CHAPTER 13

The Medicare prescription drug program (Part D): Status report

CHAPTER 13

The Medicare prescription drug program (Part D): Status report

Chapter summary

In 2025, Part D paid for outpatient prescription drug coverage on behalf of more than 55 million Medicare beneficiaries. Medicare's payment system for Part D differs from Part A and Part B in that it does not pay for outpatient prescription drugs directly and instead pays private plans to administer the prescription drug benefit.

Between 2023 and 2024, Medicare's Part D program spending is estimated to have increased nearly 18 percent, representing a sharp acceleration from growth of just over 10 percent in 2023. In 2024, payments to stand-alone prescription drug plans (PDPs) and Medicare Advantage Prescription Drug plans (MA–PDs), including premiums paid by enrollees, totaled $148.3 billion. Of that amount, Medicare paid $90.3 billion in subsidies for basic benefit costs and $41.3 billion in extra financial support for enrollees who receive the low-income subsidy (LIS), while Part D enrollees paid $16.7 billion in premiums for basic benefits. Not included in this total is an additional $17.7 billion in cost sharing paid by enrollees and $0.5 billion in retiree drug subsidies paid by Medicare to employers who provide drug coverage to their retirees.

Major changes taking place beginning in 2025—The Inflation Reduction Act of 2022 (IRA) made the most significant changes to Part D since its

In this chapter

inception, fundamentally altering the structure and financing of the Part D program. The redesign improves the affordability of medicines by reducing beneficiaries' cost-sharing liability and strengthens plan incentives to manage costs but also introduces new uncertainties and financial pressures for plans, Medicare, and the pharmaceutical supply chain. Key provisions include new cost-sharing protections, particularly for beneficiaries using high-cost drugs, and a shift from cost-based reinsurance to monthly capitated direct-subsidy payments as the primary mechanisms for subsidizing Part D premiums. Many of the IRA changes are directionally consistent with the Commission's 2020 recommendations to strengthen plan incentives to manage drug spending. However, the elimination of cost sharing above the annual out-of-pocket threshold and the lowering of that threshold, while improving affordability, likely created significant utilization uncertainties as plans lack cost-sharing tools to manage spending once beneficiaries reach the threshold. The Commission has consistently emphasized that when plan sponsors assume greater insurance risk, they should also have tools to manage spending.

By capping annual growth in enrollees' share of benefit costs (premiums) at 6 percent, the IRA increased Medicare's share of program spending to more than 83 percent in 2025 (up from the 74.5 percent originally set in law). The IRA also included policies to address high drug prices (inflation rebates for manufacturers and the Medicare Drug Price Negotiation Program), areas where the Commission has not made recommendations.

Since the implementation of the redesign, the national average bid increased nearly 180 percent in 2025 and an additional 33 percent in 2026, likely driven, at least in part, by higher plan liability and uncertainty about the increase in utilization. For 2025, we estimate that most of the increase resulted from substantially shifting Part D's financing from cost-based reinsurance to capitated direct subsidies. In contrast, for 2026, our estimate suggests that nearly all of the increase reflects higher projected spending. While the Medicare Premium Stabilization Demonstration for PDPs helps limit premium increases that otherwise would have followed from higher bids for those plans, premiums for PDPs remain higher than for MA–PDs and continue to vary widely. The demonstration also increases program spending by adding costs beyond the subsidy amounts set by law. The Commission will continue to monitor the effects of the IRA and other drug-pricing policies, including the implementation of the Drug Price Negotiation Program.

Historical trends and long-term stability of the PDP market—Part D's market structure continues to evolve. With the ongoing enrollment shift from PDPs to MA–PDs, PDPs now account for less than 42 percent of all Part D enrollees, down from 53 percent in 2020. The number of PDPs has declined, especially among enhanced plans, while the number of special-needs plans (SNPs)—a type of MA plan—has grown. Despite the decline in PDP offerings, in 2026, beneficiary choices include an average of 11 PDPs offered by five major insurers and 32 MA–PDs offered by an average of eight insurers. The number of benchmark plans (premium-free options for fee-for-service (FFS) beneficiaries with the LIS) remained relatively stable in 2026, but there are ongoing concerns about the availability of benchmark plans in some regions. Trends through 2025 showed stable average premiums for beneficiaries, but significant differences remain between PDPs and MA–PDs. In 2026, monthly premiums are projected to average $44 for PDPs and $11 for MA–PDs (including SNPs).

Lower Part D premiums, along with more generous drug coverage—such as lower deductibles and cost sharing—and extra benefits offered under Medicare Advantage (MA) financed primarily by MA rebates, may be contributing to the broader shift in Medicare from FFS to MA. Recent work by the Commission has also found diverging trends in Part D risk scores and costs in the two markets. This divergence suggests a potential misalignment between Medicare's payments to plans and enrollees' drug costs that may be discouraging insurer participation in the PDP market and accelerating the shift to MA.

The risk-adjustment model is intended to align payments with expected costs, but analysis shows Part D's risk scores have tended to overpredict costs for MA–PDs and underpredict for PDPs. In response, CMS began applying separate normalization factors to MA-PD and PDP risk scores in 2025 to better reflect actual costs. However, further refinements may be needed for balanced competition and accurate payment adjustments to ensure the stability of the PDP market. The Commission will continue to monitor how recent changes to the separate normalizations of PDP and MA–PD risk scores may have affected the relationship between risk scores and costs.

Part D prices and Medicare's negotiation program—Brand-name drugs with very high prices are the primary driver of Part D spending. Brand-name drugs and biologics without a generic (or biosimilar) competitor now account for over 83 percent of gross Part D spending, despite constituting less than 10 percent

of prescriptions. The first two rounds of drugs selected for the Medicare Drug Price Negotiation Program represent over $103 billion in gross spending—more than 36 percent of total gross Part D spending—and accounted for more than 60 percent of all manufacturer rebates in 2024. The shift from rebates to maximum fair prices (MFPs) under the negotiation program is expected to lower point-of-sale prices for beneficiaries but also affect plan operations in a way that places both downward and upward pressure on premiums and Medicare's subsidies. For example, reduced rebates tend to put upward pressure on benefit costs and premiums, though reduced prices at the point of sale would tend to lower costs for patients and Medicare's LIS. The net effect of those factors on program spending is uncertain. Pharmacies, especially independents, have raised concerns about how changes in reimbursement structures and the timing of payments may affect their operations.

Quality of Part D plans and beneficiary access to needed medicines—The quality of Part D plans and enrollee satisfaction is closely related to access to medicines and patient experience with the plan. Historically, the Part D program has generally enjoyed high levels of satisfaction. Part D plans use various tools to manage spending and design products that are attractive to beneficiaries. These tools can reduce benefit spending, program costs, and premiums. However, when used inappropriately, they can limit access to needed medications. Recent policy changes may also affect pharmacy finances and the contracting environment, potentially influencing decisions to remain open or exit markets. We plan to analyze trends in pharmacy networks to assess how evolving incentives affect pharmacy participation and beneficiaries' access.

The Medicare Plan Finder helps beneficiaries compare coverage and costs among plan options. However, CMS has raised concerns about the accuracy of drug prices displayed on Plan Finder during the annual enrollment period (AEP), which may affect plan choice and enrollee costs. Our analysis of Plan Finder data for 2024 found that prices displayed during the AEP generally aligned with those at the start of the benefit year and did not raise immediate concerns about price accuracy. However, more detailed analysis may reveal plan- or drug-level variation that affects beneficiaries who pay coinsurance. We encourage CMS to continue monitoring Plan Finder prices and consider implementing a measure to ensure accuracy of prices during the AEP. ■

Each year, the Commission provides a status report on Medicare's Part D prescription drug program. In 2025, 55.8 million Medicare beneficiaries were enrolled in the Part D program for outpatient prescription drug coverage. This coverage is provided by private insurers that offer stand-alone prescription drug plans (PDPs) for fee-for-service (FFS) beneficiaries and Medicare Advantage Prescription Drug plans (MA–PDs), which combine medical and prescription drug coverage, for beneficiaries enrolled in Medicare Advantage (MA). These Part D plans compete to attract enrollees based on the breadth of the drugs they cover, premiums, cost sharing, pharmacy networks, and quality of services. The Budget Reconciliation Act of 2022 (commonly referred to as the Inflation Reduction Act (IRA)) redesigned the Part D benefit and substantially changed the financing of the program costs. These changes were expected to result in higher bids. However, the nearly 180 percent increase in average bids in 2025, followed by an additional 33 percent increase in 2026, may have exceeded expectations. In 2026, beneficiaries have access to an average of 11 PDPs and 32 MA–PDs. In 2024, Part D program costs are estimated to total over $148 billion (Boards of Trustees 2025).

Background

The Part D program is in its 20th year. The Part D market has evolved over time in response to policy changes as well as changes in the business strategies of insurers participating in Part D. As described below, the latest policy changes were enacted through the IRA; the first change took effect in 2022 while other provisions are scheduled to take effect in 2026 or later.

Medicare's payment system for Part D is different from payment systems under Part A and Part B because Medicare does not pay for outpatient prescription drugs directly. Instead, the Medicare program makes payments to Part D plans to provide coverage for each enrolled beneficiary. Medicare makes two payments on behalf of enrollees in their plans:

- ***Direct subsidy***—For each enrollee, Medicare pays a monthly (capitated) prospective payment that is set as a share of the national average bid for Part D basic benefits, adjusted for the risk of the individual enrollee.
- ***Reinsurance***—For enrollees in the catastrophic phase of the benefit—who have drug spending above an annual out-of-pocket (OOP) threshold—Medicare makes payments that cover a portion of spending above the threshold.[1]

Combined, Medicare's monthly direct subsidy and reinsurance payments aim to cover 74.5 percent of the expected cost of basic benefits. Beneficiary premiums are designed to cover the remaining 25.5 percent of the expected cost of basic benefits. (Some beneficiaries pay higher premiums, for example, for additional coverage beyond the basic benefit.) In addition to monthly premiums, Part D enrollees also pay any cost sharing required by their plans. For enrollees who qualify for Part D's low-income subsidy (LIS), Medicare pays plans an additional amount on their behalf that covers most or all cost sharing and premium liabilities.

The Commission had long been concerned that past changes to Part D's benefit design combined with trends in prescription drug pricing and spending had weakened plans' incentives for cost control (Medicare Payment Advisory Commission 2022, Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2016). Between 2007 and 2023, plans' overall financial liability for basic-benefit spending declined markedly, from 75 percent to less than 30 percent, while Medicare's reinsurance grew from about one-fourth to over 70 percent.

The Commission had also voiced concerns about enrollee cost sharing under Part D. Because beneficiaries historically paid an unlimited amount of cost sharing in the catastrophic phase of the benefit, a small but significant share of enrollees had high OOP spending that could pose a financial burden and hinder adherence to treatment. At the same time, limits on cost sharing for enrollees eligible for the LIS blunted their incentives to use lower-cost drugs and has made it more difficult for plan sponsors to manage benefit costs.

In 2020, the Commission recommended major changes to the Part D program to restructure the defined standard benefit and strengthen financial incentives

for plans and beneficiaries to use lower-cost medicines (Medicare Payment Advisory Commission 2020b). In addition, the Commission recommended that plans be given tools to manage enrollee spending as they assume greater insurance risk.[2]

The IRA changed many aspects of the Part D program, including a benefit redesign that reflected key elements of the Commission's recommendations. However, the elimination of cost sharing above the annual OOP threshold and the lowering of that threshold, while improving affordability of medicines for patients at the point of sale (POS), likely introduced considerable uncertainty regarding utilization growth because plans can no longer rely on cost-sharing tools to manage spending after beneficiaries reach the threshold. (Plans may still apply utilization-management tools such as requiring prior authorization.) The IRA also included provisions that are expected to affect the broader pharmaceutical supply chain, such as requiring manufacturers to pay rebates when the price of their drug rises faster than inflation and establishing the Medicare Drug Price Negotiation Program ("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. The Commission has not made recommendations related to either of those new policies.

Recent work by the Commission has highlighted diverging trends in premiums, plan costs, and risk scores in the PDP and MA–PD markets (Medicare Payment Advisory Commission 2025c). (See text box on pp. 492–493 on the concerning trends.) These differences have made MA–PDs increasingly attractive because they offer more generous prescription drug coverage—such as lower deductibles and cost sharing—while keeping premiums relatively low, largely due to MA–PDs' ability to use MA rebates to buydown Part D premiums, a feature unavailable to PDPs. The growing divergence between the two markets raises concerns about the long-term stability of the PDP market, which plays a critical role in ensuring the availability of drug coverage options for FFS beneficiaries.

Our analysis found that some of the difference in risk-standardized costs—that is, costs divided by risk scores—was explained by higher coding intensity among MA–PDs compared with PDPs.[3] Because of the substantial overlap in the diagnoses used in Part D's risk-adjustment model, the prescription drug hierarchical condition category (RxHCC) model, and the model used to risk adjust Part C payments to MA plans, the finding that Part D risk scores are also impacted by the difference in coding intensity between MA and FFS is consistent with expectations (Medicare Payment Advisory Commission 2025c). Our findings imply that systematic differences in coding practices by MA–PDs and PDPs affected the ability of the RxHCC model to accurately predict costs for either sector. At the same time, a substantial difference in average risk-standardized costs remained unexplained between the two sectors even after accounting for differences in coding intensity, suggesting that there are other factors that differentially affect spending in the two markets.

In its announcement for 2025, CMS noted that the RxHCC model historically overpredicted costs for MA–PDs and underpredicted costs for PDPs (Centers for Medicare & Medicaid Services 2024e). Because of the systematic prediction errors CMS had observed across the two markets, the agency has begun applying a separate normalization factor for MA–PDs and PDPs to "more accurately reflect Part D costs in each of these two sectors" (Centers for Medicare & Medicaid Services 2025h, Centers for Medicare & Medicaid Services 2024e). The agency noted that the separate normalization factors are expected to increase PDP risk scores and decrease MA–PD risk scores.

However, to the extent that there are other inaccuracies in the RxHCC model that systematically affect the risk scores for the two sectors, the application of separate normalization factors alone may not be sufficient to ensure balanced competition or accurate payment adjustments. Further, the shift in financing from cost-based to capitated payments under the redesign has increased the importance of risk adjustment. The Commission will continue to examine how Part D's risk adjustment can be improved to ensure payment accuracy and to promote balanced competition across and within the two markets.

In this chapter, we describe our findings from analysis of Part D plan bids and other program data to assess how the IRA and other policy changes are affecting the Part D program.

Part D plans continue to adjust to the IRA and other Part D policies

The redesign of Part D's benefit structure, one of the most significant changes to the program, became effective with the 2025 plan year. The IRA changes are expected to continue to have wide-ranging impacts on Part D plans and their enrollees (see the text box, pp. 480–481, summarizing IRA provisions).[4] The redesign of the Part D benefit is expected to improve plan incentives to manage prescription drug spending. At the same time, several provisions improve Part D enrollees' access to and affordability of drugs covered under Part D, with savings estimated to be in the thousands of dollars for enrollees with the highest spending (Assistant Secretary for Planning and Evaluation 2024). These benefits, however, have trade-offs. Lower cost sharing for patients makes medications more affordable but is likely to put upward pressure on overall drug utilization and benefit costs, which in turn increases both beneficiary premiums and Medicare payments to plans.

In 2026, the national average bid (a measure of plan benefit liability that is used to determine Medicare's capitated payments to plans) continued to increase, likely reflecting early 2025 spending and utilization trends that exceeded plan expectations, as well as continued uncertainty about utilization and the impact of the negotiation program (Cline et al. 2025b). For 2025, many plans expected an increase in the use of specialty drugs and other high-cost brand medications "as a direct result of the new cost-sharing limits and flexibilities created by the IRA" (Cline and Liner 2024). This significant uncertainty about how much utilization would increase likely drove the variation in 2025 bids (Cline and Liner 2024, Cline et al. 2025b). In this section, we provide an overview of the Part D redesign and how 2026 bids, premiums, and the numbers of plans have responded to these recent changes.

The IRA redesigned the Part D benefit

Medicare law defines the standard Part D basic benefit that plans must offer (or coverage that is actuarially equivalent to that standard). The design and actuarial value of the standard basic benefit have changed numerous times over the years. The transition to the IRA's new benefit design for non-LIS beneficiaries was fully implemented in 2025, while the transition for LIS beneficiaries started in 2025 and will continue through 2031 (see text box on pp. 480-481 on IRA provisions). Since the last major reforms to the benefit design in 2010, LIS beneficiaries have had a different benefit design than non-LIS beneficiaries, but that will no longer be the case once the new benefit structure is fully implemented for LIS enrollees. (However, Medicare's low-income cost-sharing (LICS) subsidy will continue to pay most of the cost-sharing liabilities on behalf of enrollees who receive the LIS.)

In 2026, Part D's defined standard benefit for enrollees without the LIS (76 percent of enrollees in 2025), includes a deductible; beneficiaries pay 100 percent of costs until the deductible is met. Next, in the initial coverage phase, beneficiaries are responsible for 25 percent of drug spending until reaching the catastrophic-coverage limit (Figure 13-1, p. 482). There is no longer a coverage gap (or "donut hole"), and beneficiaries now have a maximum OOP cap, both representing a significant departure from the historical design. Each year, the standard benefit's parameters change at the same rate as the annual change in beneficiaries' average drug expenses. For 2026, the deductible in Part D's standard benefit is $615 and the OOP threshold is $2,100, which is expected to be reached after a beneficiary incurs approximately $6,555 worth of drug spending (Centers for Medicare & Medicaid Services 2025g).

Although the OOP threshold is $2,100 in 2026, the "true OOP" (TrOOP) required to reach the OOP threshold varies by plan and can be substantially lower for many enrollees. Beginning in 2025, TrOOP-eligible costs for enhanced plans include the "value of supplemental benefits" calculated as the difference between the cost sharing under the defined standard benefit (e.g., 25 percent coinsurance) and the actual cost sharing required under the plan (e.g., $50 copay).[5] Because enhanced plans, by definition, offer more generous coverage than the defined standard benefit, counting the value of supplemental benefits as TrOOP means many beneficiaries will meet their annual OOP limit without incurring the full amount (Karcher et al. 2024).[6] In 2025, one analysis found that non-LIS enrollees, on average, spent about $1,200 to reach the annual OOP threshold ($2,000) (Feller et al. 2025). This method for calculating TrOOP is

The Inflation Reduction Act of 2022 and other recent Part D policies

The passage of the Inflation Reduction Act of 2022 (IRA) and other recent Part D policies changed many aspects of the Part D program. Table 13-1 lists the key IRA provisions and other Part D policies that redesign the Part D benefit (and notes the year in which the provision was implemented). Beginning with prescriptions filled on or after October 1, 2022, manufacturers must pay a rebate to Medicare equal to the price increase above the rate of inflation for drugs dispensed

(continued next page)

TABLE 13–1

Key IRA and other Part D provisions and implementation timeline

IRA provisions	Implementation year
Rebates paid to Medicare from drug manufacturers if they increase prices faster than inflation	2022
Limit beneficiary cost sharing on insulin to $35/month	2023
Eliminate beneficiary cost sharing for adult vaccines	2023
Cap on annual increase in BBP to no more than 6%	2024
Expand LIS eligibility (from 135% FPL to 150% FPL)	2024
Limit beneficiary OOP spending	2024 (remove 5% coinsurance in the catastrophic phase) 2025 ($2,000 annual OOP limit)
MDP replaces the Coverage Gap Discount Program*	2025 (phase in over 6 years for LIS beneficiaries)
Drug price negotiations on selected drugs (Part D drugs for 2026 and 2027, Part B and Part D drugs in 2028 and thereafter)	2026 (10 drugs), 2027 and 2028 (15 drugs), 2029+ (20 drugs)
Medicare Prescription Payment Plan: Spread out OOP costs over the year	2025
Selected Drug Subsidy Program (payment from CMS to plan sponsors for 10% of drug price in the initial coverage phase for drugs selected for negotiation)	2026
Require that the BBP cover at least 20% of basic benefit costs (modifying the 6% cap on annual increases in the BBP that began in 2024)	2030
Other Part D policies	**Implementation year**
Pharmacy DIR payment adjustments to be applied at the point of sale (POS) such that pharmacies' initial reimbursements are the lowest possible amount	2024
Part D Premium Stabilization Demonstration	
Lower PDP premiums by up to $15 and cap annual increase at $35 and provide a more generous risk-corridor protection	2025
Lower PDP premiums by up to $10 PMPM and cap annual increase at $50 PMPM	2026
Separate RxHCC normalization factors used for PDPs vs. MA–PDs	2025

Note: IRA (Inflation Reduction Act of 2022), BBP (base beneficiary premium), LIS (low-income subsidy), FPL (federal poverty level), OOP (out-of-pocket), MDP (Manufacturer Discount Program), DIR (direct and indirect remuneration), PDP (prescription drug plan), PMPM (per member per month), RxHCC (prescription drug hierarchical condition category), MA–PD (Medicare Advantage Prescription Drug [plan]).
* Under the MDP, manufacturers are exempt from providing discounts for drugs selected for negotiation; instead, Medicare pays higher reinsurance (40 percent) and an additional subsidy for spending between the deductible and the OOP threshold under the Selected Drug Subsidy Program.

Source: MedPAC analysis of Part D program guidance and regulations from CMS.

The Inflation Reduction Act of 2022 and other recent Part D policies (cont.)

to Part D beneficiaries. The IRA also placed limits on out-of-pocket (OOP) costs applied to insulin products and vaccines beginning in 2023. In 2024, the IRA eliminated cost sharing once an individual reaches the annual OOP threshold, referred to as the catastrophic phase of the benefit. For individuals with low income and limited assets, the IRA expanded the eligibility for the full low-income subsidy (LIS) by raising the income threshold from 135 percent to 150 percent of the federal poverty level.

A separate regulatory change that went into effect in 2024 required the postsale payments (called pharmacy direct and indirect remuneration or DIR) that pharmacies often pay to plans to be reflected in the prices at the point of sale (POS). Before 2024, Part D plans that used pharmacy fees typically applied retroactive adjustments (DIR fees), which, on net, resulted in payments from pharmacies to plans. The new policy requires that the initial reimbursements at the POS must be the lowest possible amount they could receive for a given drug dispensed.

In 2025, the IRA's redesign increased the generosity of the benefit by limiting cost sharing for beneficiaries. This shift improves insurance protection for all enrollees, but also raises enrollee premiums and Medicare's program costs. To address anticipated increase in premiums, the IRA imposed a limit on the annual increase in average beneficiary premiums. The Medicare Part D Premium Stabilization Demonstration that CMS implemented in 2025 further reduced some of the largest premium increases observed among PDPs, shifting those costs to the program. The redesign also reduced the role of Medicare's reinsurance payments—the cost-based reimbursement that had paid for most of the costs incurred by enrollees with high spending—while increasing the role of Medicare's monthly capitated direct-subsidy payments in financing the benefit.

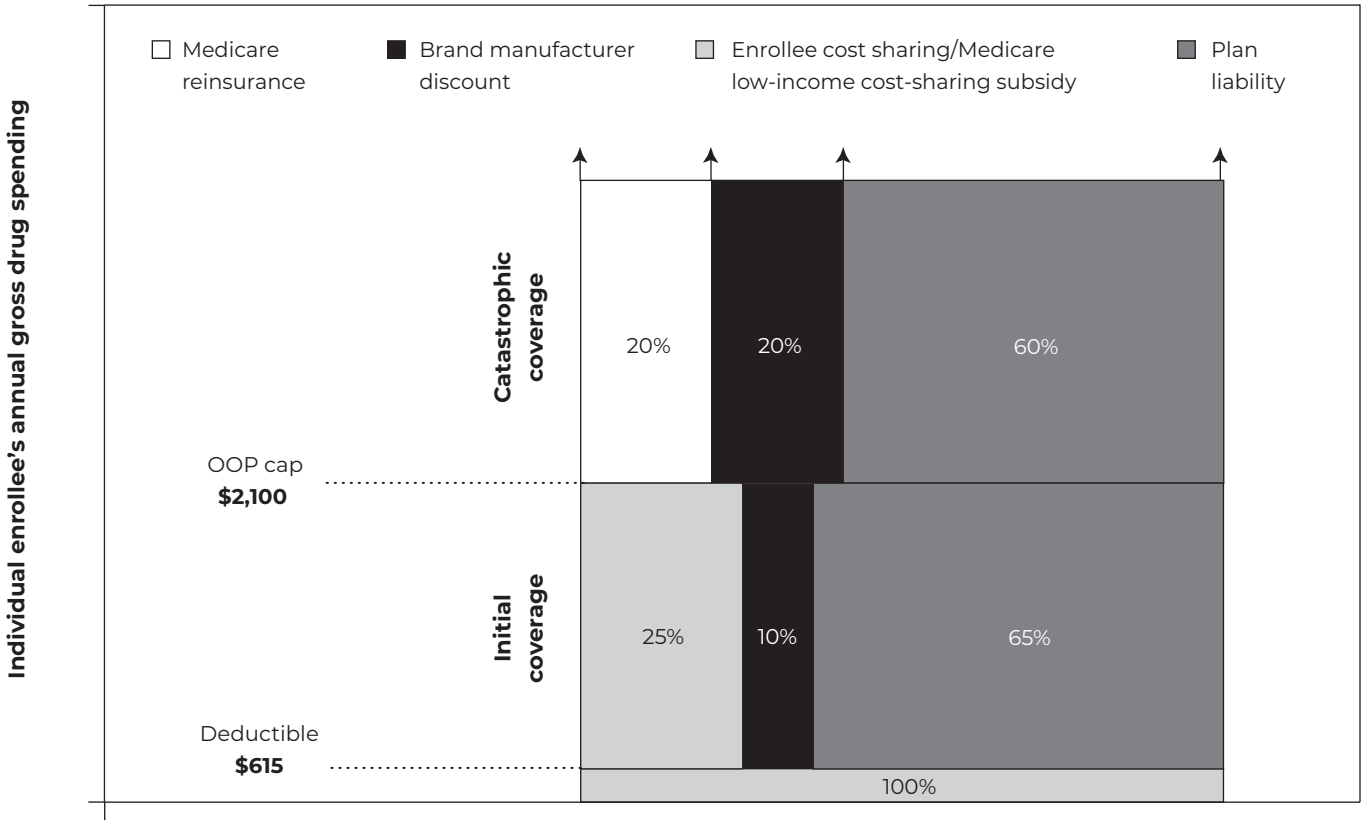
The IRA also includes provisions aimed at addressing rising drug prices, such as requiring manufacturers to pay rebates to Medicare when the price of their drug rises faster than inflation and the Medicare Drug Price Negotiation Program, which requires manufacturers of selected drugs to engage in negotiations with the Secretary of Health and Human Services over prices charged under Medicare Part B and Part D.[7] In 2026, for the first time, the prices of 10 single-source drugs with the highest total gross Part D spending will be set at the price negotiated by the government under the negotiation program; additional drugs will be selected in subsequent years. ■

expected to improve beneficiaries' access to drugs by reducing cost-sharing liabilities for many beneficiaries without the LIS. It may also lead to more beneficiaries reaching the OOP threshold and to higher overall spending among those beneficiaries because plans can no longer use financial incentives (e.g., differential cost sharing) to manage utilization once beneficiaries reach the catastrophic phase of the benefit.

For beneficiaries with low incomes and limited assets, Medicare's LIS pays the difference between cost-sharing amounts set by each plan and nominal copayments set by law. In 2026, individuals receiving the LIS will pay between $0 and $5.10 per prescription for generics and between $0 and $12.65 per prescription for brand-name drugs.[8] Above the OOP threshold, LIS enrollees have never paid cost sharing; Medicare's LICS subsidy paid the 5 percent coinsurance they previously would have owed if they did not receive the LIS. As of 2024, neither LIS nor non-LIS beneficiaries pay cost sharing above the OOP threshold. Since these costs had previously been

FIGURE 13–1

Recently redesigned defined standard benefit, 2026



Note: The "defined standard benefit" is depicted as it would apply to brand-name drugs and biologics. For generic drugs, plans must pay 75 percent of covered benefits between the deductible and OOP cap. Medicare will pay 40 percent reinsurance above the OOP cap, with plans paying the remaining 60 percent. Total spending at the $2,100 OOP cap is expected to be $6,555. For beneficiaries with the low-income subsidy and for certain small manufacturers, the new manufacturer discount program will be phased in over time, reaching final levels by 2031. In addition, Medicare's low-income cost-sharing subsidy will continue to pay most of the cost-sharing liabilities on behalf of enrollees who receive the low-income subsidy.

Source: MedPAC depiction of Part D benefit structure for 2026.

covered for LIS enrollees by the LICS subsidy, this change has reduced Medicare's costs for this subsidy and increased plans' liability.

In 2025, the IRA also required plans to allow enrollees to "smooth" their cost-sharing liabilities over the course of the year through the Medicare Prescription Payment Plan (M3P). Plans must advertise the program to all enrollees and specifically notify individuals who could benefit from this program of that likelihood. Beneficiaries who enroll in the M3P with their plan pay nothing when filling their prescriptions at the pharmacy. Instead, plans pay the pharmacy the full cost-sharing amount and enrollees pay their cost-sharing liability directly to their plans over the course of the year. The amount owed each month will be based on the total cost-sharing liability owed at the time of the opt-in, the amount of TrOOP already accumulated toward the annual OOP limit, the number of months remaining in the year, and any new charges incurred in subsequent months for additional drugs. This formula could result in large fluctuations in payment amounts throughout the year that do not coincide with when individuals fill their prescriptions. This mismatch may

cause confusion for some beneficiaries. CMS thus notes that the program may be more helpful for some beneficiaries than others (Centers for Medicare & Medicaid Services 2024f). The M3P may also require Part D plans to set up new infrastructure to bill patients and to notify the pharmacy staff in a way that fits with their workflow, a process that could be administratively complex (Dusetzina et al. 2024). Plans may also be at risk of beneficiaries not paying these bills in full, potentially contributing to higher risk premiums assumed in their bids. However, evidence to date suggests that the use of M3P has been limited in its first year of implementation (Feller et al. 2026).

The national average monthly bid amount continued to increase in 2026

The IRA substantially redesigned the Part D program, shifting how the benefit is financed, restoring the role of the capitated direct subsidy as the primary mechanism for subsidizing Part D premiums instead of Medicare's cost-based reinsurance. Last year, we reported that changes in the 2025 average monthly bid amount, base beneficiary premiums (BBPs), capitated direct subsidy, and cost-based reinsurance were all directionally consistent with the changes that were expected due to the IRA's redesign. However, the magnitude of the changes exceeded expectations (BGR Group 2024, Cline et al. 2024).[9] In 2025, the national average monthly bid amount (NAMBA) increased by 180 percent, and Medicare's total expected benefit cost (which is composed of the NAMBA plus expected reinsurance) also substantially increased, by 42 percent (Medicare Payment Advisory Commission 2025d).

This year, in 2026, the NAMBA continued to grow, increasing by 33 percent to $239 per member per month (PMPM) (Table 13-2, p. 484). At the same time, expected cost-based reinsurance also increased by 41 percent, resulting in an increase in the total expected basic benefit cost of 35 percent. This growth comes after CMS engaged in negotiations with plans to limit significant increases in cost sharing or reductions in benefits and even deny, for the first time, bids that CMS viewed as having significantly high year-over-year premium increases or were outliers in their region, suggesting that initial bid submissions were even higher than these final amounts (Centers for Medicare & Medicaid Services 2025a).

To better understand the drivers of the growth in bids in both 2025 and 2026, we used plans' bids submitted to CMS through the bid pricing tool to examine plans' projections of enrollee spending and estimate how the IRA and other Part D policies shifted financing of the benefit. This analysis is described in the appendix to this chapter. That work provides background on how the Part D benefit is financed, how CMS pays plans, and the bidding process used to determine the direct subsidy and beneficiary premiums.

Based on our analysis of the bid data, we estimated that the increase in bids in 2025, with the start of the IRA redesign, was mostly (82 percent) due to shifting financing for the Part D benefit to the capitated direct subsidy and premium payments and away from cost-based reinsurance, beneficiary cost sharing, and the LICS subsidy. The remaining 18 percent was attributed to increases in plans' expected spending for 2025 relative to 2024. That increase in expected spending was estimated to be related to underpredicted spending in 2024 bids and expected growth in spending in 2025. In contrast, we estimate that the growth in 2026 bids was mostly (72 percent) due to plans' expected increases in spending in 2026 relative to 2025 (though we cannot yet estimate how much of that increase was correcting for the "underprediction" of spending in 2025 rather than higher expected spending in 2026). Plan actuaries we interviewed pointed out that first-quarter data in 2025 revealed higher-than-expected pharmacy costs among non-LIS enrollees, which plans reflected in their 2026 bids (see more below on interviews with actuaries, pp. 491–494). The 41 percent growth in expected reinsurance costs in 2026 (Table 13-2, p. 484) may be related to the higher reinsurance (40 percent instead of 20 percent) Medicare will pay for drugs selected for the negotiation program. Under the IRA, the drugs selected for negotiation are exempt from the MDP. As a result, Medicare's reinsurance covers the share of spending in the catastrophic phase that would have been the responsibility of manufacturers under the MDP.[10]

The IRA capped the annual increase in the BBP at 6 percent starting in 2024.[11] As shown in Table 13-2 (p. 484), the effect of the cap is greater in 2026 than in 2025 due to cumulative effects.[12] The reduction in the BBP is financed by the Medicare program paying a higher capitated direct subsidy to plans. As shown in

TABLE 13–2

Increases in the Part D national average monthly bid amount and total expected basic benefit cost, 2025–2026

	2025	2026	Percent change
Total expected basic benefit cost	$219.53	$295.61	35%
National average monthly bid amount	179.45	239.27	33
National average expected reinsurance	40.08	56.34	41
Base beneficiary premium			
Before the application of the 6% cap (25.5% of the total expected benefit cost)	55.98	75.38	35
After the application of the 6% cap	36.78	38.99	6
Effect of the 6% cap	*–19.20*	*–36.39*	
Medicare's direct subsidy			
Before the application of the 6% cap	123.47	163.89	33
After the application of the 6% cap	142.67	200.28	40
Effect of the 6% cap	*19.20*	*36.39*	
Medicare's total subsidy costs (direct subsidy plus reinsurance payments)			
Before the application of the 6% cap	163.55	220.23	35
After the application of the 6% cap	182.75	256.62	40
Effect of the 6% cap	*19.20*	*36.39*	
Medicare's subsidy rate			
Before the application of the 6% cap	74.5%	74.5%	
After the application of the 6% cap	83.2	86.8	

Note: The "national average monthly bid" is the enrollment-weighted average of plan bids, which include plans' expected benefit liability net of the plan's share of postsale rebates and discounts, plus administrative costs and profit margin. The "national average expected reinsurance" is estimated based on the expected reinsurance costs, accounting for Medicare's share of postsale rebates and discounts, and is used to calculate the base beneficiary premium (BBP) before the application of the 6 percent cap. By law, the BBP is calculated as 25.5 percent of the total expected benefit cost per enrollee. Under the changes made by the Inflation Reduction Act of 2022, beginning in 2024, the annual increase in the BBP is limited to 6 percent through 2029. In 2030, the BBP increase will continue to be limited to 6 percent. However, the BBP cannot be less than 20 percent of the average basic benefit costs. For subsequent years, the BBP's share of the expected benefit costs will remain at the level set for 2030. Medicare's direct subsidy is computed as the difference between the national average monthly bid amount and the BBP. Figures do not reflect the effects of the Part D Premium Stabilization Demonstration discussed on p. 485. Figures in this table do not include the bids of special-needs plans since they are not used in calculating the national average monthly bid amount.

Source: CMS's annual release of Part D national average monthly bid amount and other Part C and Part D bid information.

the last row of Table 13-2, after application of the cap, Medicare's subsidy rate (including capitated direct subsidy and reinsurance) is projected to comprise 86.8 percent of total basic benefit costs in 2026. The remainder (13.2 percent) is the beneficiary's share of the basic benefit costs. However, as discussed in the next section, other Part D policies further reduced beneficiary premiums and increased program costs.

Medicare policies that mitigate the growth in enrollees' premiums play a large role in 2025 and 2026

Capping BBP annual growth at 6 percent was intended to help stabilize premiums as the IRA redesign was expected to substantially increase benefit costs and premiums. The BBP growth cap, first implemented in 2024, combined with a demonstration to limit PDP

premium increases, helped stabilize average PDP premiums. In 2025, the monthly total premium after applying those additional subsidies averaged about $23 across all plans (down from $26 in 2024). For 2026, we project the average total premium will increase slightly to $24, which is still below the 2024 average.[13] Premiums do, however, vary widely across and within plan types, as discussed below.

Part D Premium Stabilization Demonstration lowered PDP premiums for enrollees

In 2025, CMS noted large increases and greater variation in bids submitted by PDPs compared with bids submitted by MA–PDs, which could have resulted in premium changes causing "disruptive enrollment shifts in the PDP market during the initial implementation of the IRA benefit improvements" (Centers for Medicare & Medicaid Services 2024b). To mitigate these "destabilizing" effects, CMS implemented the Part D Premium Stabilization Demonstration for PDPs in 2025. Participating plans' total premiums were lowered by up to $15, and annual premium increases were limited to $35. CMS also narrowed risk corridors to provide more generous protection against losses. In 2026, the second year of the demonstration, participating PDPs' premiums were lowered by up to $10, and the annual increase in their total monthly premiums was capped at $50. Risk corridors returned to their original parameters in 2026. The demonstration was estimated to cost the government about $6 billion in 2025 and about 40 percent less in 2026 (Mathews and Whyte 2025).

In 2026, the average PDP total (basic and supplemental) premium is expected to be $44, up from $39 in 2025 (solid line at the bottom of Figure 13-2, p. 486).[14] Without the BBP growth cap and the Premium Stabilization Demonstration, the average total PDP premium would have been substantially higher at $97 (dotted line with triangles at the top of Figure 13-2). The BBP growth cap was responsible for most (70 percent) of this difference in average total premium, with the demonstration accounting for the remaining difference. In 2025, without the BBP growth cap and the demonstration, the average total PDP monthly premium would have been $84, compared with the actual average of $39.[15] The effect of the demonstration was larger in 2025, lowering the post-BBP growth cap premium from $65 to $39 (Figure 13-2). As a result, overall, in 2026, we expect a relatively small increase in the average PDP total premium: From 2025 to 2026, average premiums for basic PDPs are expected to grow from $35 to $39 and for enhanced plans from $42 to $48 (data not shown).

MA rebate buydowns lower MA–PD plan premiums for enrollees

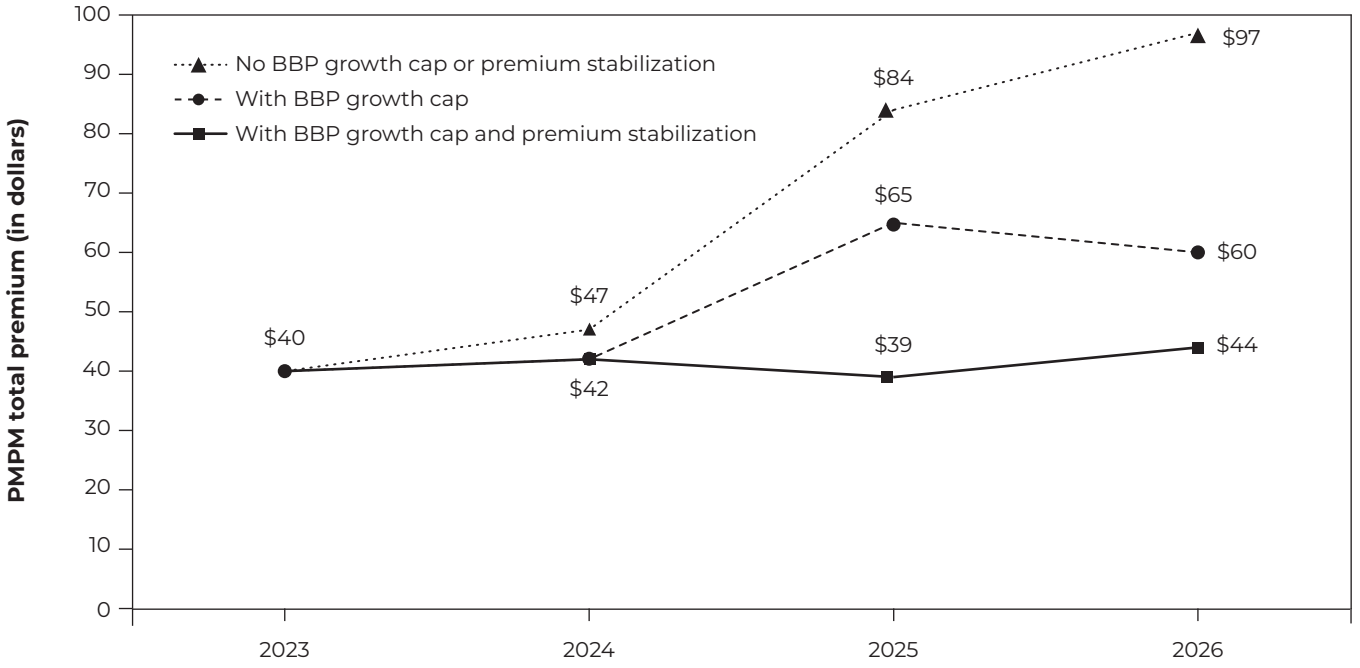
Across all MA–PDs, the expected average total premium in 2026 is $11, down from $13 in 2025. These amounts reflect both the BBP growth cap and premium reductions (or "buydowns") that MA plans offer, financed with MA rebates. However, buydown amounts and the resulting premiums vary across types of MA–PDs.

In 2026, the average premium for conventional MA–PDs prior to the application of the BBP growth cap and MA buydowns rose from $70 to $98 PMPM (Figure 13-3, p. 487). This increase is likely related to the separate risk-score normalization for PDPs and MA–PDs introduced in 2025, which increased the average PDP risk score and lowered the average MA–PD risk score. Lower risk scores increase risk-standardized bids and, therefore, premiums (see pp. 519–521 in the appendix to this chapter for more information on how premiums are calculated from plans' bids). However, in 2026, MA rebate buydowns, combined with the BBP growth cap, are projected to lower average premiums for conventional MA–PDs from $98 to $9, a slight increase from $7 in 2025 (Figure 13-3). The BBP growth cap accounted for 40 percent of the reduction, while MA rebate buydowns accounted for the remaining 60 percent. As a result, in 2026, average total premiums for conventional MA–PDs continue to be below that of PDPs. Higher PDP premiums are consistent with one of the concerning trends that may affect the long-term stability of the PDP market we highlighted in our June 2025 report to the Congress (Medicare Payment Advisory Commission 2025c) (see the text box on concerning trends, pp. 492–493).

For special-needs plans (SNPs), in 2026, the BBP and MA rebate buydowns are estimated to lower premiums from $72 to $16, the lowest average SNP premium in recent years (Figure 13-3, p. 487). The BBP growth cap accounted for over 60 percent of the reduction, and the MA rebate buydowns accounted for the remainder. Thus, the BBP growth cap played

FIGURE 13–2

PDP premiums are lowered through the BBP growth cap and Premium Stabilization Demonstration, 2023–2026



Note: PDP (prescription drug plan), BBP (base beneficiary premium), PMPM (per member per month). The "BBP growth cap" is a provision in the Inflation Reduction Act of 2022 that limits annual growth in the BBP to no more than 6 percent, starting in 2024. "Premium stabilization" refers to the Part D Premium Stabilization Demonstration that began in 2025 for PDPs whereby CMS provides additional subsidies to participating PDPs to decrease total premiums and caps year-over-year premium growth (see p. 485 for more details).

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

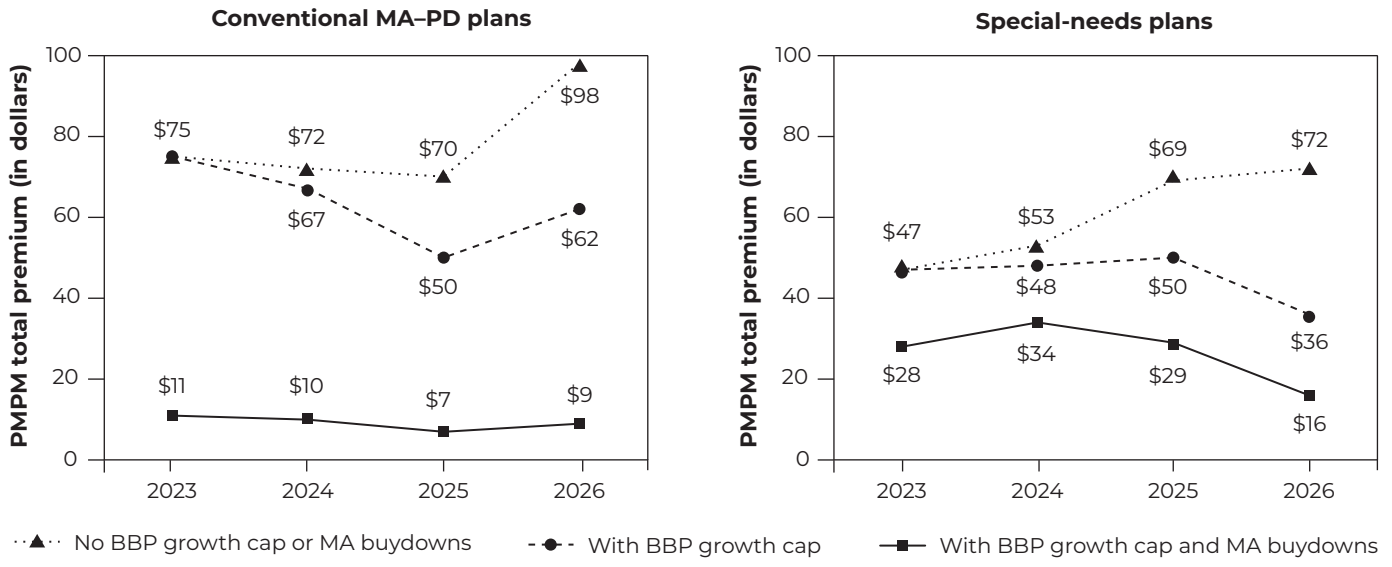
a larger role in lowering premiums for SNPs than for conventional MA–PDs, but among all MA–PDs, the BBP growth cap was a significant contributor to lowering premiums (reducing the need to use more MA rebates to lower premiums).

SNPs include of three types of plans—dual-eligible special-needs plans (D–SNPs), chronic-condition special-needs plans (C–SNPs), and institutional special-needs plans (I–SNPs).[16] D–SNPs are the most common type of SNP, although the number of C–SNPs has been growing rapidly in recent years (see discussion below on p. 490). All D–SNP enrollees receive the LIS and pay no premium for basic benefits. Historically, most D–SNPs were basic-benefit plans, and their premiums were at or below the LIS benchmark.[17] However, in 2026, 80 percent of D–SNPs are now enhanced plans. Still, the total premium for nearly all LIS beneficiaries in D–SNPs will be $0.

D–SNPs generally do not need to use as much of their MA rebate for buydowns because their target premiums are LIS benchmarks (unlike conventional MA–PDs that typically aim to charge $0 premiums), and reducing premiums below that benchmark does not help them attract additional enrollees (instead, D–SNPs tend to devote more of their rebate dollars to non-Medicare services).[18] The average buydown for D–SNPs is projected to be $13 in 2026, compared with $53 for conventional MA–PDs. C–SNPs, which are less likely to enroll beneficiaries with the LIS, have a projected average buydown of $63 in 2026, with 60 percent of the rebates being used to buy down the supplemental portion of the premium. I–SNPs enroll only individuals

FIGURE 13–3

MA–PDs' premiums substantially lowered by BBP growth cap and MA rebate buydowns, 2023–2026



Note: MA–PD (Medicare Advantage Prescription Drug [plan]), BBP (base beneficiary premium), MA (Medicare Advantage), PMPM (per member per month). The "PMPM total premium" refers to the Part D portion of the MA–PD premiums. Beneficiaries enrolled in MA–PDs may pay a separate premium for their MA benefits. The "BBP growth cap" is an Inflation Reduction Act of 2022 (IRA) provision limiting annual growth in the BBP to no more than 6 percent, starting in 2024. "MA buydown" refers to MA plans' use of Part C rebates to lower Part D premiums for their enrollees.

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

living in an institution and, like D–SNPs are much more likely to enroll beneficiaries with the LIS; however, these plans tend to have higher bids (and therefore higher premiums) and are expected to use $68 in MA rebates to lower Part D premiums in 2026.

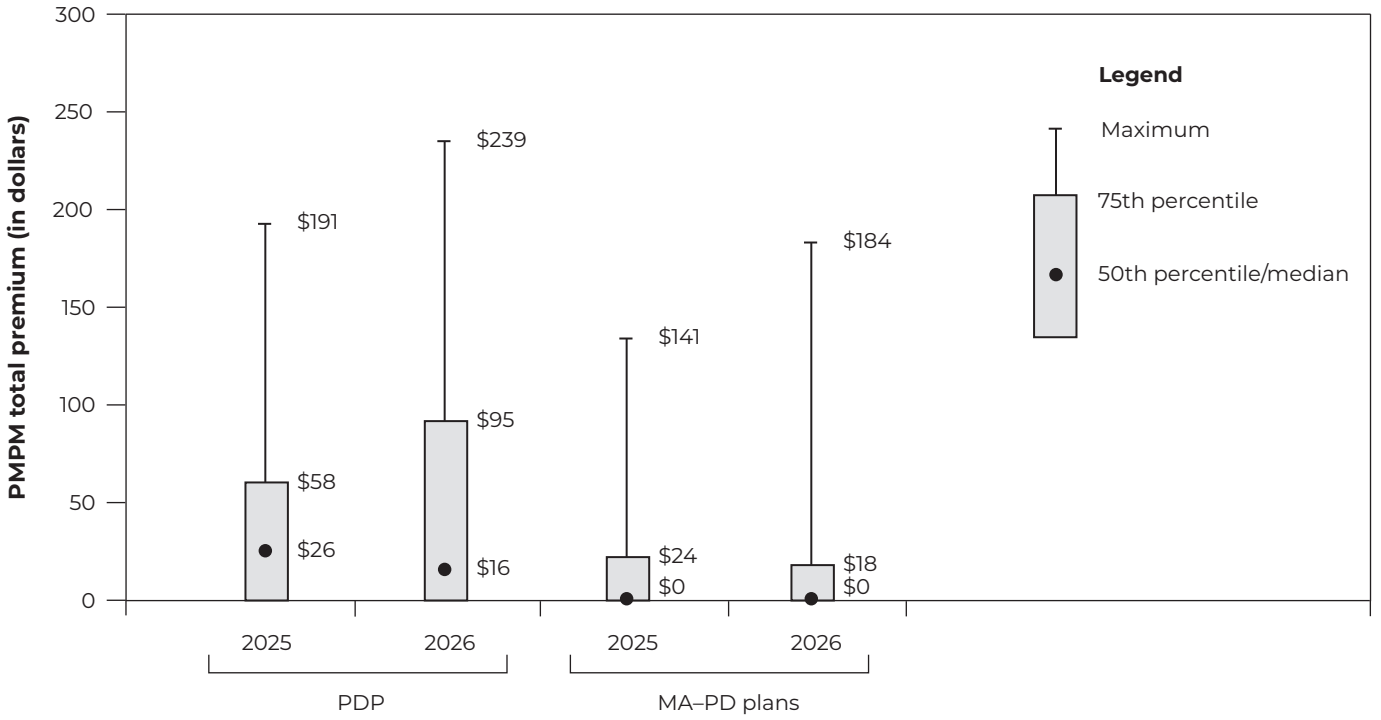
These average monthly premiums discussed above do not include two factors that can affect the premiums that enrollees pay. First, higher-income enrollees pay a higher monthly premium, known as the Income-Related Monthly Adjustment Amount. This amount reduces the monthly capitated direct subsidy that Medicare pays on their behalf. In 2025, such individuals paid between $13.70 and $85.80 in additional monthly premiums, depending on specified income thresholds and tax-filing status (Centers for Medicare & Medicaid Services 2025d).[19] In 2025, about 8 percent of enrollees were subject to the income-related premium, compared with less than 3 percent in 2011 (Liu and Centers for Medicare & Medicaid Services 2025). Second, individuals enrolling outside their initial enrollment period must have proof that they had drug coverage that was expected to pay, on average, at least as much as the standard benefit in order for them to avoid the late-enrollment penalty (LEP) that would be added to their premiums for the duration of their Part D enrollment.[20] In 2025, about 6 percent of Part D enrollees paid the LEP (Liu and Centers for Medicare & Medicaid Services 2025).[21]

Premiums vary across and within types of plans

As shown above, premiums are substantially higher for PDPs than for MA–PDs, primarily due to sizable MA-rebate buydowns that MA–PDs use to lower

FIGURE 13–4

Greater premium variation among PDPs than MA–PDs, 2025–2026



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), PMPM (per member per month). The "PMPM total premium" is the sum of basic and supplemental premiums for Part D plans. The figure shows the 50th percentile, 75th percentile, and maximum plan premiums. For both PDPs and MA–PDs in 2025 and 2026, the 25th percentile premium was $0. Premiums in 2025 were combined across plans using April 2025 enrollment. Premiums in 2026 were combined across plans using April 2025 enrollment after applying CMS's plan crosswalk files between 2025 and 2026.

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

MA–PD premiums. If underlying premium trends continue, the difference in premiums between PDPs and MA–PDs could widen as the Premium Stabilization Demonstration is scheduled to end after 2027 and the BBP growth cap is modified in 2030 by a new formula that sets a floor for the BBP at 20 percent of Part D's total basic benefit cost (the BBP covers just 13 percent of basic benefit costs in 2026).

Even within plan types, premiums varied substantially in 2025, with large projected increases for some plans between 2025 and 2026. For PDPs, the median PDP premium was $26 PMPM, the 75th percentile was $58, and the maximum premium was $191 (Figure 13-4). In 2026, the distribution of PDP premiums widened: The median PDP premium was lower at $16, but the 75th percentile and maximum plan premiums both increased. In both 2025 and 2026, the median MA–PD premium was $0 (Figure 13-4). The maximum MA–PD premium is projected to increase in 2026 (from $141 to $184), though the 75th percentile MA–PD premium is projected to decrease (from $24 to $18).

The variation in premiums across plans reflects a multitude of factors that affect plans' bids, such as assumptions about drug pricing and utilization trends, new drug launches, costs, enrollment, and risk adjustment. Several plan actuaries we interviewed noted that recent CMS changes to the risk-adjustment model, including separate normalization for PDPs and

TABLE 13–3 **PDPs continue to decline while enhanced SNPs have grown dramatically, 2023–2026**

					Average annual percent change	
	2023	2024	2025	2026	2023–2026	2025–2026
Total number of plans	5,597	5,522	5,127	5,028	–4%	–2%
Basic	1,045	1,197	1,165	717	–12	–38
Enhanced	4,868	4,325	3,962	4,311	–4	9
PDPs	804	709	464	360	–23	–22
Basic	305	266	196	183	–16	–7
Enhanced	499	443	268	177	–29	–34
Conventional MA–PDs	3,539	3,507	3,246	2,967	–6	–9
Basic	71	72	56	66	–2	18
Enhanced	3,468	3,435	3,190	2,901	–6	–9
SNPs	1,254	1,306	1,417	1,701	11	20
Basic	669	859	913	468	–11	–49
Enhanced	585	447	504	1,233	28	145

Note: PDP (prescription drug plan), SNP (special-needs plan), MA–PD (Medicare Advantage Prescription Drug [plan]). We include PDPs, local and regional preferred provider organizations' Part D plans, and HMOs' Part D plans. Plan counts exclude plans offered in U.S. territories and employer group waiver plans.

Source: Part D landscape file from CMS.

MA–PDs, raised PDP risk scores, which allowed some PDPs to offer lower premiums and remain competitive. However, these actuaries noted that further improvements were needed to ensure longer-term PDP market stability (see pp. 491–494 for a discussion of interviews with actuaries).

The number of PDPs declined, and the number of SNPs rose in 2026

In 2026, 5,028 Part D plans will be offered, a 2 percent decline from 2025 (Table 13-3). On average, the total number of Part D plans has declined by 4 percent annually since 2023, though trends in plan offerings have varied widely for PDPs, conventional MA–PDs, and SNPs.

Between 2025 and 2026, the number of PDPs decreased from 464 plans to 360 plans (22 percent decline), which is similar to the average annual decline since 2023 (Table 13-3). Nationwide, the 34 PDP regions have an average of 11 plans per region, down from an average of 14 per region in 2025 (data not shown). These plans are offered by five parent organizations per region, on average, down from an average of seven in 2024.[22]

The decline in PDPs is concentrated among enhanced PDPs (a 34 percent reduction from the prior year), while basic PDPs declined by 7 percent (Table 13-3). The decline in enhanced PDPs was primarily a result of two organizations that offer Part D plans choosing to offer just one enhanced plan instead of two. For the first time since 2012, enhanced plans represent less than half of all PDP offerings. Of the 104 PDPs that did not continue into 2026, 48 plans fully terminated, and 56 consolidated with other plans.[23] Most of the fully terminated plans were enhanced (35 of the 48 fully terminated plans).

The number of PDPs has generally been declining since 2022 due to a variety of factors, including growth in MA enrollment. PDPs experienced an outsized decline of 35 percent (to 464 plans) in 2025. Speaking specifically about the most recent changes in PDP offerings, several experts we interviewed told us that the PDP market has become more "commoditized" under the redesigned benefit, which limits plans' ability to differentiate by benefit parameters and cost-sharing amounts. This change may have contributed to the decline in enhanced PDPs (see pp. 491-494 discussing interviews with actuaries).

Conventional MA–PDs also experienced a 9 percent decline in 2026 compared with the prior year (from 3,246 to 2,967) (Table 13-3, p. 489). The average beneficiary has 32 conventional MA–PDs from which to choose (offered by an average of eight insurers), down from 34 in 2025.

At the same time, the number of SNPs increased by 20 percent, and the share of enhanced SNPs grew considerably, now accounting for 72 percent of plans, up from 36 percent in 2025 (Table 13-3, p. 489). This overall growth in the number of SNPs was driven by a 46 percent increase in C–SNPs and 13 percent increase in D–SNPs (data not shown). While SNPs continue to primarily be D–SNPs (59 percent), the number of C–SNPs now accounts for about one-third of all SNPs. (However, in terms of enrollment, in 2025, C–SNP enrollees accounted for only 17 percent, while D–SNP enrollees made up 82 percent of overall SNP enrollment.) The growth in enhanced SNP offerings is likely due to the end of the value-based insurance design (VBID) model which, from 2017 to 2025, had allowed MA–PDs to offer basic benefit plans with supplemental benefits (e.g., no cost sharing for certain drugs); with the end of the VBID model, such benefits may now be offered only in enhanced plans (Schmidt and Graham 2025).

There have been substantial changes in plan offerings since the IRA reforms have begun to take effect. While two-thirds of conventional MA–PDs required no deductible in 2023, just 15 percent of plans offer the same in 2026, although 84 percent of plans now have some drugs not subject to the deductible compared with just 33 percent in 2023. SNPs took a similar approach this year: Fewer plans are offering a $0 deductible, despite a much greater number of enhanced plans, but 75 percent have some drugs that are not subject to the deductible. For PDPs, the number of plans with some formulary tiers not subject to the deductible has instead declined from 53 percent in 2023 to 39 percent in 2026. As a result, MA–PDs, on average, continue to offer a more generous benefit compared with PDPs.

The number of benchmark plans is stable in 2026

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, Part D's enrollment has also shifted from PDPs to MA–PDs. MA–PDs continue to offer more generous prescription drug coverage (for example, with fewer product exclusions and lower cost sharing) to enrollees at lower premiums (Ippolito and Vabson 2024, Joyce et al. 2024). At the same time, PDPs play an important role because they provide drug coverage for FFS beneficiaries and, critically, ensure that premium-free plan options ("benchmark" plans) are available for FFS beneficiaries with low incomes and limited assets. There are program rules that ensure the availability of at least one benchmark plan in every region.[24] However, when only a few plans—or just one plan—participate in a region, it can undermine the competitive model that Part D relies on and increase costs for Medicare.

In 2025, there was a large drop in the number of benchmark plans (to 90 from 126 in 2024). In 2026, the number has remained relatively stable at 88 benchmark plans, and the average remained the same at 3 per region. While some regions have more and some regions have fewer compared with 2025, the number of regions with a single benchmark plan declined from four to two. Still, the number of regions with limited choice in benchmark plans grew in 2026: 2 regions (Region 11 (Florida) and Region 22 (Texas)) have just one benchmark plan, and 16 regions have two, compared with 15 regions that had just one or two benchmark plans in 2025.[25] We will continue to examine characteristics of regions with few benchmark plans and other concerns related to the long-term stability of the PDP market (see text box on trends that raise concerns, pp. 492–493).

The benchmark amounts varied widely across regions, ranging from $0 in New Mexico and Alaska to $59 in New York. This range is wider than the

historical trend but similar to last year. For example, in 2024, benchmarks ranged from $28 in Texas to $49 in New York, a difference of about $20. The larger variation in the LIS benchmarks across regions is due, in part, to the greater variability in PDP bids compared with prior years (Centers for Medicare & Medicaid Services 2024d). For 2026, CMS expects to reassign about 94,000 LIS enrollees who were in plans that were terminated or lost the benchmark status to a different plan that is premium free for LIS enrollees (Liu and Centers for Medicare & Medicaid Services 2025). (That figure is significantly lower than the 400,000 LIS enrollees who were reassigned to a benchmark plan in 2025.)

Amid ongoing uncertainty, actuaries point to risk adjustment as key to PDP market stability

To better understand how Part D plans are affected by the IRA and other recent policy changes, Commission staff interviewed individuals with extensive knowledge of the Part D market. Additional details of our interviews and findings are provided in Appendix 13A.

Recent trends in the NAMBA

Before the start of 2025, a nearly 180 percent increase in the NAMBA for 2025 was viewed by many as reflecting cautious bids due to uncertainty and higher liability under the IRA's benefit redesign. However, in the first quarter of 2025, plans began to observe higher-than-expected pharmacy costs for brand-name and specialty drugs, including glucagon-like peptide-1 receptor agonists (GLP-1s). Interviewees noted that changes to TrOOP calculations—counting supplemental benefits as enrollees' OOP—likely had a greater impact on utilization than plans expected. Consequently, plans adjusted bids upward for 2026, with much of the 33 percent NAMBA increase reflecting accelerated utilization trends during the first half of 2025.

Interviewees noted that 2026 bids varied widely, driven by continued uncertainty related to the IRA and accelerated spending trends. They also cited the implementation of maximum fair prices (MFPs) for drugs selected under the Medicare Drug Price Negotiation Program ("selected drugs") as a major source of uncertainty, with effects expected to differ across plans due to variation in utilization and rebate levels of the selected drugs. Predicting utilization changes from the effectuation of MFPs and the impact of rebate loss complicated bid preparation. For example, plans with higher baseline utilization of selected drugs or greater reliance on rebates faced more unpredictability in how MFPs would affect their benefit costs. Some interviewees also expressed concerns that lower OOP costs for selected drugs could increase utilization, but the magnitude of the increase was difficult to predict. In addition, because rebate revenue historically lowered bids and premiums rather than cost sharing, the loss of rebates could mean higher costs for plans even if MFPs achieve costs similar to net-of-rebate costs since some savings previously achieved through rebates would now offset cost sharing. These challenges were compounded by other policies that affect drug prices. In response, plans adopted divergent strategies, ranging from aggressive low-premium bids to conservative approaches to hedge against the impact of MFPs and other drug-pricing policies, which also contributed to variation. Some plans bid above benchmarks to prioritize margins over enrollment growth, while others exited unprofitable markets.

State of the PDP market

The PDP market has evolved significantly since the program began. Several trends have raised concerns about the long-term stability of the market (see text box on trends that raise concerns, pp. 492–493). Interviewees emphasized that uncertainty from the IRA changes—combined with the persistence of selection effects within the PDP market, benchmark plan dynamics, and recent risk-adjustment changes—continue to shape the market.

Historically, PDPs offered national insurers the scale for rebate negotiations and access to enrollees who could be moved to MA products (i.e., MA–PDs). However, the introduction of MFPs is expected to reduce the role of rebates in lowering benefit costs, eroding this financial advantage. One interviewee noted that the "squeeze" in MA margins has also diminished the value of "PDP-to-MA conversions." These changes, coupled with higher operational costs, limited the ability to absorb margin pressure, and less regulatory flexibility relative to MA–PDs may have prompted some insurers to consolidate offerings or exit the PDP market.

Trends that raise concerns about the long-term stability of the stand-alone PDP market

Our analysis included in the Commission's June 2025 report to the Congress identified four trends that reveal differences that may affect competition between prescription drug plans (PDPs) and Medicare Advantage Prescription Drug plans (MA–PDs) and, in some cases, competition within each sector. These differences may also affect the benefits that plans offer (Medicare Payment Advisory Commission 2025c).

First, the Commission has found that Part D premiums charged by PDPs for the basic benefits have tended to exceed those of MA–PDs. Because premiums are one of the key price signals that beneficiaries compare when choosing a plan, this difference likely influences beneficiary enrollment decisions. In general, beneficiaries would be less likely to choose a plan that charges a higher premium without any obvious or perceived difference in benefits (e.g., generosity of drug coverage or breadth of pharmacy networks) relative to another plan with a lower premium. For some beneficiaries without the low-income subsidy (LIS), the higher premiums charged by PDPs may pose a barrier to remaining in fee-for-service (FFS) Medicare even if that is their preferred option for Medicare coverage.

Second, the number of PDPs qualifying as benchmark plans in certain areas of the country has continued to decline. In some regions, FFS beneficiaries receiving the LIS have had only one premium-free benchmark plan available in 2025 and 2026. For FFS beneficiaries, PDPs are the only option for Part D's drug coverage; for FFS beneficiaries who receive the LIS, benchmark PDPs are the only premium-free option for Part D coverage. If the decline in the number of benchmark plans is the result of the PDP market lacking a sufficient number of PDPs to sustain competitive pressure, this factor could result in higher costs for the program and for beneficiaries paying premiums that do not reflect competitive market forces.

(continued next page)

The IRA dramatically reduced enrollees' cost-sharing liabilities through the benefit redesign and other coverage and cost-sharing requirements. Multiple interviewees noted that these changes have made the PDP market increasingly "commoditized," as plans now have limited ability to differentiate themselves through benefit structures or cost-sharing amounts. In turn, selection effects become more pronounced, with the lowest-premium plans attracting healthier, lower-utilization members. Several interviewees observed that this narrowing of options to manage utilization or distinguish themselves in the market encourages plans to compete primarily on premiums, reinforcing selection effects and contributing to wide variation in risk profiles and financial outcomes across PDPs.

LIS benchmark plans

Plans that bid below the regional benchmark receive FFS beneficiaries who have the LIS through CMS's auto-assignment process, which ensures drug coverage at no premium for enrollees who have not selected a plan. Interviewees explained that, because these "auto-enrollees" tend to have lower utilization and more predictable claims experience and because the process eliminates the need for marketing, auto-assignment creates strong incentives for aggressive bidding to qualify as a benchmark plan. This competitive pressure can lead to lower bids and premiums, benefiting both beneficiaries and Medicare. However, these dynamics may also contribute to market instability: If a plan's premium rises above the benchmark, it risks losing

Trends that raise concerns about the long-term stability of the stand-alone PDP market (cont.)

Third, drug costs, on average, were higher among PDPs compared with MA–PDs, despite enrolling a population that had lower average risk scores than MA–PDs between 2019 and 2023. Risk scores are intended to reflect average drug costs across a group of individuals, so the systematic difference raises questions about the accuracy of the risk-adjustment model. These two trends could be explained by PDPs managing benefit costs relatively inefficiently compared with MA–PDs, by differences in diagnostic coding in FFS compared with MA, or by other factors. In our analysis of plan formularies, we did not find any evidence to support the notion that MA–PDs achieved lower costs compared with PDPs by applying more restrictions to the drugs used by their enrollees. Our analysis of the Part D data for 2019 through 2023 found that differences in coding intensity contributed to higher risk scores for MA–PD enrollees and lower risk scores for PDP enrollees, on average. Because coding differences can cause plans with lower relative coding intensity to receive lower Medicare payments than other plans with higher relative coding intensity (and may lead those plans to charge higher premiums to enrollees), the result can disadvantage PDPs relative to MA–PDs.

Finally, PDPs have been more likely to incur losses compared with MA–PDs. Part D's risk corridors limit each plan's overall losses or profits. Between 2018 and 2022, the most recent years of data available at the time of this analysis, aggregate risk-corridor payments showed that plans, on net, incurred losses in the risk corridors and that most of those losses were incurred by PDPs. A plan's overall losses or profits are closely related to the risk adjustments that affect the payments that plans receive from Medicare. That is, PDPs' higher costs despite lower average risk scores suggest that Part D's payment system may not have adequately adjusted for PDPs' higher costs. ■

a significant portion of its enrollees, which can have major implications for revenues. An interviewee explained that "it costs a lot of money to try and get back to benchmark status, and you don't get back all the auto-assigned members you lost." Benchmark dynamics may also reinforce selection effects since plans with benchmark status receive auto-assignments of LIS enrollees with lower risk relative to other enrollees with the LIS, potentially giving them a competitive advantage over other plans.

Risk adjustment

Interviewees noted that recent CMS enhancements to the risk-adjustment model, including separate normalization for PDPs and MA–PDs, have improved the attractiveness of the PDP market to insurers that sponsor Part D plans. They explained that applying separate normalization factors for PDPs and MA–PDs raised PDP risk scores and payments, especially for LIS members, allowing some plans to offer lower premiums and remain competitive. However, interviewees cautioned that while these changes improved near-term financial prospects for PDPs, using separate normalization to "drive revenue to PDPs" does not seem sustainable. Some cautioned that the "mathematical underpinnings [of separate normalization] are not sound." Instead, interviewees argued that the long-term sustainability of the PDP market will depend on continued refinement of risk-adjustment and market-stabilization policies. They noted that, by compensating plans fairly for differences in expected costs, accurate risk adjustment would also help neutralize selection effects within the PDP market.

There was broad agreement that the current model is not keeping pace with actual utilization trends, particularly for beneficiaries without the LIS. The 2026 risk-adjustment model uses 2023 Part D data,

predating the increase in spending and use of high-priced drugs among beneficiaries without the LIS following the elimination of cost sharing above the annual OOP threshold. Some interviewees noted that the data lag has resulted in misvalued hierarchical condition categories (HCCs), in which "certain HCCs are undervalued in a way that lowers risk scores for [the] non-LIS population." However, there was less consensus on the best approach to improve the accuracy of Part D's risk-adjustment model. Some suggested using separate models for PDPs and MA–PDs, though others expressed concerns that separate models could create "artificial incentives" and potentially distort competition between the two markets. Others recommended incorporating rebates in the model, given that, for drugs subject to MFPs, rebates are effectively reflected at the POS, or using actual drug utilization in the model as a predictive factor rather than relying solely on diagnoses.

Understanding the full impact of the IRA changes

In our analysis of the bid data, we estimate that over 80 percent of the increase in 2025 bids was attributable to IRA changes that shifted insurance risk from beneficiaries (premiums and cost sharing) and Medicare (reinsurance and the LICS subsidy) to plans. In contrast, in 2026, higher expected drug spending under the benefit accounted for most of the growth in bids. Actuaries we interviewed attribute much of the higher cost projections to a correction for "underbidding" in 2025 as they observed accelerated utilization trends among beneficiaries without the LIS who were most affected by the reduction in cost-sharing liabilities under the IRA (Cline et al. 2025a, Cline et al. 2025b). Interviewees also highlighted continued uncertainty from the effectuation of MFPs and other drug-pricing policies as a factor in higher and varied bids for 2026.

It may take several years before the full impact of the IRA is realized. Over the coming years, we expect plans to continue to adjust as they gain claims experience and as pharmaceutical manufacturers and other supply-chain participants respond to evolving market dynamics. Ongoing policy changes, such as the effectuation of MFPs, are likely to interact in a way that complicates our understanding of the impact of any given policy in isolation. Independent and other smaller pharmacies, for example, have raised concerns about MFPs' impact on their ability to operate in Part D. The Commission plans to continue to monitor the effects of the IRA on the program, enrollees, and stakeholders beyond the initial years of implementation.

Recent trends in Part D enrollment

In this section, we discuss historical trends in enrollment, spending, and other aspects of the Part D program. The substantial changes affecting the Part D benefit will likely create departures from many of these trends, but this analysis will serve as important context and a baseline for measuring those changes as they are implemented.

In 2025, 55.8 million individuals—80 percent of all Medicare beneficiaries—were enrolled in Part D plans (Table 13-4). Another 1 percent of beneficiaries obtained drug coverage through former employers that provided a prescription drug benefit that was at least as generous as Part D's defined standard benefit and received Medicare's retiree drug subsidy (data not shown).

More enrollees in MA–PDs and enhanced plans

Beginning in 2020, the number of enrollees in PDPs has declined as more beneficiaries opt to enroll in MA and accompanying MA–PDs. Enrollees in MA–PDs are more likely to be in enhanced plans that have more generous benefits than enrollees in PDPs. Beneficiaries with the LIS are more likely to be in basic-benefit plans.

Enrollment continues to shift toward MA–PDs

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, the distribution of Part D enrollment has moved gradually toward MA–PDs. The number of enrollees in PDPs began to decline in 2020, from 25.1 million (data not shown) to about 22.5 million in 2023 (Table 13-4). In 2025, however, PDP enrollment saw a slight tick up for the second year in a row, reaching 23.4 million. Still, PDPs accounted for less than 42 percent of all Part D enrollees, down from 53 percent in 2020 (latter data not shown).

In 2025, 13.6 million beneficiaries (24 percent of Part D enrollees) received the LIS. Of these individuals, 9.1 million were eligible for both

TABLE 13–4

Part D's enrollment has gradually shifted toward MA–PDs

	2021	2022	2023	2024	2025	Average annual change 2021–2025
Total Medicare enrollment (in millions)	**63.8**	**65.0**	**66.3**	**68.0**	**69.5**	**2.2%**
Total enrollment in Part D plans (in millions)	**48.3**	**49.8**	**51.5**	**54.1**	**55.8**	**3.7**
As a share of total Medicare enrollment	*76%*	*77%*	*78%*	*80%*	*80%*	
Part D plan enrollment by plan type (in millions)						
PDP	24.0	23.3	22.5	23.0	23.4	–0.7
MA–PD	24.3	26.5	29.1	31.0	32.4	7.5
Full LIS enrollment (in millions)*						
PDP	6.0	5.5	5.2	4.7	4.3	–8.0
MA–PD	6.8	7.7	8.6	9.3	9.3	8.2
Overall	12.8	13.3	13.8	14.0	13.6	1.5

Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), PDP (prescription drug plan), LIS (low-income subsidy). Part D enrollment figures do not include beneficiaries in employer-sponsored plans that receive the retiree drug subsidy but do include enrollees in employer group waiver plans. Components may not sum to totals due to rounding, and percentage changes were calculated on unrounded data.
* In addition to beneficiaries who receive full LIS assistance, a small number (0.2 million in 2023) received partial assistance; in 2024, partial assistance was replaced with full LIS benefits for all who previously qualified for only partial benefits.

Source: MedPAC analysis based on the 2025 Medicare Trustees' report and CMS Part D enrollment data.

Medicare and full Medicaid benefits ("dually eligible" beneficiaries) (data not shown) (Boards of Trustees 2025).[26] Between 2021 and 2024, LIS enrollment grew 2.9 percent per year, on average, compared with 4.2 percent per year among non-LIS enrollees (data not shown). Then in 2025, LIS enrollment declined for the first time in program history, which may be at least partly due to the changes regarding Medicaid eligibility that took effect between 2023 and 2024.[27] At the same time, the share of LIS enrollees in MA–PDs grew from 53 percent in 2021 to 68 percent in 2025, while LIS enrollment in PDPs declined by nearly a third during this period. In 2025, just 18 percent of PDP enrollees receive the LIS compared with 29 percent of MA–PD enrollees. Much of the LIS enrollment growth in MA–PDs has been in D–SNPs.

Majority of beneficiaries without the LIS chose enhanced plans in 2025

While statute sets the parameters for the defined standard benefit, in practice, most plans use alternative benefit designs that include lower deductibles or tiered copayments for some formulary tiers rather than the uniform coinsurance under the defined standard benefit. Plans, however, must demonstrate that their basic benefits have the same average value as the defined standard benefit.

An organization offering PDPs must offer a basic-benefit plan in a region before it can offer an enhanced-benefit plan (i.e., a plan that combines basic Part D benefits with supplemental drug coverage). MA–PDs do not have to offer a basic-benefit plan in order to offer an enhanced-benefit plan, which likely explains the difference in plan offerings between PDPs and

TABLE 13–5 **Majority of PDP and conventional MA–PD enrollees chose enhanced coverage, 2025**

	PDP		Conventional MA–PD		SNP	
	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent
Total	18.2	100%	20.3	100%	7.1	100%
Type of coverage						
Basic	7.6	42	0.1	1	5.1	73
Enhanced	10.6	58	20.2	99	2.0	27
Type of deductible						
Zero	2.8	16	8.0	39	0.4	6
Reduced	1.4	8	10.0	49	0.9	12
Defined standard	13.9	77	2.4	12	5.8	81

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]), SNP (special-needs plan). Enrollment excludes employer group waiver plans (EGWPs), plans offered in U.S. territories, 1876 cost plans, demonstrations, and Part B–only plans. The "defined standard" deductible category includes plans that are actuarily equivalent. Beneficiaries enrolled in EGWPs, a specific type of PDP or MA–PD in which an employer contracts with a Medicare Part D carrier to provide coverage for their Medicare-eligible retirees, totaled 8.9 million. Components may not sum to totals due to rounding.

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

conventional MA–PDs, with the latter offering nearly exclusively enhanced-benefit plans. In 2025, 99 percent of enrollees in conventional MA–PDs were in enhanced plans compared with 58 percent of enrollees in PDPs (Table 13-5).

MA–PDs can use a portion of their MA payments to supplement their Part D benefits or to lower Part D premiums. As a result, enrollees in conventional MA–PDs tend to have more generous benefits than enrollees in PDPs. For example, in 2025, 88 percent of conventional MA–PD enrollees were in plans with either no or a reduced deductible, compared with roughly 24 percent of PDP enrollees (Table 13-5).

There is also a growing share of non-LIS beneficiaries in C–SNPs (SNPs exclusively for people with certain chronic conditions); these are almost entirely enhanced plans. Enrollment in these plans has grown 160 percent in the past two years, reaching 1.2 million, with over 820,000 non-LIS beneficiaries in 2025. As such, SNPs are no longer serving LIS beneficiaries nearly exclusively, as they previously had.

Beneficiaries with the LIS were more likely to enroll in basic plans

Historically, beneficiaries eligible for the LIS have primarily enrolled in premium-free plans, which are mostly basic plans and typically either PDPs or SNPs, as opposed to conventional MA–PDs.

Of the 4.3 million LIS enrollees in PDPs in 2025, 3.6 million were enrolled in benchmark plans, which are, by definition, basic plans. Benchmark plans are those with a premium at or below the regional benchmark, which is the maximum premium amount Medicare will subsidize for LIS enrollees. Because benchmark plans require no premium from LIS beneficiaries, these plans are also the only ones into which FFS LIS beneficiaries may be auto-enrolled if they fail to choose their own plan. As a result, most PDP enrollees with the LIS are in benchmark plans. In 2025, on

average, 65 percent of the enrollees in benchmark PDPs received the LIS, a decline from 79 percent in 2024 but still substantially more compared with nonbenchmark PDPs, in which only 5 percent of enrollees received the LIS (data not shown).

For the large share of LIS beneficiaries who have chosen to enroll in an MA–PD, they have largely chosen SNPs (primarily D–SNPs). Of the roughly 9 million LIS beneficiaries in MA–PDs, only 78,000 were in basic conventional MA–PDs because almost all conventional MA–PDs are enhanced (and enrolled 2.7 million LIS beneficiaries). More than 5.1 million were in basic SNPs, though a growing share are in enhanced SNPs—1.1 million in 2025.

Still, nearly all D–SNPs and I–SNPs have historically been basic-benefit plans that use Part D's defined standard benefit structure, which requires an enrollee to pay a defined standard deductible and 25 percent coinsurance on all covered drugs. Because all dually eligible beneficiaries receive the LIS, they themselves do not pay the deductible or cost sharing set by plans; they pay nominal copays set in law, and the LICS subsidy pays most of their cost-sharing liabilities. Also, any extra cost for supplemental coverage is not covered by Medicare. Thus, LIS beneficiaries do not typically gain the same value from an enhanced plan with lower cost sharing or no deductible as non-LIS beneficiaries. Further, plans' value of the low-income premium subsidy they receive for LIS enrollees is maximized when such beneficiaries enroll in a basic plan with a premium equal to the benchmark. These factors contribute to the increased likelihood of LIS beneficiaries being in a basic plan rather than an enhanced plan. However, given the change in plan offerings for 2026, with 72 percent of SNPs now being enhanced plans, the enrollment of LIS beneficiaries in predominantly basic plans is likely to change (Table 13-3, p. 489).

Part D program spending

In 2024, the IRA provision eliminating cost sharing above the annual OOP threshold took effect. This policy was expected to increase utilization, particularly among the beneficiaries without the LIS, who no longer faced the 5 percent coinsurance in the catastrophic phase of the benefit. However, the actual increase in utilization may have exceeded plan expectations. Net risk-corridor payments from Medicare to plans totaled $3.6 billion in 2024—the largest net payments CMS has made to offset plan losses since the program began—indicating that average drug spending under the benefit was substantially higher than plans reflected in their bids.

In 2024, Part D expenditures continued to accelerate

In 2024, Part D expenditures are estimated to have totaled $148.3 billion. Medicare made payments to Part D plans of $22 billion for the monthly capitated direct subsidy, $68.3 billion for reinsurance, and $41.3 billion for the LIS. Medicare also paid $0.5 billion in retiree drug subsidies (RDSs) to employers who provide creditable drug coverage to their retirees.[28] Enrollees paid the remaining $16.7 billion in premiums for basic benefits (Table 13-6, p. 498). Not included in this total is an additional $17.7 billion in cost sharing paid by enrollees, down from $18.8 billion in 2023—a decrease that is likely largely attributable to the IRA changes that reduced enrollees' cost-sharing liabilities.

Between 2023 and 2024, program spending increased nearly 18 percent (from $112.3 billion to $132.1 billion), representing a sharp acceleration from growth of just over 10 percent in 2023 (Table 13-6, p. 498). The growth was driven primarily by the uptick in the use of costly medications—such as GLP-1s—as well as the IRA's redesign, which had the effect of increasing basic benefit costs.[29] Between 2023 and 2024, Medicare's spending for basic-benefit costs (i.e., spending other than LIS and RDS costs) rose by about 34 percent (from $67.6 billion to $90.3 billion). By comparison, between 2020 and 2023, Medicare's spending for basic benefits grew at an average annual rate of 4.4 percent—a markedly slower pace than in 2024.

Two IRA provisions that took effect in 2024—the elimination of the 5 percent cost sharing above the annual OOP threshold and a cap limiting the annual increase in the BBP to no more than 6 percent—substantially increased Medicare's capitated direct-subsidy payments to plans. First, the elimination of the 5 percent cost sharing in the catastrophic phase of the benefit shifted liability for drug expenses from beneficiaries and Medicare's LIS to plans, thereby increasing the direct-subsidy payments that finance plan liability.[30] Second, the IRA change limiting the

TABLE 13–6

Medicare spending and enrollee premiums for Part D

	Annual spending (in billions)					Average annual change, 2020–2024
	2020	2021	2022	2023	2024	
Total Part D program spending	$93.0	$94.8	$101.7	$112.3	$132.1	9.2%
Capitated payments (direct subsidy)	10.9	7.1	4.9	4.5	22.0	19.2
Cost-based reinsurance payments	48.5	52.1	56.8	63.1	68.3	8.9
Subtotal, basic benefits	59.4	59.2	61.7	67.6	90.3	11.0
Low-income subsidy	33.0	35.0	39.4	44.2	41.3	5.8
Retiree drug subsidy*	0.6	0.6	0.6	0.5	0.5	–4.5 5.3
Enrollee premiums for basic benefits**	13.6	15.0	15.5	15.7	16.7	

Note: Figures for capitated payments account for risk-sharing payments that plans make or receive under Part D's risk corridors. Figures for amounts that are paid prospectively (cost-based reinsurance and the low-income subsidy) have been reconciled to actual spending amounts. Beneficiaries paid $17.7 billion in cost-sharing. Components may not sum to totals due to rounding.
* Subsidy for employers providing prescription drug coverage to their retirees that is comparable with or more generous than Part D's defined standard benefit.
** Excludes low-income premium subsidies.

Source: MedPAC analysis based on Table IV.B10 of the 2025 annual report of the Boards of Trustees of the Medicare trust funds.

annual increase in the BBP required that any growth in expected average basic-benefit costs (including expected average reinsurance) above the 6 percent threshold be covered through higher direct-subsidy payments from Medicare. This provision raised Medicare's subsidy rate to 77.5 percent in 2024, a rate that is higher than the original statutorily set amount of 74.5 percent. As a result, Medicare's payments for the capitated direct subsidy grew by nearly 400 percent compared with about 8 percent growth in payments for reinsurance, reversing the previous trend toward greater reliance on cost-based reinsurance payments.[31]

The 6 percent cap on the annual increase in the BBP, when binding, shifts the costs of basic benefits from beneficiaries to the Medicare program. In 2024—the first year the provision took effect—the cap shifted about $2.5 billion from enrollee premiums to Medicare's direct subsidy. Because the cap was binding again in both 2025 and 2026, these effects continue to grow. In 2025 and 2026, we estimate the provision increased Medicare's direct-subsidy costs by about $10.5 billion and $20 billion, respectively. Separately, as noted earlier, under its Part D Premium Stabilization Demonstration, Medicare is estimated to have spent about $6 billion in 2025 and is projected to spend more than $3 billion in 2026 (Mathews and Whyte 2025).

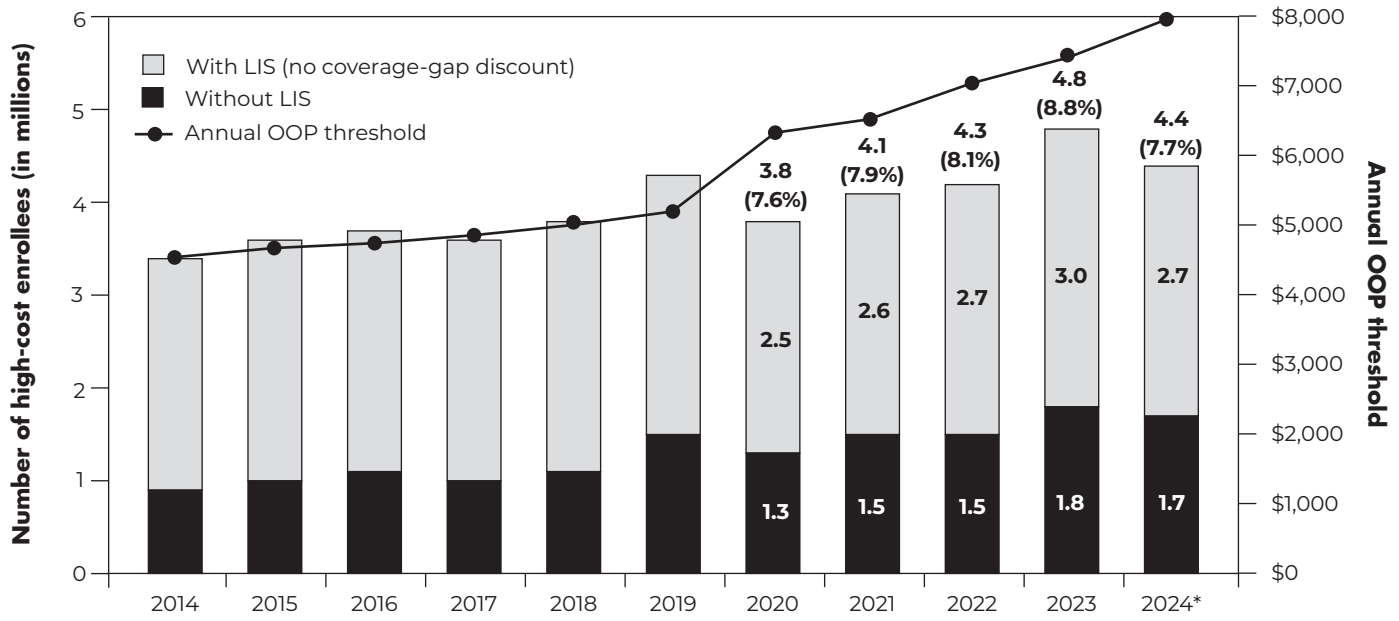
Greater uncertainty in projecting benefit costs in 2024

In addition to shifting costs from beneficiaries and Medicare's LIS to plans, the cap on annual OOP costs was expected to increase basic-benefit costs by reducing cost-sharing obligations for beneficiaries with very high drug expenses who did not receive the LIS. This change in Part D's benefit design introduced new uncertainty for plans in projecting benefit costs because enrollees faced a dramatic shift in financial incentives, creating the potential for significant and varied behavioral responses.

Coinciding with this change was a new regulatory requirement—effective January 1, 2024—to reflect

FIGURE 13–5

Part D enrollees reaching the benefit's catastrophic phase, 2014–2024



Note: LIS (low-income subsidy), OOP (out-of-pocket). Percentages shown in parentheses are high-cost enrollees as a share of all Part D enrollees. Components may not sum to totals due to rounding.
* Amounts are based on preliminary Part D prescription drug event data.

Source: Enrollee counts for 2014 to 2024 are based on MedPAC analysis of Part D prescription drug event data.

all possible pharmacy price concessions, known as pharmacy direct and indirect remuneration (DIR), at the point of sale (POS) (see text box, pp. 416–417, on the regulatory change affecting prices paid at the POS in the March 2025 report to the Congress).[32] By lowering POS prices, this policy reduced OOP costs when cost sharing was based on a percentage of POS prices (coinsurance), thereby slowing progression toward the annual OOP threshold.[33] In turn, this policy change may have further increased uncertainty in projecting spending and the share of benefit costs for which plans bear risk.

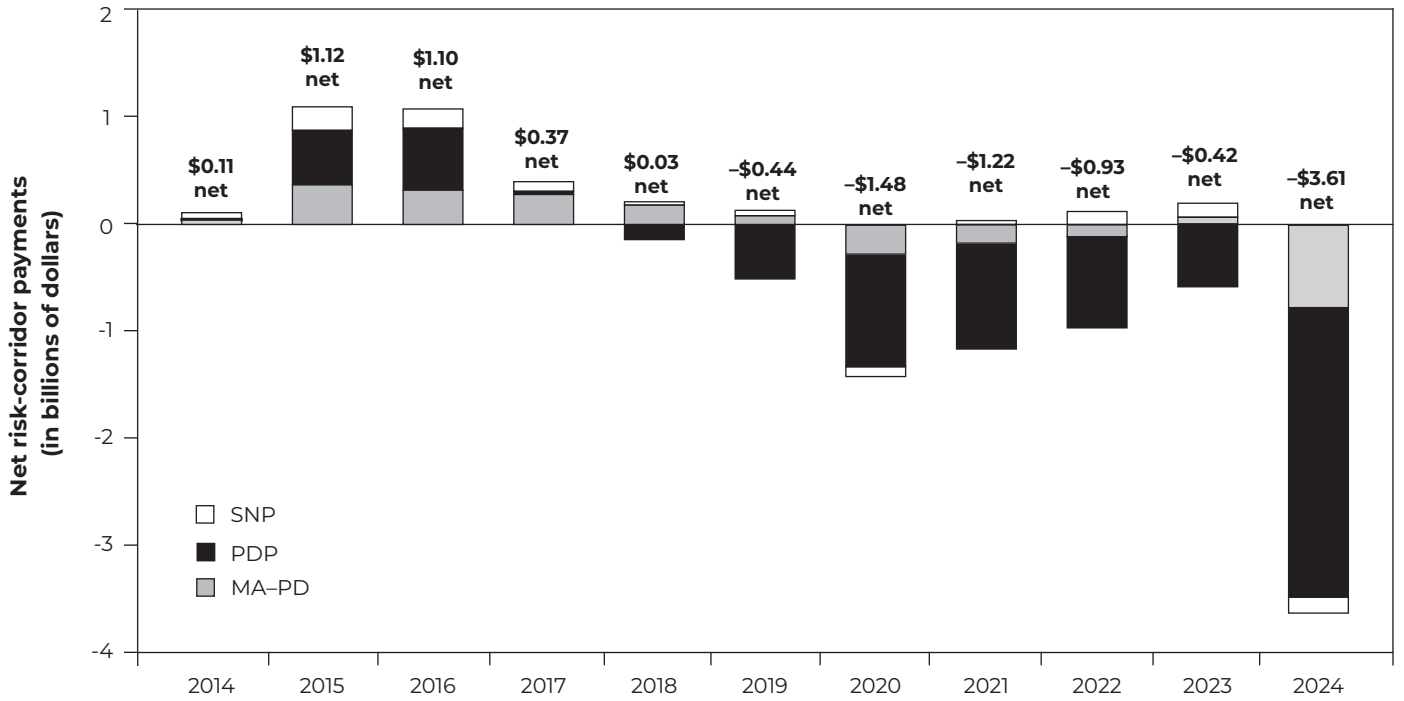
Change in pharmacy DIR policy led to significant decline in POS prices in 2024

Pharmacy DIR payments have grown substantially, from less than 5 percent of total DIR in 2014 to 23 percent by 2023, one year before the regulatory change took effect that required pharmacy DIR to be reflected in prices at the POS. As a result, total DIR fell by 14 percent between 2023 and 2024, dropping from $92 billion to about $79 billion.

Following the implementation of the pharmacy DIR policy, POS prices for Part D drugs declined sharply, reversing years of steady growth. Measured by the national drug code (NDC)–level price index, POS prices for all drugs and biologics declined by 11 percent in 2024 (see Table 13-7, p. 502).[34] (The index measures price changes for existing products and does not reflect launch prices of new products.) Because pharmacy DIR offsets a larger share of generic drug prices, POS prices for generic drugs saw the largest decline (–34 percent), while POS prices for single-source brand-name drugs and biologics fell by about 7.7 percent.[35]

FIGURE 13–6

Net risk-corridor payments between plans and Medicare, 2014–2024



Note: SNP (special-needs plan), PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]). Positive amounts reflect the amount by which total risk-corridor payments from plans to Medicare (for a portion of the profits beyond the amounts assumed in plan bids) exceeded total risk-corridor payments from Medicare to plans. Negative amounts reflect the amount by which total risk-corridor payments from Medicare to plans (to cover a portion of their losses in risk corridors) exceeded total risk-corridor payments from plans to Medicare. Figure excludes employer group waiver plans (EGWPs), Program of All-Inclusive Care for the Elderly (PACE), and demonstration plans. EGWPs do not submit bids and are excluded from the risk-corridor reconciliation process. Between 2014 and 2024, the share of profits or losses accounted for by Medicare–Medicaid plans and PACE plans ranged from less than 1 percent to about 9 percent of the total risk-corridor payments. CMS determines whether any risk-corridor payments are due by comparing plan bids for basic benefits with actual spending. When actual spending exceeds the target amount by more than 5 percent, CMS makes payments to plans to offset a portion of the losses (and vice versa, when actual spending is lower than the target amount by more than 5 percent, CMS recoups a portion of the profit (i.e., plans make payments to CMS)).

Source: Plan reconciliation data from CMS.

Fewer high-cost enrollees but a surge in spending among those without the LIS in 2024

The annual OOP threshold is set each year according to a formula set in law. Between 2023 and 2024, this threshold increased from $7,400 to $8,000 (Figure 13-5 p. 499). In 2024, a substantial portion of this OOP amount was met by Medicare's payments for the LICS subsidy and by discounts paid by manufacturers of brand-name drugs for prescriptions filled in the coverage-gap phase.[36] As a result, most beneficiaries who reached the catastrophic phase of the benefit paid significantly less than the full threshold amount.[37]

In 2024, 4.4 million beneficiaries reached the catastrophic phase of the benefit ("high-cost enrollees"), a decrease of about 8 percent from 4.8 million in 2023, marking a shift from an upward trend since 2020 (Figure 13-5, p. 499). The decrease in the number of high-cost enrollees was greater among those with the LIS compared with those without the LIS (about an 11 percent and 4 percent decrease, respectively). As a result, in 2024, the share of high-cost enrollees with the LIS continued its decline to 61 percent, down from over 70 percent in 2014.

In addition to the differential trends in the number of high-cost enrollees with and without the LIS, spending among those without the LIS shifted toward more expensive drugs in 2024. High-priced medications contributed to a 24 percent increase in the specialty trend among beneficiaries without the LIS, whose cost sharing fell from 5 percent of POS prices to $0 as a result of the IRA change that eliminated cost sharing above the OOP threshold (Cline et al. 2025b, Niyogi and Glass 2025). The average gross cost per prescription for high-cost enrollees without the LIS increased by 20 percent compared with just 4 percent for those with the LIS. Further, spending in the catastrophic phase for enrollees without the LIS rose 27 percent—more than five times the growth rate for those with the LIS. The substantial gap in catastrophic spending growth between high-cost enrollees with and without the LIS likely reflects the impact of the catastrophic cost-sharing change, which altered financial incentives only for those without the LIS.

Higher utilization among enrollees without the LIS may have exceeded plan expectations

Medicare shares financial risk with plan sponsors not only through reinsurance but also through risk corridors that limit each plan's overall losses or unexpected profits if actual drug spending (i.e., claims costs excluding profit margin and administrative expenses), excluding Medicare's reinsurance, is higher or lower than anticipated in its bid (Medicare Payment Advisory Commission 2025c). Since 2008, the structure of risk corridors has remained unchanged with the exception of 2025, when CMS narrowed risk corridors for PDPs participating in the Part D Premium Stabilization Demonstration to provide PDPs with more generous protection from losses (see our June 2025 report to the Congress for more discussion of the risk corridors used under the demonstration) (Medicare Payment Advisory Commission 2025c). Plans are fully at risk, meaning they do not receive or owe any risk-corridor payments when their actual drug spending falls within the range of 95 percent to 105 percent of a target amount (TA) based on their bid.[38] If actual spending is between 105 percent and 110 percent of the TA (or between 90 percent and 95 percent), Medicare splits the losses (or profits) evenly with the plan. Beyond 110 percent (or below 90 percent), Medicare covers 80 percent of losses (or recoups excess profits).

Aggregate net risk-corridor payments show that plans, on net, incurred losses in the risk corridors after 2018 (Figure 13-6). Between 2018 and 2024 (the most recent year for which data are available), most of those losses were incurred by PDPs. Net risk-corridor payments from Medicare to plans totaled $3.6 billion in 2024, the largest net payments CMS has made since the program began, with PDPs accounting for about 75 percent of the payments.

In 2024, higher utilization among enrollees without the LIS may have exceeded plan expectations. Net risk-corridor payments that year were more than double the previous record aggregate payments Medicare made in 2020 (Figure 13-6).[39] Several factors likely contributed to these large risk-corridor payments. The IRA change shifting costs from beneficiaries and Medicare to plans increased the amount of plan liability that was subject to risk-corridor protection. That increase resulted in a doubling of the expected average plan liability used in risk-corridor calculations between 2023 and 2024.[40] Some portion of these losses likely stemmed from higher-than-expected use of specialty and other expensive medications by enrollees without the LIS.

How the Medicare Drug Price Negotiation Program may affect Part D prices and costs

Prices paid at the pharmacy (POS prices) are an important indicator of Part D program costs. Overall, Part D plans have used formulary tools effectively to encourage enrollees to use generic drugs: Since 2017, generic drugs have accounted for about 90 percent of all Part D prescriptions. Because generic prices, on average, decline over time, this high penetration rate has helped moderate overall POS price growth for Part D prescriptions (Table 13-7, p. 502).[41] As a result, the overall price index, accounting for generic substitution, has historically grown at a more moderate rate and, in 2024, decreased by 12.4 percent compared with a decrease of 11.3 percent before accounting for generic substitution.[42,43]

While most Part D enrollees use primarily generic drugs, and many (but not all) generic prices remain low, enrollees without the LIS who use brand-name

TABLE 13–7

Single-source drugs increasingly affect overall Part D prices and costs, 2020–2024

	2020	2021	2022	2023	2024
	Price index as of 4th quarter (1st quarter 2014 = 1.00)				
All drugs and biologics					
Before accounting for generic substitution	1.33	1.38	1.43	1.48	1.31
After accounting for generic substitution	1.10	1.13	1.16	1.18	1.04
Generic drugs	0.51	0.47	0.43	0.41	0.27
Single-source drugs	1.66	1.78	1.88	1.98	1.82
	Annual percentage change*				
All drugs and biologics					
Before accounting for generic substitution	2.6%	4.1%	3.8%	3.4%	–11.3%
After accounting for generic substitution	1.3	3.4	2.6	1.9	–12.4
Generic drugs	–8.9	–8.3	–7.4	–5.7	–34.2
Single-source drugs	5.2	6.7	5.9	5.0	–7.7
Share of Part D spending on single-source drugs	76.7	78.8	76.8	79.0	82.5

Note: Indexes are calculated using chain-weighted Fisher price indexes and are measured at the median of the distribution relative to prices as of the first quarter of 2014. Prices reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies. Indexes shown are rounded. Price indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They do not reflect the effect of new products' launch prices. The decrease in point-of-sale (POS) prices in 2024 reflects the new direct and indirect remuneration (DIR) policy requiring pharmacy fees to be reflected at the POS. Pharmacy fees, on average, accounted for a larger share of spending for generic drugs compared with brand-name drugs and biologics. As a result, the impact of the DIR policy was greater on the generic price index than on the overall index including brand-name drugs and biologics. In 2022, the launch of generic Revlimid (lenalidomide) resulted in its reclassification to multisource drug, reducing Part D spending on single-source drugs.
* Annual percentage changes reflect growth in the price index since the fourth quarter of the previous year, calculated on unrounded data.

Source: Acumen analysis for MedPAC.

drugs often feel the effects of rising POS prices when they pay a deductible or coinsurance. Before the IRA capped the annual OOP costs ($2,100 in 2026), these effects were particularly pronounced among the relatively small share of enrollees who use high-priced specialty drugs.

Driven primarily by the shift in the drug-development pipeline, Medicare now spends significant amounts on products without generic alternatives—brand-name drugs and biologics produced by a single manufacturer ("single-source drugs"). While the introduction of single-source drugs often represents important advances in pharmacological therapy, their high prices may create barriers to access and affordability concerns for patients and taxpayers who finance the Part D program.

In 2024, single-source drugs accounted for about 10 percent of prescriptions but about 83 percent of gross Part D spending, up from 70 percent in 2014 (Table 13-7; latter data not shown). Between 2019 and 2024, POS prices of single-source drugs grew by between 5.0 percent and 6.7 percent per year, with the exception of 2024, when prices decreased by 7.7 percent, compared with nearly 9 percent annual growth before 2018 (latter data not shown).[44]

Plans negotiate postsale rebates and discounts from manufacturers, reducing prices after POS transactions.

These "net prices" affect enrollee premiums and Medicare's subsidies. Manufacturer rebates grew from about $16 billion in 2014 to about $77 billion in 2024, growing by an average of 17 percent per year.[45] Despite this growth, net prices of single-source drugs still rose by about 4 percent per year, on average, during this period and by about 5.5 percent annually between 2014 and 2023, before the new pharmacy DIR policy took effect.[46]

Incentives throughout the pharmaceutical supply chain often contribute to higher POS prices because their revenues are often tied to price (Fein 2018, Feldman 2018, Garthwaite and Morton 2017, Sood et al. 2021). Meanwhile, manufacturers' focus on developing drugs and biologics for smaller patient populations, while potentially leading to significant improvements in health for Medicare beneficiaries, means many products launch at high prices and lack direct therapeutic competitors. Over time, these factors, combined with the consolidation among supply-chain participants, have pushed POS prices higher (Sood et al. 2020).

Medicare negotiation program and selected drugs

Beginning in 2026, prices of several single-source drugs selected under the Medicare Drug Price Negotiation Program ("the negotiation program") will be capped at the MFP negotiated by the Secretary of Health and Human Services (see text box on the Medicare Drug Price Negotiation Program, pp. 505–507). This change lowers prices at the POS, reducing cost sharing for beneficiaries whose plans use coinsurance rather than copays for selected drugs. Implications for program spending and plan costs may be more mixed. The negotiation program is also likely to affect revenues of pharmaceutical manufacturers and may affect their future investment decisions regarding pharmaceutical research and development and strategies for new-product launches. However, estimates of possible effects have varied widely (Avalere 2022, Congressional Budget Office 2022, Filson et al. 2025, Gassull et al. 2023, Girvan 2022, Philipson et al. 2023).

Spending and rebates are highly concentrated in selected drugs

Selected drugs account for a substantial share of spending at POS prices (gross spending). As a share of gross spending on single-source drugs in 2024, drugs selected for the 2026 applicable year under the negotiation program accounted for about 26 percent, while those selected for the 2027 applicable year accounted for 18 percent (Table 13-8, p. 504). Nearly all selected drugs have high POS prices, often costing $500 or more per month, with some in the tens of thousands of dollars (Centers for Medicare & Medicaid Services 2025f, Centers for Medicare & Medicaid Services 2024c). As a result, gross spending can reach billions of dollars even when the drug is used by a small number of beneficiaries.

On average, selected drugs are among the most highly rebated drugs in Part D. Across all single-source drugs, manufacturer rebates averaged just under 30 percent in 2024 ($68.7 billion / $232.7 billion). By comparison, rebates for drugs selected for 2026 averaged about 45 percent, and those for 2027 averaged about 34 percent—both well above the overall average for single-source drugs. Combined, the selected drugs for 2026 and 2027 accounted for more than 60 percent of all rebates on single-source drugs.

Expenditure growth for selected drugs was driven more by quantity than price

While high prices contribute to high expenditures, utilization growth has also contributed significantly over the past decade. We constructed indexes that measure percentage changes in Part D gross spending relative to a reference period to assess the impact of utilization growth. These expenditure indexes allow us to examine the relative contributions of price and quantity trends on the growth in total expenditures.

Expenditure growth for drugs selected under the negotiation program has been driven more by increases in quantity than by price. Between 2014 and 2024, our expenditure indexes for selected drugs grew at an average annual rate of over 25 percent, while our quantity index rose by 17 percent to 21 percent—far outpacing price growth, which averaged 6 percent to 7 percent at the POS and less than 3.5 percent net of rebates (Table 13-8, p. 504). That is, utilization growth, rather than price increases, has been the primary contributor to spending growth for selected drugs.

However, there was wide variation in how price trends versus quantities consumed contributed to overall expenditure growth. Among the 2026 selected drugs, four products (Januvia, Enbrel, Imbruvica, and

TABLE 13–8

Medicare Drug Price Negotiation Program's selected drugs compared with single-source brand-name drugs and biologics, 2014–2024

	Single-source drugs		
		Selected drugs*	
	All	CY 2026	CY 2027
Total gross spending in 2024 (billions)	$232.7	$61.2	$42.3
As a share of all single-source drugs		26%	18%
Total manufacturer rebates in 2024 (billions)	$68.4	$27.8	$14.2
As a share of all single-source drugs		41%	21%

	Index value	Average annual growth	Index value	Average annual growth	Index value	Average annual growth
Indexes as of 4th quarter of 2024 (1st quarter of 2014 = 1.0)						
Expenditure index	3.92	13.6%	11.11	25.1%	14.10	27.9%
Quantity index	2.15	7.4	5.45	17.1	7.58	20.7
Price index (gross)	1.82	5.7	2.04	6.9	1.86	5.9
Price index (net of rebates)	1.45	3.5	1.36	2.9	1.45	3.5

Note: CY (calendar year). "Single-source drugs" include both single-source brand-name drugs and biologics. Indexes are calculated using chain-weighted Fisher indexes and are measured at the median of the distribution in the fourth quarter of 2024 relative to prices as of the first quarter of 2014. Expenditure and price indexes reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies. Index values shown are rounded. The quantity index measures the percentage change in the number of units (e.g., tablets or grams) dispensed, weighted by prices (using chain weights). Price indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They do not reflect the effect of new products' launch prices. In 2024, aggregate gross spending for all Part D–covered drugs totaled $288.8 billion.
* Drugs selected for price-applicability years 2026 and 2027 under the Medicare Drug Price Negotiation Program.

Source: Acumen analysis for MedPAC.

Fiasp/Novolog) saw changes in prices exert a greater impact on expenditures than changes in quantity.[47] In contrast, for 2027 selected drugs, increases in quantity for GLP-1s (Ozempic, Rybelsus, and Wegovy), which accounted for about 36 percent of spending and 42 percent of prescriptions for selected drugs for 2024, drove the overall trend. For GLP-1 drugs, expenditures grew by about 68 percent annually, while POS prices rose just 3.3 percent per year and net prices by about 1 percent per year. That is, nearly all of the expenditure growth for GLP-1s was explained by increase in utilization rather than price increases.[48]

Drugs selected for applicable year 2027 also differed from those selected for 2026 in that more drugs were in the so-called "protected classes" (see text box on the Medicare Drug Price Negotiation Program, pp. 505–507). Part D's protected-class policy requires plans to cover "all or substantially all" drugs in six classes—anticonvulsants, antidepressants, antipsychotics, immunosuppressants, antiretrovirals, and antineoplastics—which expands beneficiaries' access to drug therapies but can reduce plans' negotiating leverage with manufacturers and contribute to higher prices (Kakani et al. 2024).[49] Compared with all single-

The Medicare Drug Price Negotiation Program

The Inflation Reduction Act of 2022 (IRA) established the Medicare Drug Price Negotiation Program ("the negotiation program"), under which the Secretary of Health and Human Services has new authority to negotiate directly with manufacturers for the prices of drugs covered under Medicare Part B and Part D.

The law specifically instructs the Secretary to select single-source drugs or biologics ("single-source drugs") without therapeutically equivalent generics or biosimilar alternatives from among the top-selling drugs in Medicare based on total expenditures. The IRA authorizes the Secretary to exempt certain single-source drugs from negotiation, including cases when there is a "high likelihood" of imminent biosimilar competition.[50] Manufacturers that fail to comply with the requirements of the negotiation program may be subject to an excise tax of up to 95 percent on certain sales of the drug or be required to withdraw entirely from the Medicare and Medicaid programs.

The price negotiations for applicable years 2026 (10 Part D drugs) and 2027 (15 Part D drugs) have concluded, with the publication of negotiated prices on August 15, 2024, and November 25, 2025, respectively (Centers for Medicare & Medicaid Services 2025f, Centers for Medicare & Medicaid Services 2024c). (All drugs selected for 2026 and 2027 are Part D drugs. Beginning in 2028, the Secretary is required to include Part B drugs in the pool of negotiation-eligible drugs.[51]) By law, the negotiated price, referred to as the "maximum fair price" (MFP), for selected Part D drugs cannot be greater than the lower of:

- the average Part D price, net of all price concessions and rebates, weighted by plan enrollment; or
- the applicable percentage of the drug's average nonfederal average manufacturer price.[52]

For the negotiation process, the Secretary may consider prices of available therapeutic alternative(s), along with information submitted by manufacturers of the selected drugs, to arrive at the MFP.[53]

Selected drugs account for significant shares of Part D spending and rebates

Selected drugs represent a substantial share of Part D spending. Gross Part D spending for the first 10 drugs selected for negotiation totaled $61.2 billion in 2024, representing 21 percent of total gross Part D spending (see Table 13-8). (Gross spending reflects point-of-sale (POS) prices paid at the pharmacy.) The 15 drugs selected for the second round accounted for $42.3 billion, or 15 percent of total gross Part D spending. Combined, the two rounds represent $103.5 billion in gross

(continued next page)

source drugs, expenditures for protected-class drugs have grown more rapidly, driven by both increases in utilization and prices, with very little difference between gross and net price trends. Protected-class drugs selected for negotiation tended to exhibit similar trends; however, the magnitude of expenditure growth and the relative contributions of prices and utilization varied widely across products.

MFPs will be consequential for all stakeholders

The concentration of rebates among selected drug cohorts suggests potentially material changes in plan costs as MFPs replace a large share of rebates previously used to lower plan costs and enrollee premiums. Trustees projected total DIR to decline by about 5 percentage points in 2026, reflecting the shift away from price competition that relied heavily on rebates (Boards of Trustees 2025).

The Medicare Drug Price Negotiation Program (cont.)

spending—over 36 percent of total gross Part D spending in 2024.

Rebates for selected drugs represent a disproportionate share of total manufacturer discounts. Many selected drugs, particularly those selected for 2026, are in competitive therapeutic classes with historically high rebates. In 2024, rebates for 2026 selected drugs totaled nearly $28 billion (about 35 percent of all rebates negotiated by Part D plans), while rebates for 2027 selected drugs totaled about $14 billion, or about 18 percent (Table 13-8). Together, these cohorts accounted for more than 55 percent of all manufacturer rebates in 2024, highlighting the magnitude of financial shifts that are expected to occur as MFPs replace rebates beginning in 2026.

Uncertainty in measuring changes in Medicare's program spending

For 2026 selected drugs, CMS estimates that, relative to list price (wholesale acquisition cost), negotiated prices achieved discounts ranging from 38 percent for Imbruvica to 79 percent for Januvia, averaging about 61 percent across the 10 products (Table 13-9). Discounts for 2027 selected drugs were similar, ranging from 38 percent for Austedo to 85 percent for Janumet, with an overall average of about 64 percent.

Although overall estimated discounts off list prices are similar for both cohorts, the estimated change in Part D's net prices differs substantially. For drugs selected for the 2026 applicable year, the agency estimated that, had the MFPs been in place in 2023, net prices would have been approximately 22 percent lower (a difference of about $6 billion) (Centers for Medicare & Medicaid Services 2024c). In comparison, for drugs selected for the 2027 applicable year, the estimated change in net prices was about $8.5 billion, or roughly 36 percent below net prices paid under Part D in 2024 (Centers for Medicare & Medicaid Services 2025f).

The difference is primarily driven by rebates.[54] Both cohorts include drugs in competitive therapeutic classes—such as diabetes-related drugs, anticoagulants, and treatments for asthma and COPD—in which competition among therapeutic alternatives tends to generate higher rebates. However, these drugs accounted for over 90 percent of spending in the 2026 cohort compared with about 67 percent in the 2027 cohort. Further, the 2027 cohort includes more drugs in Part D's protected classes (four cancer drugs, one for mental illnesses) and a larger number of specialty drugs—products for which market forces were most limited in lowering prices in Part D (Anderson-Cook and Frank 2025).[55] Our analysis found that rebates reduced gross Part D costs by nearly 45 percent for the 2026 cohort versus about 34 percent for the 2027 cohort. Consequently, the negotiation program appears to be more effective in lowering prices for the 2027 cohort, where rebate offsets were smaller and initial net prices were higher.

At the same time, there is considerable uncertainty about the actual magnitude of savings from the negotiation program. One reason is that the prices and utilization of selected drugs can change substantially between the selection or announcement of MFPs and their effectuation. For instance, Novo Nordisk's insulin products had gross expenditures totaling $2.6 billion in 2023 when they were selected for negotiation, but by 2024, spending fell to less than $1 billion primarily due to the launch of lower-priced products and, to a lesser extent, reduced utilization.[56] Savings from the negotiation program may also be affected by other drug-pricing policies.[57]

Finally, savings for the Medicare program should be considered alongside potential additional costs. Similar to POS rebates, MFPs lower POS prices by largely replacing the existing rebate mechanism. That change may increase benefit costs because rebates are now effectively paid prospectively, and

(continued next page)

The Medicare Drug Price Negotiation Program (cont.)

part of those rebates will be used to lower cost sharing. As a result, Medicare could face higher direct-subsidy and reinsurance costs unless MFPs are set sufficiently below current net prices. In addition, because selected drugs are exempt from the new Manufacturer Discount Program, Medicare will pay higher reinsurance for these products and an additional subsidy under the Selected Drug Subsidy Program. The net effect of savings from lower prices and higher costs is uncertain. ■

TABLE 13–9 **Drugs selected for the Medicare Drug Price Negotiation Program for 2026 and 2027**

First applicable year	Example(s) of commonly treated conditions	Selected drugs	Gross Part D spending, 2024		Estimated discount relative to list price*
			Dollars (in billions)	Percent of total Part D	
2026	Blood clots	Eliquis, Xarelto	$26.9	9%	56%–62%
	Diabetes	Jardiance, Januvia, Farxiga, Fiasp, Novolog	21.5	7	66–79
	Autoimmune conditions	Enbrel, Stelara	6.6	2	66–67
	Heart failure	Entresto	4.0	1	53
	Blood cancers	Imbruvica	2.3	1	38
	Total, 2026 selected drugs		**61.2**	**21**	**61**
2027	Diabetes, obesity	Ozempic, Rybelsus, Wegovy, Tradjenta, Janumet, Janumet XR	17.3	6	71–85
	Asthma, COPD	Trelegy Ellipta, Breo Ellipta	6.7	2	73–83
	Prostate cancer, breast cancer, blood cancers	Xtandi, Pomalyst, Ibrance, Calquence	9.3	3	48–60
	Autoimmune conditions	Linzess, Xifaxan, Otezla, Otezla XR	4.2	1	63–75
	Idiopathic pulmonary fibrosis	Ofev	2.1	1	50
	Tardive dyskinesia	Austedo, Austedo XR	1.7	1	38
	Major depressive disorder, schizophrenia	Vraylar	1.1	0	44
	Total, 2027 selected drugs		**42.3**	**15**	**64**

Note: COPD (chronic obstructive pulmonary disease). Negotiated prices for drugs selected for the 2026 applicable year were updated to reflect inflation since the announcement of the prices in August 2024. Total gross spending for selected drugs for the 2027 applicable year ($42.3 billion) differs from CMS's total ($42.5 billion), which may be due to different data used to aggregate spending across national drug codes. Three drugs—Entresto, Stelara, and Xarelto—were dropped from Medicare's negotiation program for 2027 because they now face generic/biosimilar competition. Average overall discount off of list price is weighted by gross spending. Components may not sum to totals due to rounding.
* CMS used wholesale acquisition costs to estimate discount relative to list prices. For 2026 selected drugs, estimated discounts are based on a 30-day supply using prescription fills in Part D in 2022.

Source: Centers for Medicare & Medicaid Services 2025f, Centers for Medicare & Medicaid Services 2024c, and gross spending based on Acumen analysis for MedPAC of the Part D prescription drug event data.

The shift from rebates to MFPs is expected to lower POS prices for beneficiaries. At the same time, this change is also expected to affect plan operations in a way that places both downward and upward pressure on premiums and Medicare's costs. For example, reduced rebates tend to put upward pressure on spending, but lower POS and net prices would tend to lower benefit costs. The net effect of those factors is uncertain.

Further, complicating the effects of MFPs on Medicare's program spending is Medicare's higher liability for spending on selected drugs under the new MDP. Selected drugs are exempt from the MDP, which requires manufacturers to provide 10 percent discounts for spending between the deductible and the annual OOP threshold and 20 percent for spending above the annual OOP threshold. As a result, Medicare will incur higher reinsurance costs (40 percent) for these drugs. In addition, Medicare will provide an additional 10 percent subsidy for spending below the OOP threshold under the Selected Drug Subsidy Program. In 2024, payments by manufacturers for the selected drugs of the 2026 applicable year under the Coverage-Gap Discount Program (a mandatory discount program that has subsequently been replaced by the MDP) totaled about $7 billion.

The importance of rebates in pricing dynamics also suggests that effectuation of MFPs will have significant impact on financial flows across the pharmaceutical supply chain. Pharmacy benefit managers (PBMs) and plans may lose a key source of revenue to offset benefit costs and fund administrative expenses and profits. Pharmacies could see lower margins if revenue structures tied to list prices are not adjusted. Independent pharmacies have raised concerns that the effects of lower margins could be especially severe for them because they have limited capacity to absorb financial losses and may face heightened risk of market exit (Coster 2025, National Community Pharmacists Association 2025, Three Axis Advisors 2025).

Quality of Part D plans and enrollee satisfaction

The quality of Part D plans and enrollee satisfaction are closely related to access to medicines and patient experience with the plan. Historically, the Part D program has generally enjoyed high levels of satisfaction, based on surveys and focus groups.

CMS collects quality and performance data to monitor plan sponsors' operations and evaluate access to medicines, enrollee experience, and patient safety. A subset of these data are used in the 5-star-rating system made available through Medicare's Plan Finder at Medicare.gov to help beneficiaries evaluate their plan options (see text box on Medicare Plan Finder for more information).[58] Measures relate to beneficiary satisfaction, medication adherence, price accuracy, and medication reviews completed by pharmacists. Star ratings are also used, in part, to determine whether a plan should no longer be available to beneficiaries, if ratings are too low for three consecutive years, and as part of the MA quality-bonus payment determination. (Although both MA–PDs and stand-alone PDPs are evaluated with star ratings, only MA–PDs are eligible for quality-bonus payments through the Part C payment system.)

The average star ratings for plans offered in 2026 are slightly lower than recent years, but MA–PDs have consistently averaged roughly 4 stars, while PDPs have consistently averaged 3 stars over the past four years (Centers for Medicare & Medicaid Services 2025c). Of the plans earning 5 stars, 18 are MA–PDs while just 2 are PDPs. Approximately 40 percent of MA–PDs earned 4 stars or better for 2026, and these plans enrolled 64 percent of MA–PD enrollees in 2025. In contrast, fewer than one-fourth of PDPs being offered in 2026 have a star rating of 4 or higher, and these plans enrolled just 2 percent of all PDP enrollees in 2025.

For the three star measures related to medication adherence, scores have been relatively stable or declined slightly for the past three measurement years. Given that these measures account for one-fourth of the star measures, plans may find it valuable to try and improve these scores. Adherence is measured by the proportion of days in the year that a beneficiary who has been prescribed medication in one of the three drug classes of interest has the medication on hand. The three drug classes for which adherence is measured are noninsulin diabetes medications, renin-angiotensin system antagonists for hypertension, and statins for cholesterol. A recent investigation by the *Wall Street Journal* found that mail-order pharmacies, often owned by plans or their PBMs, often sent "early

Accuracy of drug prices displayed on Medicare Plan Finder

Medicare Plan Finder allows beneficiaries to estimate their total annual costs—including premiums and out-of-pocket expenses—and select plans that best meet their financial and medication needs. For beneficiaries to make informed decisions when choosing a plan, it is essential that the drug prices displayed on Plan Finder reflect what beneficiaries are likely to pay at the pharmacy if they enroll in that plan. However, CMS has previously raised concerns about the accuracy of the drug-price information displayed on Plan Finder during the annual enrollment period (AEP) when beneficiaries have the opportunity to choose a new (or different) Part D plan. Based on our analysis of Plan Finder drug-pricing data for benefit year 2024, prices displayed on Plan Finder during the AEP generally appeared to reflect prices displayed on Plan Finder at the start of the benefit year. However, by August, we found that prices displayed on Plan Finder tended to be higher than those displayed during the AEP. These patterns of price changes are consistent with expectations since manufacturers of brand-name drugs have historically raised prices around July (46Brooklyn 2025, Assistant Secretary for Planning and Evaluation 2023).

CMS's actions to ensure accuracy of prices displayed on Plan Finder

CMS currently uses the Plan Finder Price Accuracy measure to evaluate the accuracy of drug prices displayed on Plan Finder. This measure compares a drug's total cost at the pharmacy—which reflects both ingredient cost and dispensing fees and is calculated from Part D's prescription drug event (PDE) data—with the price displayed on Plan Finder (Centers for Medicare & Medicaid Services 2024a). Plans receive a score based on the magnitude and frequency of when the drug's cost at the pharmacy exceeds the Plan Finder price. A higher score indicates greater alignment between Plan Finder prices and actual costs at the pharmacy (i.e., greater accuracy of Plan Finder prices) for a given plan.

In the calendar year (CY) 2025 Advance Notice and Final Rate Announcement, CMS considered adopting a new measure to evaluate the accuracy of drug prices displayed on Plan Finder because the existing measure did not address CMS's concern that some Part D plans may be engaging in "pricing tactics" during the AEP (Centers for Medicare & Medicaid Services 2024a). Specifically, CMS noted that some plans may be "submitting artificially high or low prices" for display on Plan Finder to either "encourage" or "discourage" beneficiaries from selecting their plans.

In the CY 2027 proposed rule, CMS proposed retiring their current Plan Finder Price Accuracy measure starting in 2029 (Centers for Medicare & Medicaid Services 2025g). In the proposed rule, CMS noted that there is a lack of variability across contracts in this measure and that average scores across Medicare Advantage Prescription Drug plans (MA–PDs) and stand-alone prescription drug plans (PDPs) tend to be very high for this measure (98 and 97, respectively). If this measure is retired, CMS noted that it will continue to monitor the performance of plans related to displayed drug pricing on Plan Finder.

Analytical approach

We conducted an analysis of Plan Finder drug-pricing data to understand the extent to which prices displayed during the AEP provided an accurate representation of the prices that beneficiaries encountered during the benefit year. Our analysis differs from CMS's Plan Finder Price Accuracy measure, which assesses whether PDE prices align with Plan Finder pricing data for the same time period.

We compared 11-digit national drug code (NDC)–level unit costs of oral drugs for each Part D contract for benefit year 2024 during the AEP (October 2023), at the start of the benefit year (January 2024), and at midyear (August 2024) (one

(continued next page)

Accuracy of drug prices displayed on Medicare Plan Finder (cont.)

TABLE 13–10

Distribution of unit costs for oral drugs at the AEP, 2024

	10th percentile	Median	Mean	90th percentile
Unit cost at the AEP	$0.06	$0.20	$5.25	$11.71

Note: AEP (annual enrollment period). Analysis limited to oral drug products for Medicare benefit year 2024. Unit costs are weighted by Medicare Part D enrollment and utilization (number of claims per standard 30-day supply). Analysis based on Medicare Plan Finder data summarized at the contract–national drug code level.

Source: Medicare Plan Finder data (October 2023 pricing file), Part D monthly enrollment data (July 2024), Medicare Part D prescription drug event data (2024).

month after July, which historically has seen the second-highest number of list-price changes for brand-name drugs after January) (46Brooklyn 2025, Assistant Secretary for Planning and Evaluation 2023).[59] For each contract and NDC combination, we calculated an average unit cost across pharmacies in each contract's network.[60] Analyses were weighted by contract-level enrollment and volume, measured by prescriptions standardized to a 30-day supply ("weighted-contract NDCs").

Summary of findings

Unit costs at the AEP for benefit year 2024 averaged about $5 and ranged from $0.06 at the 10th percentile to about $12 at the 90th percentile (Table 13-10). For an oral medicine taken once daily, these unit costs would be roughly equivalent to $1.80 to $360 per month. At the AEP, about three-quarters (76 percent) of the weighted-contract NDCs in our study had unit costs of less than $1, while about 3 percent of the weighted-contract NDCs had unit costs greater than or equal to $20 (data not shown). That is, most drugs in our study were relatively inexpensive drugs, whereas about 3 percent were brand-name or specialty drugs with a monthly price of $600 or higher.

Between the AEP and January 2024, when the benefit year began, most products (about 95 percent) experienced either an increase or decrease in unit costs within the same contract, with very few products (4.4 percent) showing no price change (Table 13-11). Nearly half of weighted-contract NDCs experienced an increase in unit cost, with an average increase of $0.14, or 2.7 percent of the average AEP unit cost. A comparable share of weighted-contract NDCs had a decrease in unit cost, but by a smaller amount than the average increase ($0.03, or −0.5 percent of the average AEP unit cost). The average AEP unit costs of products that experienced an increase in unit cost were similar to those that experienced a decrease in unit cost ($5.20 vs. $5.52). However, a unit-cost decrease was somewhat more common among contract NDCs with slightly higher AEP unit costs.

Between the AEP and August 2024, unit-cost increases were more common (72.5 percent vs. 48.5 percent in January), with the average size of the increase rising to $0.39 (about 6 percent of the average AEP unit cost) (Table 13-11). Products with unit-cost increases in August also had higher unit costs at the AEP ($6.75 vs. $5.20 in January).

(continued next page)

Accuracy of drug prices displayed on Medicare Plan Finder (cont.)

TABLE 13–11

Change in unit cost from the AEP to January and August 2024

	Number of weighted-contract NDCs[a]	Share of weighted-contract NDCs	Average unit cost at the AEP	Average dollar change in unit cost	Percentile of dollar change in unit cost	
					10th	90th
January 2024						
No change	107,355	4.4%	$2.87	$0	$0	$0
Decrease	938,317	47.2	5.52	–0.03	–0.01	0[b]
Increase	843,275	48.5	5.20	0.14	0[c]	0.10
Missing	25	<1	1.56	N/A	N/A	N/A
August 2024						
No change	5,124	<1%	$0.52	$0	$0	$0
Decrease	609,436	24.7	1.08	–0.14	–0.15	0[b]
Increase	1,034,936	72.5	6.75	0.39	0[c]	0.71
Missing	239,476	2.7	3.12	N/A	N/A	N/A

Note: AEP (annual enrollment period), NDC (national drug code), N/A (not applicable). Analysis is limited to oral drug products for Medicare benefit year 2024. Unit costs are weighted by Medicare Part D enrollment and utilization (number of claims per standard 30-day supply).
[a] Analysis based on Medicare Plan Finder data summarized at the contract–NDC level.
[b] Greater than –0.01 (rounds to zero).
[c] Less than 0.01 (rounds to zero).

Source: Medicare Plan Finder data (October 2023, January 2024, and August 2024 pricing files), Part D monthly enrollment data (July 2024), Medicare Part D prescription drug event data (2024).

Overall, most products had only small changes in unit costs in both January and August.[61] For example, in January 2024, 90 percent of products with unit-cost increases changed by $0.10 or less. Even in August 2024, when the unit-cost changes were larger, 90 percent of products with increases had changes of less than $0.71. These small changes suggest that, on average, prices displayed on Plan Finder during the AEP generally reflected those at the start of the benefit year. At the same time, mean unit-cost changes falling outside of the 10th and 90th percentiles indicate a skewed distribution, driven by a small number of products with large increases or decreases in unit cost.

Overall, the trend shifted from a relatively modest unit-cost change in January to a somewhat larger upward trend in costs by August. This difference makes sense since, as noted above, pharmaceutical manufacturers typically raise prices twice a year—once in January and again in July (Assistant Secretary for Planning and Evaluation 2023). Smaller unit-cost changes in January may also reflect how Part D plans—or their pharmacy benefit managers—are likely better able to incorporate expected January price changes into unit-cost prices displayed on Plan Finder during the AEP. ■

refills" of prescriptions, which former health plan executives and industry actuaries suggested could help improve performance on quality measures like adherence ratings (Weaver et al. 2025). However, repeated early refills can result in an oversupply of medicines, which can put patients and their families at risk. The *Wall Street Journal* found that auto-shipping of excess medicines cost Medicare and its beneficiaries $3 billion between 2021 and 2023. The article specifically mentions prescriptions of noninsulin diabetes medication Jardiance and cholesterol medication atorvastatin as two of the most common automatically refilled medications.

Star-rating calculations also include performance on two measures of enrollee experience with the plan ("rating of drug plan" and "getting needed prescription drugs"). These scores are based on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey responses from a random sample of each contract's enrollees.[62] Enrollees in both MA–PD and PDP contracts rated their coverage and experiences favorably overall in 2024 (Centers for Medicare & Medicaid Services 2025b). The 2024 MA–PD CAHPS score for "rating of drug plan" was 88 (scored on a scale of 0 to 100), which is higher than the 83 for stand-alone PDPs. The 2024 MA–PD CAHPS score for "getting needed prescription drugs" was 90, which is similar to the PDP score of 88. These results have been relatively stable over the past few years.

Consistent with CAHPS results, in focus groups convened for the Commission, Medicare beneficiaries generally continue to rate their prescription drug coverage highly, though some had complaints regarding access to medicines (NORC at the University of Chicago 2025, NORC at the University of Chicago 2024).[63]

Surveys have also found that many beneficiaries are unaware of some of the recent changes to the program affecting drug prices and spending. For example, a survey from KFF in 2024 found that most were aware of the $35 monthly cap for insulin products, but just over a third knew about the new annual OOP cap or provisions related to government negotiation of drug prices; less than 10 percent were aware of the inflation rebates (Sparks et al. 2024). The annual survey from the Healthcare Leadership Council found that most beneficiaries (74 percent) are unaware of the Medicare Prescription Payment Program, which allows beneficiaries to pay their OOP costs over the course of the year rather than all at once, but among the 5 percent who have enrolled in a payment plan, most say it has helped them afford their medication more easily (Morning Consult 2025).

Beneficiaries' access to needed medicines

Part D plans use different tools—such as tiered cost sharing—to manage benefit spending and design products that offer attractive benefits to current and potential new enrollees. When used appropriately, these tools can lower benefit spending, which in turn lowers program spending and enrollee premiums. To aid beneficiaries in finding plans that meet their medication needs, Medicare provides a Plan Finder tool that gives personalized estimates of OOP costs based on a beneficiary's prescription drug regimen and their pharmacies of choice. Pharmacy networks can be used to direct beneficiaries to higher-value pharmacies and offer lower cost sharing at a subset of in-network pharmacies designated as preferred. However, these networks can impede access to needed medications, for example, if beneficiaries face reduced convenience when nearby pharmacies are excluded from a plan's preferred or standard networks.

Medicare Plan Finder can help beneficiaries choose plans that meet their medication needs

Medicare beneficiaries can use the Medicare Plan Finder to compare and select plans available in their geographic area. Plan Finder provides enrollees with a list of Part D plans along with information such as plan premiums, cost-sharing amounts, and star ratings. The cost estimates displayed on Plan Finder may be personalized to a beneficiary's current prescription drug regimen and their pharmacies of choice if beneficiaries input that information. By default, Plan Finder sorts available plans based on these cost estimates for the specific drugs and pharmacies of interest, first displaying the plan with the lowest estimated premium and OOP cost for a beneficiary.

CMS has raised concerns about the accuracy of the drug prices shown on Plan Finder during the annual

enrollment period (AEP), when beneficiaries select a Part D plan, because inaccuracies can affect expected costs and plan selection. Cost of prescriptions is one of the most significant factors that influence beneficiaries' Part D plan decision-making (Stults et al. 2018). Given the importance of costs in plan selection, price changes during the year can have significant health and financial consequences, such as unexpected financial burden that may lead to abrupt interruptions in drug therapy. Cost-related nonadherence can lead to serious health consequences and has been associated with increased mortality rates (Chandra et al. 2024).

Based on our analysis of Plan Finder data for benefit year 2024, prices displayed on Plan Finder during the AEP generally aligned with those at the start of the benefit year (see text box, pp. 509–511, on the accuracy of drug prices displayed on the Medicare Plan Finder). However, by August, prices were typically higher than those displayed during the AEP. These changes are consistent with typical midyear price increases for brand-name drugs. Our analysis for benefit year 2024 did not raise immediate concerns about prices displayed during the AEP. However, we found that products typically experience small price increases during the course of the year, and prices displayed on Plan Finder during the AEP do not anticipate those increases. We have not done a more granular analysis to assess variation across plans or for specific drugs to learn whether certain beneficiaries face information challenges when choosing plans. It is also important to note that, depending on the benefit design, changes in prices may or may not translate directly to changes in OOP costs. For example, price changes will have no effect if the plan uses fixed copayments rather than coinsurance. We encourage CMS to continue monitoring Plan Finder prices and consider implementing a measure to ensure accuracy of prices, particularly during the AEP.

Pharmacy networks and access to pharmacies

Part D sponsors contract with pharmacies to create plan-specific networks, including preferred-pharmacy arrangements that are intended to offer lower cost sharing at a subset of in-network pharmacies, although the extent of these savings varies across plans and drug types. Medicare Part D plans must meet CMS's standards for convenient access to network pharmacies. Under these standards, plan sponsors must demonstrate that, on average, at least 90 percent of beneficiaries in urban areas live within 2 miles of a network retail pharmacy, 90 percent of beneficiaries in suburban areas live within 5 miles, and 70 percent of beneficiaries in rural areas live within 15 miles. Recent pharmacy closures among both independent and chain pharmacies could make it difficult for plans to meet the access requirement (Guadamuz et al. 2024). However, focus groups and external surveys continue to indicate high beneficiary satisfaction with the Part D program and do not point to widespread problems with access to pharmacies or prescribed medications (Morning Consult 2024).

Several factors are reported to contribute to recent pharmacy closures. Pharmacies report increasing financial pressure as reimbursement rates for prescription dispensing have fallen amid the growing negotiating leverage of PBMs. Competition has intensified as more patients use mail-order pharmacies or fill prescriptions through large retail chains that can leverage scale to offer lower prices, making it difficult for independent and community pharmacies to match margins (Abelson and Robbins 2024). Rising operating costs and staffing shortages are also leading to reduced capacity to sustain retail operations (Berenbrok et al. 2025). These challenges have affected both independent pharmacies and large chains: Several national retailers have announced substantial reductions in their store footprints in recent years, citing low profitability and shifting market conditions (Berenbrok et al. 2025). When a nearby pharmacy closes, patients may need to travel farther to fill prescriptions, face longer wait times, or rely on mail-order options (Span 2024). Limited access and longer travel to pharmacies can reduce patients' ability to obtain medications or adhere to their prescriptions (Anderson et al. 2024, Qato et al. 2019). Patients may also face reduced access to pharmacists, who play an important role in providing vaccinations and medication management (Le et al. 2022).

Recent policy changes may also be altering the financial and contract environment for pharmacies, potentially influencing decisions about remaining open or exiting markets. The IRA's drug-price-negotiation provisions and redesign of the Part D benefit are expected to change how plan sponsors and PBMs manage costs, rebates, and formulary strategy. At the same time,

the recent change in the pharmacy DIR policy—which requires pharmacy price concessions to be reflected in POS prices beginning in 2024—has led to substantial declines in POS prices and may have shifted the timing and level of pharmacy reimbursement.[64] These shifts may affect pharmacy finances, which could have downstream implications for Part D pharmacy-network participation. If plans and PBMs anticipate lower drug prices or changes in rebate structures, they may renegotiate pharmacy contracts or networks, including the composition of preferred cost-sharing arrangements. We plan to analyze recent trends in Part D plans' pharmacy networks to assess how evolving incentives are influencing pharmacy participation and beneficiaries' access to in-network and preferred pharmacies. ■

APPENDIX 13–A

Analyzing recent increases in Part D bids

Part D uses a competitive bidding model in which private plans, typically sponsored by commercial insurers, bid to offer prescription drug coverage. Similar to commercial insurance products, these plans pool risks across their enrollees and collect premiums to cover the benefit costs with the goal of generating a profit. For Part D, policymakers chose to subsidize roughly three-quarters of the premium, with part of the subsidy taking the form of reinsurance paid on a cost basis, thereby reducing the insurance risk borne by plans. Initially, reinsurance was expected to account for about a quarter of benefit cost. However, over time, its share grew and, by 2023, accounted for more than 70 percent of benefit cost. In other words, for the majority of prescription drug spending, Part D plans were reimbursed based on actual costs.

The Inflation Reduction Act of 2022 (IRA) redesigned the benefit and shifted how Part D spending is financed (see text box, pp. 480–481, for a summary of IRA Part D provisions). Notably, the law reduced beneficiary's cost sharing (increasing the generosity of the benefit for enrollees) and restored the role of Medicare's capitated direct subsidy, which had diminished to compose a small share of benefit spending in the years before the implementation of the IRA redesign. Increasing the role of direct subsidies strengthens incentives for plans to actively manage drug spending for their enrollees, though the Commission has consistently held that, when plan sponsors bear more insurance risk, they should also be given tools to manage enrollee spending.[65] Lower cost sharing improves enrollees' access to and affordability of Part D medications, especially among those with the highest Part D drug spending, but it is expected to put upward pressure on overall drug utilization and benefit costs, which in turn increases both beneficiary premiums and Medicare payments to plans.

The amount of the capitated direct subsidy each year is determined through a process in which plans submit "bids" based on their expectation of enrollees' spending and the portion that would be covered by the fixed per capita payments. In 2025, these bids rose by 180 percent and by another 33 percent in 2026. We use CMS's data from this bidding process to decompose the growth in the direct subsidy following the IRA's implementation. With higher expected basic benefit costs, as reflected in the bid data, enrollee premiums would also be expected to grow. However, IRA provisions and other Part D policies have shielded enrollees from the full impact of higher premiums while increasing program spending. Substantial variation in bids and premiums across plans exists, and further analysis of the drivers of this variation is important for promoting access to drug plans for all Medicare beneficiaries and for managing program spending.

We conducted semistructured interviews with Part D actuaries to provide context for understanding recent trends in Part D plan bids. Interviewees explained how the shift to greater plan liability in 2025 increased uncertainty and risk for plans. They highlighted higher-than-expected increases in Part D spending in 2025, especially for enrollees most affected by the IRA's cost-sharing protections, which likely contributed to the increase in Part D bids for 2026. Our interviewees reported that, in retrospect, 2025 bids likely underestimated increases in utilization. Interviewees also discussed the effectuation of maximum fair prices (MFPs) in 2026 as a major source of uncertainty, noting that the loss of rebates and potential increases in utilization of selected drugs further complicated their bid preparation.

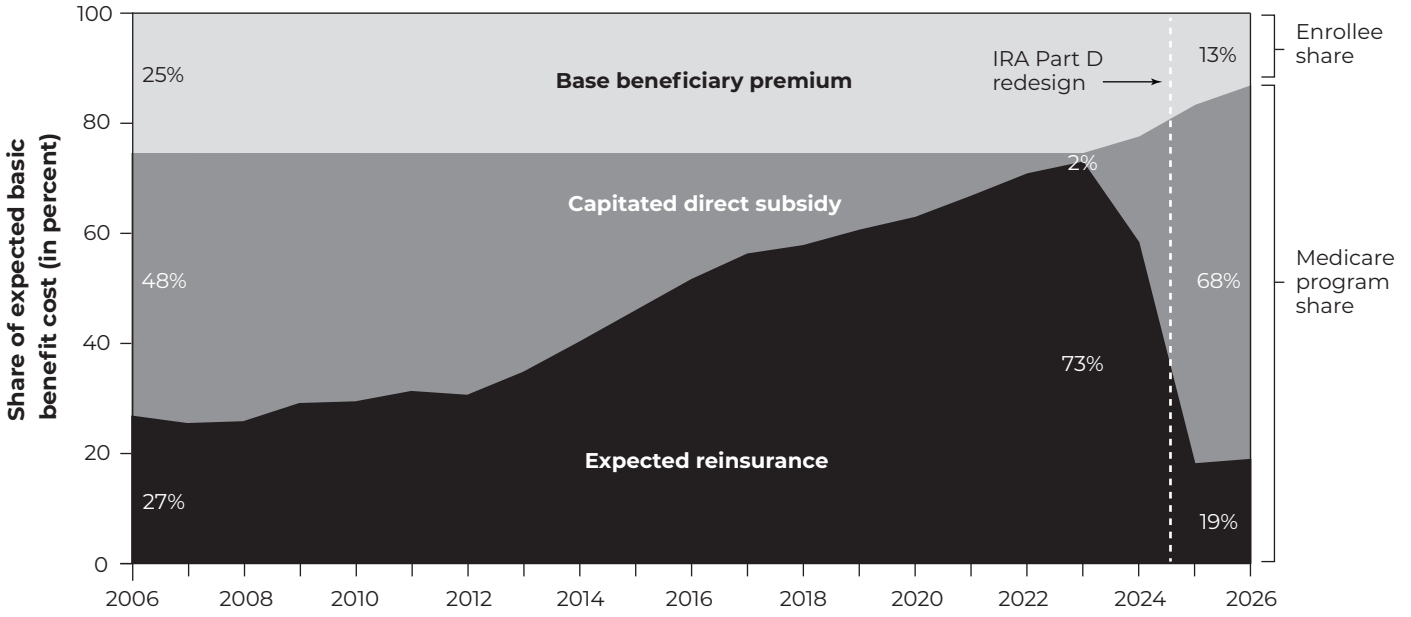
Interviewees cautioned that the lower average premiums for stand-alone prescription drug plans (PDPs) observed in 2026 relative to 2025 is not a sign of market stability but rather reflects how changes in Part D's risk adjustment, on average, increased the risk scores for PDPs, resulting in lower risk-standardized bids and premiums than would have been the case without these changes. In the interviews, they emphasized that, while CMS's changes to Part D's risk adjustment (including separate normalization factors for PDPs and Medicare Advantage Prescription Drug plans (MA–PDs)) may have improved near-term financial prospects for PDPs, the risk-adjustment model needs to be further refined to ensure the long-term stability of the PDP market.

Background on Part D bids

When the Part D benefit launched in 2006, Medicare covered 48 percent of the expected basic benefit cost through direct subsidies to plans and 27 percent through federal reinsurance (Figure 13-A1).[66] The

FIGURE 13–A1

The IRA redesign restored the direct-subsidy share of Medicare expected basic benefit costs, 2006–2026



Note: IRA (Inflation Reduction Act of 2022).

Source: CMS's bid announcements.

national average basic benefit premium (called the base beneficiary premium, or BBP) was set at about 25 percent of Medicare's expected basic benefit cost and covered the remaining share of costs. Over time, the direct-subsidy share shrunk substantially, composing only 2 percent of Medicare's expected basic benefit cost in 2023. At the same time, the expected federal reinsurance share grew to compose 73 percent of Medicare's basic benefit costs. Thus, the role of capitated direct-subsidy payments was minimal by 2023, meaning Part D plans experienced relatively low insurance risk because all other payments (besides premiums) were cost reimbursed. The decline in the direct-subsidy share was driven by rising drug prices and benefit-design changes that increased the likelihood of enrollees reaching the catastrophic phase—where, before the IRA, Medicare reinsurance covered 80 percent of spending—along with growth in rebates, which further reduced plans' overall spending (Avalere 2021, Medicare Payment Advisory Commission 2021, Medicare Payment Advisory Commission 2020b).

The IRA redesign increased the role of direct subsidies and reduced the role of federal reinsurance, in line with key elements of the Commission's 2020 recommendations to restore the plan incentives to manage drug spending that were in place at the start of the program.[67] To protect beneficiaries from rising premiums, the IRA also capped year-over-year growth in the BBP, shifting more costs to the direct subsidy. As shown in Figure 13-A1, the direct-subsidy share grew to 68 percent and the expected federal reinsurance share declined to less than 20 percent in 2026. The BBP composes only 13 percent of Medicare expected basic benefit costs in 2026.

The substantial recent growth in the direct subsidy reflects not only the benefit redesign's changes to federal reinsurance and BBP policies, but other changes in program financing, such as reductions in beneficiary cost sharing and changes to manufacturer discounts and rebates. To better understand how the IRA design affected the direct subsidy, we first explain how the direct subsidy is determined through the Part D plan-bidding process.

Part D plans project their liability for enrollees' prescription drug spending

Annually, plans submit "bids" based on their expectation of enrollees' spending and the share of the basic benefit that would be covered by the direct subsidy plus beneficiary premiums. This combined amount, referred to as "plan liability," represents the portion of Part D drug spending for which plans assume insurance risk. That is, if a plan manages enrollee costs such that the portion of costs covered by the direct subsidy and premiums is lower than those payments, the plan can retain the difference. Conversely, if those costs exceed the payments, the plan must absorb the shortfall. To account for differences in enrollee health status, these payments are risk adjusted using Part D risk scores, an index of beneficiaries' expected costs, that increase Medicare's payments to plans for beneficiaries who are expected to have higher Part D spending and vice versa. Plans also include amounts for administrative costs and profit in their bids.

Part D plans prepare bids annually using their historical experience and tools provided by CMS (see text box for a description of this process). The bids are based on plans' projections of enrollees' spending and how that spending will be apportioned based on the Part D benefit design. That is, to determine their plan liability under the standard benefit, plans must project how much enrollee spending will be covered by federal reinsurance, beneficiary cost sharing, Medicare's low-income cost-sharing subsidy, and manufacturer discounts:[68]

- ***Medicare's reinsurance*:** Federal reinsurance subsidies are payments to plans for a portion of drug spending after enrollees reach the catastrophic phase of the benefit, which occurs when the annual out-of-pocket (OOP) threshold is met. Before the IRA redesign took effect, reinsurance covered 80 percent of drug spending after the enrollee reached the catastrophic phase (15 percent was covered by plans and 5 percent by enrollees' cost sharing). Starting in 2025, the reinsurance share of payments after enrollees meet the catastrophic threshold is 20 percent (the brand manufacturers' share is 20 percent, and plans are responsible for the remaining 60 percent).[69]
- ***Beneficiary cost sharing*:** Beneficiaries who do not qualify for the low-income subsidy (LIS) pay 100 percent of drug costs until they meet their deductible. After meeting the deductible, they are responsible for 25 percent of drug costs until they reach the annual OOP threshold. Once the OOP threshold is met, the beneficiary has no cost sharing. Although the OOP cap in 2026 is set to $2,100, the true OOP (TrOOP) can be substantially lower for many enrollees because the value of enhanced benefits are counted toward the OOP limit for beneficiaries enrolled in enhanced plans (Cline et al. 2025a, Medicare Payment Advisory Commission 2025d).[70] Before 2025, enhanced plans' benefits did not count toward TrOOP, though manufacturer discounts did.
- ***Medicare's low-income cost-sharing subsidy*:** For beneficiaries with low incomes and limited assets, Medicare's LIS pays the difference between plans' cost-sharing amounts and nominal copayments set by law.[71] Before 2024, when beneficiaries exceeded the OOP threshold (and entered the catastrophic phase), they were responsible for paying 5 percent coinsurance. This amount was fully covered by Medicare for individuals receiving the LIS (referred to as the low-income cost sharing, or LICS, subsidy). After the IRA, in 2024, the 5 percent cost sharing was eliminated as was the need for Medicare's payment of the LICS subsidy during the catastrophic phase.
- ***Manufacturer Discount Program (MDP)*:** Under the Part D MDP, manufacturers are required to pay for a portion of brand-name drug costs for beneficiaries. Before 2025, under a different program (the Coverage Gap Discount Program), they were required to pay 70 percent of brand-name drug costs filled by beneficiaries without the LIS in the coverage gap (also known as the "donut

Part D plans submit bids annually using the bid pricing tool

Plan sponsors intending to participate in Part D in the upcoming year must submit bids that represent their expected plan liability based on enrollees' historical spending or comparable plan spending (depending on whether the plan is new) using guidance and tools from CMS. Plans must also provide additional information related to their bid preparations, including projections of how total enrollee spending is distributed among Medicare's reinsurance, beneficiary cost sharing, Medicare's low-income cost-sharing subsidy, and manufacturer discounts as well as expected rebates and supplemental coverage.

The process begins around January with CMS's Advance Notice detailing proposed payment and policy changes for the upcoming year. After a public comment period, the final rate announcements with program guidance are made in April. Using this information, plans that intend to participate in the upcoming year formulate their plan benefit packages and input their financial projections in the bid pricing tool (BPT). These projections provide the information needed to calculate expected plan liability, administrative expenses, and expected rebates and discounts. From the BPT submissions, CMS aggregates the risk-standardized bids to compute the capitated direct subsidy and national basic premium amounts. Plans must also submit their formularies and utilization-management requirements. Bids must comply with CMS rules and be certified by a qualified actuary.

CMS reviews the bids for compliance with statutory and regulatory requirements and may reject bids or ask for revisions from plans. In late July, CMS publishes information on the capitated direct subsidy, base beneficiary premium, and low-income premium-subsidy amount. Medicare Advantage Prescription Drug plans (MA–PDs) may adjust their Part C rebate allocations to meet target premium amounts based on these published figures (but cannot alter plan benefit packages, formularies, or service areas). In September, CMS makes final approvals and publicly

(continued next page)

hole"); this was an increase from the 50 percent set by the Affordable Care Act of 2010 (ACA) prior to 2019. After 2025, the coverage gap was eliminated, and manufacturers instead are now required to pay a portion of costs for both LIS and non-LIS enrollees: 10 percent of brand-name drug costs below the OOP threshold and 20 percent in the catastrophic phase.

- ***Plan liability:*** Plan liability is the portion of benefit spending for which plans bear risk, financed through capitated direct subsidies and enrollee premiums. It equals expected basic benefit costs (i.e., spending net of rebates and supplemental benefit costs) and excludes amounts paid by reinsurance, beneficiary cost sharing, LICS subsidies, and manufacturer discounts.[72]

Plan liability plus administrative costs and profits compose a plan's bid for providing basic Part D coverage to enrollees in the upcoming year. Plans also estimate their average Part D risk score across their enrollees and submit a risk-standardized bid, calculated for a Medicare beneficiary with an average expected cost (risk score of 1.0). Plans' bids are expressed in per member per month (PMPM) amounts.

Plans' bids determine the national average monthly bid amount and base beneficiary premium

CMS aggregates the Part D plans' bid submissions and calculates a risk-standardized nationwide enrollment-weighted average bid amount for the upcoming year, referred to as the national average monthly bid amount (NAMBA). The NAMBA represents the average expected

Part D plans submit bids annually using the bid pricing tool (cont.)

TABLE 13–A1

Number and types of plans submitting bids in the BPT, 2023–2026

	Plan year			
	2023	2024	2025	2026
Total number of plans bidding	5,666	5,587	5,260	5,067
PDPs	814	719	534	367
MA–PDs	4,852	4,868	4,726	4,700
Conventional MA–PDs	3,566	3,531	3,279	2,979
SNPs	1,286	1,337	1,447	1,721

Note: BPT (bid pricing tool), PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), SNP (special-needs plan). We include only plans whose data CMS uses to calculate direct-subsidy payments and the national average basic premium. These include PDPs, local and regional preferred provider organizations' Part D plans, and HMOs' Part D plans.

Source: Part D bid pricing tool data from CMS.

releases the Part D landscape file that lists the participating plans and their premiums.

On October 1, Medicare's Plan Finder is updated with plan data (premiums, benefits, formularies, star ratings) and plans can begin marketing to beneficiaries. Open enrollment begins October 15 and runs through December 7, with the plan year beginning on January 1.

BPT data used in this chapter

This appendix draws from Part D plans' finalized BPT submissions obtained from CMS. As noted in the timeline outlined above, plans' bids are projections of their enrollees' benefit liability and are based on experience that is necessarily lagged. That is, bids for 2026 were submitted in June 2025 and based on plans' available experience from 2024 (bids for 2025 were based on 2023 experience and so on). The BPT requires plans to report their historical experience (if they have it), and that information is also used in this chapter (labeled as "actual" data vs. projected data).[73]

We include prescription drug plans, local and regional preferred provider organizations' MA–PDs, and HMOs' MA–PDs in our analysis. Plans that either do not submit bids or whose bids are not used to determine direct-subsidy payments and premiums are excluded.[74] Table 13A-1 shows the number of plan bids in each plan year (the year for which the plans submitted bids). In 2025, the plans submitting bid data represented about 80 percent of all Part D enrollees.

Throughout this chapter, when averaging information across plans, we weight by the number of projected member months (for projections) or actual member months (for historical data). When computing national averages, CMS weights by member enrollment from June before the plan year (e.g., June 2025 enrollment for the 2026 averages). While projected member months reported in the BPT may differ from actual enrollment from June, we find that national averages are very similar using the two different weights.[75] ■

amount of capitated payments (direct subsidy plus beneficiary premium) that plans receive for providing basic Part D benefits. The NAMBA plus plans' average (enrollment-weighted) expected amount of federal reinsurance (also submitted during the bidding process each year) compose Medicare's expected average total cost of the basic Part D benefit:

> Expected total basic benefit cost = NAMBA + expected federal reinsurance

By statute, enrollees must share these costs. Historically, CMS has aimed to set beneficiary premiums to be 25.5 percent of Medicare's expected basic benefit cost:

> Base beneficiary premium (BBP) = 25.5 percent × expected total basic benefit cost

Medicare's capitated direct subsidy equals the difference between NAMBA and the BBP:

> Capitated direct subsidy = NAMBA — BBP

Starting in 2024, the IRA capped BBP growth at 6 percent annually, and this cap has been binding since then. As a result, the BBP share of total basic benefit costs has been below 25.5 percent since 2024. In 2026, BBP accounts for only 13 percent of expected basic-benefit costs.[76] A lower BBP translates into a higher Medicare capitated direct subsidy.

Bids from PDPs and conventional MA–PDs are used to determine the NAMBA and set the BBP (see text box, pp. 519–520, for the types of plans submitting bids). Special-needs plans' (SNPs') bids are not used in these calculations, but SNPs' payments and premiums are set using the NAMBA and the BBP. As shown in Table 13-A1 in the text box, SNPs represent a significant and growing share of Part D plans. In 2025, 7.1 million beneficiaries were enrolled in SNPs, accounting for 26 percent of MA–PD enrollees.

Medicare shares risk for plan liability through risk corridors

Medicare's capitated direct subsidy plus beneficiary basic premium together form the capitated, at-risk payments plans receive to cover their liability. The difference between the plan's bid and NAMBA determines the premium beneficiaries pay to enroll in that plan. If a plan's risk-standardized bid exceeds the NAMBA, enrollees pay the BBP plus the difference; if the bid is below the NAMBA, they pay the BBP minus the difference. A bid equal to the NAMBA results in a premium equal to the BBP. In short, lower bids mean lower premiums, incentivizing plans to bid competitively to attract enrollees.[77]

Capitated payments encourage plans to manage enrollee costs within this amount since they retain any savings as profits above and beyond costs projected in bids. However, actual costs can vary. To limit losses and prevent excessive profits, Medicare shares risk through symmetric risk corridors.[78] In recent years, plans' losses have exceeded gains, and Medicare has paid out more in risk-corridor payments than it has recouped. In 2024, CMS made net payments of $3.6 billion to plans, the largest net payments in program history (see Figure 13-6, p. 500).

Growth in Part D bids reflects payment shifts and rising costs

Plan bids rose significantly after the IRA benefit redesign was implemented. In 2025, the NAMBA grew from $64 PMPM to $179 PMPM—a 180 percent increase—and continued climbing in 2026 to $239, a 33 percent year-over-year increase (Table 13-A2, p. 522). The NAMBA reflects risk-standardized bids based on plans' projected enrollee risk scores. However, plans build their bids using unadjusted (or unstandardized) spending, which has also grown (Table 13-A2). In the discussion below, we use this unstandardized spending to analyze the components driving bid growth. We note that, in 2025, CMS applied separate normalization factors for PDPs and MA–PDs to better account for observed differences in risk-score trends between the two markets.[79] Interviewees emphasized that risk scores play a key role in variation in bids and premiums across plans (further discussed on p. 533). We intend to explore this area in future analysis.

While part of the 2025 NAMBA growth can be attributed to a shift toward the capitated direct subsidy, driven by the reduced role of federal reinsurance and the BBP growth cap, overall expected basic-benefit costs also rose (Figure 13-A2, p. 523). In 2025, total expected basic-benefit costs grew from $154 to $220—a 43 percent increase from the prior

TABLE 13–A2

Bids grew substantially in recent years, 2023–2026

	Per member per month averages			
	2023	**2024**	**2025**	**2026**
Risk-standardized bids (NAMBA)	$35	$64	$179	$239
Unstandardized bids	31	57	159	207

Note: NAMBA (national average monthly bid amount). All dollars are per member per month. Excludes special-needs plans since their bids are not included in the calculation of the NAMBA. Average unstandardized bids are weighted by projected member months as reported in the bid data. Average standardized bids are from CMS announcements, which are weighted by enrollment in June of the prior year.

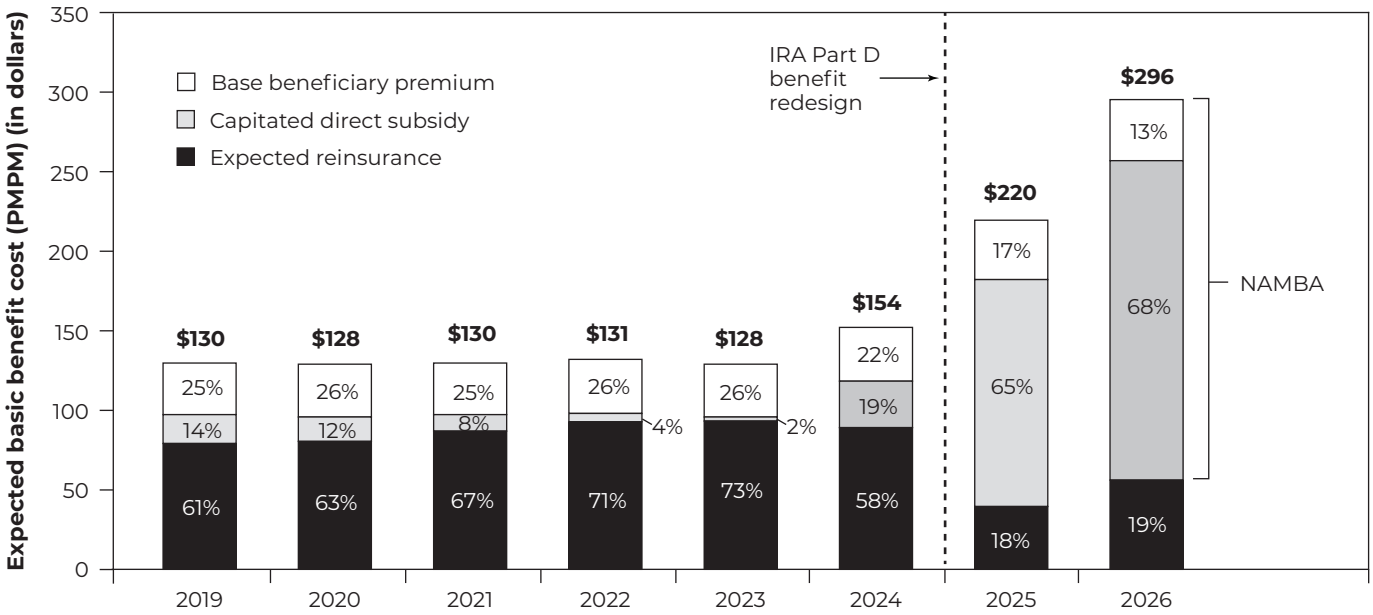
Source: Part D bid pricing tool data from CMS and CMS announcements.

year. In 2026, total expected basic-benefit costs grew to $296, a 35 percent increase from the year before. Thus, the growth in the NAMBA reflects both the rising capitated direct-subsidy share and the increase in total expected basic-benefit costs. Basic-benefit costs are expected to increase because of IRA provisions that lowered beneficiary cost sharing, shifting more costs to Medicare. This increase is further driven by higher utilization, resulting from both induced demand (from lower cost sharing) and higher drug spending not directly related to the IRA.

To examine the components of plans' growing costs, we use the bid pricing tool (BPT) data from CMS (see text box, pp. 519–520, describing the BPT data). These data include enrollee spending, which plans allocate across Part D benefit components to project plan liability. We use data from bids submitted for 2023 to 2026, which are based on the plans' actual experience from 2021 to 2024. We focus on unadjusted spending (net of rebates and supplemental cost sharing) because plans build their bids using unadjusted spending, and this approach removes the influence of risk-score trends that may differ across individual plans and plan types. We show how the financing of Part D spending, as reported by plans, has shifted since the implementation of the IRA redesign (Figure 13-A3, p. 524). Changes to each of the components can be summarized as follows:

- ***Medicare's reinsurance:*** Between 2021 and 2024, reinsurance paid for about 40 percent of Part D spending (net of rebates and supplemental cost sharing); plans projected this share to decline to 14 percent and 15 percent in 2025 and 2026, respectively.
- ***Beneficiary cost sharing:*** Plans projected that the share of Part D spending covered by beneficiary cost sharing would decrease in 2025 (8 percent) and 2026 (7 percent) compared with earlier years (e.g., 13 percent in 2021).
- ***Medicare's LICS subsidy:*** Between 2021 and 2026, the LICS portion of spending declined from 27 percent to a projected share of 7 percent.
- ***Manufacturer Discount Program (MDP):*** Plans projected that a greater share of spending would be paid through manufacturers' discounts in 2025 (18 percent) compared with 8 percent in 2021. In 2026, the share declined to 14 percent, likely related to the Medicare Drug Price Negotiation Program beginning in 2026. The drugs that are selected for negotiations are not subject to the MDP. Selected drugs are high cost and account for substantial portions of spending and thus may explain the projected decline in manufacturers' share of spending between 2025 and 2026.[80]
- ***Plan liability (financed through the capitated direct subsidy and beneficiary premiums):*** Declines in federal reinsurance, beneficiary cost sharing, and LICS subsidies shifted more responsibility to plan liability, though growth in the MDP helped offset

FIGURE 13–A2 **Expected total basic-benefit costs rose with the Part D benefit redesign, 2019–2026**



Note: IRA (Inflation Reduction Act of 2022), PMPM (per member per month) NAMBA (national average monthly bid amount). Base beneficiary premiums are calculated after application of the IRA's 6 percent cap on year-over-year growth. Medicare's capitated direct-subsidy payments and the base beneficiary premium sum to the NAMBA. Medicare's monthly expected basic-benefit costs are composed of the NAMBA plus Medicare's reinsurance.

Source: CMS announcements.

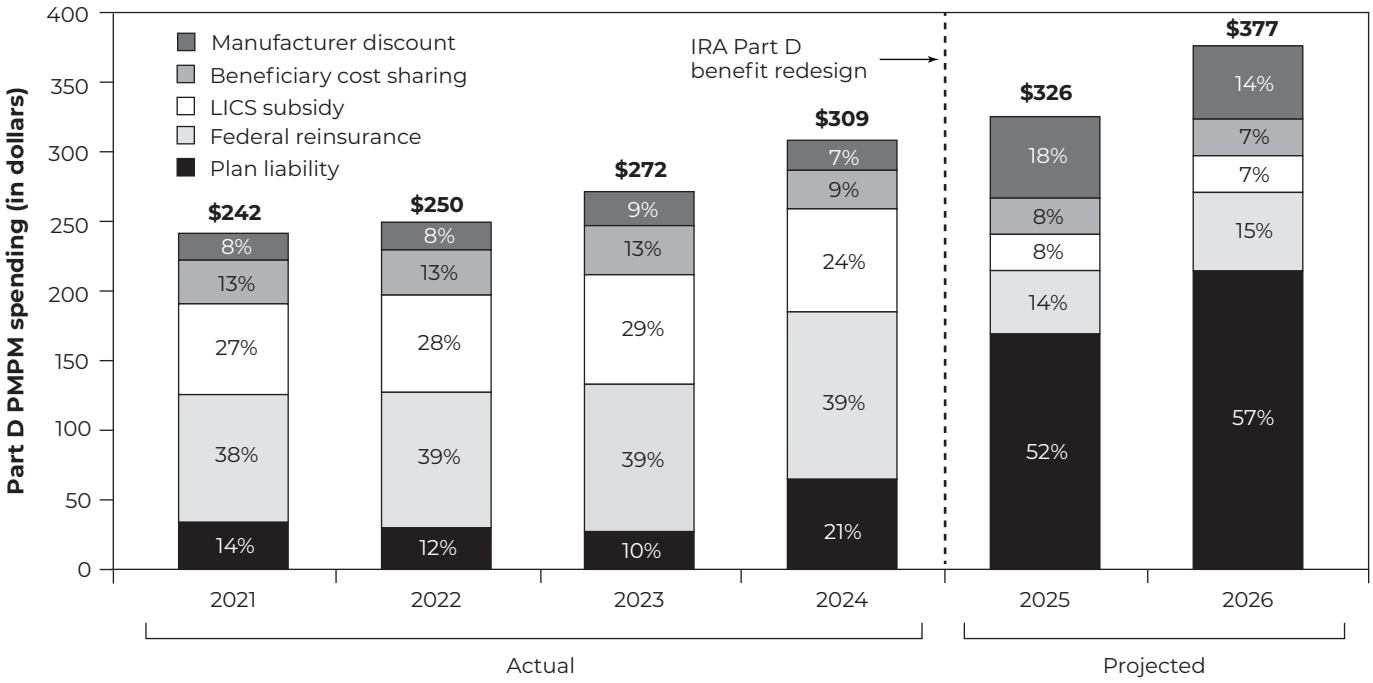
part of this shift. Plan liability—financed through Medicare's direct subsidy and beneficiary premium payments—increased from 14 percent in 2021 to a projected 57 percent in 2026.

In addition to shifts in financing, overall spending also increased—from $242 PMPM in 2021 to a projected $377 PMPM in 2026—further raising the amount covered under plan liability.

Plans' bids reflect a combination of plans' expectations of what total drug spending will be under the benefit and the portion of that total spending that plans will be liable for. To analyze bid growth, we use annual spending shares each year to approximate how much of the bid growth is driven by changes in overall drug spending versus changes in plan liability. These spending shares, shown in Figure 13-A3 (p. 524), form the basis for estimating the components of bid growth between 2024 and 2025 and separately between 2025 and 2026.[81]

We estimate that, between 2024 and 2025, 82 percent of the growth in plans' unstandardized bids could be explained by the shift toward increased plan liability (Figure 13-A4, p. 525). This growth was composed of shifts from cost-based federal reinsurance payments (54 percent of the bid difference), LICS subsidies (24 percent) and beneficiary cost sharing (10 percent) (data not shown). We also estimated that 8 percent of the increase in bids was related to higher administrative costs and margin. Manufacturer discounts increased between the two years, offsetting some of the increase in plan liability. The remaining increase in bids between 2024 and 2025 is explained by plans' projections of higher spending (18 percent) (Figure 13-A4). This

FIGURE 13–A3 **Financing for drug spending shifted under the IRA Part D benefit redesign, 2021–2026**



Note: IRA (Inflation Reduction Act of 2022), LICS (low-income cost-sharing), PMPM (per member per month). PMPM spending is net of rebates and supplemental cost sharing. Projected years are based on plans' experience from two years prior (see the text box on pp. 519–520 for a description of the Part D bid data used for this analysis). Plan liability is financed by Medicare's capitated direct-subsidy payments and beneficiary premiums.

Source: Part D bid pricing tool data from CMS.

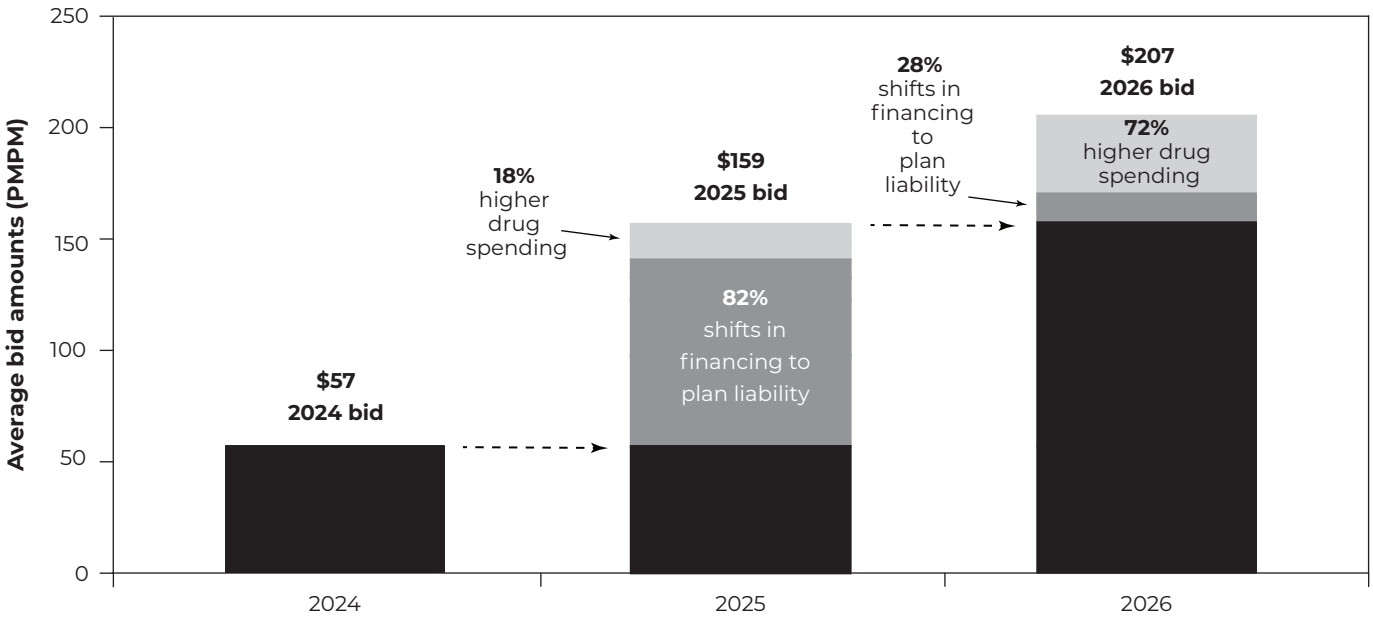
18 percent reflects two components: a 9 percent projection error in 2024 and a 9 percent expected increase in spending for 2025 compared with 2024 (data not shown). Expected spending in 2024 was underpredicted because plans had only 2022 experience available when developing those bids. Since the 2026 bids use plans' reports of actual 2024 data, we were able to quantify the projection error for 2024.[82]

Between 2025 and 2026, the average unstandardized bid increased by $48 PMPM, on average, to $207 PMPM (Figure 13-A4). We estimate that, unlike the prior year, most of the increase in 2026 (72 percent) was driven by higher projected drug spending for 2026 compared with 2025. This could reflect plans underestimating spending in their 2025 bids or anticipating additional growth in 2026. (Since 2025 actual spending data were not available at the time this analysis was conducted, we are not able to separate the 2025 projection error from expected 2026 growth.) The remaining 28 percent can be attributed to shifts in benefit financing that increased expected plan liability resulting from projected decreases in manufacturer discounts and lower cost sharing, partially offset by slightly higher federal reinsurance. The decrease in manufacturer discounts is likely related to the Medicare Drug Price Negotiation Program: Drugs selected under this program are not subject to manufacturer discounts as other brand-name drugs are.[83]

Overall, the estimates suggest that most of the increase in bids between 2024 and 2025 was driven by shifts in the distribution of financing (e.g., lower beneficiary

FIGURE 13–A4

Average unstandardized bids increased due to a shift in insurance risk toward plan liability and higher expected spending, 2024–2026



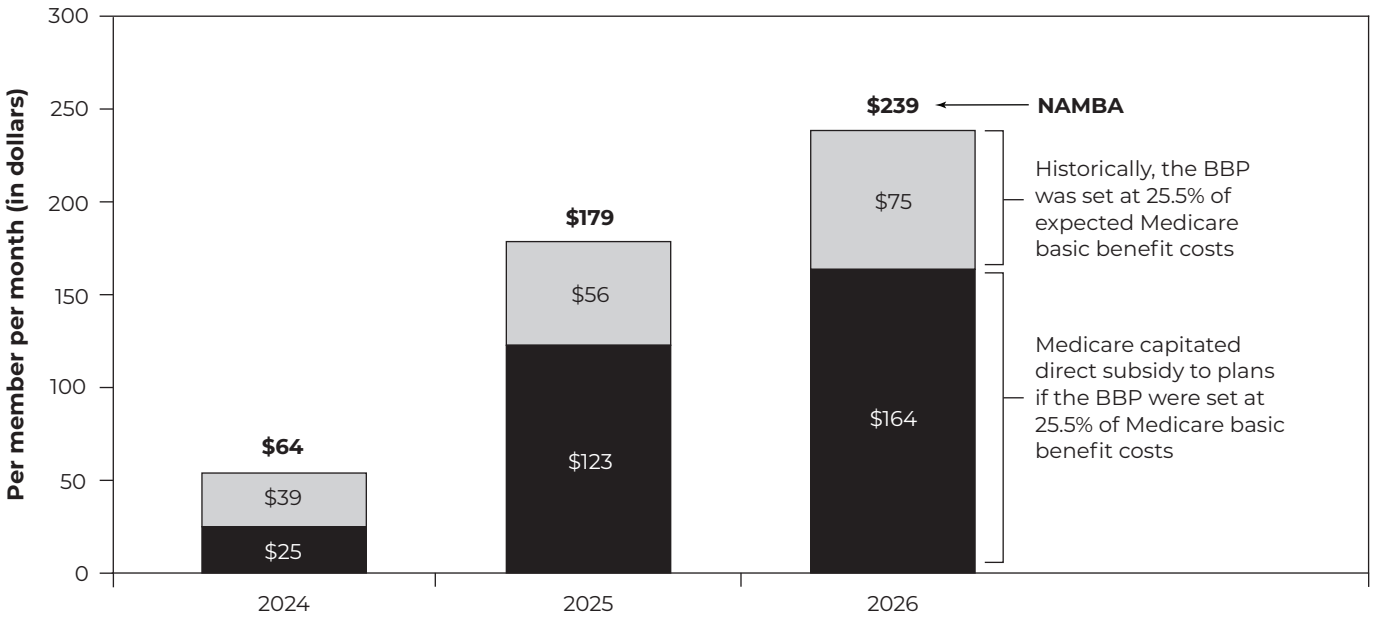
Note: PMPM (per member per month). Figure excludes special-needs plans since their bids are not included in the calculation of the national average monthly bid amount. Plan liability is financed by capitated direct-subsidy payments and enrollee premiums. To estimate the amount of change by payer source between 2025 and 2026, we applied the 2026 payer-source shares to 2025 spending (net of rebates and supplemental cost sharing). We then compared these simulated amounts with 2025 amounts from 2025 payer-source shares. The difference is our estimate of the amount attributable to each payer source that was shifted into (or out of) the bid. The residual difference after accounting for all the payer sources is our estimate of the growth in overall spending that increased the bid. The same method was used to estimate the change by payer source between 2024 and 2025.

Source: Part D bid pricing tool data from CMS.

cost sharing and higher premiums) rather than higher overall Part D spending. By contrast, the increase between 2025 and 2026 appears largely attributable to plans' expectations for higher enrollee drug spending. Several factors likely contribute to these expectations. A key driver is beneficiary behavior in response to lower cost sharing, particularly with changes to how the TrOOP threshold is set. As noted earlier, the TrOOP can be substantially lower for many enrollees because the value of enhanced benefits counts toward the limit. This value is calculated as the difference between the cost sharing under the defined standard benefit (e.g., 25 percent coinsurance) and the actual cost-sharing required under the plan (e.g., $50 copay). Because enhanced plans, by definition, offer more generous coverage than the defined standard benefit, counting the value of supplemental benefits as TrOOP means many beneficiaries will meet their annual OOP limit without incurring the full amount.[84] Based on their available 2025 experience, plan actuaries we interviewed indicated that enrollees—especially those without the LIS—tended to increase drug spending under the redesign (see p. 529). They also suggested that higher 2026 bids may reflect adjustments for underestimated spending growth in 2025. Broader cost trends unrelated to the IRA—such as the growing prevalence of high-cost drugs like glucagon-like peptide-1 receptor agonists (GLP-1s)—also play a role. In the future, we plan to examine how changes in cost sharing are affecting enrollees' use of drugs, program costs and enrollee premiums, and the quality of pharmaceutical services under Part D.

FIGURE 13–A5

Part D basic premiums would grow without IRA provisions and buydown reducing them, 2024–2026



Note: IRA (Inflation Reduction Act of 2022), NAMBA (national average monthly bid amount), BBP (base beneficiary premium). Medicare's total expected basic benefit costs are the sum of NAMBA and expected federal reinsurance. Expected federal reinsurance is not displayed in the figure. This figure excludes special-needs plans since their bids are not included in the calculation of the NAMBA.

Source: CMS's annual release of Part D NAMBA and other Part C and Part D bid information.

Finally, plans' bid projections may differ from actual spending, particularly given the uncertainty as beneficiaries and plans adjust to the benefit redesign. These figures represent averages, and variation exists across plans.

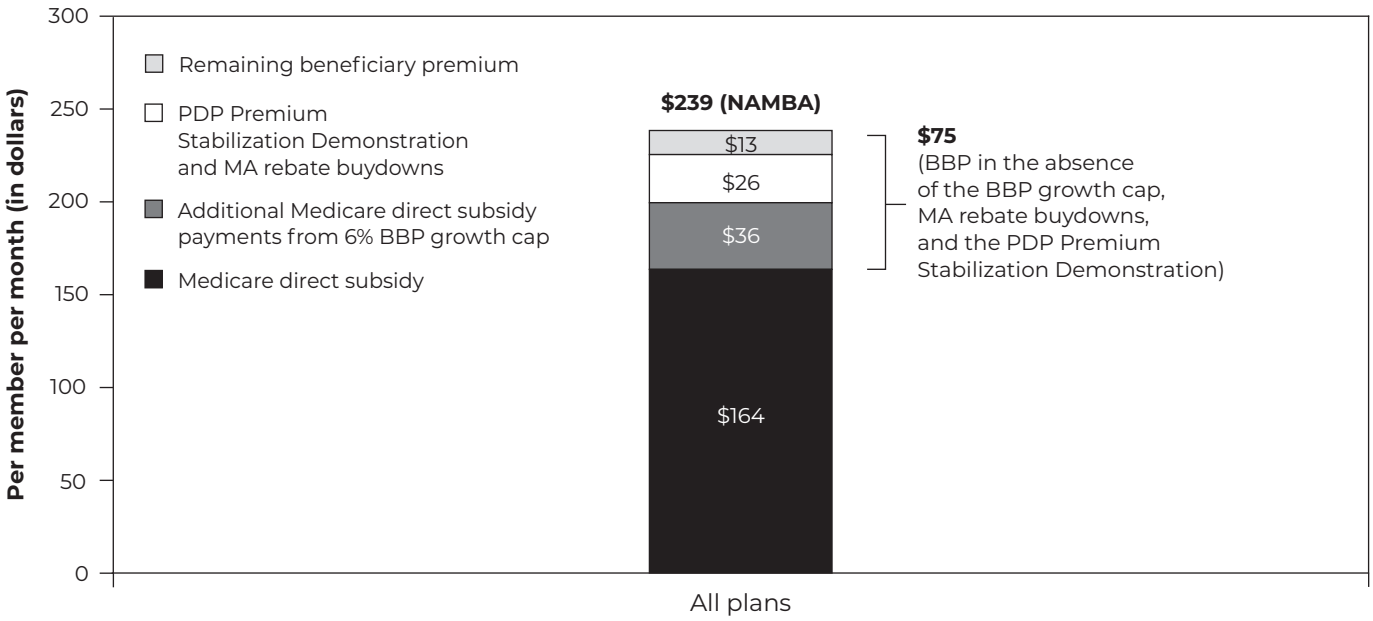
Higher bids would increase beneficiary premiums if not for substantial premium "buydowns"

Before 2024, the national average basic premium (or BBP) was set so that it composed 25.5 percent of Medicare's total expected basic-benefit costs. These costs increased substantially after the IRA redesign (see Figure 13-A2, p. 523), partly because the IRA change shifted drug-spending liabilities away from enrollee cost sharing. This shift would have increased beneficiary premiums, as shown in Figure 13-A5. Here, we show what the BBP would have been without additional policies to lower enrollees' share of Medicare's total expected basic benefit costs: The NAMBA increased from 2024 to 2026, which increased both the BBP (historically set at 25.5 percent) and the capitated direct-subsidy amount (Figure 13-A5).

However, since 2024, a provision in the IRA and policies implemented under CMS's Part D Premium Stabilization Demonstration have reduced the BBP's share of total expected basic-benefit costs. For example, in 2026, the average expected premium that enrollees actually paid for the basic Part D benefit ($13 PMPM) is substantially lower than the historically set BBP (Figure 13-A6).[85] This reduction resulted from several mechanisms aimed at lowering the premium

FIGURE 13–A6

Basic beneficiary premiums are substantially lowered through IRA provisions and buydowns, 2026



Note: IRA (Inflation Reduction Act of 2022), PDP (prescription drug plan), MA (Medicare Advantage), NAMBA (national average monthly bid amount), BBP (base beneficiary premium). Excludes special-needs plans since their bids are not included in the calculation of the NAMBA. "MA rebate buydowns" refers to MA plans' use of Part C rebates to lower Part D premiums for their enrollees.

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

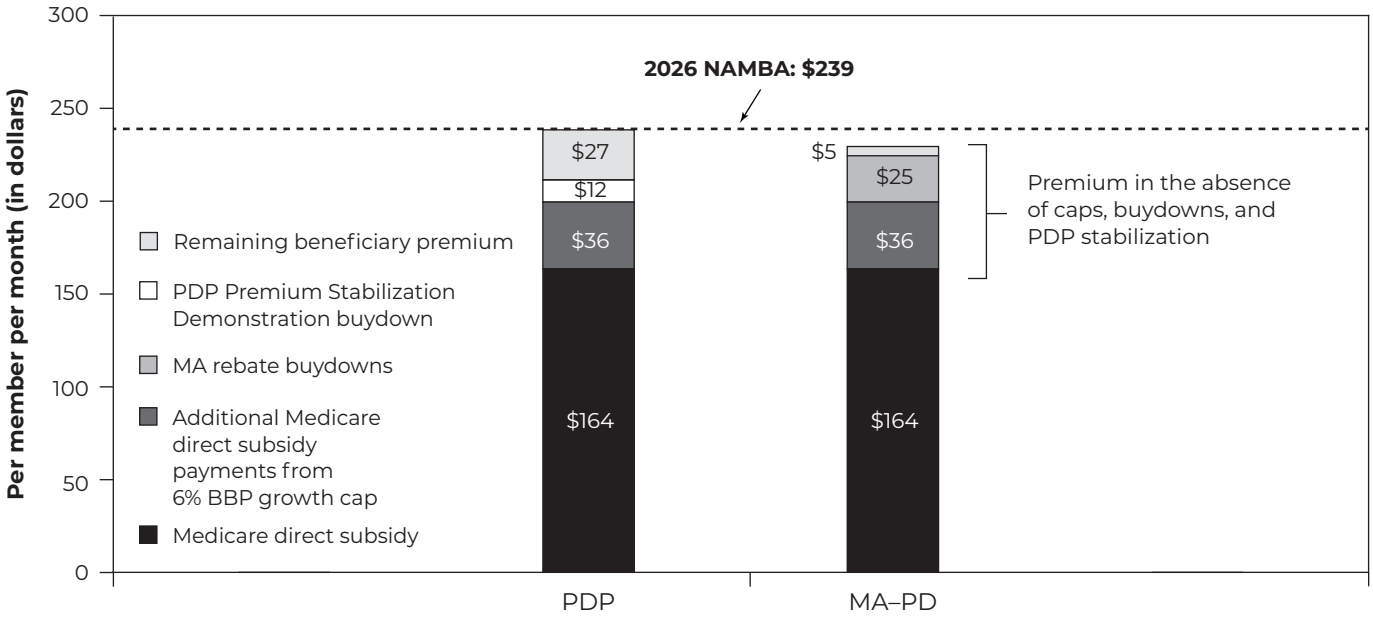
that enrollees pay. First, the IRA capped year-over-year growth in the BBP at no more than 6 percent. For 2026, this requirement resulted in a BBP of $39 instead of $75 PMPM. The difference of $36 PMPM ($75 minus $39) was covered by an increase in Medicare's direct subsidy, which increased program costs (Figure 13-A6). The additional $26 PMPM of the basic premium is lowered through mechanisms that differ for PDPs and MA–PDs (Figure 13-A7, p. 528).

MA plans have long been able to use their MA rebates to buy down Part D premiums for their enrollees. These buydowns can be substantial—on average, covering over 90 percent of the basic MA–PD premium in recent years. The MA buydowns further reduced the basic premiums for MA–PD enrollees by $25 PMPM, resulting in a remaining premium of $5 PMPM, on average (Figure 13-A7, p. 528). The Part D Premium Stabilization Demonstration targeted PDPs. This three-year demonstration lowered the BBP, capped year-over-year PDP total premium growth, and narrowed risk corridors. In 2026, the impact of this demonstration was to lower basic premiums by $12 PMPM for PDPs, on average, to $27 PMPM (Figure 13-A7).[86]

As shown in Figure 13-A7 (p. 528), the remaining basic premiums differed for PDPs and MA–PDs because MA–PDs, on average, had lower bids and because MA rebate buydowns have been sizable in recent years.[87] The Part D Premium Stabilization Demonstration, in contrast, is temporary (lasting for up to three years beginning in 2025) and has lowered the PDP basic premiums by about half the amount of MA rebates that are used to buy down basic premiums. This differential has important implications for setting Medicare's premium subsidy for LIS enrollees (called the low-income premium-subsidy amount (LIPSA)) and

FIGURE 13–A7

Basic premiums differed between PDPs and MA–PDs, 2026



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), NAMBA (national average monthly bid amount), BBP (base beneficiary premium). Excludes special-needs Part D plans since their bids are not included in the calculation of the NAMBA. "MA rebate buydowns" refers to MA plans' use of rebates to lower Part D premiums for their enrollees as a supplemental benefit.

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

PDP benchmark-plan designations (see text box, pp. 530–531).

Many plans offer supplemental coverage, which is also affected by MA buydowns and the Premium Stabilization Demonstration. The sizable MA buydowns mean that many MA–PDs have a zero-dollar total premium, while all PDPs must charge supplemental premiums that reflect the value of the enhanced benefits. The premium gap between PDPs and MA–PDs is expected to widen as the Part D Premium Stabilization Demonstration and the BBP cap on year-over-year growth are phased out. We plan to continue to examine the sources of these differences and monitor changes in Part D bids and spending as plans and enrollees adjust to the IRA Part D redesign.

Interviews with actuaries

Between August 2025 and December 2025, Commission staff conducted five interviews with 11 actuaries, all with experience preparing Part D bids or with expertise in the Part D market. Some actuaries were employees of insurers that participate in Part D (PDP and MA–PD markets), including both for-profit and nonprofit plans, and operating either in a single PDP region or across multiple regions. The interviews focused on four main topics related to recent trends in the NAMBA, the state of the PDP market, LIS benchmark plans, and risk adjustment, and were conducted in a semistructured format. While we made efforts to learn about broader perceptions among their actuarial colleagues working in the Part D market, some of the findings may not necessarily reflect the perspectives of all Part D plans.

In this section, we summarize key themes and takeaways from these interviews.

Interviews point to possible underbidding for 2025, contrary to earlier assessments

After CMS announced the NAMBA increase of nearly 180 percent for 2025 (see Table 13-A2, p. 522), interviewees agreed that there was a general consensus that plan bids were likely too conservative (i.e., too high), reflecting greater uncertainty as the IRA's benefit redesign became effective (Cline and Liner 2024). However, in the first quarter of 2025, use of brand-name and specialty drugs, including GLP-1s, may have exceeded plan expectations. Referring to the general consensus that plans may have "overbid" in 2025, one interviewee noted, "The Q1 2025 data has [sic] shown that that view was wrong." Additionally, one interviewee observed that, beyond the lower annual OOP limit and the elimination of cost sharing above that limit, the change in TrOOP calculation—whereby the value of supplemental benefits is now counted as TrOOP—is likely having a bigger impact than plans expected. As a result, in preparing their bids for 2026, plans, on average, appear to have corrected upward, responding to the actual utilization and cost trends. As one interviewee observed, in retrospect, the 33 percent increase in the NAMBA for 2026 "makes sense given the increased utilization that have [sic] already exceeded expectation in the first half of the year [2025]."

Variation in 2026 bids and premiums reflects continued uncertainty and different approaches to bidding

Interviewees generally agreed that 2026 bids continued to exhibit large variation in part due to the continued uncertainty with respect to the impact of the IRA redesign, particularly as it relates to the accelerated spending trends among beneficiaries without the LIS. At the same time, many also agreed that the effectuation of MFPs for selected drugs under the Medicare Drug Price Negotiation Program as well as other drug-pricing policies was also an important factor contributing to uncertainty. Some interviewees highlighted divergent bidding strategies taken by carriers as contributing to the variation in bids and premiums.

MFPs are a major source of uncertainty

Interviewees emphasized that the application of MFPs beginning in 2026 contributes to uncertainty; they also noted that the effects of maximum fair prices (MFPs) will not be uniform across plans. This uncertainty is due to variation across plans in the use of selected drugs and in the rebates plans received for selected drugs before the MFPs went into effect. That is, plans with higher baseline utilization of selected drugs or greater reliance on rebates on those drugs face more unpredictability in how MFPs will affect their benefit costs. Some interviewees expressed concerns that lower OOP costs for MFP drugs would likely increase utilization, but the magnitude of the increase was difficult to predict. In addition, the expected loss of rebates on selected drugs complicates the bid preparation as plans must anticipate both the loss of rebate revenue that historically has lowered their bids (and premiums) and potential shifts in member behavior. Some interviewees noted that MFPs being implemented alongside other significant policy changes further complicate efforts to predict the impact of these policies. Referring to impacts of other drug-pricing policies, one interviewee noted that "plans took different approaches, with some trying to factor this in while others did not."

Aggressive, low-premium versus conservative or opportunistic approaches to bidding

In 2026, some actuaries noted that bidding strategies were more varied than in 2025, likely adding to the large variation in bids and premiums. For example, they noted cases in which insurers were evaluating region by region, looking at expected membership and weighing "the tradeoff between the margin target versus having low premiums and being under the benchmark," while other plans took a more financially conservative approach, increasing premiums to hedge against uncertainty in utilization trends and the impact of MFPs and other drug-pricing policies. Some plans intentionally bid above the benchmark, accepting loss of enrollees who receive the LIS in exchange for higher margins on other members. One interviewee explained, "If you are going to be over [the benchmark] . . . you might as well be over by a lot to make some margins." In markets with high SNP penetration or less attractive opportunities to gain low-cost enrollees who receive the LIS, plans were more likely to bid above the benchmark or exit the market entirely. As one interviewee observed, "Florida is particularly an unattractive market for benchmark plans because of growth of SNPs." Continued uncertainty may have

LIS benchmark plans and the low-income premium-subsidy amount

Medicare subsidizes the premiums for beneficiaries who are eligible for Part D's low-income subsidy (LIS). To determine the regional low-income premium-subsidy amount (LIPSA)—the maximum amount of premium subsidy Medicare pays to Part D plans on behalf of an LIS beneficiary—CMS calculates a "benchmark" premium amount separately for each of the 34 Part D regions.

The benchmark amount for a region is based on the premiums of all stand-alone prescription drug plans (PDPs) and Medicare Advantage Prescription Drug plans (MA–PDs) serving those regions that had any LIS enrollment in the previous year. To calculate a region's benchmark, CMS computes the average basic premium in the region, weighted by LIS enrollment.[88] Plans that offer both basic and enhanced coverage have only the portion of their premium attributable to basic coverage included in the calculation. If at least one basic PDP has a premium at or below the benchmark, the region's LIPSA is equal to the benchmark amount.[89] If no basic PDP in the region has a premium below that amount, the LIPSA is equal to the lowest beneficiary premium for a basic PDP offered in the region. The premium subsidy

(continued next page)

FIGURE 13–A8

Illustrative example of determining LIPSA and benchmark plans in two PDP regions

Region A

Plan	Premium	LIS member count	Weighted average premium (benchmark)
MA–PD 1	$50	50	$42
PDP 2	$45	35	
PDP 3	$40	40	
PDP 4	$25	25	

Region A has two benchmark plans:
PDP 3 and PDP 4 premiums are lower than the benchmark
Benchmark and LIPSA amount = $42

Region B

Plan	Premium	LIS member count	Weighted average premium (benchmark)
MA–PD 1	$25	50	$35
PDP 2	$45	35	
PDP 3	$40	40	

Region B has one benchmark plan:
No PDP plans have premiums less than the benchmark.
PDP 3 has the lowest premium.
Benchmark amount = $35
LIPSA amount = $40

Note: LIPSA (low-income premium-subsidy amount), PDP (prescription drug plan), LIS (low-income subsidy), MA–PD (Medicare Advantage Prescription Drug [plan]). In this illustrative example, we assume that the PDPs that qualify as benchmark plans are basic PDPs. The benchmark amount is calculated as the average premium across the plans listed for each region weighted by the LIS member counts shown.

Source: MedPAC illustration of hypothetical LIS benchmark calculations.

LIS benchmark plans and the low-income premium-subsidy amount (cont.)

paid by Medicare is the lower of a plan's premium or the LIPSA.[90] Basic PDPs that have a beneficiary premium that is less than or equal to their LIPSA are known as "benchmark plans." Benchmark plans have their premiums for LIS enrollees fully subsidized by Medicare. Figure 13-A8 illustrates how LIPSA and benchmark plans are determined in two hypothetical PDP regions.

As more LIS beneficiaries have enrolled in MA–PDs (especially special-needs plans), the premiums of MA–PDs have greater weight in determining each region's benchmark premium amount and LIPSA. When MA–PD premiums are, on average, lower than PDP premiums, benchmark amounts decline. This situation, in turn, can reduce the number of PDPs that qualify as benchmark plans.

Benchmark plans play an important role for fee-for-service (FFS) beneficiaries who receive the LIS. Individuals who enroll in benchmark plans do not pay a premium, and those who do not select a plan on their own are automatically enrolled in benchmark plans (auto-enrollees), thereby ensuring the beneficiary has drug coverage. If there is more than one benchmark plan in a region, CMS randomly assigns auto-enrollees equally among benchmark plans.[91] Auto-enrollees have historically composed a substantial share of LIS beneficiaries in FFS Medicare (Medicare Payment Advisory Commission 2020a). ■

contributed to market consolidation, with several insurers exiting or reducing their PDP offerings. As one interviewee summarized, "Carriers are looking to be profitable, not [to gain] more membership . . . the PDP market is essentially down to five major carriers."

Competition in the PDP market is shaped by policy and plan strategies

We asked interviewees to discuss how recent policy changes, market incentives, and plan strategies have affected the PDP market. Interviewees emphasized that uncertainty related to the implementation of the IRA policies was a key factor affecting the structure and functioning of the PDP market. However, they also discussed other factors that affect the structure and stability of the PDP market: the persistence of risk selection—the differences in the risk profiles of enrollees across plans that are not accounted for by risk scores—among PDPs, benchmark-plan dynamics, and the influence of recent changes to risk adjustment.

National insurers may see less value in operating in the PDP market

Several interviewees noted that, historically, the PDP market provided national carriers (insurers) with scale and leverage in negotiating rebates with pharmaceutical manufacturers, as well as access to a pool of enrollees who could be converted to their MA products (i.e., MA–PDs). Interviewees explained that these large insurers benefited from comparatively large rebates, which provided them with a financial advantage under Part D's risk-adjustment model that was built based on gross benefit costs (before accounting for rebates) (see text box on Part D's risk-adjustment model on pp. 210–211 in the June 2025 report to the Congress). However, the effectuation of MFPs is expected to lessen the use of rebates as a tool to lower benefit costs and as revenue streams for pharmacy benefit managers (PBMs) and their vertically integrated pharmacies. Interviewees noted that as more drugs become subject to MFPs, the financial advantage will likely continue to diminish.

Several interviewees highlighted the potential need for large investment to operate and grow market share in the PDP market, where plans face more restrictions and limited ability to revamp their offerings compared with the MA–PD market. For example, Part D regulations prohibit insurers that terminate or do not renew a contract from entering or expanding into the PDP region(s) from which they exited for two years.[92]

One interviewee noted that, unlike MA–PDs, "PDPs do not have a lot of room to absorb margin pressures" that arose from the policy change on pharmacy direct and indirect remuneration (DIR) in 2024 and now from the IRA redesign and the effectuation of MFPs.

Furthermore, changes in the MA market may also affect how these insurers view the PDP market. One interviewee observed that "MA margins have been squeezed quite a bit, so the value of conversions from the PDP market has gone down." As a result, "investment in [the] PDP [market] has gone down," and several large carriers may be reassessing their participation in the PDP market, with some choosing to exit or consolidate their offerings.

Selection effects within the PDP market remain strong

Several interviewees noted that risk profiles of enrollees vary widely across PDPs and that the selection effects tend to persist due to structural and behavioral factors. Because most enrollees do not switch plans, existing members "heavily impact plan premiums," and the inability to "start over" in the PDP market contributes to the persistence of selection effects. Selection effects may also persist through CMS's auto-assignment process, which assigns beneficiaries with the LIS to benchmark PDPs that are premium free. Auto-enrollees tend to have lower utilization and more predictable claims experience. One interviewee explained that auto-enrollees consistently have a better risk profile, creating an incentive to capture them over "switchers," referring to beneficiaries with the LIS who have switched to a different plan from the one to which they were originally assigned. This difference in risk profiles between auto-enrollees and switchers means that plans with a substantial auto-enrollee population have a competitive advantage, allowing them to bid more aggressively to maintain zero-premium benchmark status.

Plans, particularly those operated by large national insurers with in-house PBMs, may be able to select favorable risk by strategically setting prices paid to pharmacies. For example, by setting higher prices for specific high-cost drugs, plans can increase enrollee cost sharing and potentially discourage enrollment by individuals who rely on those medicines (doing so would make the plan look more expensive to those individuals when they compare prices on Plan Finder to select a plan). An interviewee noted, "Plans may use benefit design and pharmacy pricing strategies to influence their enrollee mix," further reinforcing selection effects.

Benchmark-plan dynamics may drive both competition and market instability

In the PDP market, plans that have premiums below the regional benchmark are rewarded with auto-enrollees (see text box on the low-income premium amount and the determination of benchmark plans, pp. 530–531). This process gives plans incentives to bid aggressively in order to qualify as a benchmark plan to receive auto-enrollees, who typically have lower and more predictable drug costs. This competitive pressure can lead to lower premiums, benefiting both Part D beneficiaries and Medicare, which subsidizes program costs. However, the same dynamics may also contribute to market instability: If a benchmark plan's premium rises above the benchmark, it loses a significant portion of its LIS enrollees, resulting in abrupt shifts in enrollment with major implications for their revenues. As one interviewee noted, "If you accidentally go over the benchmark, you lose the auto-assigned members, and it costs a lot of money to try and get back to benchmark status, and you don't get back all the auto-assigned members you lost." This dynamic also means that small changes in premiums or risk scores can have outsized effects on membership mix and financial outcomes. Some interviewees suggested that this instability in the benchmark-plan dynamics can lead to changes in plan offerings, market exits, and plan consolidations. However, one interviewee noted that losing benchmark status does not necessarily create barriers to reentry into the LIS market, describing it as primarily a business decision rather than an operational limitation.

Limited differentiation and "commoditization" of PDP offerings

The IRA changes dramatically reduced cost-sharing liability through the redesign of the benefit as well as new coverage and cost-sharing requirements. As a result, many enrollees without the LIS are expected to pay less cost sharing than before the redesign took effect. Multiple interviewees noted that, as a result of these changes, Part D has become a "commoditized" market, limiting their ability to differentiate their plans from competitors through the use of formulary tiers

and copays. In 2025, more plans are using coinsurance, in part to avoid adverse selection but also because of the change in the TrOOP calculation that effectively lowers the annual OOP limit when plans use generous copays. As a result, decisions about formulary and benefit designs now have less impact on beneficiaries' OOP costs and on their utilization and plan choice. The commoditized market also means that there is limited ability to offer enhanced-benefit plans in the PDP market. Interviewees noted that attempts to offer richer benefits or lower cost sharing can attract higher-risk enrollees, increasing plan liability.

As the PDP market becomes more commoditized, with limited differentiation in benefits and cost sharing, selection effects can become even more pronounced. For example, plans with the lowest premiums may be able to attract healthier, lower-utilization members, which, in turn, may enable them to maintain lower premiums than competitors. This dynamic was described by one interviewee as a situation in which "the lowest premium gets you the best members and mix, particularly members who don't utilize or those that take few generics and so are low cost, and the risk-adjustment model overpays even on low-cost members because of the dynamics of not reflecting [postsale rebates and fees] and the [data] lag." Additionally, several interviewees observed that the narrowing of options to manage utilization or to distinguish themselves in the market encourages plans to compete primarily on premium, reinforcing selection effects and contributing to wide variation in risk profiles and financial outcomes across PDPs. One interviewee suggested that commoditization may reduce "frictions" for beneficiaries switching plans by ensuring a baseline level of coverage while enabling them to seek plans that offer lower cost sharing for specific drug(s), potentially increasing selection effects.

Separate normalization and other "enhancements" to risk adjustment have made the PDP market more attractive

Separate normalization and the "enhancements" that CMS implemented under the new risk-adjustment model may have improved the attractiveness of the PDP market. Interviewees explained that the application of separate normalization factors for PDPs and MA–PDs allows risk scores to better reflect the average differences in utilization patterns between the two markets. In turn, these changes have resulted in higher risk scores for PDPs—and thus higher (capitated) payments—particularly for LIS members in PDPs, allowing some plans to offer lower premiums and remain competitive. An interviewee noted that insurers who previously found the LIS population in PDPs difficult to serve may now find it "more financially viable to try to get back in under the benchmarks."

However, while interviewees generally agreed that the use of separate normalization factors has improved the short-term attractiveness of the PDP market, some cautioned that "mathematical underpinnings are not sound." Instead, interviewees argued that long-term sustainability of the PDP market will depend on continued refinement of risk adjustment and market-stabilization policies. As one interviewee put it, "using separate normalization as a way to drive revenue to PDP doesn't seem sustainable. . . . To stabilize the PDP market, coming up with a way to drive revenue that isn't reliant on separate normalization factor [sic] is something worth considering."

Improving the accuracy of risk adjustment is key for the long-term stability of the PDP market

Interviewees consistently emphasized that improving the accuracy of risk adjustment is fundamental to the stability of the PDP market. By compensating plans fairly for differences in enrollees' average expected costs, risk adjustment has the potential to neutralize the financial impact of selection effects and to promote competition. Nearly all interviewees expressed concern that the current model is not keeping pace with actual utilization trends, particularly for beneficiaries without the LIS. Some interviewees noted that the situation has resulted in misvalued hierarchical condition categories (HCCs) where "certain HCCs are undervalued in a way that lowers risk scores for non–low income population." However, there was less consensus on the best approach to improve the accuracy of Part D's risk-adjustment model. Some suggested using a separate model for PDPs and MA–PDs, though some also expressed reservations about using separate models as a long-term solution, noting that it could create artificial incentives and potentially distort competition between the two markets. Others discussed the need to reflect prices net of DIR or actual drug use rather than rely solely on diagnoses.

Interviewees also suggested other ideas as the market continues to adjust to changes, though there was less consensus. For example, one interviewee suggested that tighter risk-corridor protection for PDPs would be valuable to plans as they face greater uncertainty in predicting enrollees' utilization and pricing during this period of market transition. While this protection could be temporary, interviewees noted that, with the large increase in bids, risk corridors are no longer providing the same level of protection as before the IRA changes. That is, the current initial threshold of 5 percent (above the expected costs in plan bids) can mean major losses for plans before any payment protection is triggered. Another interviewee suggested that a policy change to allow insurers to "revamp" their PDP offerings and start anew could improve the attractiveness of the PDP market, encourage innovation, and allow PDPs to adapt to the changing market conditions. Currently, PDPs that exit from a region are not allowed to reenter the market for two years, which limits PDPs' ability to change their offerings.[93]

Finally, when we asked whether there was any reason to exclude SNPs from the calculation of the NAMBA, interviewees generally agreed that there was no compelling reason for their exclusion. Given SNPs' growing market share, interviewees generally agreed that this exclusion (in law) no longer made sense. However, there was less clarity on how including bids submitted by SNPs would affect the NAMBA and what the broader implications would be on the PDP market. Several interviewees suggested that the effects on the NAMBA would likely vary from year to year, "though theoretically, it shouldn't have that much impact."

"Steady state" may still be a few years away

Interviewees broadly agreed that a "steady state"—a return to normal variability and predictability in Part D utilization and costs—is still several years away, citing multiple sources of uncertainty and ongoing policy changes. They pointed to data lags in risk adjustment and continued volatility in utilization, especially for high-cost and specialty drugs.

Compounding these challenges are policy changes, including the effectuation of MFPs, other policies that could affect drug prices, and modifications to CMS's Premium Stabilization Demonstration, all of which make it difficult for plans to predict costs and the premiums for their enrollees. Interviewees also noted manufacturer responses, such as reduced availability of patient-assistance programs, which have shifted more cost onto Part D and increased financial pressure on plans.

Interviewees cautioned that lower average premiums for PDPs observed in 2026 relative to 2025 are not a sign of market stability but rather a reflection of how the use of separate normalization for PDPs and MA–PDs has, on average, increased the risk scores for PDPs, resulting in lower risk-standardized bids and premiums.[94] One interviewee noted that the lower premiums for PDPs were "a result of higher NAMBA and increased direct subsidy, not intentional efforts by plans to lower bids." While separate normalization and other changes to Part D's risk adjustment may have improved near-term financial prospects for PDPs, on average, interviewees emphasized that the risk-adjustment model needs further refinement. ■

Endnotes

1 Plans receive prospective payments for reinsurance that are reconciled with actual spending (net of postsale rebates and discounts) after the end of the benefit year for enrollees who reached the annual OOP threshold.

2 For example, the Commission has recommended establishing higher copayment amounts for nonpreferred and nonformulary drugs under the LIS benefit and giving plans greater flexibility regarding coverage of drugs in the protected classes, though these proposals have not yet been adopted (Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2016).

3 For example, in 2023, on average, MA–PD risk scores were an estimated 7.6 percentage points higher than PDP risk scores due to differences in coding intensity. Unlike in the MA program, higher coding intensity in Part D does not, by itself, increase program spending; rather, it affects relative payments between the two markets.

4 The changes adopted in the IRA are also likely to affect revenues of pharmaceutical manufacturers and may influence decisions related to future investment in research and development (R&D) as well as strategies for new product launches. However, estimates of these potential effects vary widely, reflecting significant uncertainty (Avalere 2022, Congressional Budget Office 2022, Gassull et al. 2023, Philipson et al. 2023). As noted in our previous reports to the Congress, the price paid by Medicare and other entities for drugs represents just one of many factors that influence investment in biopharmaceutical R&D (Medicare Payment Advisory Commission 2023, Medicare Payment Advisory Commission 2022a).

5 Before 2025, TrOOP spending excluded beneficiary cost sharing paid by most sources of supplemental coverage, though it included the 70 percent discount that manufacturers of brand-name drugs were required to pay in the coverage gap.

6 CMS requires plans to adjust their bids to remove any insurance effect of enhanced (supplemental) benefits on basic-benefit costs by applying an induced utilization factor to the expected basic benefit costs. However, the effects of enhanced benefits on TrOOP that increase basic-benefit costs are not treated as insurance effects and are excluded from the induced utilization factor.

7 For the applicable periods beginning October 1, 2022, and October 1, 2023, approximately 1,500 national drug codes (nine-digit national drug codes) experienced price increases exceeding inflation and owed more than $1.2 billion in inflation rebates. By law, inflation rebates are deposited in the Federal Supplementary Medical Insurance Trust Fund (Centers for Medicare & Medicaid Services 2026).

8 Previously, a small share of LIS enrollees with slightly higher levels of income or assets received a partial subsidy; beginning in 2024, all beneficiaries who previously would have been eligible for a full or partial LIS receive full subsidy benefits.

9 Before the 2025 bids were submitted, CMS estimated that the IRA changes would roughly double gross plan liability, and many, including CMS, expect Part D's risk adjustment to take on much greater importance (Centers for Medicare & Medicaid Services 2023a, Robb et al. 2024).

10 The MDP discount during the initial coverage phase for negotiated drugs is covered instead by Medicare through the Selected Drug Subsidy Program.

11 In 2030, the IRA requires that the BBP cover at least 20 percent of expected basic benefit costs, which may necessitate an annual increase of more than 6 percent.

12 If the BBP were set to be 25.5 percent of the total expected benefit (as originally set in law), it would have been $75.38 in 2026 (this number was $55.98 in 2025). Capping the BBP growth results in a BBP of $38.99 (lower than the BBP without the cap by $36.39). In contrast, applying the cap last year decreased the BBP by $19.20.

13 All average premium information in this chapter is enrollment weighted (unless otherwise stated). For all years before 2026, we used same-year enrollment to weight premiums across plans (e.g., Part D plan enrollment from 2025 was used to calculate average 2025 premiums). Since 2026 enrollment was unknown at the time the analysis was conducted, we used April 2025 plan members as weights for 2026. We used CMS's crosswalk files to match 2025 plans to 2026 plans to account for plans that consolidated. Because we used 2025 enrollment as weights, plans that are new in 2026 are not included in the analysis of 2026 average premiums.

14 CMS reported that the average PDP total premium was expected to decrease in 2026 to $34; this calculation was based on an assumption that some beneficiaries would switch to lower-premium plans. While switching to lower cost plans is supported by historical data, our estimate does not make such an assumption, but rather assumes all beneficiaries

remain in the same plan as in 2025. Other researchers have also reported that average PDP premiums are expected to increase in 2026 among non-LIS enrollees (Collin et al. 2025, Stengel et al. 2025).

15 Beneficiaries who receive the LIS do not pay the full premium amounts because Medicare's low-income premium subsidy pays most or all of their premiums.

16 SNPs are specialized types of MA plans that limit their enrollment to specific categories of individuals with unique needs or conditions, including dual eligibility, severe chronic conditions, or institutionalization, to provide targeted care and tailored benefit packages.

17 The LIS benchmark is the average basic premium for PDPs and MA–PDs (including SNPs) in each of the 34 PDP regions, weighted by LIS enrollment.

18 Dental, vision, hearing, and fitness benefits are the most common non-Medicare services, though policy changes have expanded the types of benefits that plans may offer, and plans have gradually covered a larger number of non-Medicare services (Medicare Payment Advisory Commission 2025c).

19 As with the income-related premium for Part B, higher Part D premiums apply to individuals with an annual adjusted gross income greater than $106,000 and to couples filing jointly with an adjusted gross income greater than $212,000 in 2025; these thresholds are updated annually.

20 The LEP amount depends on the length of time an individual goes without coverage as generous as Part D and is calculated by multiplying 1 percent of the BBP by the number of full uncovered months an individual was eligible but was not enrolled in a Part D plan and went without other creditable coverage.

21 These additional late-enrollment premiums are paid into the Part D account of the Supplementary Medical Insurance Trust Fund.

22 Fewer than half of the regions (14 out of 34) have six insurers offering PDPs; these regions have a local organization offering a plan in addition to the national carriers. Hawaii is the only region with just four insurers offering PDPs. Nearly half of all PDP beneficiaries were enrolled in a plan offered by the leading national carrier in 2025, while enrollment among the other four was roughly evenly split. The plan sponsor with nearly half of PDP enrollment is the only one to have a benchmark plan in every region, though another organization significantly increased its footprint in the benchmark market from 17 regions in 2025 to 30 in 2026.

23 Enrollment among the 48 PDPs that fully terminated averaged 10,000, with roughly 480,000 beneficiaries in such plans.

24 When the Part D program was created, the Congress contemplated such a scenario and included in the legislation a contingency plan to ensure beneficiaries would always have a minimum of two options for prescription drug coverage (see CFR Sec. 423.859.). If that minimum requirement is not met, the law allows the Secretary to approve a plan(s) that administers Part D's prescription drug benefit without taking insurance risk (or only assuming limited insurance risk). In 2025, however, all regions continued to meet the minimum number of required plans, with all enrollees having at least five qualifying PDPs.

25 The four regions with just one benchmark plan available in 2025 included Florida, Illinois, Nevada, and Texas.

26 The remainder qualified either because they received benefits through the Medicare Savings Program or Supplemental Security Income program or because they were eligible after they applied directly to the Social Security Administration.

27 During the coronavirus public health emergency, the Congress required states to pause eligibility checks for Medicaid enrollees. This requirement expired in April 2023, and at that time states began the process of once again checking eligibility during renewal periods, which took up to one year to complete. Thus, by mid-2024, disenrollment of individuals no longer eligible for Medicaid was complete. Because beneficiaries who are dually eligible for Medicare and Medicaid automatically receive the LIS, disenrollments from Medicaid lead to decreases in the number of people automatically receiving the LIS.

28 The retiree drug subsidy is paid to employers that provide prescription drug coverage to their retirees that is comparable with or more generous than Part D's defined standard benefit.

29 Medicare's Trustees noted an "unexpected surge in the use of antidiabetic drugs" that began in 2023 (Boards of Trustees 2025). The use of GLP-1s has risen across all payers, driven in part by the drugs' effectiveness in treating Type 2 diabetes and, more recently, by FDA approvals for additional indications, such as the treatment of cardiovascular disease and weight loss. Growing public awareness of GLP-1s through direct-to-consumer advertising has also likely contributed to the uptick in their use (Greenwalt and Glass 2025, Rad and Melendez-Torres 2025).

30 Between 2023 and 2024, Medicare's spending for the LICS subsidy declined from $25.7 billion to about $21 billion, while

cost sharing paid by beneficiaries who did not receive the LIS declined from $5.4 billion to $3.8 billion, likely due in large part to the IRA change. Part D spending in the catastrophic phase of the benefit in 2024 indicates that this provision may have added as much as $6 billion to plan liability.

31 Before 2024, Part D program payments increasingly shifted from capitated direct-subsidy payments to cost-based reinsurance. By 2023, reinsurance accounted for 93 percent of Part D program spending on basic benefits, up from less than 50 percent a decade earlier. In 2024, this trend was reversed, with reinsurance accounting for 76 percent of basic-benefit costs.

32 The total net pharmacy DIR payments used by Part D plans to offset benefit costs grew from less than $1 billion before 2015 to more than $21 billion by 2023, accounting for nearly a quarter of all DIR received by plans, primarily used to lower benefit costs. Rebates received by plans from pharmaceutical manufacturers accounted for the other three-quarters.

33 In 2023, on average, pharmacy DIR fees amounted to about 8 percent of the gross (or list) prices at the POS, up from less than 5 percent before 2020 (MedPAC's analysis of the Part D prescription drug event and DIR data from CMS).

34 To examine growth in prices, the Commission contracted with Acumen to construct a series of volume-weighted price indexes that reflect total amounts paid to pharmacies for Part D prescriptions (i.e., POS prices) as well as prices for single-source brand-name drugs net of postsale manufacturer discounts. The indexes reflect prices (of existing products) measured at the median of the distribution for each grouping of products associated with a specific drug or biologic. The price index measures changes in the prices of products that existed in both the measurement period and the preceding period.

35 In 2023, pharmacy DIR fees lowered the prices of generic drugs by 12 percent, on average, compared with 7 percent and 8 percent for brand-name drugs and biologics, respectively (Medicare Payment Advisory Commission 2025a).

36 Medicare's LICS subsidy continues to count toward the annual OOP threshold after 2024. However, starting in 2025, the new MDP that replaced the Coverage-Gap Discount Program will no longer count toward the annual OOP threshold.

37 In 2024, high-cost enrollees without the LIS paid, on average, about $2,250 OOP in cost sharing. Discounts paid by pharmaceutical manufacturers for prescriptions filled in the coverage gap accounted for the remainder of the annual OOP threshold amount ($8,000).

38 The TA is equal to the plan bid minus administrative costs and profits assumed in bids. The profits that are recouped under Part D's risk corridors are a portion of "excess" profits that plans made above and beyond the amounts assumed in bids.

39 In 2020, the annual OOP threshold increased by $1,250 as it reverted to the level that would have applied if the provision in the Affordable Care Act of 2010 (ACA) to temporarily slow growth from 2014 to 2019 had not been implemented.

40 Expected average plan liability used in risk-corridor calculation—plan bid minus administrative costs and profits—is referred to as the "target amount." Between 2023 and 2024, the TA across all plan types rose from $27 to over $50 PMPM. The increase, in both dollar and percentage terms, was greater for PDPs and SNPs compared with conventional MA–PDs.

41 To examine growth in prices, the Commission contracted with Acumen to construct a series of volume-weighted price indexes that reflect total amounts paid to pharmacies for Part D prescriptions (i.e., POS prices) as well as prices for single-source brand-name drugs net of postsale manufacturer discounts. The indexes are calculated using chain-weighted Fisher price indexes and are measured at the median of the distribution relative to prices as of the first quarter of 2014. Indexes reflect changes in the prices of products that existed in both the measurement period and the preceding period. They do not reflect the effect of new products' launch prices.

42 To account for generic substitution, Acumen groups NDCs that are pharmaceutically identical, aggregating prices across drug trade names, manufacturers, and package sizes. As a result, brand-name drugs are grouped with their generics if they exist, and this price index more closely reflects the degree to which market share has moved across products.

43 The decrease in POS prices in 2024 reflects the new DIR policy requiring pharmacy fees to be reflected at the POS. Pharmacy fees, on average, accounted for a larger share of spending for generic drugs compared with brand-name drugs and biologics. As a result, the impact of the DIR policy was greater on the generic price index (a decrease of 34.2 percent) than on the overall index including brand-name drugs and biologics (a decrease of 11.3 percent).

44 The decrease in POS prices in 2024 was driven primarily by the new policy requiring pharmacy fees to be reflected at the POS.

45 MedPAC calculations based on data from CMS.

46 MedPAC calculations based on analysis by Acumen for MedPAC.

47 In the case of Fiasp/Novolog, our expenditure index decreased in 2024 as prices, measured by our price index, decreased between the fourth quarter of 2023 and the first quarter of 2024.

48 These estimates reflect use for an expanding set of FDA-approved indications—including Type 2 diabetes and cardiovascular risk management—but exclude weight loss, implying utilization likely remains highly constrained relative to the full scope of approvals. CMS's planned Better Approaches to Lifestyle and Nutrition for Comprehensive Health (BALANCE) Model would allow Medicare Part D plans to cover GLP-1 drugs for weight loss at negotiated prices, potentially lowering plan costs and beneficiary OOP costs, though overall federal spending could still rise due to voluntary plan-participation incentives and expanded utilization.

49 See also Chart 10-24 in our July 2025 data book for the average rebates negotiated by plans for drugs in protected classes compared with other drug classes (Medicare Payment Advisory Commission 2025a).

50 To be selected for the negotiation program, the product must have been on the market for at least 7 years if it is a small-molecule drug and 11 years if it is a biological product. The IRA included a provision to exempt certain single-source drugs that would otherwise qualify for negotiation. For example, the law specifically excludes plasma-derived products and drugs that are approved and designated for only one rare disease ("orphan drugs"). The original law exempted from price negotiation only orphan drugs that treat exactly one rare disease. A subsequent law change expanded that exemption to include any drug that treats one or more rare diseases (see Sec. 71203 of P.L. 119-21).

51 There will be 15 drugs selected from either program in 2028 and 20 in 2029 and subsequent years.

52 The applicable percentage ranges from 40 percent for drugs that have been on the market for more than 16 years to 75 percent for drugs that have been on the market for 9 years to 12 years.

53 Manufacturers are asked to submit information related to research and development costs, prior federal financial support, unit costs of production and distribution, revenue and sales data, and information on patents and market exclusivity granted by the Food and Drug Administration (Centers for Medicare & Medicaid Services 2024c).

54 The difference in discounts paid by manufacturers of selected drugs under the Coverage Gap Discount Program were higher for the 2026 cohort than for the 2027 cohort, which also contributed to the lower savings for the 2026 cohort.

55 Under Part D's protected-class policy, plans must cover all or substantially all drugs in six protected classes, which include antineoplastics (cancer drugs). This coverage requirement has limited Part D plans' ability to negotiate lower prices or rebates for drugs used for cancer treatment. Because the Medicare Drug Price Negotiation Program sets a ceiling price that requires mandatory discounts based on the number of years the drug has been on the market, prices negotiated under the program could provide substantial discounts relative to the prices negotiated by Part D plans.

56 Some of the reduction in gross spending for Novo Nordisk's insulin products may have been due to the $35 cap on insulin products that was in place for certain Part D plans under a demonstration, the Senior Savings Model, and subsequently mandated across all Part D plans as a result of the IRA.

57 For example, the administration's agreements with two manufacturers of GLP-1s, two of which are selected drugs for 2027 (Ozempic and Wegovy), announced on November 6, 2025, set GLP-1 prices at $245, an amount below the $274 negotiated under the program (The White House 2025). Given that Ozempic and Wegovy account for a disproportionate share of projected savings, the impact of these agreements could be substantial.

58 The agency displays other Part D quality measures on the CMS website, including some metrics that are either being removed from or evaluated for addition to the star-rating system.

59 The definition of a unit can vary across drug products. CMS lists solid oral dosage forms as an example of a unit for formulation in its pricing-data submission guidance (Centers for Medicare & Medicaid Services 2021).

60 The extent of variation in unit costs across network pharmacies vary by contract and by NDC. We used simple averages (i.e., not weighted by volume or price) to assign a single-unit cost for each contract–NDC combination. Our analysis included 796 contracts, each with up to 3,774 distinct NDCs.

61 To the extent that unit costs and unit-cost changes vary across pharmacies within network pharmacies, individual beneficiary experiences may differ from these average unit-cost changes. In our analysis of unit costs of a few oral medications including both brand-name and generic drugs within the same contract, we found that unit costs for some

drugs varied widely across pharmacies, while unit costs for other drugs were identical across all network pharmacies. This finding was true at the annual enrollment period, in January, and in August of the 2024 benefit year.

62 CAHPS surveys generate standardized and validated measures of patient experience. MA organizations and Part D plan sponsors are required to contract with a third-party survey vendor to collect CAHPS survey responses from a random sample of each contract's enrollees.

63 Due to the nature of focus-group research, our sample size was limited, so findings are not generalizable to the broader Part D population.

64 For example, in the initial months of the policy in 2024, there was an expectation that some pharmacies could experience cash-flow challenges as they simultaneously faced obligations to pay price concessions (pharmacy DIR) from 2023 while also receiving lower reimbursement for prescriptions filled in 2024, consistent with the new definition of negotiated prices under the policy (see text box, p. 416–417, on the regulatory change affecting prices paid at the POS in the March 2025 report to the Congress).

65 The Commission has recommended, for example, establishing a higher copayment amount under the low-income subsidy for nonpreferred and nonformulary drugs and giving plans greater flexibility regarding coverage of drugs in the protected classes (Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2016).

66 Medicare's basic benefit cost is net of rebates, discounts, and fees paid by pharmaceutical manufacturers and pharmacies and does not include cost sharing paid by beneficiaries or any benefits covered under enhanced (supplemental) benefits.

67 There are some differences between our recommendation and the IRA design. For instance, by adding a more generous cost-sharing protections, such as the $2,000 annual limit on out-of-pocket costs, than those envisioned under our recommendation, the redesign substantially shifted liabilities for drug spending from cost sharing paid by beneficiaries at the point of sale to plans (which increases both enrollee premiums and the premium subsidies paid by Medicare) while limiting some of plans' ability to apply formulary tools to manage enrollees' spending.

68 Part D plans can and often do offer alternative coverage structures to provide the basic Part D benefit. For example, a plan can offer a deductible that is lower than the deductible under the standard benefit or use tiered copayments rather than 25 percent coinsurance as long as the alternative benefit meets certain tests of actuarial equivalence.

69 In addition, the IRA lowered the catastrophic threshold to $2,000 from $8,000 in 2024. Manufacturers of drugs selected for the Medicare Drug Negotiation Program ("selected drugs") are exempt from manufacturer discount programs, including the 20 percent discount for prescriptions filled in the catastrophic phase of the benefit. For these selected drugs, Medicare provides a higher reinsurance protection (40 percent of catastrophic spending).

70 CMS requires plans to adjust their bids to remove any insurance effect of enhanced (supplemental) benefits on basic-benefit costs by applying an induced utilization factor to the expected basic-benefit costs. However, the effects of enhanced benefits on TrOOP that increase basic-benefit costs are not treated as insurance effect and are excluded from the induced utilization factor.

71 The income limit for the LIS is 150 percent of the federal poverty level, and the asset limit in 2026 is $16,590 if single and $33,100 if married. Enrollees qualifying for Medicaid or Supplemental Security Income are also eligible for the LIS. In 2026, individuals receiving the LIS pay up to $5.10 per prescription for generics and up to $12.65 for brand-name prescriptions.

72 Since Medicare does not subsidize benefits beyond basic Part D coverage, enrollees are responsible for paying the full cost of supplemental benefits charged by plans in supplemental premiums.

73 In a given year, plan sponsors might discontinue some or all plans, and data from these plans would not be included in the BPT for that year. For example, plans that are not offered in 2026 will not appear in the 2026 BPT data even if the plan was offered in 2024. Likewise, plan sponsors may put together a bid for a new plan they intend to offer in the upcoming year; in this case, the plan's projections would be included in our analysis, but the plan would lack any historical data. However, CMS does require plans to crosswalk from prior plans to new ones since members of the prior plans would be expected to enroll in new plans. Thus, plans' projections of members in new plans will include some members previously enrolled in plans that terminated.

74 We exclude Medicare Medical Savings Account plans, MA private fee-for-service plans, Program of All-Inclusive Care for the Elderly plans, plans established through reasonable-cost reimbursement contracts under Section 1876(h) of the Social Security Act ("cost plans"), and employer group waiver plans. Special-needs plans (SNPs) submit bids, but these bids are excluded from the calculation of the direct subsidy and the national average premium. However, SNPs still receive direct-subsidy and premium payments based on those amounts. Unless otherwise noted, we include information from SNPs in our analysis.

75 We use projected member months from the bids to compute weighted averages because using enrollment from the previous June requires dropping any plans that were not in existence then (or that could not be cross walked).

76 Beginning in 2030, the BBP is required to compose at least 20 percent of the total basic-benefit cost (meaning that the year-over-year increase in the BBP may exceed 6 percent).

77 If an enrollee selects a plan that includes supplemental coverage, the enrollee must pay the full price (i.e., any supplemental premiums charged by plans) for the additional coverage (i.e., Medicare does not subsidize it).

78 Risk corridors kick in if costs deviate from a plan's bid by more than 5 percent. If the deviation is between 5 percent and 10 percent, Medicare shares the losses/gains equally. If the deviation is greater than 10 percent, Medicare incurs 80 percent of losses and recoups 80 percent of gains.

79 In 2025, CMS began applying separate normalization factors for PDPs and MA–PDs to adjust for the diverging risk-score trends in these two markets and to "more accurately reflect Part D costs in each of these two sectors" (Centers for Medicare & Medicaid Services 2024a). The agency noted that Part D's risk-adjustment model has historically overpredicted costs for MA–PDs and underpredicted costs for PDPs. The separate normalization factors are intended to fix these prediction errors by increasing PDP risk scores and decreasing MA–PD risk scores while maintaining a 1.0 risk score across all enrollees.

80 For these selected drugs, Medicare provides higher reinsurance protection (40 percent of catastrophic spending). The IRA also introduced the Selected Drug Subsidy Program whereby CMS provides a subsidy to plans of 10 percent of the negotiated price under the catastrophic threshold for drugs selected for negotiation.

81 To estimate the amount of change by payer source between 2025 and 2026, we applied the 2026 payer-source shares to 2025 spending (net of rebates and supplemental cost sharing). We then compare these simulated amounts with 2025 amounts from 2025 payer-source shares. The difference is our estimate of the amount attributable to each payer source that was shifted into (or out of) the bid. The residual difference after accounting for all the payer sources is our estimate of the growth in overall spending that increased the bid. The same method is used to estimate the change by payer source between 2024 and 2025.

82 On average in 2024, spending net of rebates and supplement cost sharing was $309 PMPM (Figure 13-A3, p. 524). However, based on 2022 experience, plans had projected $270 PMPM. This difference suggests that plans, on average, underpredicted 2024 spending by approximately $39 PMPM. Note that the bid data do not include information from plans that are not participating in the upcoming years (plans that terminated).

83 Manufacturers of drugs selected that are subject to the maximum fair price (MFP) under the Medicare Drug Price Negotiation Program are not subject to the new MDP. CMS will make separate payments to plans for the MDP below the annual OOP limit, while Medicare's reinsurance payments will be increased to pay for the portion of the MDP above the annual OOP limit. As a result, some of the increase in the expected reinsurance reflects the increase in reinsurance payments from the effectuation of MFPs in 2026.

84 Before 2025, TrOOP spending excluded beneficiary cost sharing paid by most sources of supplemental coverage, though it included the 70 percent discount that manufacturers of brand-name drugs were required to pay in the coverage gap.

85 Medicare's premium subsidy pays for most or all premiums for low-income beneficiaries.

86 CMS's Part D Premium Stabilization Demonstration lowered premiums by up to $15 in 2025 and up to $10 in 2026 for PDPs. It also capped total (basic plus supplemental) premium growth by $35 in 2025 and $50 in 2026. The $12 reflects the effects of both components of the demonstration on the basic premiums for PDPs.

87 Our June 2025 report to the Congress discusses trends in the PDP and MA–PD markets leading to differences in premiums and risk-standardized costs (Medicare Payment Advisory Commission 2025c).

88 Enrollment weights are based on June enrollment for the year when bids are submitted; for example, June 2025 enrollment is used for plan year 2026 benchmark calculations, based on each plan's LIS enrollment relative to all LIS-eligible individuals in the region. While SNPs are not included in the calculation of the national average monthly bid amount (NAMBA), they are included for purposes of calculating regional benchmarks. Bids submitted by MA private-fee-for-service plans, the Program for All-Inclusive Care for the Elderly plans, and cost plans are excluded from this calculation; employer group waiver plans do not submit bids and therefore do not affect the calculation of the benchmark.

89 The LIS-weighted premiums are calculated before the application of the Part D Premium Stabilization Demonstration and any MA rebate buydowns.

90 The lower of the LIPSA or plans' premiums after the application of the Part D Premium Stabilization Demonstration or Part C rebate buydowns is the premium subsidy paid by Medicare on behalf of the LIS enrollee.

91 Auto-enrollment only applies to FFS beneficiaries because any LIS beneficiary enrolled in MA has actively chosen an MA plan.

92 This two-year ban applies when an insurer terminates all plan benefit packages in a PDP region and is intended to promote market stability. (See CFR Sec. 423.507(a)(3) and 423.508(e) for more detail.)

93 See Endnote 92.

94 Interviewees were referring to CMS's projection that the average total premium for PDPs would decrease from $38.31 in 2025 to $34.50 in 2026 (a decrease of $3.81) (Centers for Medicare & Medicaid Services 2025e).

References

46Brooklyn. 2025. A quarterly-ish review of U.S. drug price changes. https://www.46brooklyn.com/news/drug-prices-on-review-april-to-jul-2025.

Abelson, R., and R. Robbins. 2024. The powerful companies driving local drugstores out of business. *New York Times*, October 19.

Anderson-Cook, A., and R. G. Frank. 2025. *Estimated savings from year two of the IRA Prescription Drug Negotiation Program.* Los Angeles, CA: USC Schaeffer/Brookings.

Anderson, K. E., M. Sahu, M. J. DiStefano, et al. 2024. Pharmacy closures and anticonvulsant medication prescription fills. JAMA 332, no. 21 (December 3): 1847–1849.

Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. 2024. *Medicare Part D enrollee out-of-pocket spending: Recent trends and projected impacts of the Inflation Reduction Act*. Washington, DC: ASPE. https://aspe.hhs.gov/sites/default/files/documents/1b652899fb99dd7e6e0edebbcc917cc8/aspe-part-d-oop.pdf.

Assistant Secretary for Planning and Evaluation, Department of Health and Human Services. 2023. *Changes in the list prices of prescription drugs*, 2017–2023. Washington, DC: ASPE. https://aspe.hhs.gov/sites/default/files/documents/0cdd88059165eef3bed1fc587a0fd68a/aspe-drug-price-tracking-brief.pdf.

Avalere. 2022. *Drug pricing bill could reduce manufacturer revenue by over* $450B. https://avalere.com/insights/drug-pricing-bill-could-reduce-manufacturer-revenue.

Avalere. 2021. *Trends in Part D program spending: Stable premiums & rising reinsurance costs*. https://advisory.avalerehealth.com/wp-content/uploads/2021/06/Direct-Subsidy-Blog_Revised_Avalere-White-Paper.pdf.

Berenbrok, L. A., M. Murphy, and S. Herbert. 2025. Community pharmacies are closing. Here's what to do if your neighborhood location does too. *PBS News*, February 22.

BGR Group. 2024. Announcement of 2025 Part D premium and bid information, Premium Stabilization Demonstration. https://bgrdc.com/wp-content/uploads/2024/07/2024.07.31-Policy-Update-2025-Part-D-Announcement.pdf.

Boards of Trustees, Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. 2025. *The 2025 annual report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds*. Washington, DC: Boards of Trustees. https://www.cms.gov/oact/tr/2025.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2026. Fact Sheet: Medicare Part D inflation rebates for October 1, 2022–September 30, 2023 & October 1, 2023–September 30, 2024. https://www.cms.gov/files/document/medicare-part-d-inflation-rebates-fact-sheet-ap1-ap2.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025a. 2026 Medicare Part D bid information and Part D Premium Stabilization Demonstration parameters. https://www.cms.gov/newsroom/fact-sheets/2026-medicare-part-d-bid-information-and-part-d-premium-stabilization-demonstration-parameters.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025b. CAHPS survey national response rates. https://www.ma-pdpcahps.org/globalassets/ma-pdp/comparative-data/2025/current-and-historic-cahps-overall-response-rates.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025c. Fact sheet: 2026 Medicare Advantage and Part D star ratings. https://www.cms.gov/files/document/2026-star-ratings-fact-sheet.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025d. How much does Medicare drug coverage cost? https://www.medicare.gov/health-drug-plans/part-d/basics/costs.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025e. Medicare Advantage and Medicare Prescription Drug programs expected to remain stable in 2026. https://www.cms.gov/newsroom/press-releases/medicare-advantage-medicare-prescription-drug-programs-expected-remain-stable-2026.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025f. Medicare Drug Price Negotiation Program: Negotiated prices for initial price applicability year 2027. https://www.cms.gov/files/document/fact-sheet-negotiated-prices-ipay-2027.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025g. Medicare program; contract year 2027 policy and technical changes to the Medicare Advantage and Medicare Prescription Drug benefit program, and Medicare Cost Plan Program. Proposed rule. *Federal Register* 90, no. 227 (November 28): 54894–55030.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2025h. Memo to Medicare Advantage organizations, prescription drug plan sponsors, and other interested parties regarding the announcement of calendar year (CY) 2026 Medicare Advantage (MA) capitation rates and Part C and Part D payment policies. April 7. https://www.cms.gov/files/document/2026-announcement.pdf.

Centers for Medicare & Medicaid Services. 2024a. Advance notice of methodological changes for calendar year (CY) 2025 for Medicare Advantage (MA) capitation rates and Part C and Part D payment policies. https://www.cms.gov/files/document/2025-advance-notice.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024b. CMS releases 2025 Medicare Part D bid information and announces Premium Stabilization Demonstration. https://www.cms.gov/newsroom/fact-sheets/cms-releases-2025-medicare-part-d-bid-information-and-announces-premium-stabilization-demonstration.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024c. Medicare Drug Price Negotiation Program: Negotiated prices for initial price applicability year 2026. https://www.cms.gov/files/document/fact-sheet-negotiated-prices-initial-price-applicability-year-2026.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024d. Memo to all Medicare Advantage organizations and Medicare Prescription Drug Plan sponsors regarding the annual release of Part D national average monthly bid amount and other Part C & D bid information. https://www.cms.gov/files/document/july-29-2024-parts-c-d-announcement.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024e. Memo to Medicare Advantage organizations, prescription drug plan sponsors, and other interested parties regarding announcement of calendar year (CY) 2025 Medicare Advantage capitation rates and Part C and Part D payment policies. https://www.cms.gov/files/document/2025-announcement.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2024f. Memorandum from Meena Seshamani to interested parties re: Medicare prescription payment plan: Final Part One guidance on select topics, implementation of Section 1860D–2 of the Social Security Act for 2025, and response to relevant comments. February 29. https://www.cms.gov/files/document/medicare-prescription-payment-plan-final-part-one-guidance.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023a. 2025 Part D risk adjustment model update user group. https://www.csscoperations.com/internet/csscw3_files.nsf/F2/PtDUserGroupSlideDeck_20230914_508.pdf/$FILE/PtDUserGroupSlideDeck_20230914_508.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2023b. Announcement of calendar year (CY) 2024 Medicare Advantage (MA) capitation rates and Part C and Part D payment policies. https://www.cms.gov/files/document/2024-announcement-pdf.pdf.

Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2021. Memo to all Part D plans regarding contract year (CY) 2022 Part D pricing data submission guidance. May 28. https://www.cms.gov/files/document/cy2022drugpricingsubmissionguidelines05282021final.pdf.

Chandra, A., E. Flack, and Z. Obermeyer. 2024. The health costs of cost sharing. *Quarterly Journal of Economics* 139, no. 4 (November): 2037–2082.

Cline, M., M. Gill, and K. Pierce. 2025a. *MOOP there it is: In 2025, Part D beneficiaries are spending $1,200 on average to satisfy the $2,000 out-of-pocket maximum*. Seattle, WA: Milliman. https://www.milliman.com/en/insight/moop-2025-part-d-beneficiaries-spending.

Cline, M., R. Madden, and K. Holcomb. 2025b. Part D Trend insights: 2024 trend analysis reveals sharp increase in specialty drug utilization among non-low income beneficiaries. Seattle, WA: Milliman. https://www.milliman.com/en/insight/part-d-trend-insights-analysis-specialty-drug-utilization.

Cline, M., H. Rogers, and J. Karcher. 2024. *Breaking bid: What just happened?* Seattle, WA: Milliman. https://www.milliman.com/-/media/milliman/pdfs/2024-articles/9-18-24_breaking-bid-what-just-happened.ashx?la=en&hash=C0B1F26D572F6B7CEC3AF19D21555D5B.

Cline, M., and D. M. Liner. 2024. *Navigating new waters: How the Inflation Reduction Act alters government funding for Medicare Part D*. Seattle, WA: Milliman. https://www.milliman.com/en/insight/navigating-new-waters-inflation-reduction-act-medicare-part-d.

Collin, D., J. Hamilton, and J. Klaisner. 2025. *Continued concentration and sustained stabilization: A 2026 Medicare Prescription Drug plan market overview*. Seattle, WA: Milliman.

Congressional Budget Office. 2022. *Estimated budgetary effects of Public Law 117–169, to provide for reconciliation pursuant to Title II of S. Con. Res. 14*. Washington, DC: CBO. https://www.cbo.gov/system/files/2022-09/PL117-169_9-7-22.pdf.

Coster, J. M. 2025. *Operational and policy considerations in the effectuation of Medicare's maximum fair drug prices for Part D*. Los Angeles, CA: USC Schaeffer/Brookings. https://schaeffer.usc.edu/research/medicare-drug-prices-mfp-effectuation/.

Dusetzina, S., A. D. Zuckerman, N. L. Keating, et al. 2024. Medicare Part D's new prescription payment plan may not reduce costs for all. *Health Affairs Forefront*, February 8. https://www.healthaffairs.org/content/forefront/medicare-part-d-s-new-prescription-payment-plan-may-not-reduce-costs-all.

Fein, A. 2018. Building a new drug wholesaler compensation model: What happens as brand inflation slows? *Drug Channels* blog. July 24. https://www.drugchannels.net/2018/07/building-new-drug-wholesaler.html.

Feldman, R. 2018. Perverse incentives: Why everyone prefers high drug prices—except for those who pay the bills. *Harvard Journal on Legislation* 303. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3162432.

Feller, M., M. Gill, and K. Pierce. 2025. *MOOP there it is: In 2025, Part D beneficiaries are spending $1,200 on average to satisfy the $2,000 out-of-pocket maximum*. Seattle, WA: Milliman. https://www.milliman.com/en/insight/moop-2025-part-d-beneficiaries-spending.

Feller, M., R. Madden, K. Holcomb, et al. 2026. *Milliman MedIntel Part D trend insights*. Seattle, WA: Milliman.

Filson, D., K. Van Nuys, D. Lakdawalla, et al. 2025. *The elasticity of pharmaceutical innovation: How much does revenue drive new drug development?* Los Angeles, CA: USC Schaeffer/Brookings.

Garthwaite, C., and F. Morton. 2017. Perverse market incentives encourage high prescription drug prices. *ProMarket* blog. November 1. https://promarket.org/perverse-market-incentives-encourage-high-prescription-drug-prices/.

Gassull, D., H. Bowen, and D. Schulthess. 2023. IRA's impact on the U.S. biopharma ecosystem. https://vitaltransformation.com/wp-content/uploads/2023/10/VT-BIO_IRA_v14.pdf.

Girvan, G. 2022. *Medicare drug price negotiation is having a minimal impact on pharma R&D*. Washington, DC: Foundation for Research on Equal Opportunity.

Greenwalt, L., and R. Glass. 2025. Obesity deep dive: The unparalleled launch success of Mounjaro and Zepbound. Parsippany, NJ: IQVIA. https://www.iqvia.com/locations/united-states/blogs/2025/09/obesity-deep-dive-the-unparalleled-launch-success-of-mounjaro-and-zepbound.

Guadamuz, J. S., G. C. Alexander, G. P. Kanter, et al. 2024. More U.S. pharmacies closed than opened in 2018–21; Independent pharmacies, those in Black, Latinx communities most at risk. *Health Affairs* 43, no. 12 (December): 1703–1711.

Ippolito, B., and B. Vabson. 2024. *How do prescription drug benefits differ between Medicare Advantage and stand-alone Part D drug plans?* Washington, DC: The AEI Press. https://www.aei.org/research-products/report/how-do-prescription-drug-benefits-differ-between-medicare-advantage-and-stand-alone-part-d-drug-plans/.

Joyce, G., B. Blaylock, J. Chen, et al. 2024. Medicare Part D plans greatly increased utilization restrictions on prescription drugs, 2011-20. *Health Affairs* 43, no. 3 (March): 391–397.

Kakani, P., M. A. Kyle, A. Chandra, et al. 2024. Medicare Part D protected-class policy is associated with lower drug rebates. *Health Affairs* 43, no. 10 (October): 1420–1427.

Karcher, J., J. Magnusson, and M. Robb. 2024. *Out of whose pocket? Many beneficiaries will spend less than expected to reach the IRA's new $2,000 out-of-pocket spending limit*. Seattle, WA: Milliman. https://www.milliman.com/en/insight/out-of-whose-pocket-inflation-reduction-act.

Le, L. M., S. K. Veettil, D. Donaldson, et al. 2022. The impact of pharmacist involvement on immunization uptake and other outcomes: An updated systematic review and meta-analysis. *Journal of the American Pharmacists Association* 62, no. 5 (September–October): 1499–1513 e1416.

Liu, L., and Centers for Medicare & Medicaid Services. 2025. Personal communication with author. December 12.

Mathews, A. W., and L. E. Whyte. 2025. Medicare Part D drug plan premiums set to rise. *Wall Street Journal*, July 28.

Medicare Payment Advisory Commission. 2025a. *A data book: Health care spending and the Medicare program*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2025/07/July2025_MedPAC_DataBook_SEC.pdf.

Medicare Payment Advisory Commission. 2025b. *Payment basics: Part D payment system*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2024/10/MedPAC_Payment_Basics_25_PartD_FINAL_SEC.pdf.

Medicare Payment Advisory Commission. 2025c. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2025d. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2023. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2022. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2021. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2020a. Improving competition among Part D's benchmark plans. Presentation at the Commission's November public meeting. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/meeting-materials/part-d-benchmark-plans-medpac-nov-2020.pdf.

Medicare Payment Advisory Commission. 2020b. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Medicare Payment Advisory Commission. 2019. Comment letter on CMS's notice of proposed rulemaking entitled "Modernizing Part D and Medicare Advantage to lower drug prices and reduce out-of-pocket expenses." January 16.

Medicare Payment Advisory Commission. 2016. *Report to the Congress: Medicare and the health care delivery system.* Washington, DC: MedPAC.

Morning Consult. 2025. Memorandum to Healthcare Leadership Council regarding views on policy implications. https://static1.squarespace.com/static/65f213684db2716417d00bb0/t/6900e85cf6a3622fbce3d0cd/1761667164374/2509021_HLC_Seniors+on+Medicare_Policy+Memo.pdf.

Morning Consult. 2024. Memorandum to Healthcare Leadership Council re: Perceptions of care and policy implications. https://static1.squarespace.com/static/65f213684db2716417d00bb0/t/66d876760c0ed5568b4e9a7f/1725462134237/2024+Senior+Satisfaction+Survey_MEMO.pdf.

National Community Pharmacists Association. 2025. *Policy summary: ASCP and NCPA's recommendations to manufacturers to effectuate Medicare's maximum fair price (MFP) for pharmacies with material cash flow concerns.* Alexandria, VA: NCPA. https://www.ncpa.co/pdf/2025/advocacy/ncpa-ascp-abridged-recommendations-manufacturers.pdf.

Niyogi, S., and R. Glass. 2025. *The upside of the IRA: $0 catastrophic cost-sharing and patient benefits.* Parsippany, NJ: IQVIA. https://www.iqvia.com/locations/united-states/blogs/2025/01/the-upside-of-the-ira.

NORC at the University of Chicago. 2025. *Beneficiary and clinician perspectives on Medicare and other issues: Findings from 2025 focus groups in St. Louis, Missouri, and 2021–2025 rural focus groups.* Report prepared by staff from NORC at the University of Chicago for the Medicare Payment Advisory Commission. Bethesda, MD: NORC.

NORC at the University of Chicago. 2024. *Beneficiary and clinician perspectives on Medicare and other issues: Findings from 2024 focus groups in select states*. Report prepared by staff from NORC at the University of Chicago for the Medicare Payment Advisory Commission. Chicago, IL: NORC.

Philipson, T. J., Y. Ling, R. Chang, et al. 2023. *Policy brief: The potentially larger than predicted impact of the IRA on small molecule R&D and patient health.* Chicago, IL: University of Chicago. https://bpb-us-w2.wpmucdn.com/voices.uchicago.edu/dist/d/3128/files/2023/08/Small-Molecule-Paper-Aug-25-2023.pdf.

Qato, D. M., G. C. Alexander, A. Chakraborty, et al. 2019. Association between pharmacy closures and adherence to cardiovascular medications among older U.S. adults. *JAMA Network Open* 2, no. 4 (April 5): e192606.

Rad, J., and G. J. Melendez-Torres. 2025. Critical discourse analysis of social media advertisements for GLP-1 receptor agonist weight loss drugs: Implications for public perceptions and health communication. *BMC Public Health* 25, no. 1 (September 1): 2996.

Robb, M., J. J. Petroske, and D. I. Rodrigues. 2024. *A prescription for change: How the 2025 Medicare Part D risk adjustment (RxHCC) model overhaul will affect risk scores.* Seattle, WA: Milliman. https://www.milliman.com/en/insight/prescription-for-change-2025-medicare-part-d-risk-adjustment-model.

Schmidt, R., and C. Graham. 2025. *What to know about CMS's announcement that it plans to terminate VBID.* Washington, DC: Georgetown University. https://medicare.chir.georgetown.edu/what-to-know-about-cmss-announcement-that-it-plans-to-terminate-vbid/.

Sood, N., K. Mulligan, and K. Zhong. 2021. Do companies in the pharmaceutical supply chain earn excess returns? *International Journal of Health Economics and Management* 21, no. 1 (March): 99–114.

Sood, N., M. Ribero, M. Ryan, et al. 2020. *The association between drug rebates and list prices.* Los Angeles, CA: USC Schaeffer, Leonard D. Schaeffer Initiative for Innovation in Health Policy & Economics.

Span, P. 2024. As drugstores close, older people are left in "pharmacy deserts." *New York Times*, December 21.

Sparks, G., A. Kirzinger, I. Valdes, et al. 2024. *KFF health tracking poll September 2024: Support for reducing prescription drug prices remains high, even as awareness of IRA provisions lags.* Washington, DC: KFF. https://www.kff.org/medicare/kff-health-tracking-poll-september-2024-support-for-reducing-prescription-drug-prices-remains-high/.

Stengel, K., A. Tripp, Y. He, et al. 2025. *Part D choices continue to shrink with fewer PDPs in 2026.* Washington, DC: Avalere Health.

Stults, C. D., A. S. Baskin, M. K. Bundorf, et al. 2018. Patient experiences in selecting a Medicare Part D prescription drug plan. *Journal of Patient Experience* 5, no. 2 (June): 147–152.

Three Axis Advisors. 2025. *Unpacking the financial impacts of Medicare drug price negotiation: Analysis on pharmacy cash flows.* Prepared for National Community Pharmacists Association.

Weaver, C., T. McGinty, and A. W. Mathews. 2025. Pharmacies flood Medicare patients with $3 billion of extra drugs. *Wall Street Journal*, December 26.