MEDPAC

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# Issues and potential policy directions in Part D

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# Topics covered in this presentation

1. Background
2. The Part D redesign's effects on bids, benefit costs, and premiums
3. Part D spending trends using newly available data
4. Drivers of Part D spending growth
5. Potential policy directions for addressing spending growth
6. Next steps and discussion

# Background

# In Part D, private insurers compete to deliver outpatient pharmacy benefits

- Plans accept insurance risk and provide outpatient prescription drug benefits
  - PDPs for FFS beneficiaries
  - MA–PDs, combined medical and prescription drug plan, for MA enrollees
- Medicare limits plans' insurance risk through reinsurance, risk corridors, and risk adjustment
- Plans and PBMs negotiate with:
  - Pharmacies for network contracts and payments for dispensed prescriptions
  - Pharmaceutical manufacturers for postsale rebates
- Benefit costs are borne by Medicare (taxpayers) and enrollees
  - Medicare subsidizes a substantial portion of benefit costs
  - Enrollees pay premiums and cost sharing

**Note:** PDP (stand-alone prescription drug plan), FFS (fee-for-service), MA–PD (Medicare Advantage–Prescription Drug [plan]), MA (Medicare Advantage), PBM (pharmacy benefit manager).

# What has worked well in Part D

- **High enrollment** among Medicare beneficiaries, with about 80% of Medicare beneficiaries enrolled in Part D plans
- **High satisfaction and good access to medications** reported in surveys and focus groups, likely, in part, due to broad formulary coverage
- **Good plan availability** with multiple plan options with varying premiums, benefit designs, and formularies, but declines in PDPs in recent years
- **Plans achieve high generic use**, accounting for 90% of prescriptions, which helps put downward pressure on prices, benefit costs, and premiums

**Note:** PDP (stand-alone prescription drug plan). Enrollment share excludes beneficiaries in employer-sponsored retiree drug plans receiving the retiree drug subsidy under Part D.

**Source:** https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch13_MedPAC_Report_To_Congress_SEC.pdf.

# Emerging challenges in Part D

- The benefit redesign reduced cost sharing and improved affordability for enrollees with high drug spending
- These changes have increased Part D benefit spending
  - Temporary policies to reduce premiums also increase Medicare spending
- Continued growth in benefit costs after these policies phase out could lead to substantial increases in enrollee premiums
- Higher benefit costs and premiums may affect the long-term stability of the Part D market, especially for PDPs

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

# The Part D redesign's effects on bids, benefit costs, and premiums

# The IRA's redesign includes key elements of the Commission's 2020 recommendations

- The Commission's recommendations sought to address:
  - Weakened plan incentives to manage spending as Medicare payments increasingly shifted from capitated to cost based
  - Access barriers for enrollees who need high-priced medicines
- Recommended increasing plan liability to improve plan incentives and providing financial protections to beneficiaries
- The redesign is directionally consistent with MedPAC recommendations:
  - Increased the role of capitated direct-subsidy payments, while reducing cost-based reinsurance
  - Eliminated the coverage gap and enhanced financial protection for enrollees with high spending

**Note:** IRA (Inflation Reduction Act of 2022).
**Source:** June 2020 Report to the Congress: Medicare and the Health Care Delivery System – MedPAC.

# The IRA introduced major changes to the Part D program

## 2023

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

## 2024

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

## 2025

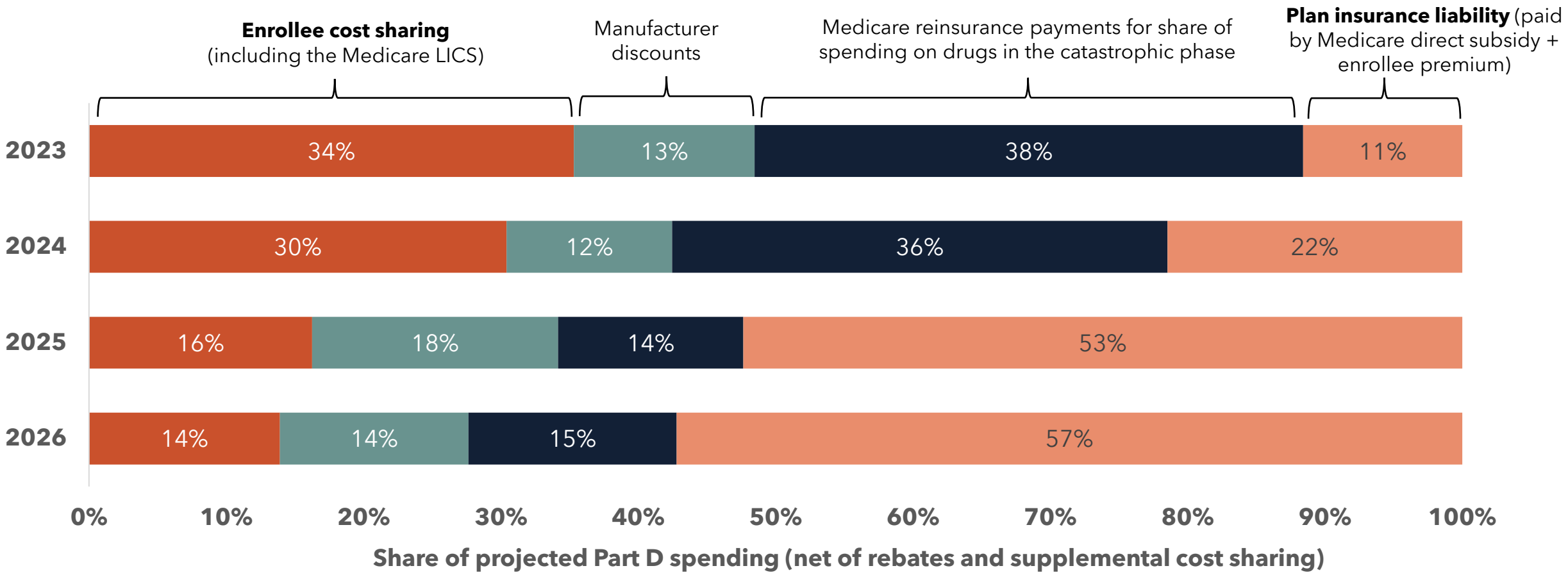
- **Benefit redesign reduced cost sharing, including lower OOP cap**
- **Increased the role of the capitated direct subsidy in financing Part D benefit costs**

## 2026

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

**Note:** IRA (Inflation Reduction Act of 2022), OOP (out-of-pocket), LIS (low-income subsidy), DIR (direct and indirect remuneration), POS (point of sale), MFP (maximum fair price). * The change in the Pharmacy DIR was a regulatory change implemented by the CMS.

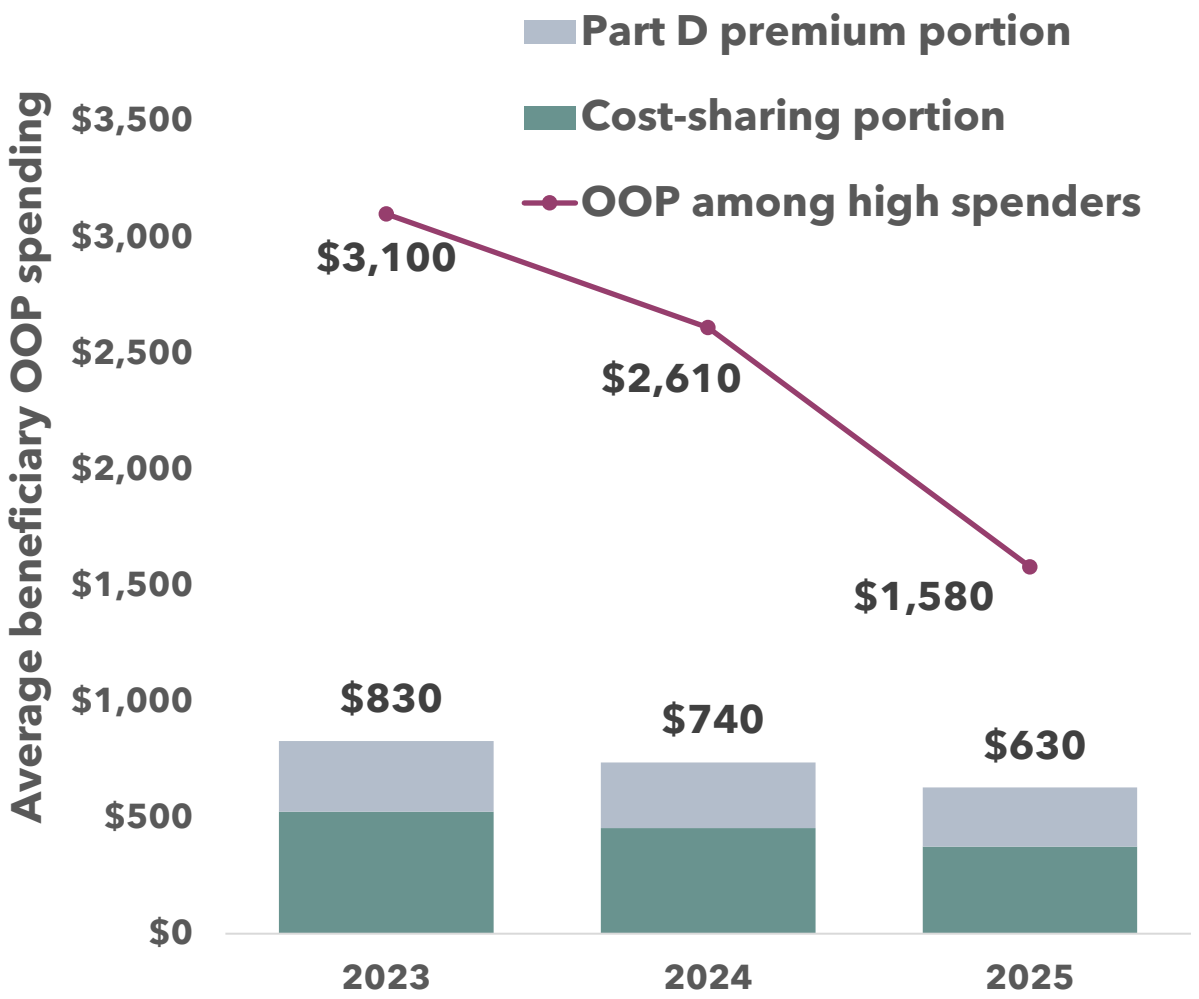
# IRA redesign capped and lowered enrollee cost sharing while increasing plan insurance liability




**Note:** IRA (Inflation Reduction Act of 2022). Shares based on plan's projections. Figure includes only plans used to calculate the national average monthly bid amount (i.e., excludes special needs plans and other "non-bidding" plans).

**Source:** Part D bid pricing tool data from CMS.

# Non-LIS enrollees' OOP spending declined from 2023 to 2025 (inflation-adjusted)

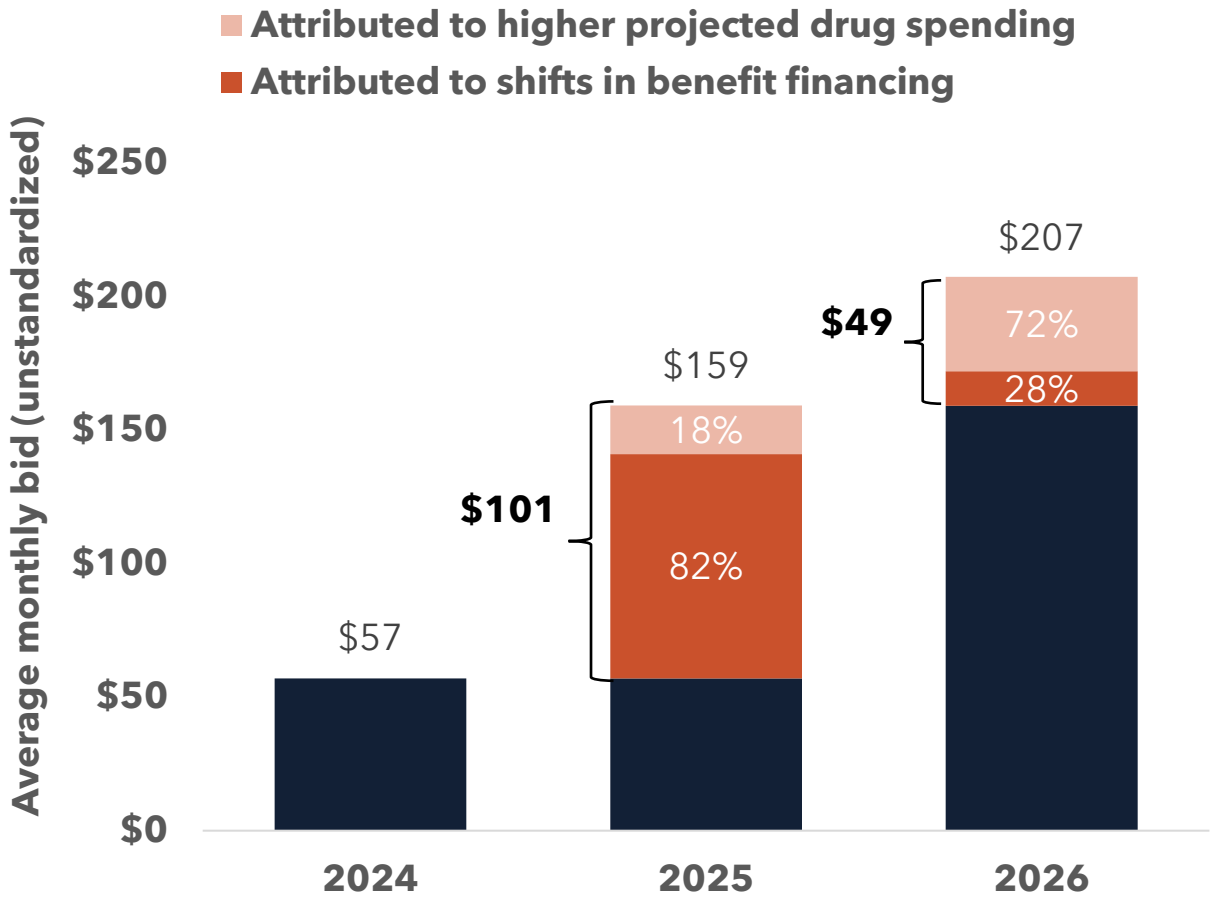



- OOP spending declined by $200 (25%), on average, from 2023 to 2025
  - Cost sharing declined by 30%
  - Premium spending by 16%
- Among high-spenders, OOP spending declined by 50%
- Over the same time, program spending per enrollee increased by 30% (data not shown)

**Note:** LIS (low-income subsidy). OOP (out-of-pocket), "Beneficiary OOP spending" is the sum of cost sharing plus and total Part D premiums paid OOP. "OOP among high spenders" is the average OOP spending among the top 10 percent highest-spending enrollees. Figures exclude LIS beneficiaries and those enrolled in employer group waiver plans. Spending reflects gross spending before retrospective rebates and discounts.

**Source:** MedPAC analysis of Part D prescription drug event (preliminary for 2025) and landscape data from CMS.

# Plan liability (Part D bids) rose due to shifts in financing and higher spending

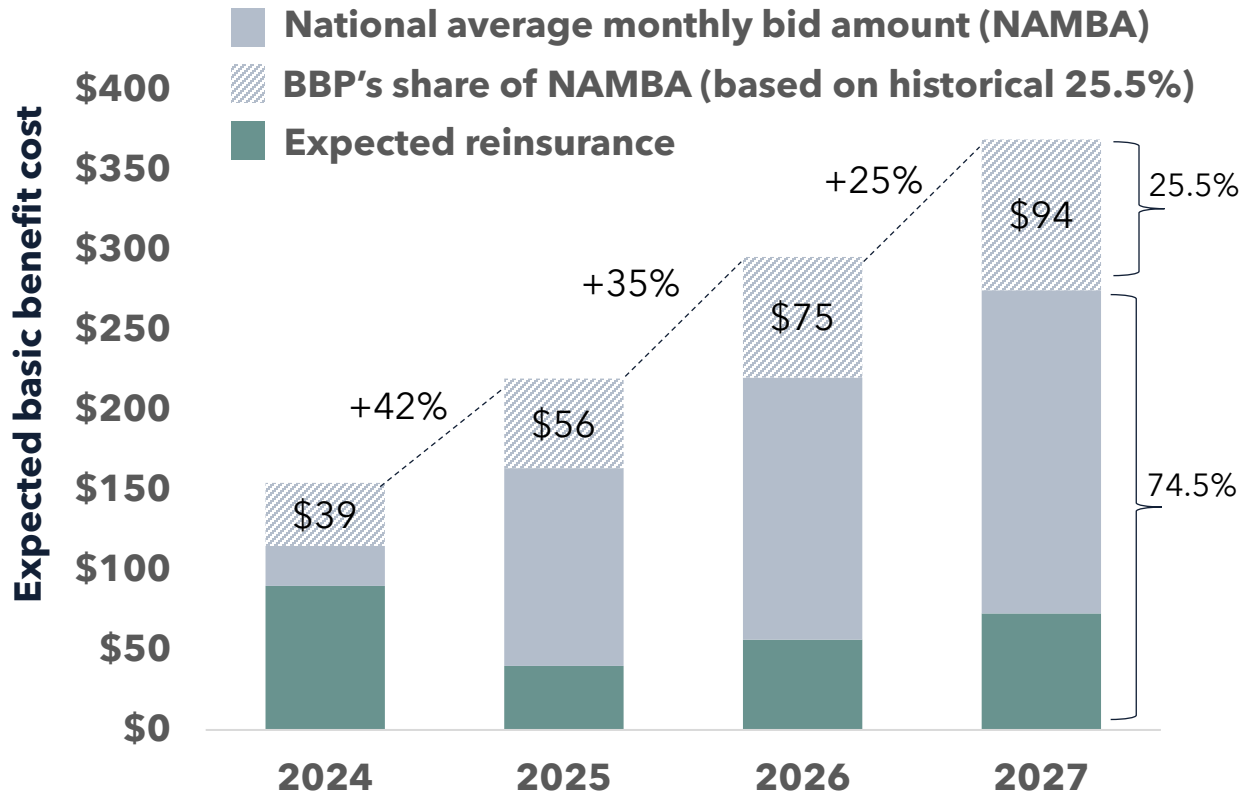



- We decomposed increases in average Part D bids using unadjusted spending projections reported by plans
  - In 2025, most of the increase in bids was attributed to the IRA's shifts in benefit financing
  - In 2026, most of the increase was attributed to higher expected drug spending
  - In both years, bids also reflected uncertainty regarding utilization growth under the redesigned benefit
- In 2027, plan bids continued to grow, by 24%, on average (data not shown)*

**Note:** IRA (Inflation Reduction Act of 2022). The dark bottom parts of the bars represent the average bid for 2024 and the prior year's average bids for 2025 and 2026. Figure excludes special-needs plans since their bids are not included in the calculation of the national average monthly bid amount. We used unadjusted spending amounts since this is how plans build their bids. For more information on how we attributed bid growth to shifts in benefit financing vs. higher projected drug spending, see March 2026 Report to the Congress (Chapter 13) https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch13_MedPAC_Report_To_Congress_SEC.pdf.
* https://www.cms.gov/newsroom/fact-sheets/medicare-part-d-2027-national-average-monthly-bid-amount-information
**Source:** Part D bid pricing tool data from CMS.

# Absent policy interventions, enrollee premiums would have been higher

- Basic benefit costs (average bids + expected reinsurance) rose sharply between 2024 and 2027
- Absent policy interventions, these increases would have raised enrollee premiums
  - Historically, the base beneficiary premium (BBP) amount was set to 25.5% of expected basic benefit costs
  - Enrollees' basic premiums would then increase with higher expected costs ($94 in 2027)




**Note:** The NAMBA is the sum of the capitated direct subsidy plus the average basic premium (or base beneficiary premium). The bid amount is standardized using plans' expected Part D risk scores. (In contrast, the prior slide showed unstandardized bids).

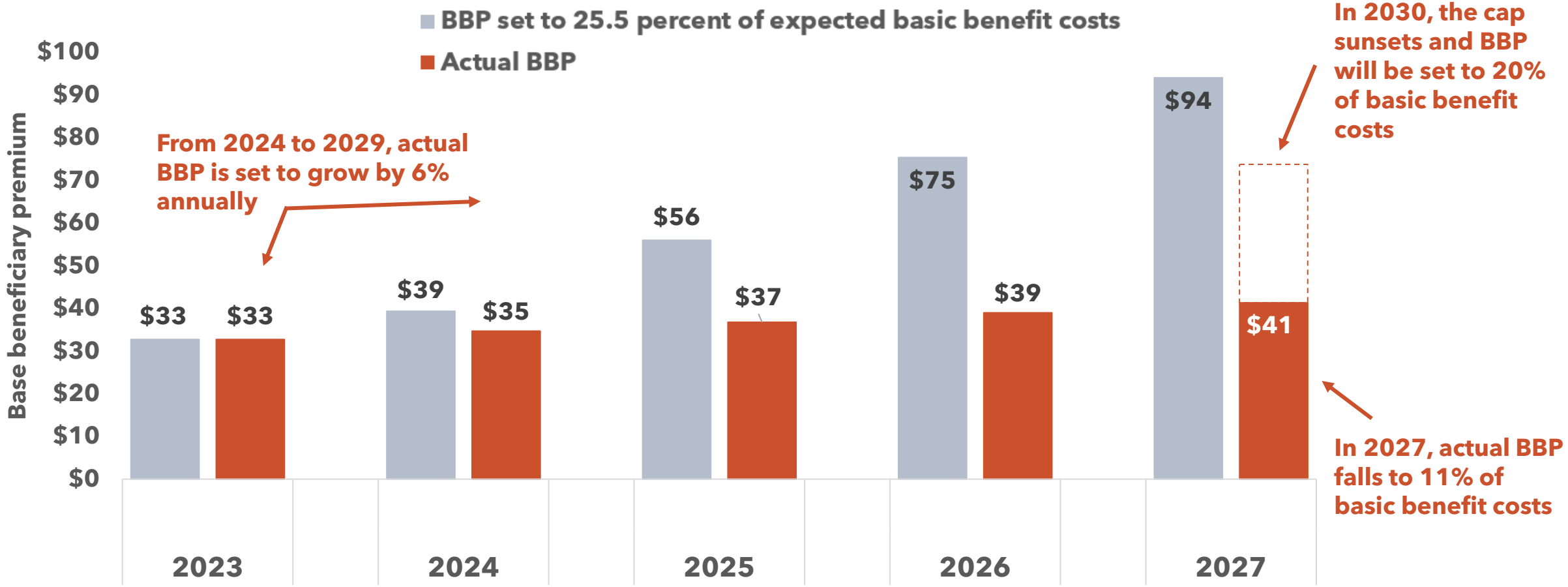
**Source:** CMS's bid announcements.

# Medicare program spending increased to maintain lower enrollee premiums

- The IRA capped annual growth in the BBP at 6%, increasing Medicare's direct subsidy costs by $33B (2024-2026)
- The Part D Premium Stabilization Demonstration lowered PDP premiums, increasing Medicare spending by $10.7B (2025-2026)[1]
- Impact on overall Medicare spending is lower than the summed $44 billion due to offsetting effects (e.g., lower low-income premium subsidy amount when premiums are lower)
- The BBP growth cap ends in 2029, and the Premium Stabilization Demonstration ends after 2026; premiums are expected to rise sharply in 2030

**Notes:** IRA (Inflation Reduction Act of 2022), BBP (base beneficiary premium), B (billion), PDP (stand-alone prescription drug plan). [1] Estimates were obtained from conversations with CMS and include projections of increased risk-corridor payments.

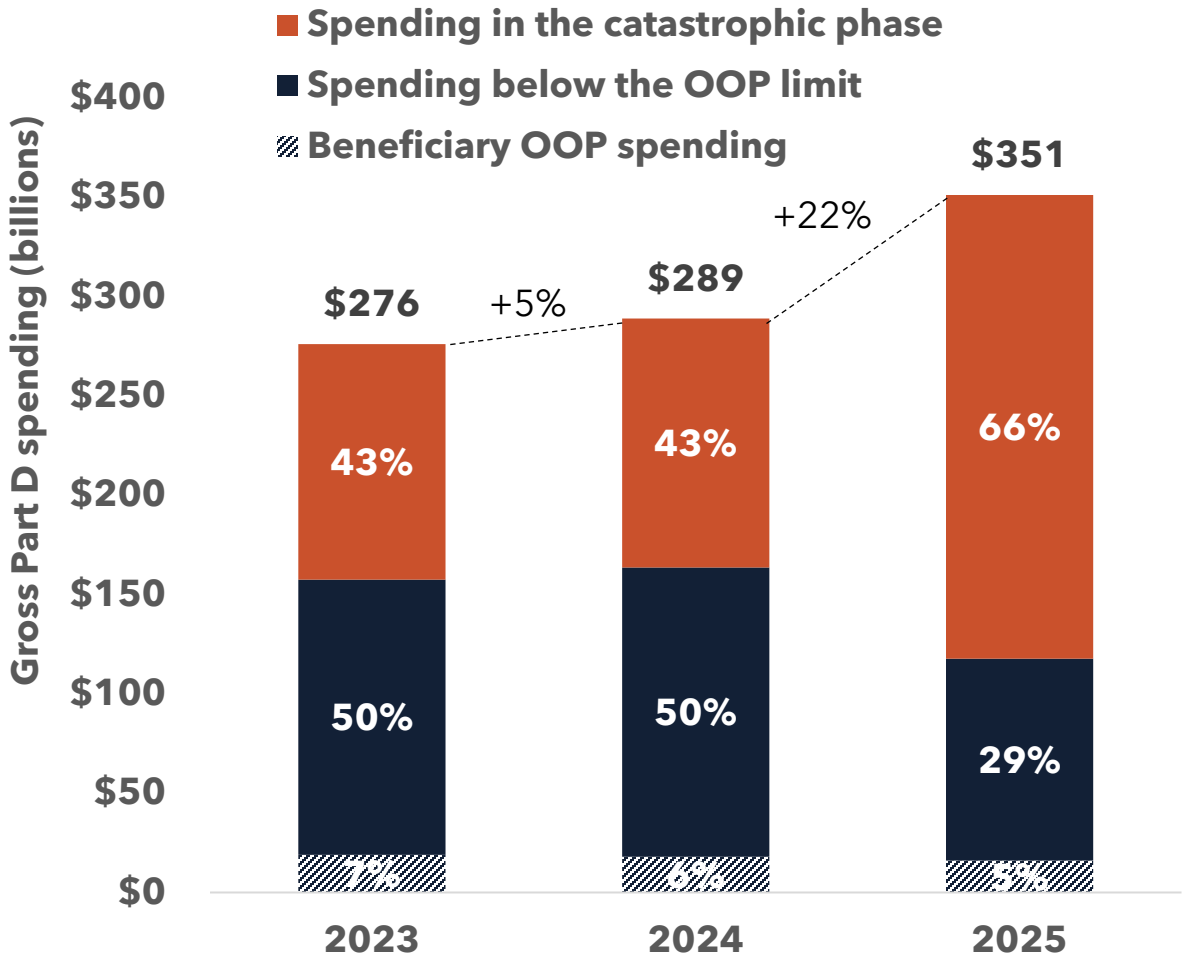
# Premiums are likely to rise sharply when the basic premium growth cap is sunset




**Note:** BBP (base beneficiary premium).
**Source:** MedPAC analysis of BBP amounts in CMS's announcements of Part D national average monthly bid amount.

# Part D spending trends using newly available data

# Gross spending increased sharply, with two-thirds of Part D spending above the OOP limit, in 2025




- High growth in spending to $351B
- Beneficiary OOP share fell to 5%
- Catastrophic spending as a share of total spending grew to 66%
  - Redesigned benefit was expected to increase spending in this phase
  - Majority of spending in 2025 not subject to any cost sharing

**Note:** OOP (out-of-pocket), Spending is gross spending before retrospective rebates and discounts. "Spending in the catastrophic phase" occurs when enrollees reach the OOP limit in the year. "Spending below the OOP limit" excludes beneficiary OOP spending shown in the bottom portion of the bars. See Figure 13-1 of the March 2026 Report to the Congress for how the benefit is financed below and above the OOP limit.

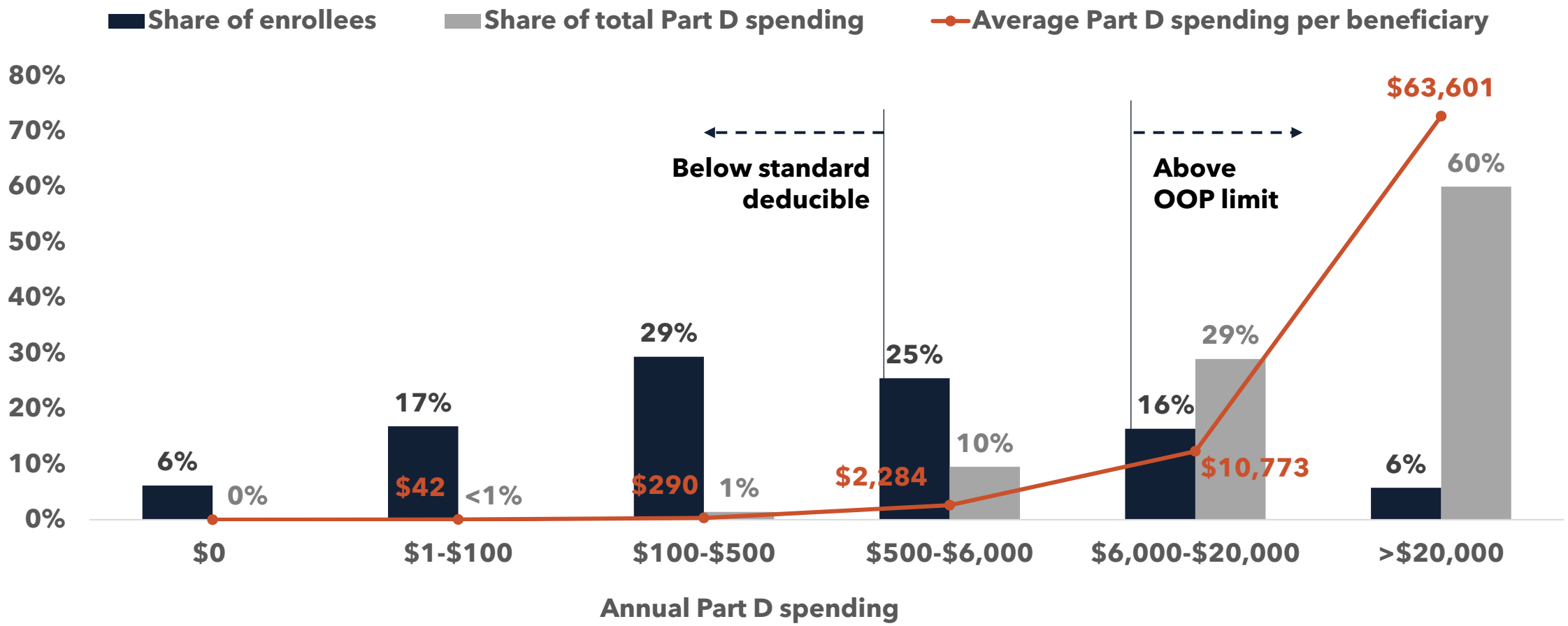
**Source:** MedPAC analysis of Part D prescription drug event data (preliminary for 2025) and Part D enrollment data from CMS.

# Increase in non-LIS enrollees reaching the OOP limit driving spending growth

| | Average gross spending per enrollee | | Average % of spending above the OOP limit | % of enrollees who reached the OOP limit |
|---|---|---|---|---|
| 2025 | $5,950 | 18% ↑ | 66% | 22% |
| 2024 | $5,050 | | 43 | 8 |
| **Non-LIS enrollees** | | | | |
| 2025 | $4,890 | 26% ↑ | 65 | 18 |
| 2024 | $3,870 | | 37 | 4 |
| **LIS enrollees** | | | | |
| 2025 | $8,650 | 10% ↑ | 69 | 30 |
| 2024 | $7,840 | | 51 | 16 |

**Note:** OOP (out-of-pocket), LIS (low-income subsidy). Spending reflects gross spending before retrospective rebates and discounts.
**Source:** MedPAC analysis of Part D prescription drug event data (preliminary for 2025) and Part D enrollment data from CMS.

# Top 6% of enrollees with highest spending composed 60% of Part D spending, 2025




**Note:** OOP (out-of-pocket). Spending reflects gross spending before retrospective rebates and discounts.
**Source:** MedPAC analysis of Part D prescription drug event (preliminary for 2025) and enrollment data from CMS.

# Double-digit spending growth observed across therapeutic classes, 2024-2025

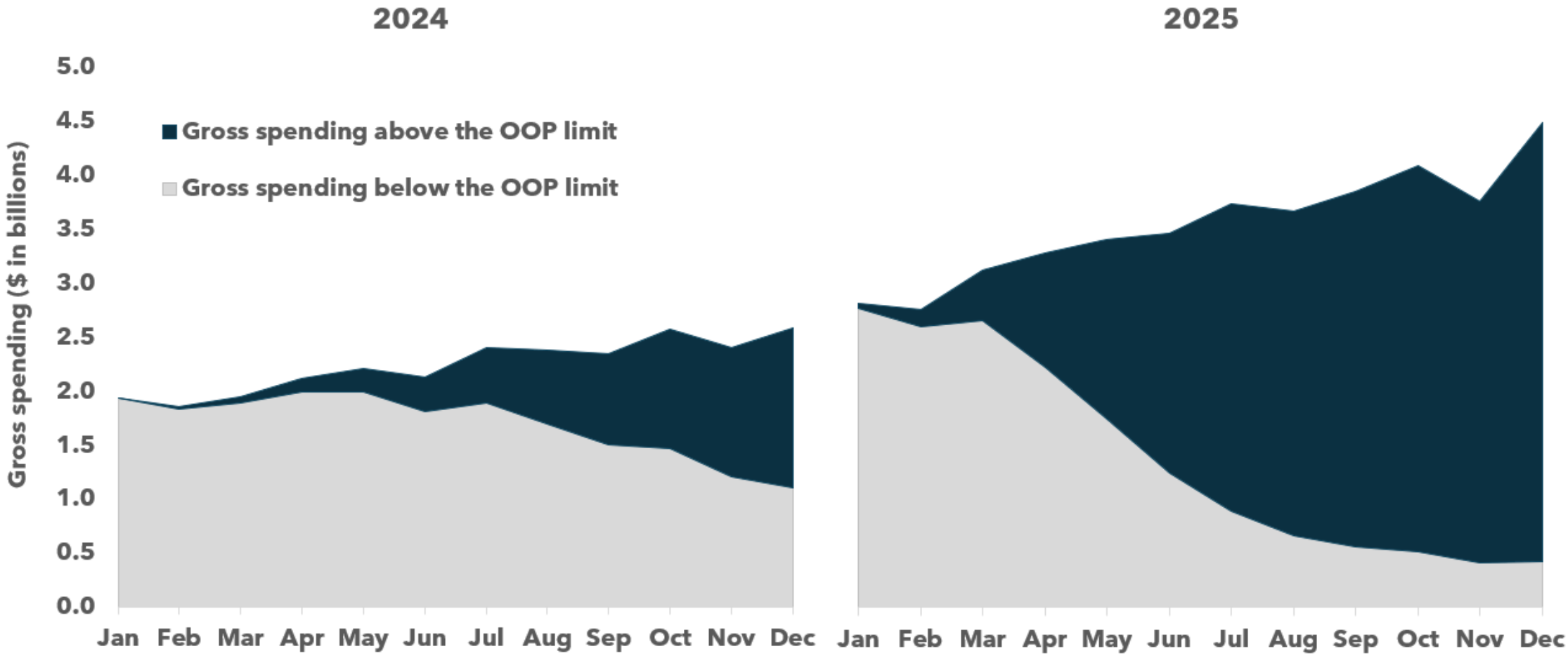
**Gross spending by select therapeutic class**
**(in billions)**

| Therapeutic class | 2024 | 2025 | Increase 2024-'25 |
|---|---|---|---|
| Antineoplastics | $43 | $56 | 32% |
| Injectable Antidiabetic Agents | 35 | 44 | 27 |
| Factor Xa Inhibitors | 27 | 31 | 13 |
| Oral Antidiabetic Agents | 25 | 28 | 12 |
| Asthma/COPD Therapy Agents | 16 | 18 | 11 |
| DMARD | 15 | 18 | 26 |
| Antivirals | 11 | 12 | 10 |
| Antipsoriatics | 9 | 12 | 38 |
| Antihyperlipidemics | 6 | 7 | 19 |
| Anti-Obesity Agents | <1 | 2 | 577 |
| Other | 103 | 122 | 19 |

**Note:** COPD (chronic obstructive pulmonary disease), DMARD (disease-modifying anti-rheumatoid drugs). Spending reflects gross spending before retrospective rebates and discounts.
Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System.
**Source:** MedPAC analysis of Part D prescription drug data (preliminary for 2025) from CMS.

- Increase in spending was broad based, with every class shown growing by at least 10%
- Antineoplastics and diabetes drugs accounted for the largest increases in spending
- Anti-obesity agents had the fastest growth, increasing from just $0.3 billion in 2024

# GLP-1 spending shifted to the catastrophic phase earlier in 2025




**Note:** GLP-1 (glucagon-like peptide-1 [receptor agonist]), OOP (out-of-pocket). Spending reflects gross spending before retrospective rebates and discounts. Therapeutic classification is based on the First DataBank Enhanced Therapeutic Classification System.

**Source:** MedPAC analysis of Part D prescription drug event data (preliminary for 2025) from CMS.

# Drivers of Part D spending growth

# Understanding the drivers of spending growth is important

- Underlying price and utilization trends for specialty drugs
- Eliminating cost sharing in the catastrophic phase likely accelerated spending growth in 2024
- The IRA strengthened plan incentives to manage spending but may also limit plans' ability to manage spending
  1. TrOOP policy: Supplemental benefits counting as TrOOP lowers the effective OOP limit and may increase spending
  2. Benefit design: Lower OOP limit combined with high deductible and 25% coinsurance compress initial coverage phase and may increase spending

**Note:** IRA (Inflation Reduction Act of 2022), TrOOP (true out of pocket), OOP (out-of-pocket).
**Source:** https://www.cms.gov/oact/tr/2024, https://www.cms.gov/oact/tr/2025, https://www.cms.gov/oact/tr/2026; https://www.milliman.com/en/insight/moop-2025-part-d-beneficiaries-spending; https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch12_MedPAC_Report_To_Congress_SEC.pdf, Changes in Medication Use After Medicare Part D Annual Out-of-Pocket Spending Caps | Health Policy | JAMA Health Forum | JAMA Network.

# 1. TrOOP policy: Lowers effective OOP limit and increases Part D costs

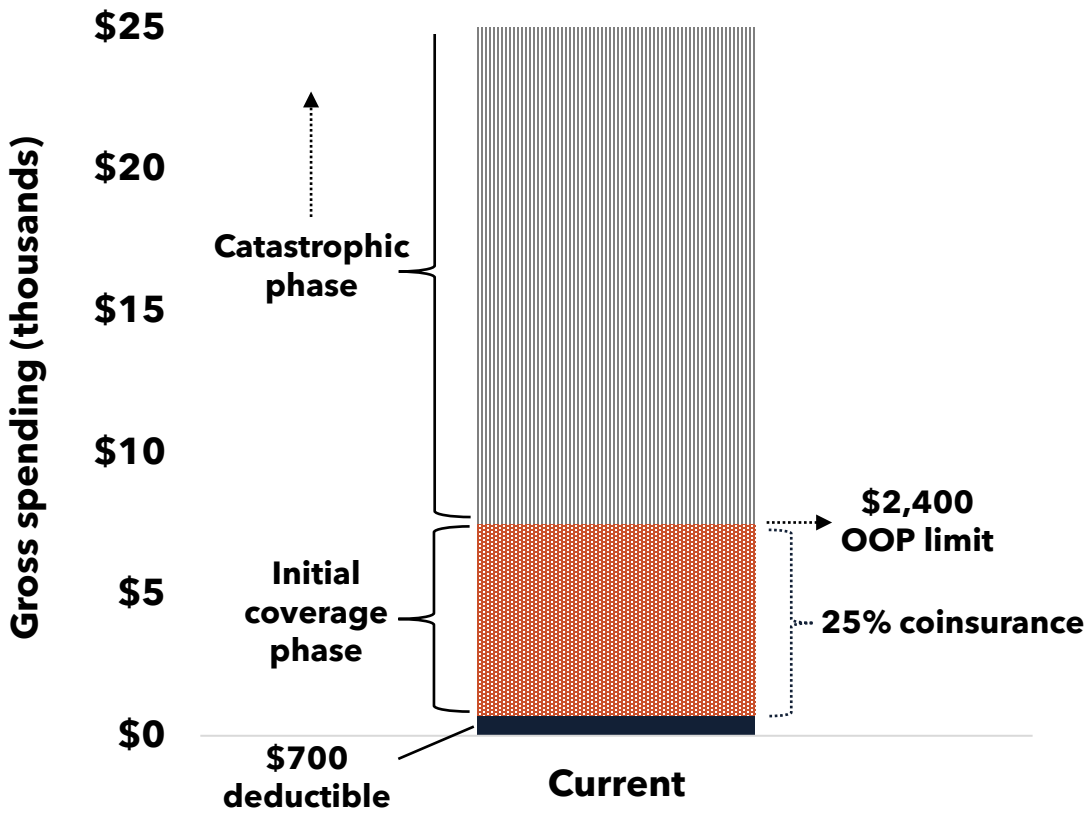
- Supplemental benefits count toward the OOP limit
  - Enrollees in enhanced plans may reach the catastrophic phase with OOP spending well below the OOP limit
  - In 2025, median OOP cost sharing was ~$960[1]
- Contributes to higher program costs
  - Benefit covers 80% of catastrophic spending vs. 65% in the ICP[2]
  - No cost sharing in the catastrophic phase may increase medication use
- Higher basic benefit costs increase
  - Basic premiums and Medicare's reinsurance payments
  - Medicare's direct subsidies for all plans

**Note:** TrOOP (true out of pocket), OOP (out-of-pocket), ICP (initial coverage phase). [1] Excludes LIS beneficiaries. [2] The share of spending covered in the ICP (65%) is for brand-name drugs and biologics. For generic drugs, basic benefit covers 75% in the initial coverage phase.

**Source:** MedPAC analysis of Part D prescription drug event and enrollment data from CMS.

# 2. Benefit design: shortened initial coverage phase limits plans' ability to manage spending

- Use of cost sharing differentials to manage utilization is limited to prescriptions filled in the ICP
- High deductible and lower OOP limit has shortened the ICP
  - TrOOP treatment of supplemental benefits further shorten the ICP
- Current benefit design may limit plans' ability to:
  - Encourage use of lower-cost drugs
  - Negotiate rebates from manufacturers




**Note:** ICL (initial coverage phase). OOP (out-of-pocket), TrOOP (true out of pocket).
**Source:** MedPAC depiction of Part D's defined standard benefit in 2027.

# Further analysis of Part D spending to inform policy discussion

- Changes in utilization associated with redesign, including comparisons:
  - Between non-LIS and LIS enrollees;
  - Between basic and enhanced plan enrollees; and
  - Across therapeutic classes
- Exploratory analysis and literature review to understand drivers of spending growth, including improved adherence and shifts away from lower-cost therapies
- Distributional analysis of policies' effects on beneficiaries
- Continue discussions with plans and actuaries

**Note:** LIS (low-income subsidy), OOP (out-of-pocket).

# Potential policy directions for addressing spending growth

# High spending growth increases Medicare costs and ultimately enrollee premiums if not addressed

- Reductions in cost sharing under the redesign improve access to medicines but limit plans' ability to manage utilization
- Elevated spending growth results in higher program costs
- Expiration of temporary Medicare policies that limited premium growth will result in substantially higher premiums in 2030
  - Particularly affects PDPs since, unlike MA–PDs, they cannot use Part C rebates to buydown premiums
  - May make Part D coverage less attractive to beneficiaries with relatively low drug spending

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

# Excluding supplemental benefits from TrOOP could reduce spending growth in enhanced plans

- Slows progression to the catastrophic phase
  - Increase enrollee cost sharing up to the OOP limit (from an average of about $900 in 2025)[1]
  - Lower basic benefit costs and premiums
  - May increase supplemental benefit costs and premiums[2]
- Increase the share of spending in the initial coverage phase
  - May increase plans' ability to influence utilization and spending through tiered cost sharing
  - Reduces the share of spending in the catastrophic phase

**Note:** TrOOP (true out of pocket), OOP (out-of-pocket). [1] Average OOP spending among enhanced-plan enrollees who do not receive Part D's low-income subsidy. [2] If the enhanced plans do not adjust supplemental benefits in a manner that maintain or lower the actuarial value of the supplemental benefit. Plans may increase supplemental premiums.

**Source:** MedPAC analysis of Part D prescription drug event and enrollment data from CMS.

# TrOOP change alone is unlikely to substantially slow spending growth

- Enrollees reaching the OOP limit may fall by half if TrOOP were based solely on enrollee OOP spending

| | % of enrollees reaching the catastrophic phase | Gross spending in the catastrophic phase | |
|---|---|---|---|
| | | ($) | (% of total spending) |
| Current TrOOP definition | 35% | $78B | 66% |
| Alternative TrOOP definition | 17% | $62B | 53% |

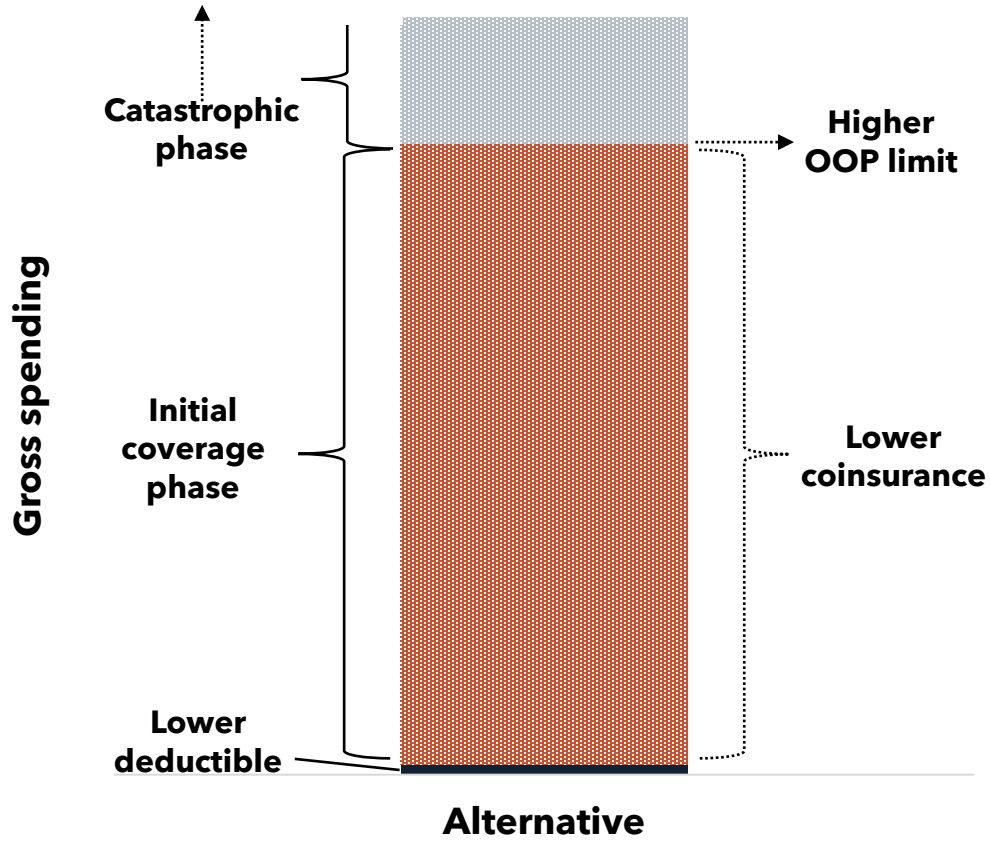
- Additional policies may be needed to slow spending growth
  - A substantial share of spending would remain in the catastrophic phase
  - Basic-plan enrollees would not be affected by the TrOOP change; catastrophic spending also accounted for about two-thirds of spending

**Note:** TrOOP (true out of pocket), OOP (out-of-pocket), B (billion) Simulated for 12.7 million enrollees in enhanced plans. Analysis was limited to individuals who did not receive Part D's low-income subsidy and individuals who had spending exceeding plan deductibles. We did not adjust for medications that are exempt from the deductible or for potential changes in plan and beneficiary behaviors.

**Source:** MedPAC analysis of Part D prescription drug event, landscape, and enrollment data from CMS.

# Extending the ICP may help moderate spending growth across all plans

- Modifying benefit parameters can extend the initial coverage phase (ICP)
  - Lower deductible
  - Lower coinsurance
  - Higher annual OOP limit
- More spending in the ICP may allow plans to more effectively manage spending
  - Lower basic benefit costs and premiums
- LIS enrollees would continue to receive extra help with cost sharing




**Note:** OOP (out-of-pocket), LIS (low-income subsidy).
**Source:** MedPAC example.

# Additional tools and flexibilities could help plans manage spending

- Moderating the growth in catastrophic spending may require additional changes that give plans more management tools and formulary flexibilities
- Allow plans to use fixed-dollar copays for certain prescriptions filled in the catastrophic phase, while maintaining hard OOP cap for preferred and lower-cost therapies
- Commission's standing recommendations (June 2020) include:
  - Giving plans more flexibility to manage protected class drugs
  - Establishing a higher copayment for nonpreferred and nonformulary drugs under Part D's LIS

**Note:** OOP (out-of-pocket), LIS (low-income subsidy).

**Source:** June 2020 Report to the Congress: Medicare and the Health Care Delivery System – MedPAC.

# Next steps and discussion

# Discussion

- Questions or comments
- Feedback on planned analysis
- Interest in exploring policy options to address spending growth:
  - Redefine true out-of-pocket (TrOOP) to exclude supplemental benefits
  - Modify benefit parameters to extend initial coverage phase
  - Give plans additional tools and flexibilities to manage spending
  - Other approaches?

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