

Examining drivers of recent changes in Part D bids after the implementation of the Inflation Reduction Act

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BACKGROUND

The Medicare Part D benefit is financed by Medicare (taxpayers), drug manufacturer discounts, and enrollee premiums and is administered by private plans. The Inflation Reduction Act of 2022 (IRA) redesigned the benefit and restructured how it is financed. Notably, it shifted Medicare's payments away from cost-based reinsurance to capitated direct subsidies for which plans bear insurance risk, restoring plans' incentives to manage benefit costs that were present at the start of the program. The law also reduced beneficiaries' cost sharing, improving affordability but likely increasing drug utilization and benefit liability—raising both enrollee premiums and Medicare payments to plans. The national average bid amount, a measure of plan benefit liability that determines Medicare's capitated direct subsidy, increased by 180% in 2025 and by an additional 33% in 2026.

RESEARCH OBJECTIVE

We estimate the relative contribution to the growth in the national average bid amount from shifts in financing of Part D drug costs (e.g., shifts from enrollee cost sharing to benefit liability and from cost-based reinsurance to the capitated direct subsidy) versus growth in expected spending (e.g., the underlying trend in the use of high-cost drugs such as GLP-1s)¹. We also examine how premiums have been affected by the growth in plans' bids.

METHODS

We use Part D plans' bid data from 2024 to 2026, CMS's landscape files, and Medicare enrollment data.² We decompose unstandardized spending, which reflects how plans construct bids prior to risk adjustment. We hold overall spending constant and allocate enrollees' projected spending to cost sharing, reinsurance, manufacturer discounts, and administrative costs before and after the redesign. Resulting dollar changes are used to estimate the financing shifts attributable to IRA's benefit redesign, while the residual increase in bid amounts is attributed to the growth in expected spending.

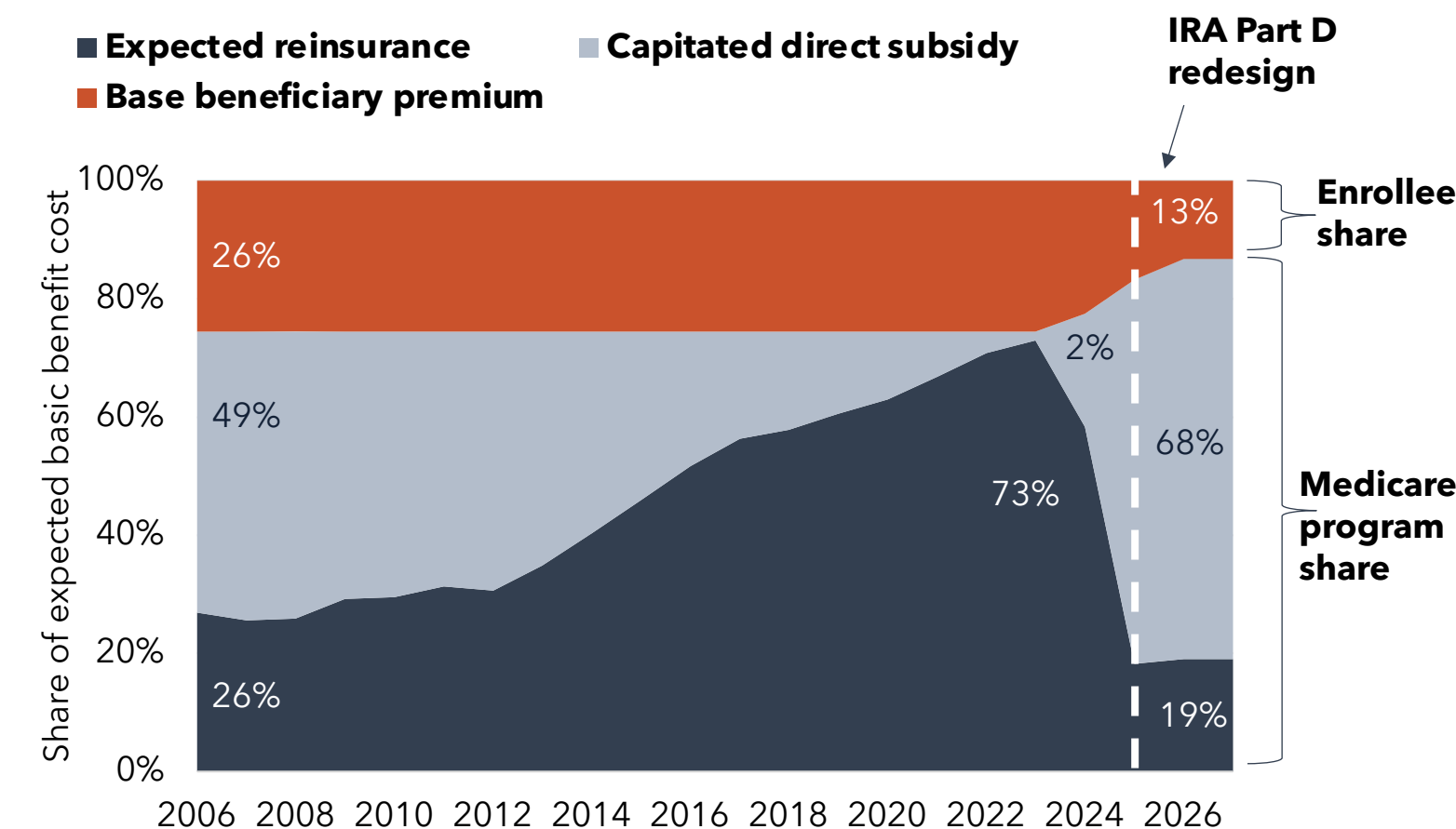
¹ GLP-1s refer to glucagon-like peptide-1 receptor agonists.

² Part D plans' bids for 2024 to 2026 are based on their enrollees' experience from 2022 to 2024 (two-year lag in data used by plans to compose bids).

PRINCIPAL FINDINGS

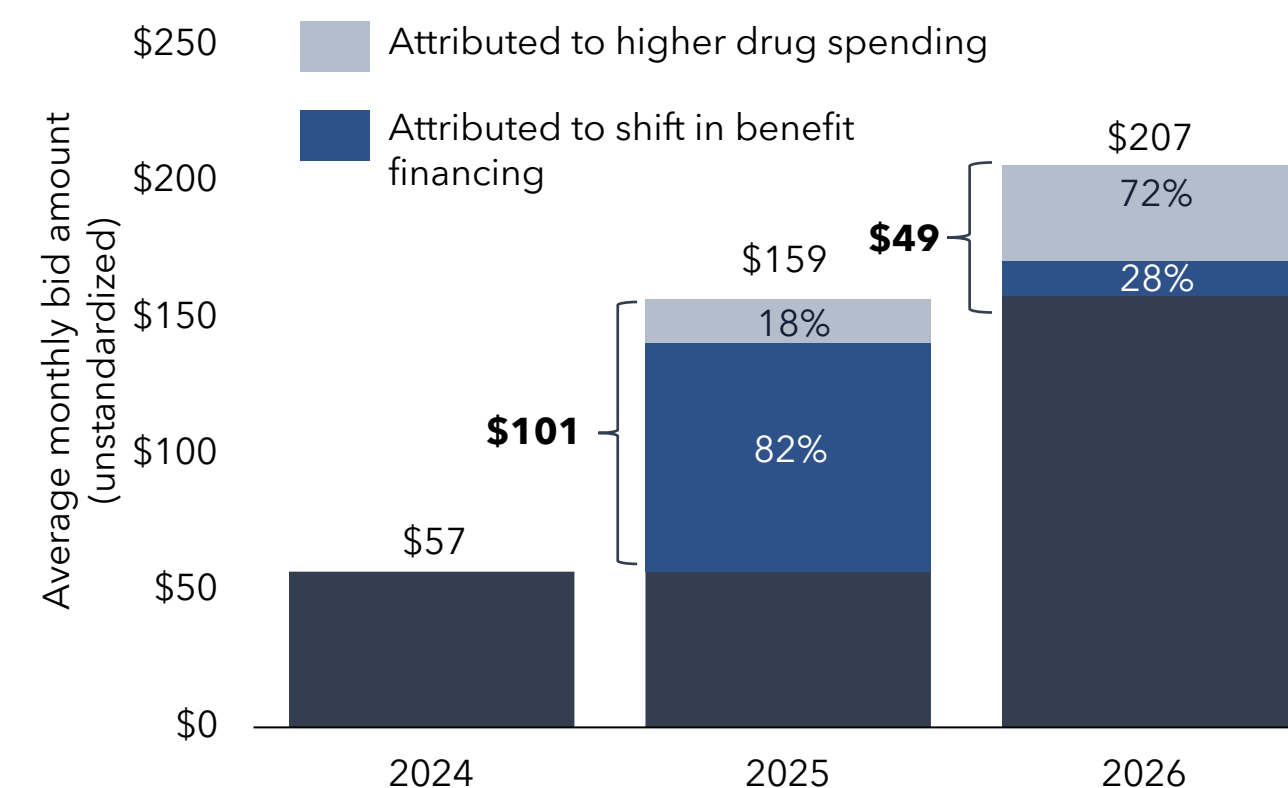
The IRA restored the role of capitated direct subsidy payments

- The direct subsidy amount is determined by plans' bids and is now the primary way Medicare pays for the Part D benefit



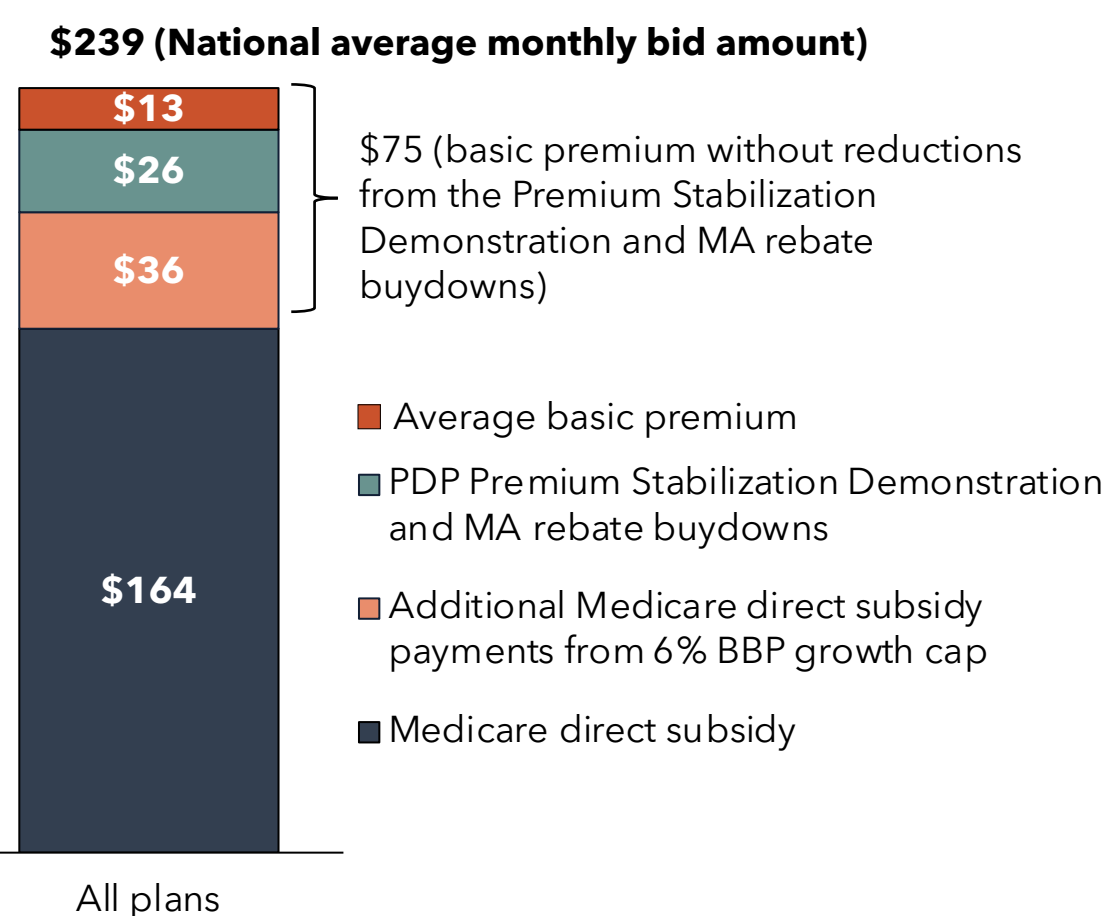
Part D plan bids increased from shifts in financing and increases in spending

- In 2025, most of the increase in average bids was attributed to the IRA's shifts in benefit financing
- In 2026, most of the increase was attributed to higher expected drug spending



Medicare policies reduced enrollee premiums and increased program spending, 2026

- In 2026, Part D's average basic premium is \$13, instead of the \$75 based on plan bids, due to the following policies:
 - Starting in 2024, the IRA capped the growth in base beneficiary premium (BBP) to no more than 6% (the BBP is the share of basic benefit costs paid for by enrollees, historically set in law to be 25.5%), shifting the difference to program spending
 - For 2025 and 2026, CMS implemented the Part D Premium Stabilization Demonstration, which lowered enrollee premiums and increased Medicare payments to participating PDPs
 - MA-PDs can use MA rebates to buydown Part D premiums
- Effects of these policies on individual plan premiums vary across plans and plan types (PDP vs. MA-PD)



Note: IRA (Inflation Reduction Act of 2022), PDP (prescription drug plan (stand-alone Part D plan)), MA-PD (Medicare Advantage prescription drug plans), MA (Medicare Advantage), BBP (base beneficiary premium). We exclude special-needs Part D plans since their bids are not included in the calculation of the national average monthly bid amount. For more information, please refer to MedPAC's March 2026 report to the Congress.

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

CONCLUSIONS

IRA provisions increased the generosity of the Part D benefit and shifted benefit financing to restore plans' incentives to manage enrollee spending. Our estimates show that while financing shifts accounted for rising average bids in 2025, higher expected spending accounted for most of the increase in average bids in 2026. This increase reflected plans' expectations about underlying trends in drug prices and utilization, induced demand from lower cost sharing, and continued uncertainty as IRA provisions are implemented. Rising benefit costs would increase enrollee premiums in the absence of Medicare policies that constrain premium growth, though most of these policies shift costs to the program.

IMPLICATIONS FOR POLICY AND PRACTICE

Policymakers should assess how the increased generosity and other changes to the Part D benefit affect beneficiaries' use of services, program spending, enrollee premiums, and the quality of pharmaceutical care. It is also important to closely monitor the stand-alone PDP market—particularly as temporary premium stabilization policies expire—to evaluate market stability and ensure that FFS beneficiaries have access to Part D drug coverage.

LIMITATIONS

Plans' bid projections, on which our analysis is based, may be subject to larger projection errors given the uncertainty as beneficiaries and plans adjust to IRA changes. The results shown in these figures represent averages, and variation exists across plans.

REFERENCES

Medicare Payment Advisory Commission. 2026. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC. https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch13_MedPAC_Report_To_Congress_SEC.pdf.

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