MEDPAC

Advising the Congress on Medicare issues

Analyzing recent increases in Part D bids

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Presentation roadmap

1. Background
2. Using Part D plans' bid data to analyze recent increases
3. Medicare policies limiting effects on beneficiary premiums
4. Interviews with actuaries
5. Discussion

Major Part D–related provisions of the Inflation Reduction Act of 2022

2023

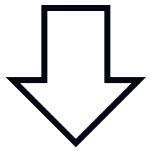
- Mandatory manufacturer rebate to Medicare if drug prices rise faster than inflation
- $35 monthly cap on insulin cost sharing
- No cost sharing for recommended adult vaccines

2024

- No cost sharing once Part D enrollees reach OOP threshold ($8,000)
- Growth in national average premium limited to 6%
- Expanded eligibility for full LIS benefits
- Pharmacy DIR must be applied at POS*

2025

- **New benefit design for Part D**



- Greater role of the capitated direct subsidy and other shifts in Part D benefit financing
- Reduction in cost sharing, including lower OOP cap

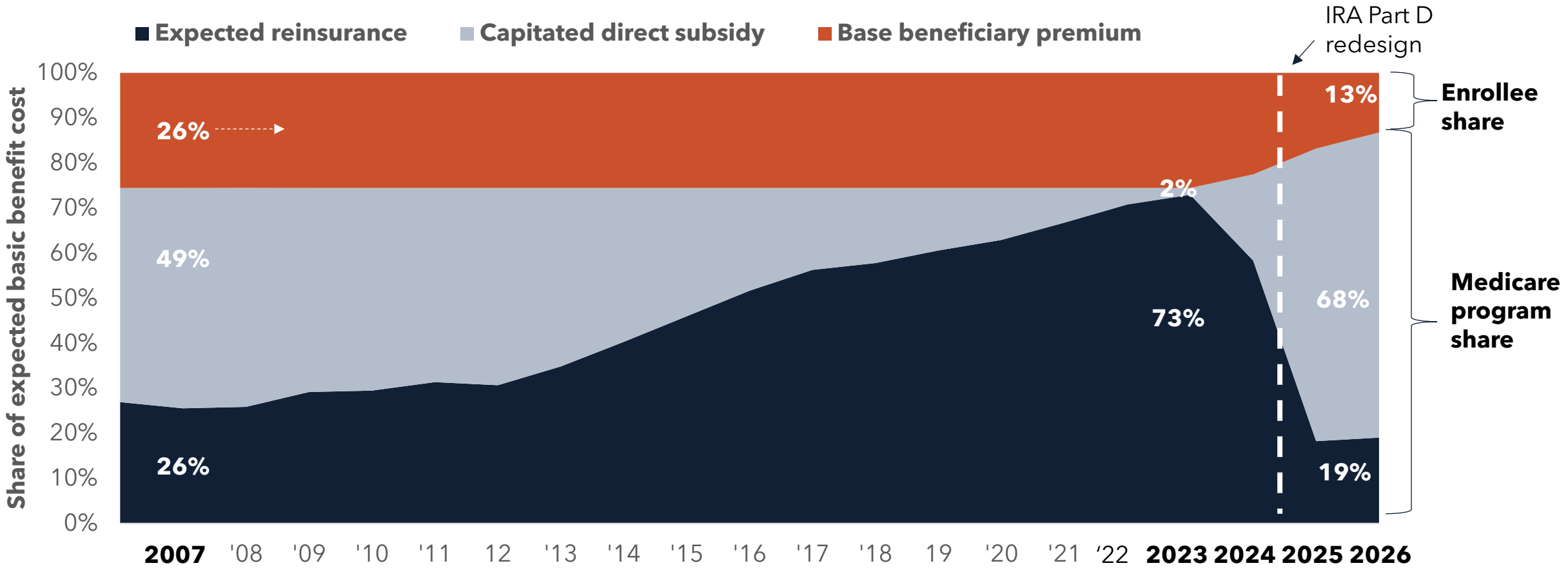
2026

- Secretary-negotiated prices (MFPs) for first 10 drugs take effect

Note: OOP (out-of-pocket), LIS (low-income subsidy), DIR (direct and indirect remuneration), POS (point of sale), MFP (maximum fair price).

* Pharmacy DIR change was made via rulemaking, not as part of the Inflation Reduction Act of 2022.

The IRA restored the role of capitated direct subsidy payments



Note: IRA (Inflation Reduction Act of 2022).
Source: CMS's bid announcements.

Part D benefit redesign significantly lowered cost sharing

- Removed the coverage gap, eliminated cost sharing above the OOP limit, and lowered the OOP limit ($8,000 → $2,000)
- New "True OOP" results in more enrollees reaching the limit with lower OOP spending
  - Value of enhanced benefits count towards the limit
  - Study estimates that the number of enrollees reaching the OOP limit will double from 2023 to 2025
- Improves affordability, especially for the highest-spending beneficiaries, but also induces higher utilization
- Increases the costs of the benefit, translating to higher premiums (in the absence of any policies reducing them)

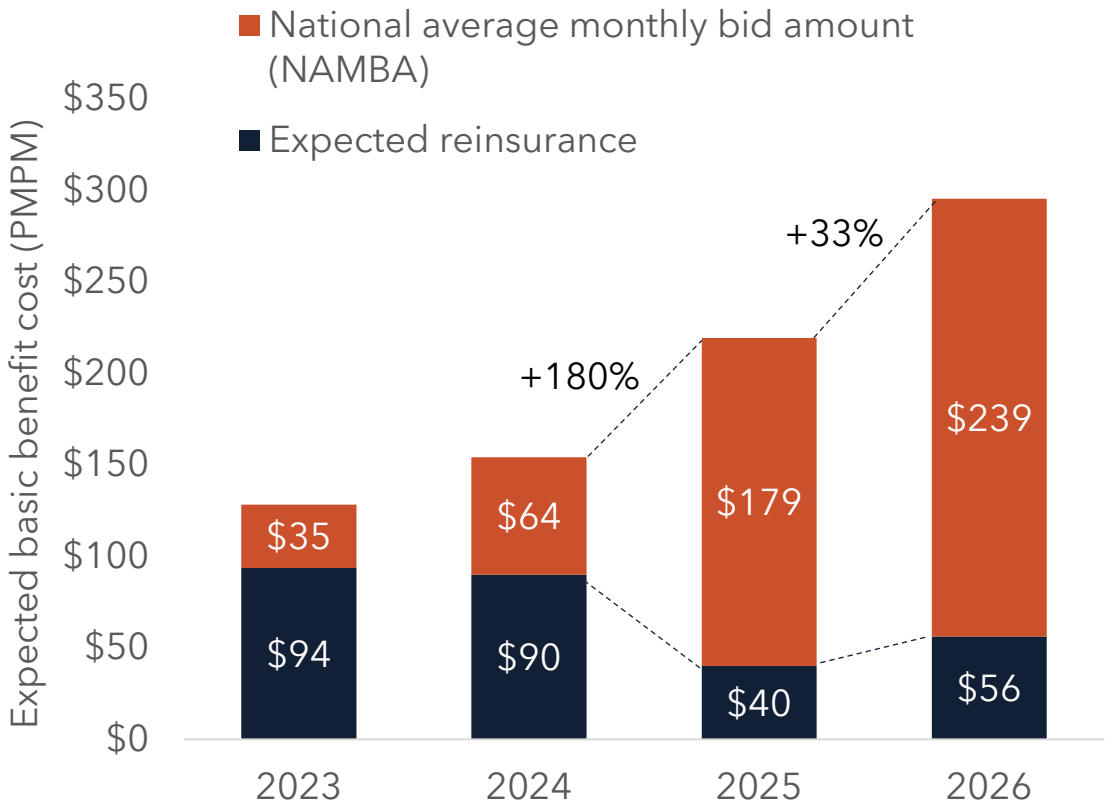
Note: OOP (out-of-pocket). The OOP calculation prior to 2025 allowed manufacturer discount amounts to be counted toward meeting the limit.
Source: Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. 2025. *Projecting the impact of the $2,000 Part D out-of-pocket cap for Medicare Part D enrollees with high prescription drug spending*. Washington, DC: ASPE.

Interest in understanding the increase in plan bids and effects on Medicare's costs

- Commissioners expressed interest in learning more about the effects of the redesign
- The National Average Monthly Bid Amount (NAMBA) is a measure of plan benefit liability that is used to calculate Medicare's capitated payments to plans
  - Increased by 180% in 2025 and by 33% in 2026
- Medicare's total subsidy for basic benefits (capitated direct subsidy + expected reinsurance) also rose
  - Increased by 53% in 2025 and 40% in 2026

Multiple factors contribute to growth in Part D plans' bids

- Shift to the capitated direct subsidy payments from cost-based reinsurance increases bids
- Higher expected basic benefit costs increases bids:
  - Reductions in beneficiary cost sharing (shifting financing of drug cost to premiums)
  - Induced utilization increasing spending
  - Trends in greater use of high-cost drugs such as GLP-1s



Note: GLP-1s (Glucagon-Like Peptide-1). The NAMBA is the sum of the capitated direct subsidy plus the base beneficiary premium.

Source: CMS's bid announcements.

Medicare and enrollees share Part D basic benefit costs

Total expected basic benefit cost = Medicare expected reinsurance + Medicare capitated direct subsidy + Base beneficiary premium (Historically 25.5%)

National average monthly bid amount (NAMBA)
(Based on risk-standardized plan bids)

Preliminary and subject to change

Analysis of trends using plans' bid data

- Medicare requires Part D plans to submit information projecting their costs annually
  - Two-year lag in data (e.g., 2025 bids are based on 2023 experience)
- Plans compute their expected distribution of enrollee spending
  - Project cost sharing, reinsurance, manufacturers' discounts and rebates
  - Remainder is referred to as "plan liability"
- The average plan liability across plans, enrollment-weighted and risk standardized, is the NAMBA*
- Bid data are available through 2026

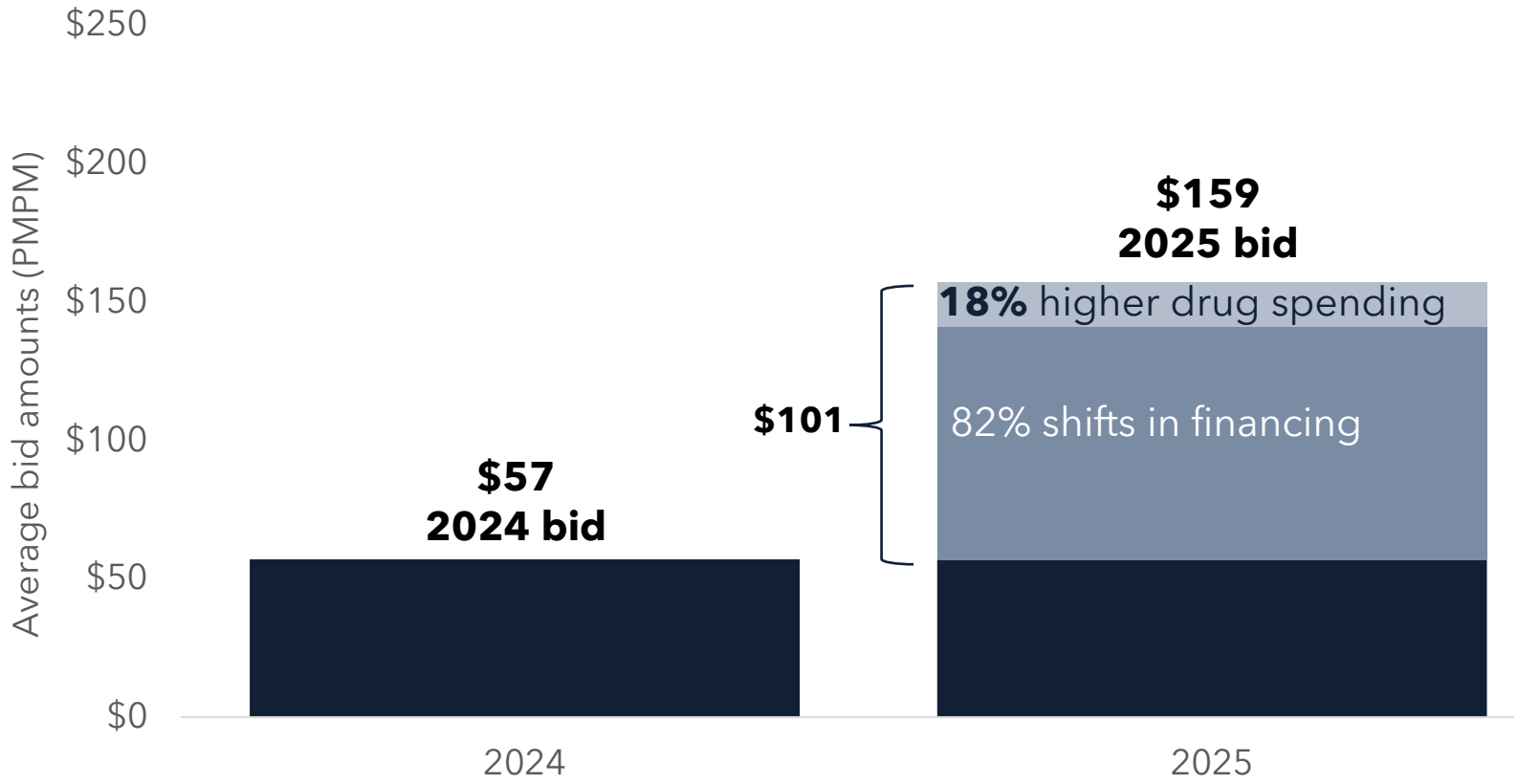
Note: NAMBA (national average monthly bid amount).*Plans' bids are the sum of plan liability, administrative costs, and margin.

Decomposing growth in plan bids

- Estimate the relative contribution of:
  - Shifts in benefit financing (e.g., reduction in beneficiary cost sharing)
  - Higher drug spending (e.g., trends in use of high-cost drugs, induced demand from lower cost sharing, corrections to prior-year underbids)
- Use unstandardized spending, reflecting how plans construct bids and removing the influence of risk-score changes
- Apply plans' projected distribution of enrollees' spending before and after the redesign, holding overall spending constant*
  - Sum changes in amount of cost sharing, reinsurance, manufacturers' discounts, and administrative costs
  - Residual difference in bids estimated to be growth in expected total spending

Note: *Specifically, to estimate shifts in benefit financing for 2025, we apply plans' projected spending shares in 2025 to overall spending in 2024; for 2026, we apply projected shares to overall spending in 2025.

In 2025, bid growth was primarily related to shifts in financing to plan liability

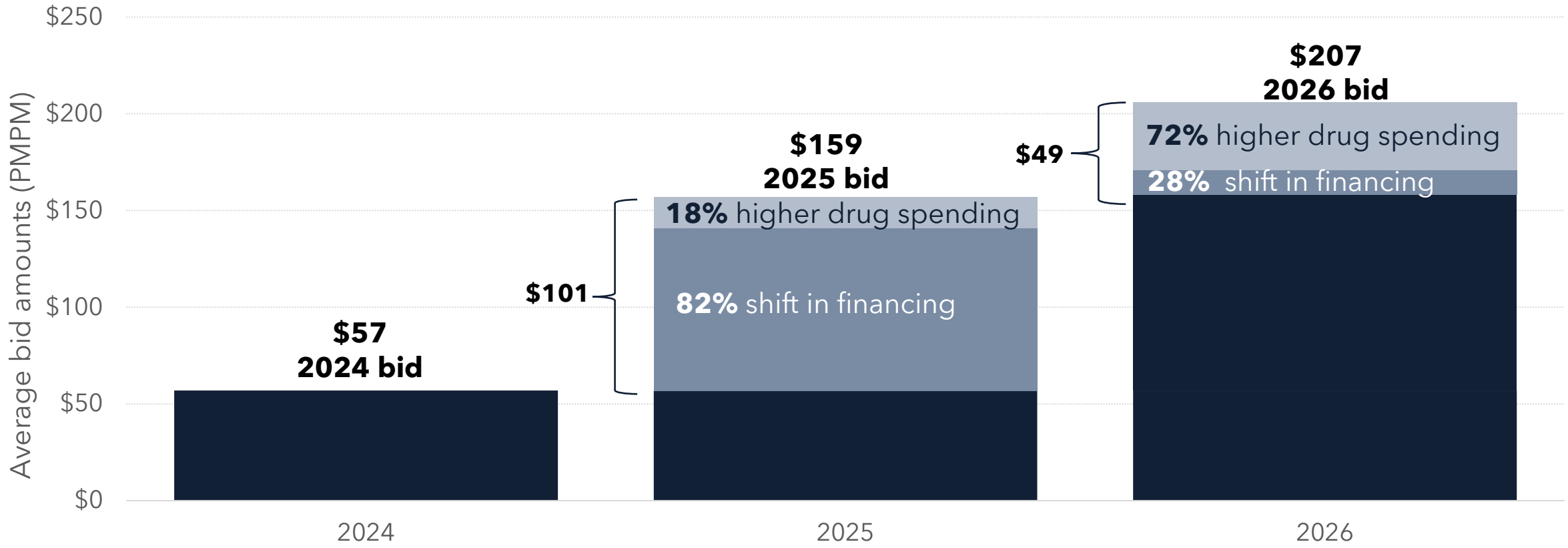


- Shift to plan liability from reductions in:
  - Medicare's reinsurance
  - Beneficiary cost sharing
  - LICS subsidies
- Offset by higher manufacturer discounts
- Higher 2025 spending reflects:
  - Correction for 2024 underbid
  - Expected trend for 2025

Note: PMPM (per member per month), LICS (low-income cost-sharing). Plan liability is financed by Medicare's capitated monthly "direct subsidy" payments and enrollee premiums. To decompose the bid growth, we applied plans' projected distribution of enrollees' spending in 2024 and 2025, holding overall spending constant. We then summed changes in the components of enrollee spending and the residual difference in bids is attributed to the growth in expected total spending.

Source: Part D bid pricing tool data from CMS.

In 2026, bid growth was primarily related to higher expected drug spending



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Source: Part D bid pricing tool data from CMS.

Despite higher benefit costs, Medicare policies reduced enrollees' premiums

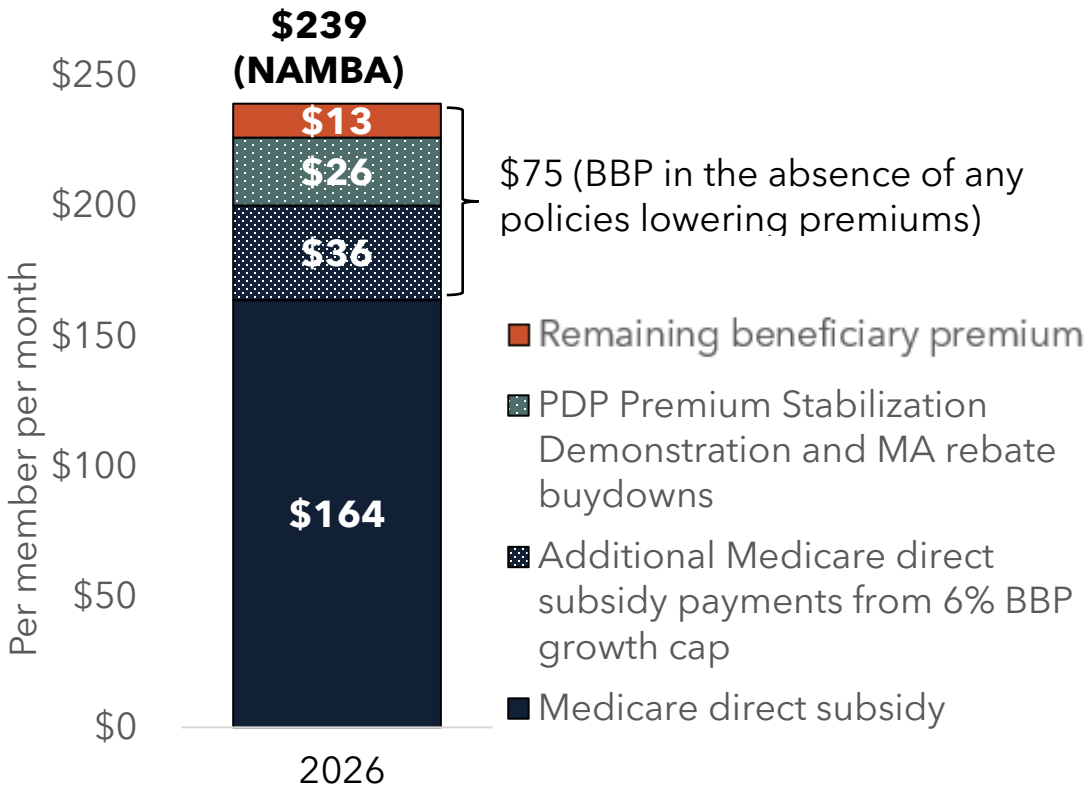
- Without such policies, premiums would have increased by 18% in 2024 and 44% in 2025
- IRA capped base beneficiary premium growth at 6% annually
  - Reduced enrollees' share of basic benefit costs to 13% in 2026
  - Increased Medicare's share costs to 87%
- PDP Premium Stabilization Demonstration: Medicare paid PDPs to lower premiums and cap annual growth, increasing program spending
- MA rebate buydowns for MA-PD plans: A common supplemental benefit among MA plans is buying down Part D premiums

Note: PDP (standalone prescription drug plan), MA-PD (Medicare Advantage Prescription drug). Beginning in 2030, the base beneficiary premium must be set to account for least 20 percent of total expected basic benefit costs. The PDP Premium Stabilization Demonstration also included narrowed risk corridors in 2025.

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

Premiums paid by enrollees significantly reduced by Medicare policies, 2026

- In 2026, the average expected basic premium is $13
- The premium would be $75 with no buydowns
- Difference is financed, in large part, by Medicare through higher direct subsidy payments and PDP demonstration payments
- Variation by plan type



Note: NAMBA (National Average Monthly Bid Amount), BBP (base beneficiary premium), PDP (standalone prescription drug plan).
Source: Part D and MA Bid Pricing Tool data, and Part D landscape files from CMS.

Interviews with actuaries

- Purpose: To understand how policy changes are affecting Part D bids and market dynamics
- Semistructured interviews with 11actuaries with Part D expertise
  - Conducted between August and December 2025
  - Represented PDP and MA–PD markets, for-profit and nonprofit plans, and serving single or multiple regions
  - Focused on recent trends in the bids, the PDP market, LIS benchmark plans, and risk adjustment
- May not reflect perspectives of all Part D plans

Note: PDP (stand-alone prescription drug plan), MA–PD (Medicare Advantage–prescription drug [plan]), LIS (low-income subsidy).

Interview findings: Possible underbidding in 2025 and bid adjustments in 2026

- Spending for brand-name and specialty drugs in 2025 likely exceeded plan expectations, particularly among non-LIS beneficiaries, due to:
  - Lower OOP limits and new True OOP calculation
  - Underlying utilization trend for specialty drugs
- In response, plans increased bids in 2026 but large variation remained, likely driven by continued uncertainty:
  - Full impact of the IRA is not known
  - Effects of MFPs on rebates and costs expected to vary across plans
  - Different approaches to bidding (e.g., prioritize margins over enrollment gains, or vice versa)

Note: OOP (out-of-pocket), IRA (Inflation Reduction Act of 2022), MFP (maximum fair price).

Interview findings: Policies and plan strategies shaping the PDP market

- Insurers may see less value in operating PDPs
- IRA redesign "commoditizes" the market by limiting plan differentiation and increasing focus on premium competition
- LIS benchmark-plan dynamics may drive both competition and market instability
- Risk selection within the PDP market remains strong, reinforced by:
  - Use of pricing and benefit design to influence enrollee mix
  - Benchmark plans' ability to gain/retain auto-enrollees with lower, predictable claims relative to other LIS enrollees

Note: PDP (stand-alone prescription drug plan), IRA (Inflation Reduction Act of 2022), LIS (low-income subsidy).

Interview findings: Improving risk adjustment is crucial for long-term PDP market stability

- A PDP market with predictable utilization and costs may still be a few years away
- CMS's use of separate normalization factors improved short-term financial prospects for PDPs by increasing their average risk scores and payments
- However, long-term viability of the PDP market would likely require:
  - Further refinements of the risk-adjustment model to address risk selection
  - Potential other policies (e.g., temporarily enhanced risk-corridor protection)

Note: PDP (stand-alone prescription drug plan).

Summary

- Shift in drug spending liabilities was the main driver of the bid increase in 2025; in 2026, rising costs and uncertainty in pricing and use were the primary factors
- Buydowns and temporary subsidies have offset premium increases for enrollees but led to higher Medicare costs, including:
  - Higher premium subsidies for LIS enrollees
  - Higher direct subsidies and costs for Part D Premium Stabilization Demonstration for PDPs
- Significant increase in bids, driven by catastrophic spending, and diverse plan strategies highlight the need for policies that address high spending and promote balanced competition and market stability

Note: NAMBA (national average monthly bid amount), LIS (low-income subsidy), PDP (stand-alone prescription drug plan).

Discussion

- Questions
- Feedback or comments on material
- Material will be published as an appendix to the Part D status report in the March 2026 report

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