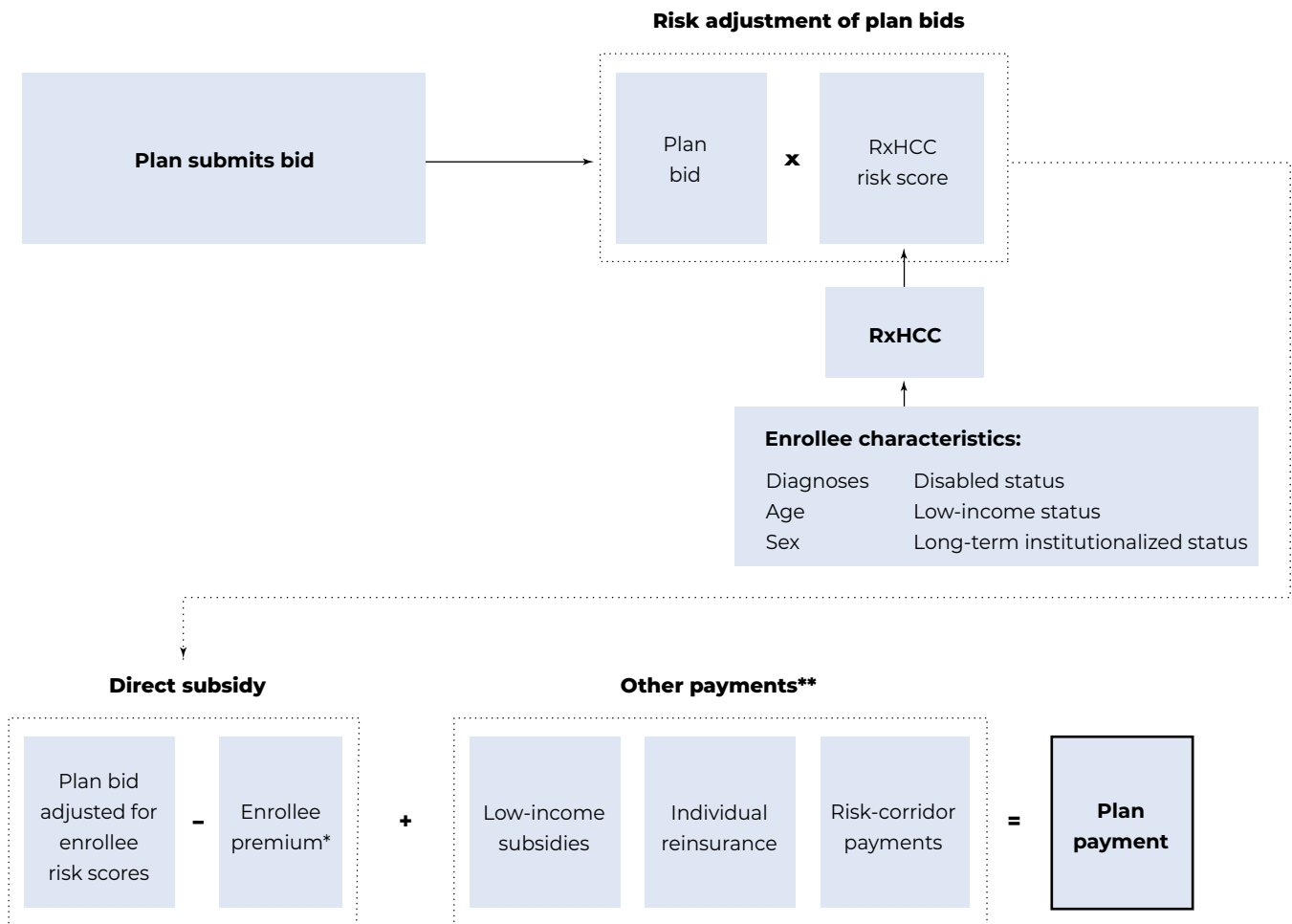
In addition, Medicare establishes symmetric risk corridors separately for each plan in order to limit a plan's overall losses or profits. Under risk corridors, Medicare limits a plan's losses (or gains) by financing some of the higher-than-expected costs (or recouping higher-than-expected profits). Also, Medicare

pays plans most of their LIS enrollees' cost sharing and premiums.

Note that although plans get essentially the same level of direct subsidy per enrollee (modified by risk scores), the level of other payments differs substantially from plan to plan. Other payments vary depending on the characteristics of the individuals that each plan enrolls (e.g., their income), as well as whether a plan's losses or profits trigger provisions of its risk corridors.

Part D serves as the primary source of prescription drug coverage for individuals who are dually eligible for Medicare and Medicaid. However, states continue to help finance the costs of drug coverage

Figure 2 Part D payment system, 2026



Note: RxHCC (prescription drug hierarchical condition category). The RxHCC is the model that estimates the enrollee risk score. CMS uses five separate sets of model coefficients for long-term institutionalized enrollees, aged low-income enrollees, aged non-low-income enrollees, disabled low-income enrollees, and disabled non-low-income enrollees.

* Figure 3 outlines the process for calculating enrollee premiums.

** Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.

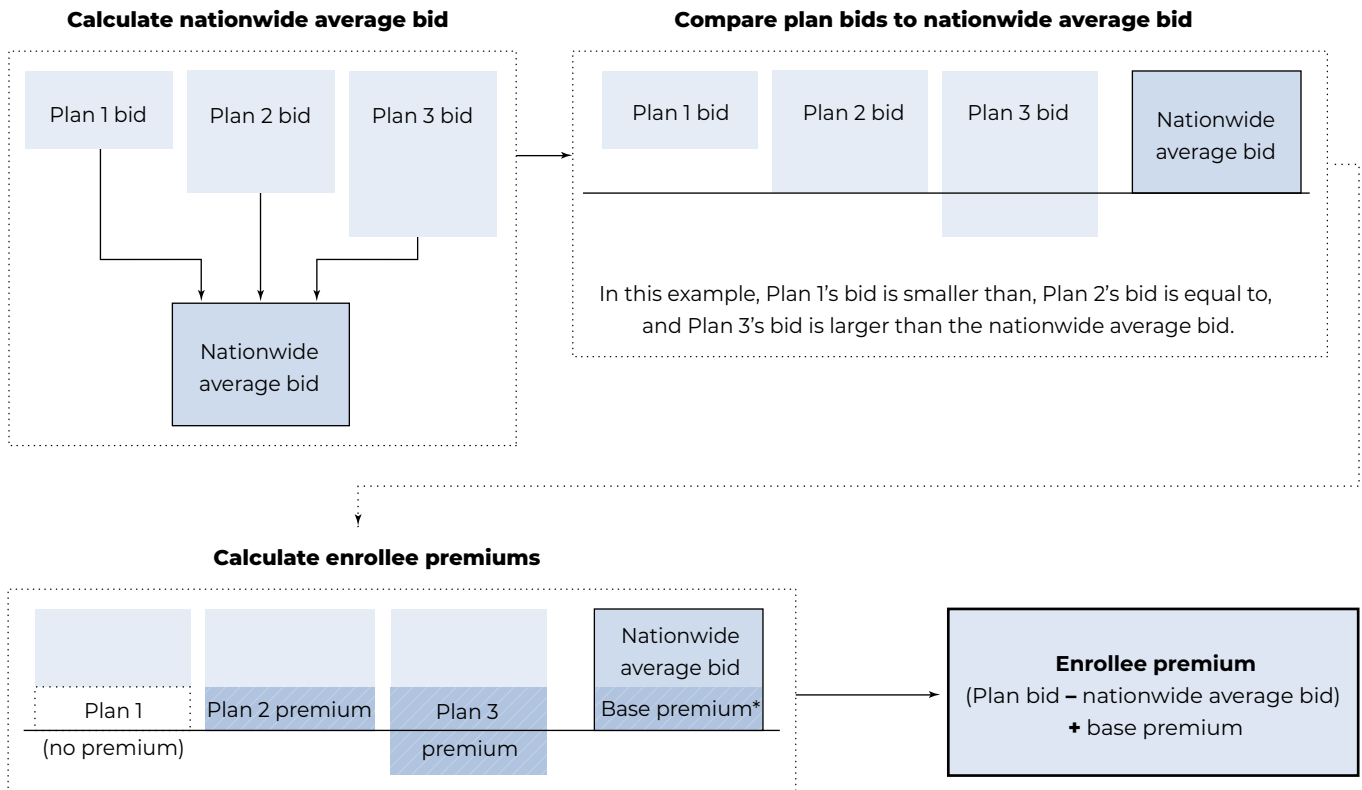
for dually eligible beneficiaries by making monthly lump-sum payments to Medicare.

Medicare's payments to plans

Each plan submits a bid annually to CMS by the first Monday in June for plans that will be offered starting in January of the following year. The bid reflects the plan's expected basic benefit costs plus administrative costs and profits after deducting expected federal reinsurance subsidies. Plans base their bids on expected costs for a beneficiary with an average risk score.

The direct subsidy that CMS pays to each plan takes the form of a monthly prospective payment for each enrollee based on the plan's approved bid. The plan bid is first adjusted by the enrollees' diagnoses and other factors, namely low-income status and long-term institutionalized status through the prescription drug hierarchical condition category (RxHCC) risk score (Figure 2). A second adjustment to the plan's bid is the subtraction of the enrollee's premium. (See the following section on how premiums are calculated.) The agency reconciles payments to reflect the actual levels of enrollment, risk

Figure 3 Calculating enrollee premiums for basic benefits, 2026



Note: *The base premium is a share of the nationwide average bid. It equals the nationwide average times a factor with a numerator of 25.5 percent and a denominator of 100 percent minus CMS's estimate of aggregate plan revenues for Part D benefits that plans receive through federal individual reinsurance subsidies. Beginning in 2024, the Inflation Reduction Act of 2022 limits the annual increase in the base premium to no more than 6 percent. When this provision is binding (as it has been in each year since it became applicable), the base premium's share of Part D benefit costs is less than 25.5 percent applied to the nationwide average bid amount. Beginning in 2011, Part D began collecting additional premiums from higher-income enrollees. The extra premium amount is a percentage applied to the nationwide average bid and is based on modified adjusted gross income from one's 2024 tax return.

factors, and levels of incurred allowable drug costs (after rebates and other discounts) after the end of each year.

The changes made under the IRA will cause much more of the program's subsidy of basic benefits to take the form of capitated direct-subsidy payments rather than cost-based reinsurance payments, but Medicare's expected overall subsidy rate remains unchanged at 74.5 percent (unless required to increase to accommodate the 6 percent cap on annual premium increases included in the IRA, discussed below).

Calculating enrollee premiums

CMS takes plans' standardized bid amounts for basic benefits and calculates the average

(Figure 3).⁷ The base premium is a share of the nationwide average bid, as detailed in the note for Figure 3. To enroll in a Part D plan, beneficiaries pay the base premium plus any difference between their plan's bid and the nationwide average bid.⁸ Enrollees in costlier plans face higher-than-average premiums for basic Part D coverage; similarly, enrollees in less expensive plans pay lower-than-average premiums.⁹ Beginning in 2024, the IRA limits the annual increase in the base premium to no more than 6 percent. The base premium amount for beneficiaries is \$38.99 per month in 2026. (Without the IRA change, the base premium amount would be \$75.38 per month in 2026.)

For 2026, CMS announced that it will continue the new Part D Premium Stabilization Demonstration, a voluntary demonstration for stand-alone PDPs established in 2025 and made available for up to two subsequent years. In 2026, for participating PDPs, the demonstration would lower the monthly beneficiary premium by up to \$10 and limit total monthly Part D premium (including any premium charged for supplemental benefits) increases to no more than \$50.¹⁰

Individuals with modified adjusted gross incomes exceeding certain income thresholds are subject to higher premiums, similar to the income-related premium under Medicare Part B.

Medicare pays all or most of the premium for low-income beneficiaries up to a regional threshold amount, calculated as an enrollment-weighted average premium for each PDP region.

Mandatory rebates to Medicare for rapid price growth

As a result of the IRA, all covered Part D drugs are subject to inflation rebates as of October 1, 2022. Manufacturers are required to provide rebates to the Medicare program for increases in the price of drugs sold in Part D that are greater than the increase in inflation over the same period, relative to a 2021 benchmark.

The Medicare Drug Price Negotiation Program

The IRA also implemented the Medicare Drug Price Negotiation Program, which requires manufacturers of selected drugs to engage in negotiations with the Secretary of Health and Human Services over prices charged under Medicare Part B and Part D. Negotiated prices for first 10 selected Part D drugs go into effect in 2026. ■

¹ As a result of the changes made by the Inflation Reduction Act of 2022, beginning in 2024, the annual increase in the base premium is limited to no more than 6 percent. When this provision is binding (as has been the case for 2024, 2025,

and 2026), the base premium's share of Part D benefit costs is less than 25.5 percent applied to the nationwide average bid amount, and, as a result, Medicare's subsidy rate can be higher than the 74.5 percent specified in law. In addition, the premium subsidy is reduced for higher-income beneficiaries. For more information, refer to the section on calculating enrollee premiums.

- 2 The IRA eliminated cost sharing above the OOP limit in 2024 and, effective in 2025, eliminated the program's former coverage gap. The IRA also made changes to plan liability, manufacturer discounts owed, and Medicare's reinsurance liability. (See Endnote 1.)
- 3 The term "true out-of-pocket" (TrOOP) refers to those costs that count toward the catastrophic threshold. In addition to a beneficiary's own OOP expenditures or payments made on behalf of the beneficiary (e.g., charity), beginning in 2025, the value of supplemental coverage provided by enhanced plans and employer group waiver plans also counts towards TrOOP. The inclusion of supplemental coverage towards TrOOP is a result of changes made by the IRA. Conversely, mandatory manufacturer discounts are no longer counted towards TrOOP, another change of the IRA. Beneficiaries need to adhere to their plan's formulary, prior authorization, and formulary exceptions processes in order to receive credit for their OOP spending toward the \$2,100 limit.
- 4 Starting in 2024, the IRA expanded the eligibility for the full LIS to beneficiaries who earn between 135 percent and 150 percent of the federal poverty level and meet the asset test. Prior to 2024, these beneficiaries qualified for only a partial LIS.
- 5 MA-PD plans may use Part C rebates to "buy down" their enrollees' premiums, including premiums for enhanced prescription drug coverage.
- 6 See Endnote 1.
- 7 For enhanced plans, the cost for basic benefits is calculated separately from that of supplemental benefits, allowing just the portion for basic benefits to be included in this calculation.
- 8 Premiums for individual plans vary widely, with many MA-PDs charging \$0 after applying a portion of Part C rebates to offset premium costs that MA-PD enrollees would otherwise pay.
- 9 Beneficiaries (other than those who receive the LIS) who delay enrolling in Part D until after their initial enrollment period and who do not have creditable coverage must also pay a late-enrollment penalty each month, similar to that for Part B. "Creditable coverage" refers to prescription drug benefits through sources such as a former employer that are at least as generous as the standard Part D benefit.
- 10 The first year of the demonstration in 2025 provided greater risk-corridor protection from losses. This provision was eliminated for 2026.