CHAPTER 4

Part D prescription drug plans for beneficiaries in fee-for-service Medicare and Medicare Advantage

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Chapter summary

Beneficiaries can choose among Medicare coverage options that include traditional fee-for-service (FFS) Medicare and an array of Medicare Advantage (MA) plans. The Commission supports the availability of these options, which allow beneficiaries to choose between the reduced premiums and cost-sharing liability offered by MA and the broad network of providers and minimal utilization management offered by FFS.

Beneficiaries who opt for FFS Medicare can obtain Part D prescription drug coverage by enrolling in a stand-alone prescription drug plan (PDP). (Many FFS beneficiaries also purchase a Medigap plan to reduce their cost-sharing liability for medical services.) With MA, beneficiaries generally do not separately enroll in a prescription drug plan because their plan is an MA–Prescription Drug plan (MA–PD) that includes prescription drug coverage. Throughout its existence, the Part D program has evolved, and the numerous changes have altered the dynamics in the stand-alone PDP market and the MA–PD market. The different dynamics of the two markets have important implications for plan choice, beneficiary costs, and access to medications.

Consistent with the shift in enrollment from FFS to MA in the broader Medicare program, Part D's enrollment has also shifted from PDPs

In this chapter

to MA–PDs. MA–PDs increasingly offer more generous prescription drug coverage (e.g., lower deductibles) to enrollees at lower premiums. At the same time, PDPs continue to play an important role because they provide drug coverage for FFS beneficiaries and, critically, they ensure that premium-free plan options ("benchmark" plans) are available for FFS beneficiaries with low income and limited assets. The average number of PDPs available to FFS beneficiaries has fluctuated over time, with two consecutive years of decline since 2023. The average number of PDPs available in 2025 was the lowest since the program began, but FFS beneficiaries continue to have at least 12 PDPs from which to choose.

Four trends raise concerns about the long-term stability of the PDP market. Those trends reveal differences that may affect the competition both within and between the two sectors and the benefits that PDPs and MA-PDs offer to Medicare beneficiaries. First, the Commission has found that Part D premiums for the basic benefits charged by PDPs have tended to exceed those of MA–PDs. Second, the number of PDPs qualifying as benchmark plans in certain areas of the country has continued to decline. In some regions, beneficiaries receiving the low-income subsidy (LIS) have just one premium-free benchmark plan available. Third, drug costs, on average, have been higher among PDPs compared with MA–PDs, but average risk scores for PDPs have been lower. Risk scores are intended to reflect average drug costs across a group of individuals. PDPs' higher costs yet lower risk scores suggest that Part D's payment system may not have adequately adjusted for PDPs' higher costs before 2025. Finally, PDPs have been more likely to incur losses in Part D's risk corridors compared with MA–PDs.

With more than half of Part D beneficiaries receiving their drug coverage through MA–PDs, certain MA and Part D policies that were primarily intended to guide plan operations in the MA market may be having unintended effects on PDP and MA–PD offerings and benefits:

- MA–PDs have an additional funding source ("MA rebates") that can be used to enhance their Part D plan offerings or to reduce their premiums.
- MA–PDs may adjust their premiums after CMS publishes Part D subsidy amounts, allowing them to better target particular premium amounts.
- MA–PDs can offer dual-eligible special-needs plans (D-SNPs) that are open only to individuals who are dually eligible for Medicaid and Medicare, which allows them to restrict enrollment to enrollees who receive Part D's LIS and to tailor their benefits more effectively to balance enrollees' needs and plans' financial goals.

The effects of these policies may be that, over time, the PDP market will become less attractive to insurers. There may be other differences between PDPs and MA–PDs. For example, compared with PDPs, MA–PDs may be able to manage drug costs more effectively through their contractual relationships with clinicians who prescribe medicines to their enrollees; face different incentives for managing drug spending, particularly for medications that affect medical spending; or employ diagnostic coding practices that, on average, increase Medicare's relative payments to MA–PDs. Such differences create a divergence between the relative costs and payments for MA–PDs and PDPs and could compound the effects of MA and Part D policies discussed above.

We conducted further analyses of PDP and MA–PD drug costs and risk scores between 2019 and 2023 to understand why they have diverged. By combining those data, we find that risk-standardized costs—that is, costs divided by risk scores—were lower for MA–PDs than for PDPs in those years. MA–PDs may have had lower risk-standardized costs due to differences in the effectiveness of plans' management of drug spending (which lowers costs), coding intensity (which raises risk scores), or other factors. Our analysis of plans' formularies did not find evidence that MA–PDs achieved lower costs compared with PDPs by having more narrow formularies, higher cost sharing, or greater use of utilization management. Our estimates for 2019 through 2023 show that, relative to the overall Part D population, differences in coding intensity produced higher risk scores for MA–PD enrollees and lower risk scores for PDP enrollees on average. In 2023, MA–PD risk scores were 7.6 percentage points higher than PDP risk scores due to differences in coding intensity, in aggregate. Those differences imply that systematic differences in coding practices by MA–PDs and PDPs affected the ability of Part D's risk-adjustment model to accurately predict costs for either sector in those years. Unlike in MA, differences in coding intensity for MA–PDs relative to PDPs do not increase Medicare's aggregate payments to Part D plans. However, coding differences can cause individual plans with lower relative coding intensity to receive lower Medicare subsidies than other plans with higher relative coding intensity and cause plans with lower coding intensity to charge higher premiums to their enrollees.

While differences in coding intensity explain some of the difference in average risk-standardized costs between MA–PDs and PDPs, a substantial difference remained in all years between 2019 and 2023. The persistence of a large difference in average risk-standardized costs, even after accounting

for differences in coding intensity, suggests that there are other factors that differentially affect spending in the two markets.

Finally, the redesign of the Part D benefit significantly increased plan liability for benefit spending. As more of Medicare's subsidies to Part D plans take the form of risk-adjusted capitated payments rather than cost-based payments, the difference in coding intensity between PDPs and MA–PDs and other factors that affect risk-score trends in the two markets could be amplified. CMS has taken steps that could help to address the divergence in cost and risk-score trends. In 2025, CMS began applying separate normalization factors for MA–PDs and PDPs to adjust for the diverging risk-score trends in these two markets. The use of separate normalization factors is expected to increase risk scores for PDPs (and decrease risk scores for MA-PDs) on average and, consequently, may decrease the difference in risk-standardized costs between the two plan types. However, the use of separate normalization factors alone may still result in inaccuracies in Part D's risk adjustment at the individual plan level. In turn, those inaccuracies could affect enrollee premiums and payments to plans. At the same time, CMS's Part D Premium Stabilization Demonstration, which provides additional subsidies beginning in 2025 to the PDPs to stabilize their enrollee premiums, may help moderate some of the effects of the redesign. The Congressional Budget Office expects that the additional subsidies paid to PDPs under the demonstration will increase federal spending for Part D by roughly $5 billion in 2025.

For FFS beneficiaries, PDPs are the only options available for obtaining Part D's drug coverage; for FFS beneficiaries who receive the LIS, benchmark PDPs are the only premium-free options for Part D coverage. Because of these critical roles, the Commission plans to continue to assess the drivers of differences in average risk-standardized costs between MA–PDs and PDPs and monitor the availability of PDPs—particularly benchmark PDPs—as plans adjust to the new Part D benefit structure. ■

Beneficiaries can choose among Medicare coverage options that include traditional fee-for-service (FFS) Medicare and an array of Medicare Advantage (MA) plans. The Commission supports the availability of these options since some beneficiaries may prefer to avoid the constraints of provider networks and utilization management by enrolling in FFS Medicare, while others may prefer features of MA, like reduced premiums and cost-sharing liability. Beneficiaries who opt for FFS Medicare can obtain Part D prescription drug coverage by enrolling in a stand-alone prescription drug plan (PDP). With MA, beneficiaries generally do not separately enroll in a prescription drug plan because their plan is an MA–Prescription Drug plan (MA–PD) that includes Part D coverage.

The Part D program is approaching its 20th year, and it now looks quite different than it did at the outset. The policy changes that have been made over time, as well as changes in the business strategies of Part D insurers, have facilitated a growing divergence between the stand-alone PDP market for FFS beneficiaries and the MA–PD market for beneficiaries choosing to enroll in MA. While all plans are subject to the same bidding requirements and payment mechanisms, payments to MA–PDs and the premiums paid by MA–PD enrollees have diverged from payments to PDPs and their enrollees' premiums.

Although beneficiaries, whether enrolled in FFS or MA, could forgo prescription drug coverage, most beneficiaries choose to enroll in Part D. Beneficiaries weigh several factors when choosing between MA and FFS Medicare. Many will compare the total premiums they will owe if they enroll in an MA plan with drug coverage (which includes premium components for Part D benefits and other Medicare and non-Medicare benefits) to the total premiums they will owe if they enroll in the FFS program and purchase a PDP (for drug coverage) and a Medigap plan (for additional cost-sharing coverage). Beneficiaries will also weigh any differences in premiums with differences in benefits, including cost sharing, utilization management, provider networks, drug formularies, and non-Medicare benefits. While prescription drug benefits and premiums are just one piece of that complex choice, the salience of premiums and the importance of drug coverage to beneficiaries suggest that differences between the drug coverage offered by PDPs and MA–PDs could be consequential in driving some beneficiaries' choices between MA and FFS.

Because enrollment in the broader Medicare program has shifted toward MA, the MA–PD market has grown while the PDP market has seen enrollment decline. The number and types of Part D plans offered has shifted to reflect beneficiaries' enrollment choices, with a growing number of MA–PDs and declining number of PDPs.

In this chapter, we describe MA and Part D policies that may be affecting the trends in plan offerings and how other differences in these two markets may compound these effects by creating a divergence between relative costs and payments for MA–PDs and PDPs. In addition to examining the historical trends, we discuss the ways in which the Budget Reconciliation Act of 2022 (commonly referred to as the Inflation Reduction Act (IRA)) may amplify the divergence in relative costs and payments between the two markets. We also discuss CMS's recent efforts to address concerns about the divergence, including changes to the risk-score calculation to use separate normalization factors for PDPs and MA–PDs and the implementation of a demonstration that makes additional payments to PDPs to reduce their enrollees' premiums.

Background

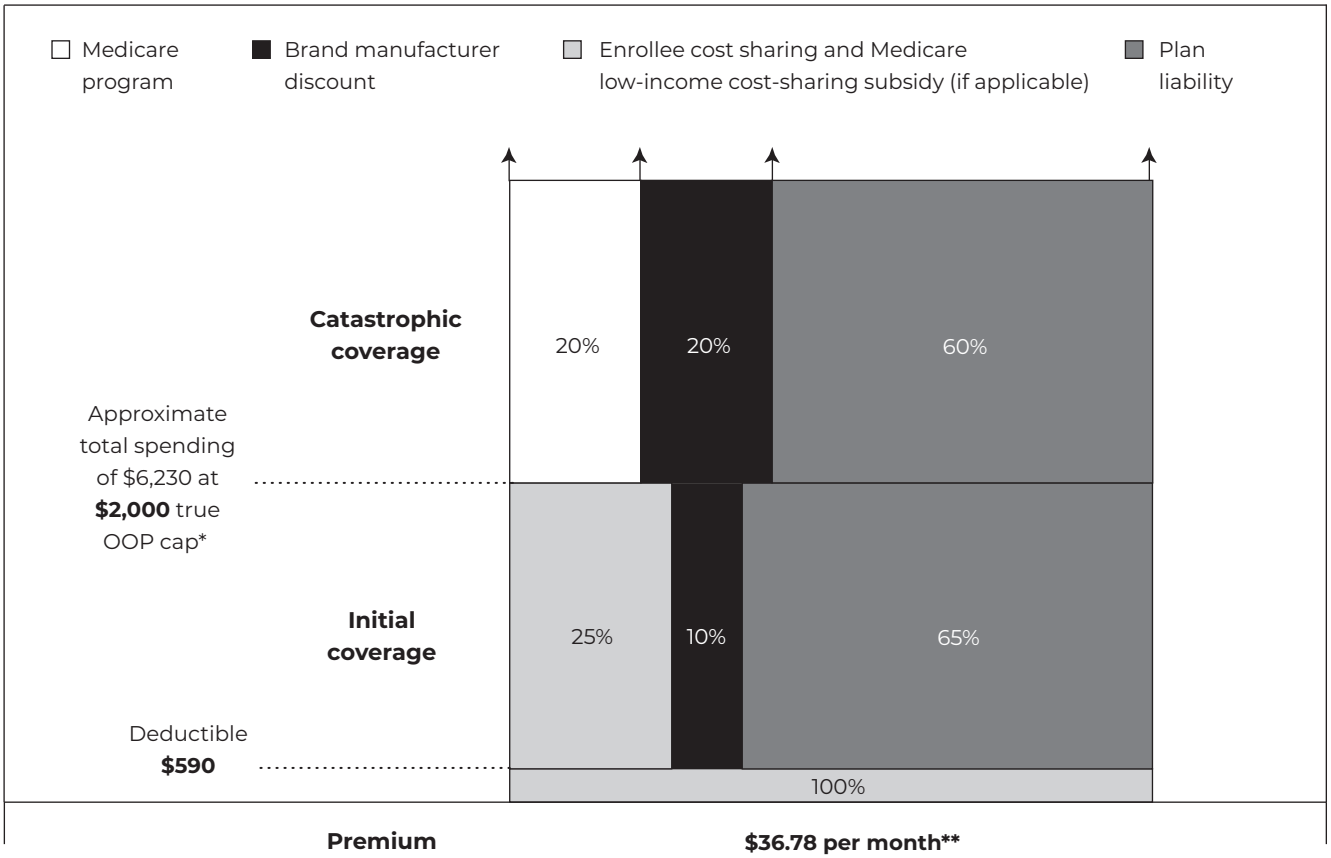
In 2023, Medicare spent over $112 billion in subsidies for the Part D program. A combination of PDPs and MA–PDs delivers this outpatient drug benefit, competing for enrollees in each of 34 regions (for PDPs) or on a county basis (for MA–PDs). Overall, Medicare subsidizes premiums by about 75 percent and provides additional premium and cost-sharing subsidies for beneficiaries who have low income and limited assets.[1] Medicare's payments to plans are determined through a competitive bidding process, and beneficiaries' premiums are calculated based on plan bids, which reflect plans' estimated costs of providing a basic benefit. Plans bear insurance risk for a portion of their enrollees' drug spending, as shown in Figure 4-1 (p. 180), though Medicare also subsidizes plan spending through a combination of risk-sharing mechanisms.

The Part D bidding process and plan premiums

Each plan submits a bid annually for the upcoming benefit year. The bid reflects a plan's expected costs for providing basic benefits (including drug costs,

FIGURE 4–1

Part D standard benefit design, 2025



Note: OOP (out-of-pocket). This benefit structure is applicable to an enrollee who has no supplementary drug coverage and is taking an "applicable drug" (i.e., a brand-name drug, biologic, or biosimilar) for which a manufacturer will owe a discount under the Manufacturer Discount Program. For generic drugs, plan sponsors must cover 75 percent of enrollee spending between the deductible and OOP cap, and Medicare's reinsurance will pay for 40 percent of spending in the catastrophic phase. For low-income subsidy (LIS) enrollees, Medicare's LIS pays for all cost sharing except nominal copayments.
* Equivalent to $2,000 in OOP spending: $590 (deductible) + $1,410 (25 percent cost sharing on $5,640). Total spending at the annual OOP limit would depend on the mix of drugs used and whether the individual received any supplemental benefits.
** There is a base beneficiary premium of $36.78 (about $441 per year), which is less than 20 percent of expected Medicare Part D benefits per person, but the actual premiums that beneficiaries pay vary by plan. Federal subsidies pay for the remainder of covered Part D benefits.

Source: MedPAC depiction of Part D benefit structure for 2025.

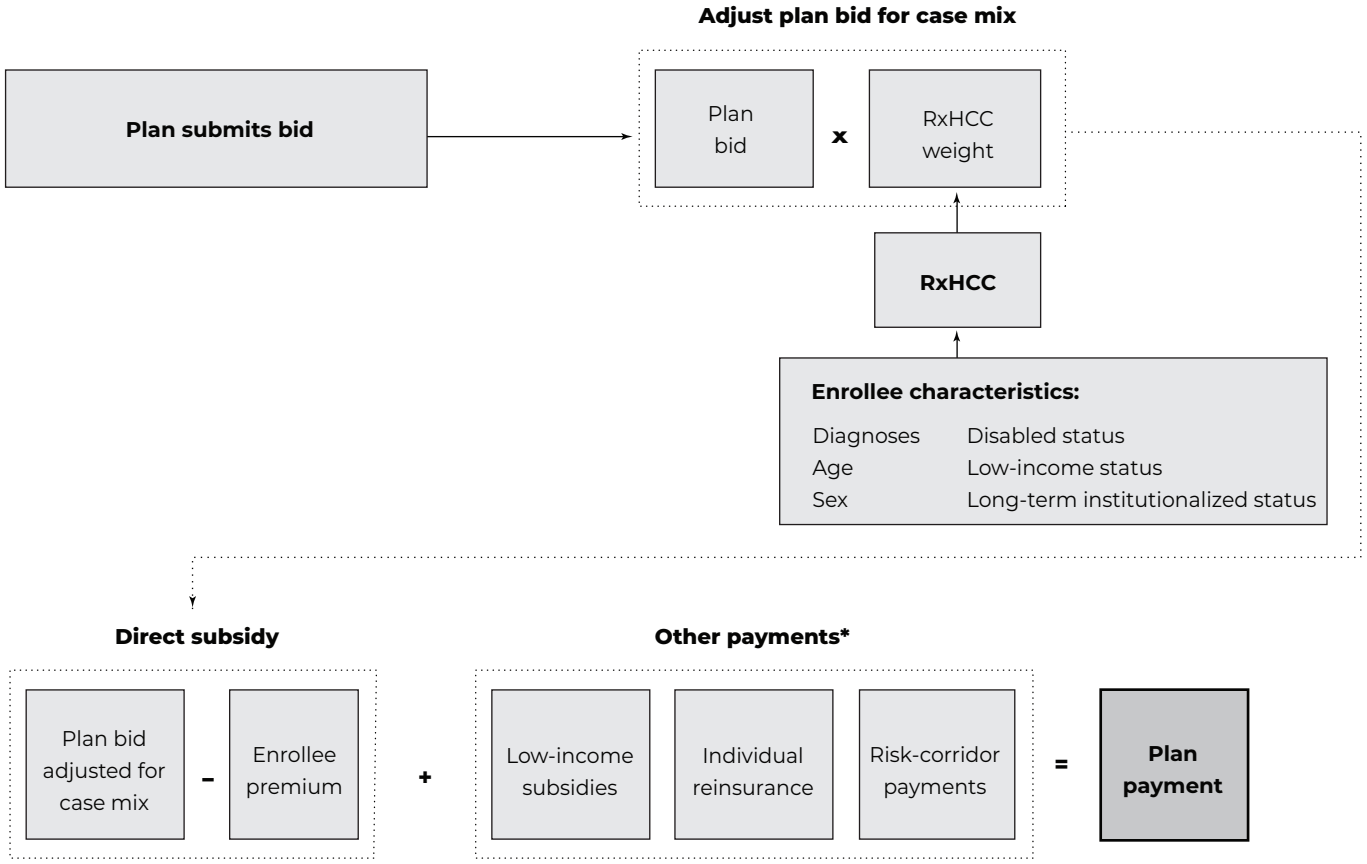
administrative costs, and profits) minus expected payments from Medicare for individual reinsurance in the catastrophic phase. CMS calculates a single enrollment-weighted nationwide average bid over all MA–PD and PDP plans, using plans' risk-standardized bid amounts for their basic benefit costs. The base premium for the upcoming year is a share of the nationwide average of the expected basic benefit costs, historically 25.5 percent.[2] To enroll in a plan, beneficiaries pay the base premium plus any difference between their plan's bid and the nationwide average bid; if their plan's bid is less than the average, their premium will be less than the base premium and could be as low as $0 if the plan's bid is less than the average by as much as the base premium amount for that year.

Medicare's payments to Part D plans

Medicare provides Part D plans with subsidies that aim to average 74.5 percent of expected basic benefit costs.[3] Those subsidies take two forms: a direct subsidy and individual reinsurance. Medicare pays a direct subsidy in the form of a capitated payment that is risk

FIGURE 4–2

Part D payment system, 2025



Note: RxHCC (prescription drug–hierarchical condition category). The RxHCC is the model that estimates the enrollee risk score. CMS uses five separate sets of model coefficients for long-term institutionalized enrollees, aged low-income enrollees, aged non-low-income enrollees, disabled low-income enrollees, and disabled non-low-income enrollees.
* Plans receive interim prospective payments for individual reinsurance and low-income subsidies that are later reconciled with CMS.

adjusted to account for differences in the expected costliness of a plan's enrollees. (See text box on Part D's risk-adjustment model, pp. 210–211.) Medicare's payments for beneficiaries with a below-average risk score are proportionately reduced, while payments for beneficiaries with an above-average risk score are proportionately increased (Figure 4-2). Medicare also pays individual reinsurance, which is a cost-based payment that covers a given share of expenses in the catastrophic phase of the benefit, serving as an additional form of risk sharing for spending incurred by the highest-cost enrollees. Medicare also pays all or most of the premium for beneficiaries with low income and limited assets who receive the low-income subsidy (LIS) (up to a regional benchmark), calculated for each PDP region as an enrollment-weighted average premium using LIS enrollees in both PDPs and MA–PDs as weights. Medicare covers most of the cost sharing for such beneficiaries.

Medicare, by law, uses symmetric risk corridors that limit each Part D plan's overall losses (across all of its enrollees) when actual spending for basic benefits is higher than anticipated and limits a plan's unanticipated profits (beyond the amount assumed in its bid) when actual spending for basic benefits is lower than anticipated. In this way, the risk corridors provide a mechanism for Medicare to share insurance risk with

plan sponsors. (For more information on Part D's risk corridors, see the discussion below on how PDPs are more likely to incur losses than MA–PDs are.)

Plan offerings and enrollment continue to shift away from PDPs

To obtain a prescription drug benefit through Part D, FFS beneficiaries must choose among PDPs offered in the state or multistate region in which they live; there are 34 regions across the country. Within each region, there is at least one benchmark PDP available at no premium cost for beneficiaries receiving the LIS since the Medicare program covers the cost up to the benchmark rate for such enrollees. LIS beneficiaries who do not proactively select a plan will be automatically enrolled into a benchmark plan in their region. Thus, benchmark plans serve an important role in ensuring that LIS beneficiaries enrolled in FFS Medicare have available drug coverage at no cost.

Beneficiaries enrolled in MA may obtain prescription drug coverage through conventional MA–PDs that are open to all beneficiaries. MA–PD service areas encompass one or more counties. MA beneficiaries who meet certain eligibility criteria may also enroll in special-needs plans, or SNPs. SNPs are a type of MA–PD designed to provide targeted benefits and are open only to individuals who are dually eligible for Medicaid and Medicare (D–SNPs), who have certain chronic conditions (C–SNPs), or who live in institutions (I–SNPs). Because dual-eligible individuals automatically qualify for the LIS benefit, D–SNPs are able to target their enrollment in ways that a PDP cannot. As we discuss later, D–SNPs have premiums that are below LIS benchmarks, and, as a result, are premium-free to LIS beneficiaries.

Finally, there is a subset of Part D plans known as employer group waiver plans (EGWPs) that are open only to retirees of the organization sponsoring such plans. EGWPs, which may be PDPs or MA–PDs, have become increasingly popular among large employers who offer retiree coverage (Skopec and Zuckerman 2024). Sponsors may contract directly with CMS or on a group basis with an insurer or pharmacy benefit manager to administer the Part D benefit. In 2024, beneficiaries enrolled in EGWPs accounted for about 16 percent of all Part D enrollees. The discussion in the remainder of this section focuses on Part D plans that are generally open to all individuals (i.e., non-EGWP plans) and SNPs.

PDP offerings affected by policy change and the shift toward MA

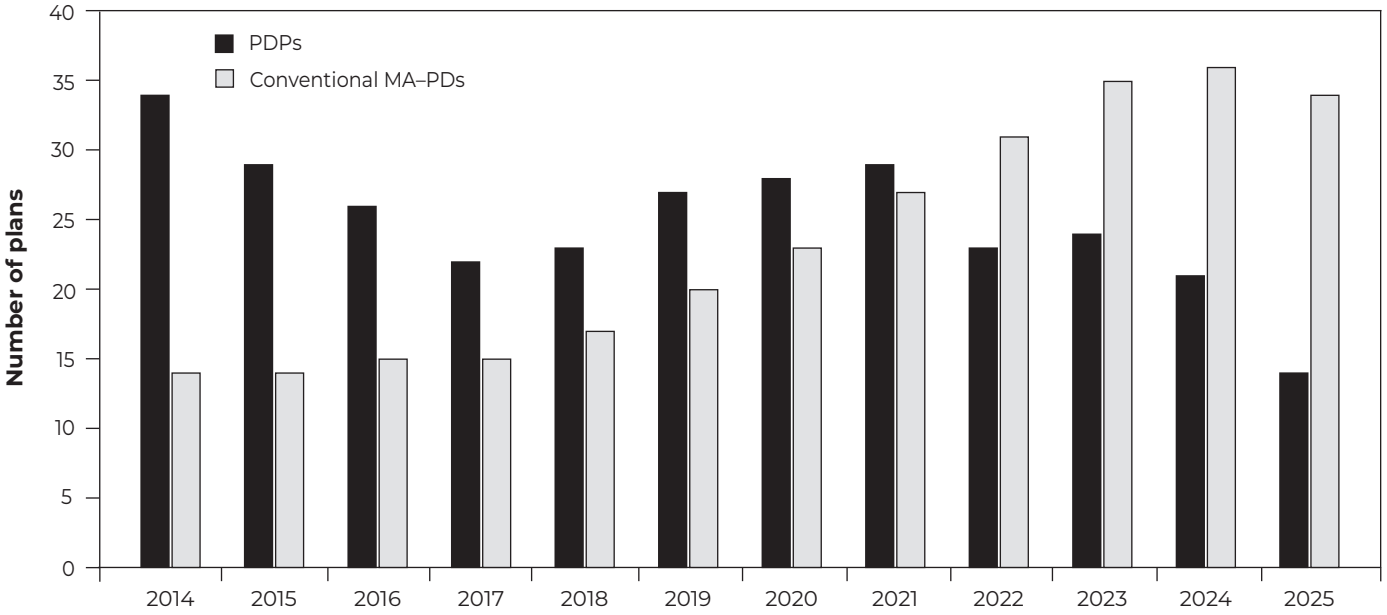
At the start of the Part D program in 2006, CMS did not specify the number or type of PDPs that sponsors could offer, except for the statutory requirement that all PDP sponsors had to offer a basic plan. As a result, between 2006 and 2010, a typical region had more than 50 PDP offerings.[4] In 2011, CMS implemented a new "meaningful difference" requirement that prohibited sponsors from offering more than one basic plan and allowed sponsors to offer up to two enhanced plans if the actuarial value of the sponsors' offerings could be shown to be meaningfully different from each other. After the implementation of that requirement, the number of PDPs offered dropped sharply, with a typical region having about 30 PDPs. These meaningful-difference requirements were intended to "ensure that beneficiaries have the tools they need to make informed decisions" and "simplify" the enrollment process (Centers for Medicare & Medicaid Services 2011, Centers for Medicare & Medicaid Services 2009).

The average number of PDPs available to a beneficiary has fluctuated over time (Figure 4-3). In 2025, the average number reached the lowest since the Part D program began, with an average of 14 PDPs available per region. The decrease in offerings since 2023 reflects exits by several insurers, including some large national insurers, as well as consolidation of PDP offerings by the largest firms (CVS Health and UnitedHealth Group). While PDP offerings have declined, FFS beneficiaries continue to have at least 12 PDPs to choose from in every region. Further, the decrease in the number of PDP options, by itself, is not necessarily a cause for concern; a large number of plans can make it more challenging for beneficiaries to make meaningful comparisons across plan options. The average number of conventional MA–PDs available to a beneficiary, on the other hand, has grown steadily, reaching 36 in 2024—the highest since the program's start (Cubanski and Damico 2023). In 2025, that figure is 34 (Fuglesten Biniek et al. 2024).[5]

Beneficiary enrollment by plan type in Part D has shifted in similar patterns as plan offerings, following

FIGURE 4–3

Average number of plans available to a beneficiary by plan type, 2014–2025



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. Conventional MA–PDs are those that are open to all MA–PD enrollees (e.g., they exclude special-needs plans).

Source: MedPAC analysis of the CMS landscape files and *Medicare Advantage 2025 Spotlight: A First Look at Plan Offerings* (Freed et al. 2024).

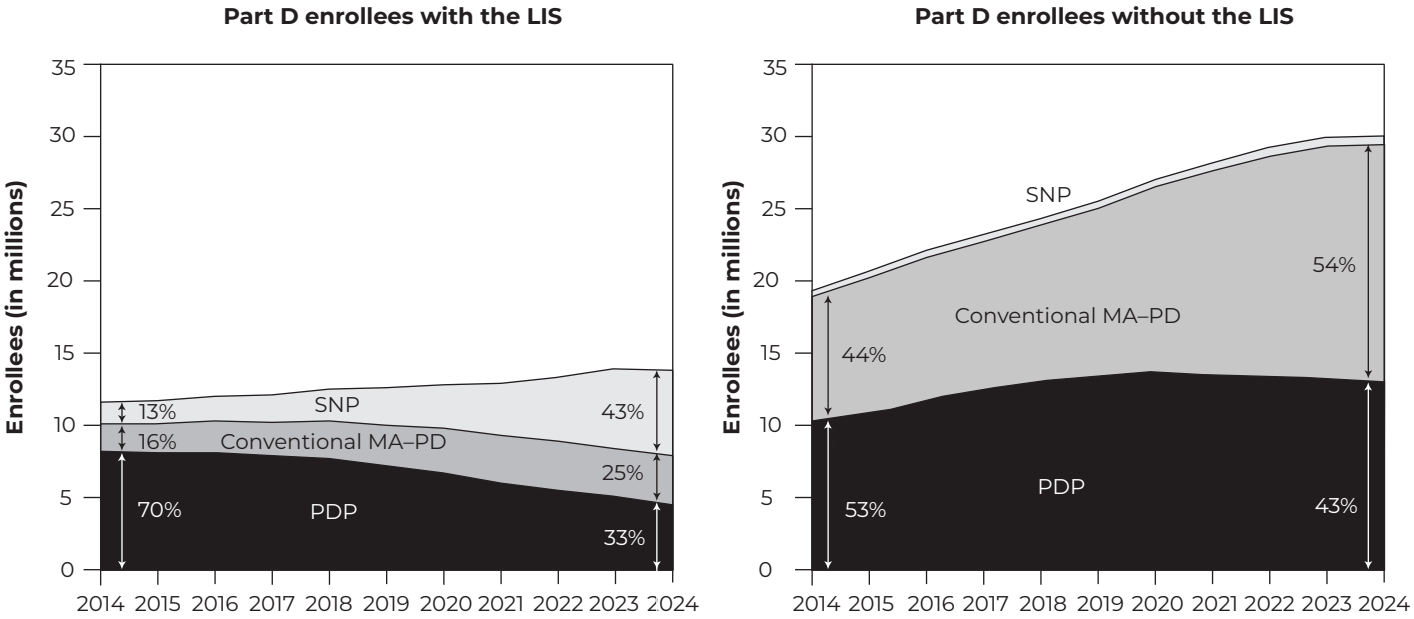
trends seen in the broader Medicare program: away from PDPs and toward MA–PDs. In 2014, 18.6 million, or more than 60 percent of Part D enrollees, were in a PDP compared with 11.5 million in MA–PDs. In 2024, the share of Part D enrollees in MA–PDs rose to nearly 60 percent, driven in part by the rise in beneficiaries enrolling in SNPs. PDP enrollment, on the other hand, had fallen to about 18 million, accounting for just 41 percent of all Part D enrollees. The decrease in the PDPs' share of all Part D enrollment reflects trends observed for the broader Medicare market, where the share of beneficiaries in FFS Medicare dropped from nearly 70 percent in 2014 to less than 50 percent in 2024 (Medicare Payment Advisory Commission 2025).

Among enrollees who do not receive the LIS, PDP market share decreased from 53 percent in 2014 to 43 percent by 2024, while the MA–PD market share saw a corresponding increase during the same period (Figure 4-4, p. 184). Nearly all MA–PD enrollees without the LIS are enrolled in conventional MA–PDs. During this period, SNPs accounted for less than 3 percent of the Part D market for non-LIS enrollees.

Among enrollees who receive the LIS, PDP market share decreased from 70 percent in 2014 to 33 percent by 2024, while the shares in conventional MA–PDs and SNPs rose to 25 percent and 43 percent, respectively, up from 30 percent for both types of plans combined in 2014 (Figure 4-4, p. 184). D–SNPs account for the vast majority of the LIS enrollment in SNPs, averaging 90 percent of SNP enrollees over the past several years.

This shift has meant a decline in the average share of PDP enrollees receiving the LIS. In 2014, 46 percent of PDP enrollees received the LIS. By 2024, that share had declined to less than 30 percent. In contrast, most of the growth in MA–PD enrollees with the LIS has been in D–SNPs that exclusively serve enrollees who receive the LIS.

FIGURE 4–4 **PDP market share has decreased among enrollees with and without the LIS, 2014–2024**



Note: PDP (prescription drug plan), LIS (low-income subsidy), MA–PD (Medicare Advantage Prescription Drug [plan]), SNP (special-needs plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs, including conventional MA–PDs, which are open to all MA enrollees, and SNPs. Percentages shown reflect enrollees in a given plan type as a share of enrollees with and without the LIS, respectively, in 2014 and 2024. (Components may not sum to 100 percent due to rounding.) SNPs accounted for 2 percent to 3 percent of enrollees without the LIS between 2014 and 2024. Analysis is based on enrollment in July of each year.

Source: MedPAC analysis of the Common Medicare Environment data.

Part D enrollment has become increasingly concentrated in plans offered by the largest organizations

In 2024, over 300 organizations offered about 700 PDPs and over 5,000 MA–PDs (including both conventional plans and SNPs). However, enrollment has become increasingly concentrated at the national level in plans owned by a small number of large insurers that operate in most or nearly all states. Between 2014 and 2024, enrollment in the five largest firms rose from 66 percent to nearly three-quarters of all Part D enrollment (Table 4-1).[6]

At the national level, the PDP market has been more concentrated than the MA–PD market. In 2024, 85 percent of all PDP enrollees were in plans offered by one of the five largest firms (UnitedHealth Group, Centene, Humana, CVS Health, and Elevance Health), compared with 64 percent and 77 percent, respectively, for conventional MA–PDs and SNPs. The PDP market was less concentrated in 2024 than in 2023, primarily as a result of a substantial loss in PDP enrollment for one of the largest firms (Cigna Group). Market concentration among MA–PDs increased during this period.

Based on enrollment in the five largest organizations, the MA–PD market is more concentrated at the regional level than at the national level, and it has increasingly become so, particularly among SNPs. Between 2014 and 2024, there was an increase in the number of regions where the five largest organizations (based on total national enrollment) accounted for over 80 percent of the region's total MA–PD enrollment.[7]

TABLE 4–1

Part D market is highly concentrated, both nationally and in each PDP region, 2014–2024

	Share of enrollment		Percentage point change, 2014–2024
	2014	2024	
In top 5 Part D organizations, national level	66%	74%	8%
PDP	78	85	7
Conventional MA–PD	49	64	15
SNP	39	77	38
In top 5 Part D organizations, PDP regional* level			
PDP	80	87	7
Conventional MA–PD	73	77	4
SNP	58	83	25
In PDP regions with HHI above "highly concentrated" threshold			
PDP	47	100	53
Conventional MA–PD	81	69	–12
SNP	86	84	–2

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), SNP (special-needs plan), HHI (Herfindahl–Hirschman Index). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs, including conventional MA–PDs, which are open to all MA enrollees, and SNPs. Analysis excludes employer group waiver plans and beneficiaries residing in U.S. territories. The "top 5" Part D firms are identified based on all Part D enrollment. In 2024, the "top 5" firms were UnitedHealth Group, Centene, Humana, CVS Health, and Elevance Health. In 2014, the "top 5" organizations included the three insurers that were among the largest in 2024 (UnitedHealth Group, Humana, and CVS Caremark). The other two were Aetna, which was subsequently acquired by CVS Health in 2018, and WellCare Health Plans, which was acquired by Centene in 2020. The HHI is a measure of market concentration that is used by antitrust enforcement agencies. It is constructed as the sum of squared market shares for all firms in a market. The U.S. Department of Justice generally considers markets in which the HHI is in excess of 1,800 points to be highly concentrated (Department of Justice and Federal Trade Commission 2023).
* There are 34 PDP regions, each consisting of a single or multiple states.

Source: MedPAC analysis of the Common Medicare Environment data.

We also examined market concentration at the PDP region level because competition at this level is most relevant to beneficiaries, who choose among plans in their region. While the top five organizations varied across regions, large national insurers were also dominant at the region level. In 2024, the five largest organizations (at the national level) were also the five largest organizations in five regions. (These five regions accounted for over 20 percent of all Part D enrollees (data not shown).) In another 26 regions (accounting for more than two-thirds of all Part D enrollees), four of the five largest organizations (at the national level) were among the five largest organizations in each region.

However, fewer MA–PD enrollees in 2024 resided in markets that were classified as highly concentrated than in 2014, as measured by the Herfindahl–Hirschman Index (HHI) (a common measure of market concentration used by antitrust enforcement agencies) (Table 4-1, p. 185). Between 2014 and 2024, the share of enrollees in PDP regions with an HHI above the "highly concentrated" threshold decreased by 12 percentage points and 2 percentage points for conventional MA–PDs and SNPs, respectively.[8] These opposing trends can be explained by the change we have observed in the MA market. For conventional MA plans (most of which are MA–PDs), our previous analysis found that the geographic expansion of large national insurers into

new markets has contributed to an increase in market concentration at the national level and a decrease in concentration in local markets (Medicare Payment Advisory Commission 2025, Medicare Payment Advisory Commission 2024c). By contrast, 100 percent of PDP enrollees were in highly concentrated regions in 2024, up from only 47 percent in 2014.

Just 21 of the roughly 300 organizations that participated in Part D in 2024 offered both PDPs and MA–PDs (in many cases, including SNPs), down from 28 organizations in 2014. However, these 21 organizations accounted for 84 percent of overall Part D enrollment in 2024 (up from 71 percent in 2014) (data not shown). Part D market shares for organizations that offer plans in both PDP and MA–PD markets have increased over time. In 2024, plans offered by these organizations accounted for 98 percent of all PDP enrollment and 75 percent of all MA–PD enrollment, up from 75 percent and 67 percent, respectively, in 2014 (data not shown).

In MA, high enrollment concentration could be a concern if it dampens the competitive pressures that might otherwise drive insurers to maintain or improve quality, make care delivery more efficient, lower premiums, or provide supplemental benefits (Medicare Payment Advisory Commission 2024c). Researchers studying MA market concentration have found evidence that market power affects the generosity of plan offerings such that greater competition was associated with increases in benefit generosity and reductions in premiums (Medicare Payment Advisory Commission 2024c).

In Part D, there may be additional concerns if the high degree of market concentration reduces the number of PDPs that qualify as benchmark plans for FFS beneficiaries with the LIS. When large insurers exit the PDP market, as was the case in both 2024 and 2025, there can be large shifts in which plans qualify as benchmark plans. Because higher market concentration tends to decrease the number of basic plans that may qualify as benchmark plans, such shifts could lead to instability in the LIS market, with a substantial number of beneficiaries needing to be reassigned with each bid cycle.

Further, because of the overlap of the dominant firms in both the PDP and MA–PD markets, the largest firms may benefit from the significant influence their bids may have on the calculation of the national average bid and the LIS benchmark amounts. That influence, in turn, could give these large firms advantages in preparing their bids, which ultimately determines their enrollees' premiums and whether a plan qualifies as a benchmark plan.

Recent exits by national and regional insurers from PDP markets may also reflect a shift in strategies among firms participating in Part D. In 2025, there are seven firms offering PDPs, down from 11 firms in 2024 (Cubanski and Damico 2024, Cubanski and Damico 2023).[9] While the largest firms continue to operate in both PDP and MA–PD markets, we are also seeing some sponsors consolidate their PDP offerings. For example, in 2025, CVS Health consolidated its three PDP offerings to just one PDP (Cubanski and Damico 2024). Because many of the large organizations that participate in Part D have a large presence in both the MA–PD and PDP markets, their decisions to exit the PDP market or consolidate their PDP offerings may also be a strategic decision that could be related to the differences between the two markets that affect premiums, payments, and profitability, discussed in the next section.

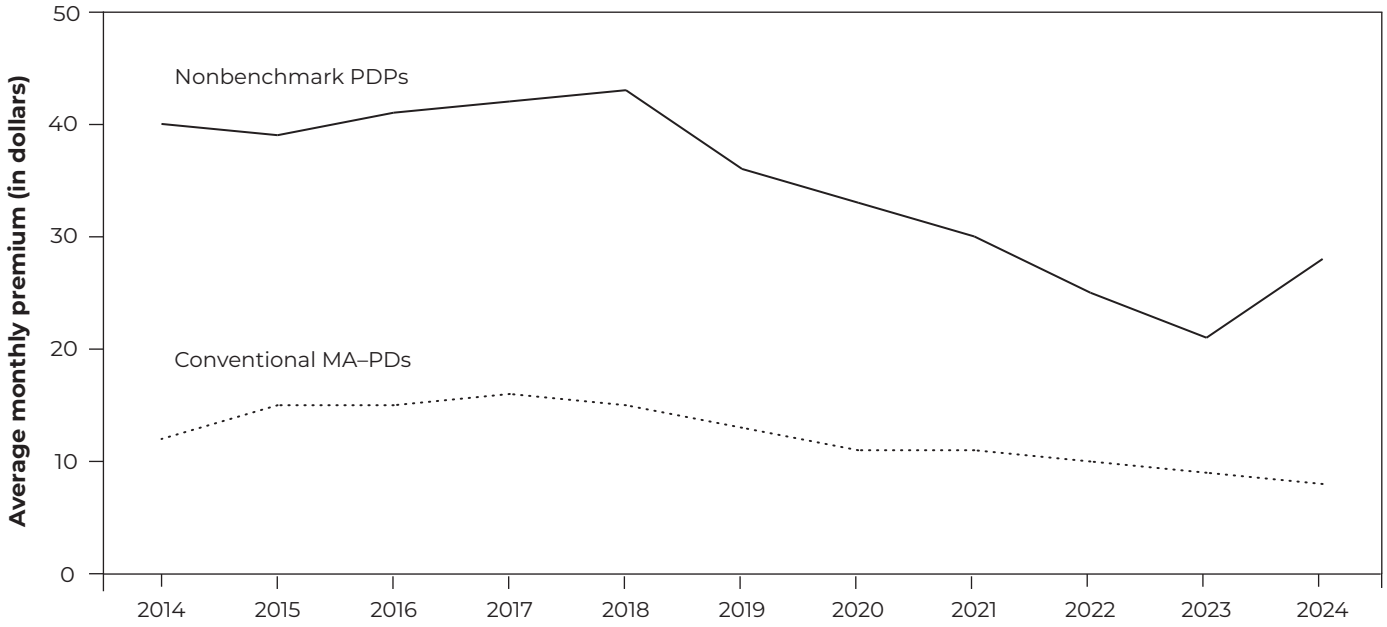
Concerning trends in the PDP market

PDPs play an important role because they provide drug coverage for FFS beneficiaries and, crucially, ensure that premium-free options (benchmark plans) are available for beneficiaries with low income and few assets. However, in an environment in which enrollment is highly concentrated in plans offered by a small number of firms, combined with recent exits by firms offering PDPs, certain trends raise concerns about the continued availability of a sufficient number of PDPs to sustain a level of competition needed to promote lower costs for Part D enrollees and Medicare while ensuring beneficiaries' access to clinically appropriate medicines.

In this section, we describe how the trends in premiums, plan costs, and profitability for PDPs differ from those of MA–PDs. We also examine the trend in the availability of premium-free (benchmark) plans. We discuss how these trends and differences between the two markets may suggest potential issues that affect the long-term stability of the PDP market.

FIGURE 4–5

Average premiums for basic benefits, nonbenchmark PDPs versus conventional MA–PDs, 2014–2024



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. Nonbenchmark PDPs are PDPs other than benchmark plans that are premium-free for fee-for-service beneficiaries with low income and limited assets. Conventional MA–PDs exclude special-needs plans. Premiums are weighted by enrollment in the month of July of each year. Average premiums for MA–PDs reflect any Medicare Advantage rebates plans applied to lower their Part D premiums for basic benefits. Note that premiums are based on plans' expected costs. As a result, for any given year, there could be systematic over- or underestimation of benefit costs when there is an unexpected event—for example, an unexpected launch of new drugs, an addition of a new indication for an existing drug that affects the uptake of the drug, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months before the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

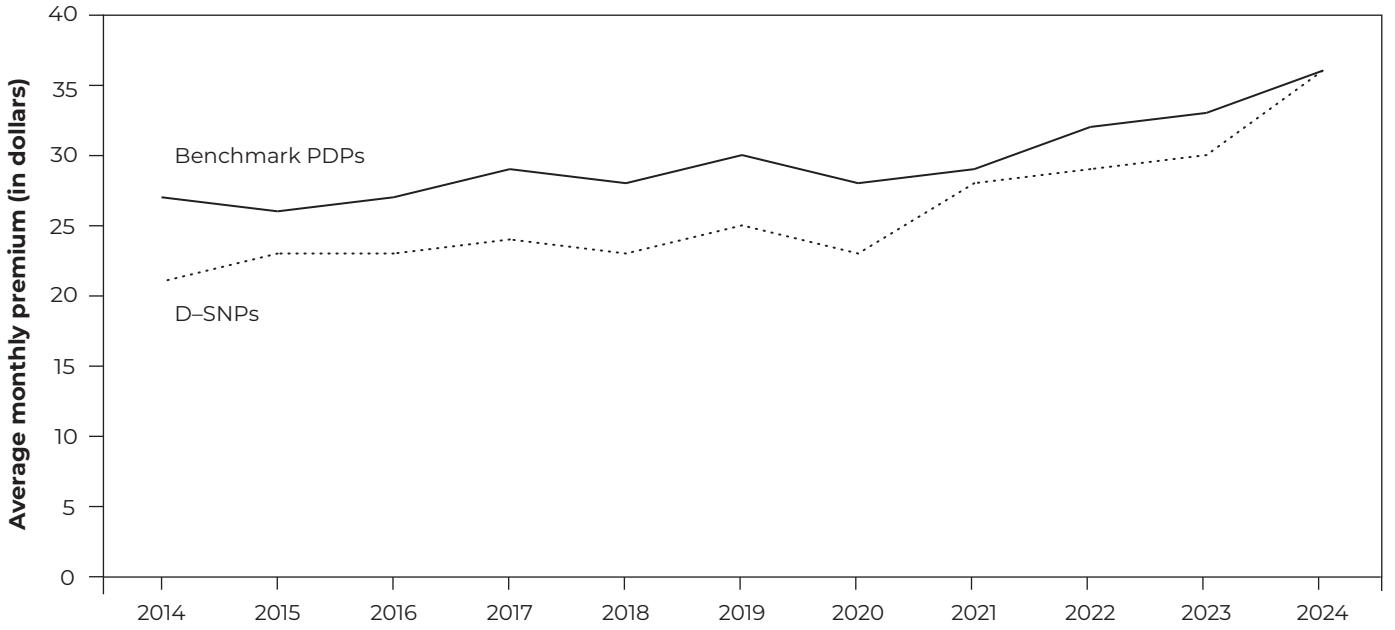
Premiums charged by PDPs, on average, exceed premiums for MA–PDs

Choosing among Part D plan offerings may require complex decisions for some individuals, as these plans differ on multiple dimensions—for instance, formularies, cost-sharing amounts, and the pharmacies in a plan's network. However, for many beneficiaries, particularly those who rely primarily on inexpensive generic medicines or are not on a regular medication regimen, premiums are likely to be the most salient feature when choosing a Part D plan.

Enrollee premiums for basic Part D benefits reflect plan bids (relative to the national average bid amount). This mechanism is intended to provide plan sponsors with incentives to balance the attractiveness of benefit offerings with benefit costs. Premiums are the price signals that beneficiaries compare when choosing a plan. 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 network) relative to another plan with a lower premium.[10]

Basic premiums charged by PDPs tend to be higher than those of MA–PDs in both the market for beneficiaries without the LIS and for beneficiaries with the LIS. (Basic premiums are for Part D benefits that have the same actuarial value as the defined standard benefit set in law. Plans may charge additional premiums for enhanced, or supplemental, prescription drug benefits.) Figure 4-5 compares "nonbenchmark" PDPs with conventional MA–PDs (i.e., excluding SNPs)

FIGURE 4–6 **Average premium for basic benefits for benchmark PDPs versus D–SNPs, 2014–2024**



Note: PDP (prescription drug plan), SNP (special-needs plan), D–SNP (dual-eligible special-needs plan). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. Benchmark PDPs are PDPs that are premium-free for fee-for-service beneficiaries with low income and limited assets. SNPs are a type of MA–PDs designed to provide targeted benefits and are open only to individuals who meet certain eligibility requirements. D–SNPs are open only to individuals who are dually eligible for Medicaid and Medicare. Premiums are weighted by enrollment in the month of July of each year. Average premiums for D–SNPs reflect any Medicare Advantage rebates plans applied to lower their Part D premiums for basic benefits. Note that premiums are based on plans' expected costs. As a result, for any given year, there could be systematic over- or underestimation of benefit costs when there is an unexpected event—for example, an unexpected launch of new drugs, an addition of a new indication for an existing drug that affects the uptake of the drug, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months before the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

because these plans primarily compete for enrollees without the LIS. Between 2014 and 2024, the average basic monthly premium for conventional MA–PDs averaged between $8 and $16, far below the average charged by nonbenchmark PDPs, which ranged between $21 and $43 during the same period. For some beneficiaries, the higher premiums charged by PDPs could be a factor in their decision to choose MA with a Part D benefit (MA–PD) over FFS Medicare with a PDP.

LIS enrollment has increasingly shifted toward D–SNPs and away from PDPs, which has meant that benchmark PDPs are increasingly competing against D–SNPs that serve beneficiaries with the LIS exclusively.

Between 2014 and 2024, average monthly basic premiums among D–SNPs remained below that of benchmark PDPs, though that difference has generally narrowed over time, reaching less than $1 by 2024 (Figure 4-6). At the same time, because the premiums for both types of plans are paid entirely by Medicare for beneficiaries who receive the LIS, the difference in the premiums is unlikely to affect beneficiaries' choice of plans. Instead, other factors are likely to influence beneficiaries' choice between a benchmark PDP and a D–SNP, such as the non-drug supplemental benefits offered by D-SNPs (although Medicaid may cover some of those same benefits for dually eligible beneficiaries, which could make the MA supplemental benefits at least partly redundant).

The IRA changed the Part D benefit to shift more of the insurance risk to plans by increasing the share of basic-benefit costs that plans are paid on a capitated basis

(direct subsidy) while reducing the share that is paid on a cost basis (reinsurance). The IRA also made the basic benefit more generous by capping out-of-pocket costs and eliminating the coverage gap. These changes were expected to result in higher bids. (See section discussing the IRA changes on pp. 214–217 for a more detailed discussion of the IRA redesign and 2025 bids.)

In 2025, the national average monthly bid amount rose by nearly 180 percent, with greater variation among PDPs than MA–PDs (Centers for Medicare & Medicaid Services 2024a). Plan sponsors have faced significant uncertainty as many of the IRA policies are implemented for the first time this year. For example, plan sponsors expected the IRA changes to increase the use of specialty drugs and other high-cost medicines, but those expectations differed based on assumptions that varied across plans (Cline and Liner 2024). The different assumptions, in turn, likely drove greater variation in plan bids.

A large variation in bids meant that, for many PDPs, their bids would have resulted in sizable increases in their monthly premiums (Cubanski 2024). (As discussed below, MA–PDs have an additional financing source—MA rebates—to offset increases in enrollee premiums.) In response, CMS implemented a new demonstration that makes additional payments to PDPs (discussed in the section on the IRA redesign and how it may amplify the effects of the differences between PDPs and MA–PDs) to "stabilize year-to-year changes in premiums for participating standalone PDPs" (Centers for Medicare & Medicaid Services 2024b). Even with the demonstration, CMS expects the average total Part D premium (including premiums for both basic and supplemental benefits) charged by PDPs to be substantially higher than those of MA–PDs ($40 vs. $13.50) (Centers for Medicare & Medicaid Services 2024a).[11] The Congressional Budget Office expects that the additional subsidies paid to PDPs under the demonstration would increase federal spending for Part D by roughly $5 billion in 2025 (Swagel 2024).

Fewer PDPs qualifying as premium-free to beneficiaries with the LIS

The average number of benchmark plans per region has also generally declined over the past decade, dropping from an average of 10 per region in 2014 to just 3 per region in 2025 (Figure 4-7, p. 190). Benchmark plans, which must be stand-alone PDPs, are important because they are the only plans into which FFS beneficiaries receiving the LIS may be automatically enrolled if they do not actively select a plan because these plans require no additional premium from the beneficiary.[12] In 2024, there are 5.3 million beneficiaries enrolled in a benchmark plan; nearly 1.4 million LIS beneficiaries are estimated to have been automatically enrolled into such plans.

Beneficiaries receiving the LIS can enroll in any plan. However, because the LIS subsidy pays for the basic premium only up to the LIS benchmark amount, a beneficiary would have to pay any basic premium cost above the LIS benchmark amount. In addition, the beneficiary would have to pay the full amount of the supplementary premium if they are in an enhanced-benefit plan.

In some years, the lowest number of benchmark plans available in a region has fallen to two, but in each of those years that minimum was only reached in a single region until 2024, when eight regions had just two plans qualifying as benchmark plans.[13] In 2025, four regions have just one benchmark plan, and 11 regions have only two, meaning nearly half of the regions across the country have no more than two LIS plans this year. When LIS enrollees have just one or two plans from which to choose (or be assigned to), there is concern about the lack of competitive pressure to keep LIS benchmark premiums low.

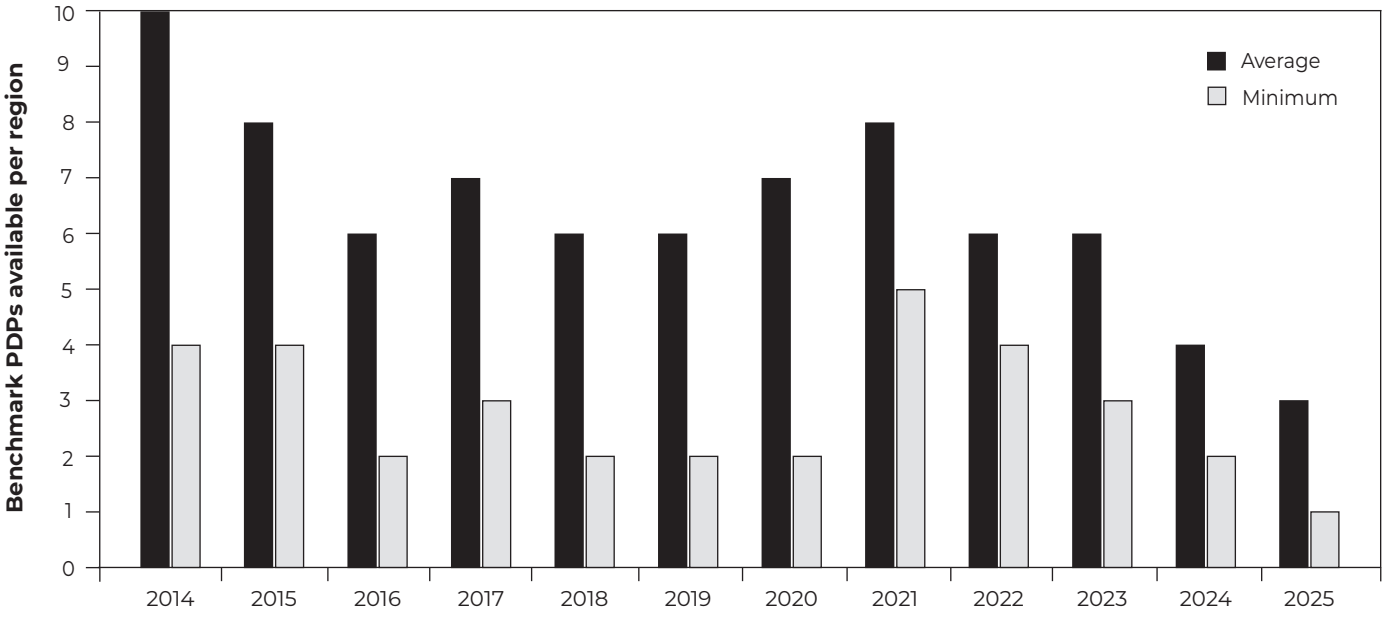
Further, in the PDP market, because each sponsor can offer just one basic plan, having fewer plan sponsors will tend to decrease the number of benchmark plans available for LIS beneficiaries. Fewer benchmark plans reduce premium-free plan choices and increase LIS enrollment in the remaining plans. In 2024, the share of enrollees with the LIS averaged 82 percent for benchmark plans, up from 75 percent in 2014. The share of enrollees with the LIS in benchmark plans varies across plans, but the variation has narrowed between 2014 and 2024: In 2014, the share ranged from about 40 percent to 94 percent, compared with a range of between 60 percent and 96 percent in 2024 (data not shown).[14]

PDPs, on average, have higher gross drug spending but lower risk scores than MA–PDs

Risk scores assigned to each enrollee aim to reflect the expected costliness of that individual relative to the overall average. Risk-adjustment models are typically

FIGURE 4–7

Average number of benchmark PDPs has generally declined, 2014–2025



Note: PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Benchmark PDPs are premium-free options for fee-for-service beneficiaries with low income and limited assets. Excludes terminated plans that are no longer eligible to enroll beneficiaries.

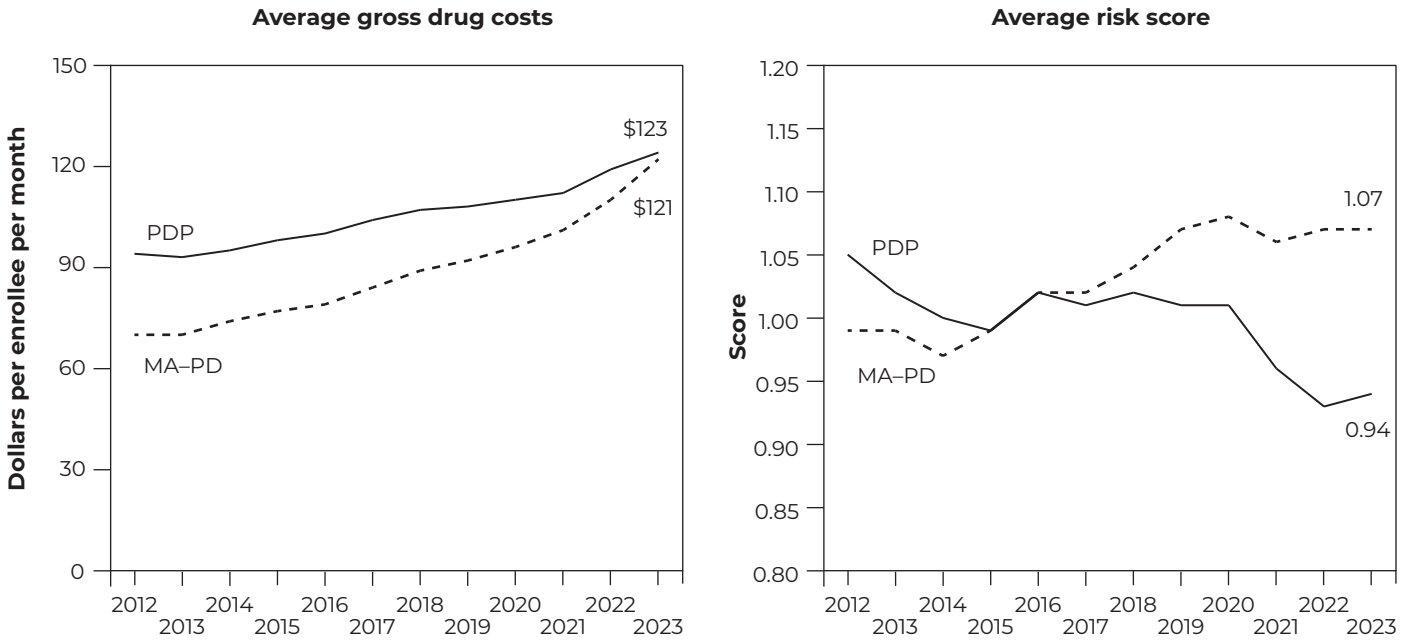
Source: MedPAC analysis of the CMS landscape files.

able to predict only a small portion of the variation in spending at the individual level, and inaccuracies in the prediction model could generate incentives for selection if plans are able to predict individual spending more accurately than the model. However, accurate plan-level payment requires only that risk models predict average spending accurately for a group of individuals, such as across all of the plan's enrollees. Part D's risk-adjustment model is based on predicting gross plan costs (for basic benefits) for enrollees in both MA–PDs and PDPs; therefore, we would expect the trends for average risk scores for PDPs and MA–PDs to reflect the trends in average costs of enrollees in the respective markets. On average, PDP enrollees had higher gross costs than MA–PD enrollees from 2012 through 2023 (the most recent year for which we have data) (Figure 4-8). Thus, we would expect the average risk score for PDP enrollees to be higher than that of MA–PD enrollees. However, beginning in 2016, the average risk score for MA–PD enrollees exceeded that of PDP enrollees (Figure 4-8). The difference in average risk scores for MA-PD enrollees and PDP enrollees has grown over time, reaching nearly 15 percent in 2022 before declining to 13 percent in 2023. In contrast, the average gross costs for MA–PDs and PDPs narrowed from over $20 in 2012 to just $2 by 2023. Still, because the average risk score for MA–PDs was substantially above that of PDPs in 2023, there continued to be a divergence in trends between gross costs and risk scores.

Taken together, these two trends imply that over this period, MA–PDs continued to have lower gross drug spending than PDPs despite enrolling a population with risk scores that predicted higher spending than PDPs. This difference could be explained by MA–PDs having relatively effective management of benefit costs compared with PDPs, differences in diagnostic coding, other factors that result in systematic differences in

FIGURE 4–8

PDPs, on average, have higher gross drug spending but lower risk scores than MA–PDs, 2012–2023



Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes both conventional MA–PDs and special-needs plans.

Source: Part D risk-score file and enrollment files from CMS.

spending on medications that are not captured by risk adjustment, or some or all of these factors combined.

When risk scores, on average, are higher for plans with lower average costs, it raises questions about the ability of the risk-adjustment model to accurately predict the relative costliness of enrollees across plans. Under the Part D payment system, higher risk scores translate into higher risk-adjusted direct subsidy payments. Therefore, the ability of risk scores to accurately reflect plan-level costs is critical to ensure appropriate relative payments to plans and the viability of the PDP market.

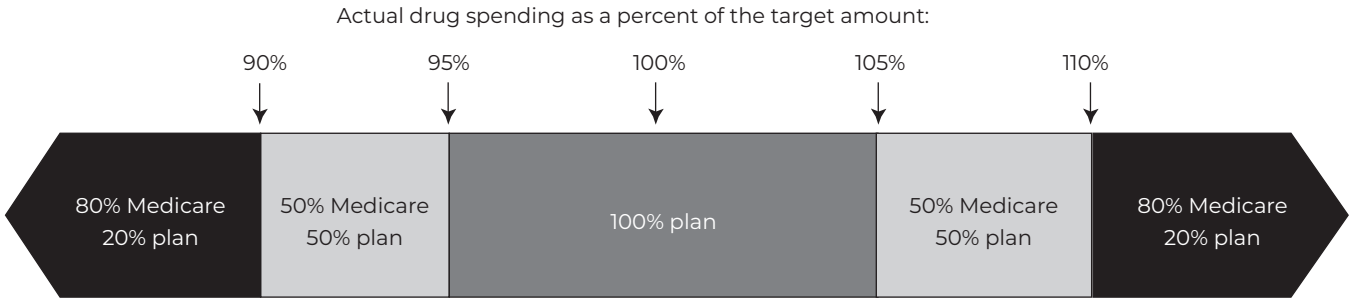
PDPs are more likely than MA–PDs to incur losses

As mentioned above, Part D has symmetric risk corridors that limit each plan's overall losses or profits (Figure 4-9, p. 192). In addition to projected benefit costs, plan bids include projections for profit margin and administrative expenses. When actual drug spending (i.e., claims costs excluding profit margin and administrative expenses) for basic benefits in the aggregate (i.e., across all of a plan's enrollees) is higher than anticipated (as reflected in their bids), risk corridors limit a plan's overall losses through payments from Medicare to those plans. Similarly, the risk corridors limit a plan's unanticipated profits when actual spending for basic benefits in the aggregate is lower than anticipated through payments from those plans to Medicare.

Since 2008, the structure of risk corridors has remained unchanged (with the exception of risk corridors used for PDPs participating in the Part D Premium Stabilization Demonstration in 2025, as discussed below). Plans are fully at risk, meaning they

FIGURE 4–9

Part D's risk corridors limit a plan's overall losses and profits when actual spending differs from a target amount based on its bid



Note: This figure depicts the risk corridors that have been in place since 2008, but it does not reflect the more generous parameters available to stand-alone prescription drug plans (PDPs) participating in the Part D Premium Stabilization Demonstration that CMS established for 2025. "Target amount" is equal to the plan bid minus administrative costs and profits. Plan bids are based on expected benefit costs net of expected postsale rebates and discounts. Risk-corridor payments are determined after actual levels of drug spending net of rebates and discounts are reconciled with prospective payments.

Source: MedPAC depiction of Part D risk corridors as set by law.

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 (Figure 4-9).[15] 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 sponsor. Beyond 110 percent (or below 90 percent), Medicare covers 80 percent of losses (or recoups excess profits).

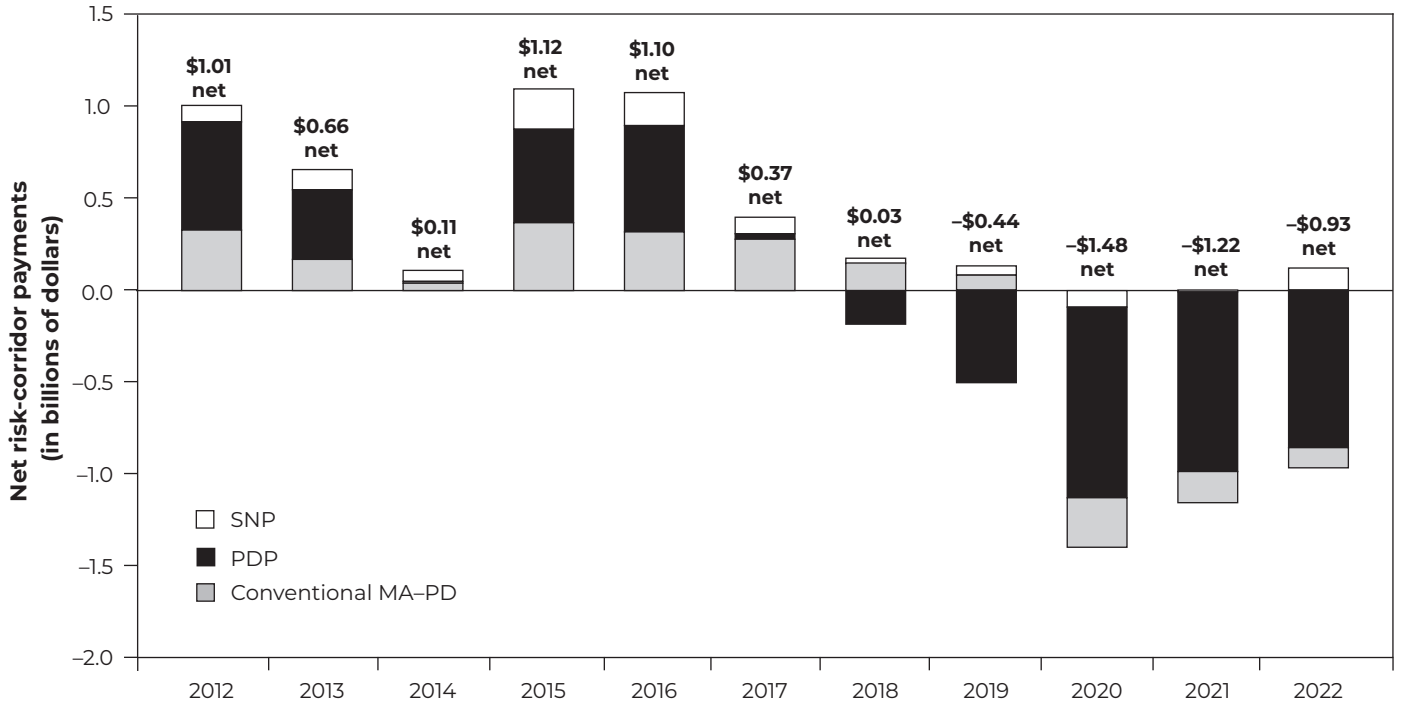
Aggregate amounts of risk-corridor payments show that plans, on net, incurred losses in the risk corridors after 2018 (Figure 4-10). Between 2018 and 2022 (the most recent year for which data are available), most of those losses were incurred by PDPs. In particular, the magnitude of aggregate net losses for PDPs in the most recent years examined (2020 to 2022) is notable. The period between 2012 and 2022 coincides with years when the average TA had dropped by more than 50 percent, as Medicare's payments to plans increasingly took the form of cost-based reinsurance. The decrease in the average TA was greater for PDPs than for MA–PDs.[16]

MA and Part D policies that may affect trends in PDP and MA–PD markets

With MA enrollment accounting for over half of all Medicare beneficiaries, MA payment policies and the distinct incentives in that program may affect how MA insurers operate the drug components of their plans. When the Part D program was created, policymakers may not have anticipated the shift in the Part D market that has taken place over the last decade. Since that time, the program has shifted from relying primarily on PDPs to a program that increasingly uses MA–PDs to provide the drug benefit, particularly for the LIS populations. As a result, certain aspects of Part D's law and regulations may no longer achieve their intended goals. In this section, we highlight MA and Part D policies that may affect plan offerings under Part D.[17] These policies allow MA-PDs to use MA rebates to offer more generous Part D benefits than PDPs and to charge lower (or $0) premiums without reducing their bids, and provide MA–PDs with an additional opportunity to adjust their MA rebates to meet a target Part D premium. MA–PDs can also more easily

FIGURE 4–10

Net risk-corridor payments between plans and Medicare, 2012–2022



Note: SNP (special-needs plan), PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage (MA) are enrolled in MA–PDs, including conventional MA–PDs, which are open to all MA enrollees, and SNPs. Risk-corridor payments limit each plan's overall losses or profits in excess of the amounts assumed in their bids. 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. 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 2012 and 2021, the share of profits or losses accounted for by Medicare–Medicaid Plans and PACE plans ranged from less than 1 percent to nearly 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. Similarly, 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.

structure plans specifically for enrollees with the LIS by offering D–SNPs (which are open only to LIS beneficiaries).

MA–PDs use MA rebates to make Part D benefits more attractive to enrollees

In addition to the Part D payments that Medicare makes to both PDPs and MA–PD plans, Medicare makes additional payments to MA–PDs (known as MA rebates) that can be used to increase the generosity of drug coverage in those plans. MA–PDs receive rebates when their MA bid for providing the medical benefits covered under Part A and Part B falls below the county-specific benchmark rates that are used to determine MA payments. Nearly all plans bid below their benchmarks and receive MA rebates. MA–PDs may use rebates to reduce Part D premiums or enhance Part D benefits, usually by lowering cost-sharing requirements for Part D drugs or covering more drugs.[18]

MA rebates have grown over time and remain at almost record levels in 2025—about $211 per enrollee per month across all plan types (Medicare Payment Advisory Commission 2025). The share of rebates that plans allocate to Part D benefits can be substantial. For example, in 2025, conventional MA plans had MA

rebates of about $188 per enrollee per month, and allocated, on average, about 23 percent of rebates to lower Part D basic premiums ($15) and to enhance Part D benefits ($29). These rebate-financed benefits provide financial protection and more generous coverage for MA–PD enrollees, but they could also affect the nature of competition among plans in the Part D market.

PDPs, on the other hand, do not generally receive additional payments to finance their drug benefits or premiums—meaning their bids determine the premiums they can charge to their enrollees. (PDPs did not receive any additional payments from the beginning of the Part D program through 2024. Beginning in 2025, Medicare makes additional payments to PDPs to reduce their premiums through a temporary demonstration.) In addition, if they were to offer supplemental benefits, they would have to charge their enrollees the full cost of those benefits, in addition to the premiums they charge for basic benefits.

MA rebates allow MA–PDs to charge low or $0 premiums without lowering their bids

The use of the MA rebates to buy down the Part D premiums, while beneficial to individuals who pay the reduced premium, may distort the price signals for beneficiaries by disconnecting premium amounts from the actual drug-benefit costs. Because the enrollee premium is one of the most salient features that beneficiaries focus on as they compare plan options, reductions in premiums by MA–PDs but not by PDPs (which must charge premiums based on their expected benefit costs) may affect beneficiaries' plan choices. Although premiums for the Part D component of MA and PDPs are just one piece of the complex choice between MA and FFS, the salience of premiums to beneficiaries suggests that lower MA–PD premiums could make beneficiaries more likely to enroll in MA plans instead of enrolling in FFS Medicare with a PDP and Medigap plan. For MA plans, using rebate dollars to lower basic Part D premiums could be a particularly effective way to grow their enrollment relative to, for example, using rebates to provide additional supplemental drug or medical benefits.

The disconnect between MA–PD bids for Part D benefits and the premiums paid by their enrollees could also have implications for plan behavior. For example, MA–PDs may compete less on managing their enrollees' benefit costs or they may not bid as low as they otherwise would have because they are able to reduce their enrollees' premiums using MA rebates. Instead, they may focus more on competing for enrollees using other strategies, such as by offering more enhanced drug benefits. That, in turn, would put upward pressure on Medicare's program spending.

Without MA rebates, average MA–PD premiums would have exceeded those of PDPs in all years from 2021 to 2024

The use of MA rebates to buy down Part D premiums has played an increasingly important role in keeping the basic premiums charged by MA–PDs stable. Since 2022, MA rebates have reduced the basic premiums for conventional MA–PDs by 75 percent, up from just under 50 percent in 2014. Without the use of MA rebates to buy down Part D premiums, the average basic premium charged by conventional MA–PDs would have exceeded that of nonbenchmark PDPs by between $5 and $15 in all years from 2021 to 2024 (Figure 4-11). Stated differently, the MA–PD bids since 2021, which set the level of enrollee premiums before the application of MA rebates to reduce them, have, on average, exceeded that of PDPs. Before 2021, on average, conventional MA–PDs would have been able to charge lower basic premiums than nonbenchmark PDPs without the use of MA rebates.

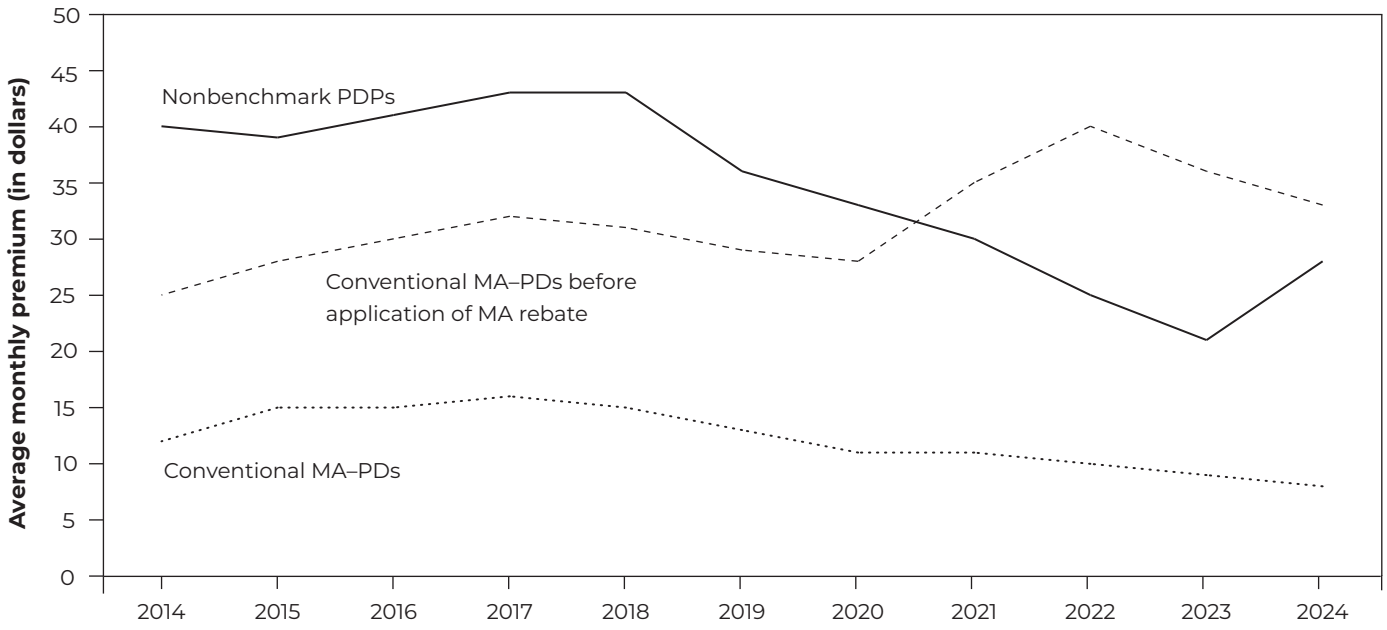
Similarly, MA rebates have been key in keeping the average monthly basic premiums among D–SNPs below that of benchmark PDPs. Average bids submitted by D–SNPs for benefit years 2014 to 2024, reflected by the average basic premiums before the application of MA rebates, were consistently higher than those for PDPs (Figure 4-12, p. 196). During this period, the average MA rebates that D–SNPs used to buy down basic premiums have fluctuated between $7 and $16 per enrollee per month (data not shown). That is, without the use of MA rebates, the average monthly basic premium for D–SNPs would have exceeded that of benchmark PDPs by between $3 and $11 in every year since 2014.

MA rebates may allow MA–PDs to submit higher Part D bids

Because MA–PDs can buy down Part D premiums, there is a concern that incentives to submit lower bids are weaker for MA–PDs than for PDPs. PDPs have a stronger incentive to submit lower bids because doing

FIGURE 4–11

Average premiums for basic benefits, nonbenchmark PDPs versus conventional MA–PDs, 2014–2024



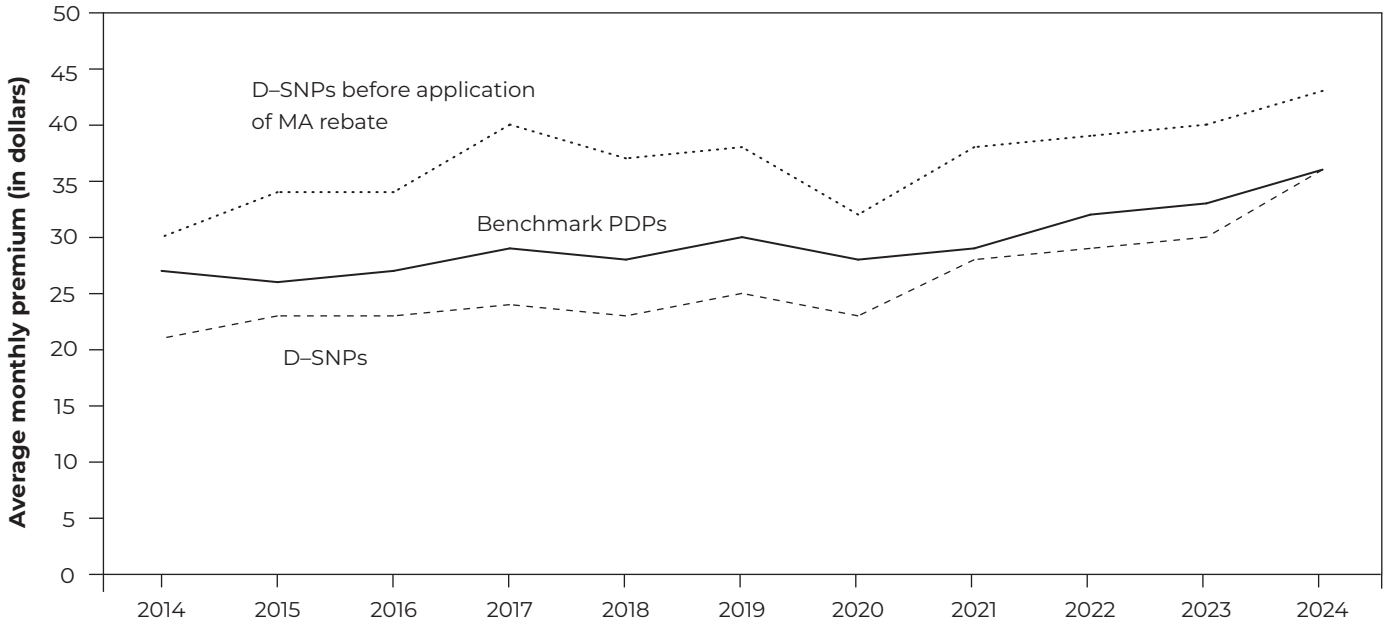
Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), MA (Medicare Advantage). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in MA are enrolled in MA–PDs. Nonbenchmark PDPs are PDPs other than benchmark plans that are premium-free for fee-for-service beneficiaries with low income and limited assets. MA plans that bid below their MA benchmarks receive MA rebates. MA–PDs may use MA rebates to reduce Part D premiums or enhance Part D benefits. "Conventional MA–PDs" excludes special-needs plans. Figures are weighted by enrollment in the month of July of each year. Note that premiums are based on plans' expected costs. As a result, for any given year, there could be systematic over- or underestimation of benefit costs when there is an unexpected event—for example, an unexpected launch of new drugs, an addition of a new indication for an existing drug that affects the uptake of the drug, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months before the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

so is the only way they can reduce their premiums (or qualify as a benchmark plan), which makes their plans more attractive to enrollees. PDPs must weigh the potentially lower enrollment they will face when submitting a higher bid (and charging the higher premium associated with that bid) to the higher premium and subsidy revenue for each enrollee they will receive when submitting a higher bid. Because MA–PDs can submit higher bids without necessarily increasing their premiums, they may be less concerned that a higher bid will reduce their enrollment. However, submitting higher bids while maintaining lower Part D premiums requires MA–PDs to use more of their MA rebates to buy down those premiums. Using more of their MA rebates requires plans to either reduce their other rebate-funded benefits (such as dental or vision coverage) or increase their rebates by lowering their MA bids, both of which come at a cost to plans. Therefore, MA–PDs still have some incentives to reduce their Part D bids.

The upward pressure that the use of MA rebates puts on MA–PD bids may also increase total Medicare payments to Part D plans. As described above, the enrollment-weighted average of plan bids is used to calculate the direct subsidy (which is risk adjusted to set payment rates for each plan) and LIS benchmark amounts. Higher average bids lead to higher Medicare payments to plans for the direct subsidy and low-income premium subsidy. As Part D enrollment has shifted toward MA–PDs, these average amounts are increasingly affected by bids submitted by MA–PDs.

FIGURE 4–12 **Average premium for basic benefits for benchmark PDPs versus SNPs, 2014–2024**



Note: PDP (prescription drug plan), SNP (special-needs plan), D–SNP (dual-eligible special-needs plan), MA (Medicare Advantage). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in MA are enrolled in MA–PDs. Nonbenchmark PDPs are PDPs other than benchmark plans that are premium-free for fee-for-service beneficiaries with low income and limited assets. MA plans that bid below their MA benchmarks receive MA rebates. MA–PDs may use MA rebates to reduce Part D premiums or enhance Part D benefits. Premiums are weighted by enrollment in the month of July of each year. Note that premiums are based on plans' expected costs. As a result, for any given year, there could be systematic over- or under-estimation of benefit costs when there is an unexpected event—for example, an unexpected launch of new drugs, an addition of a new indication for an existing drug that affects the uptake of the drug, or changes in law or Part D policy that were not expected when the bids were prepared more than seven months prior to the beginning of a benefit year.

Source: Part D premium file and enrollment files from CMS.

MA–PDs have an additional opportunity to adjust their MA rebates to meet a target Part D premium

All Part D plans submit their bids to CMS in early June of each year (for the following benefit year). However, MA–PDs have an additional opportunity to reallocate rebate amounts in their bids, after the release of the Part D national average bid, premium, and the low-income premium subsidy ("LIS benchmark") amounts in late July.

During the rebate reallocation period, MA–PD plans are permitted to make limited changes to achieve the target basic Part D premium amount (Centers for Medicare & Medicaid Services 2024b).[19] Specifically, the target amount must be set equal to either (1) the basic Part D premium net of rebates as submitted in the initial bid submission or (2) the low-income premium subsidy amount.

One practical reason for rebate reallocation is to ensure that MA–PD enrollees receive the full value of rebates—for example, when plans initially allocate more rebate than is necessary to achieve their target Part D premium. Rebate reallocations also allow MA–PDs to offer plans with more premium stability from year to year, but they may also give MA–PDs competitive and financial advantages relative to PDPs. The ability of MA–PDs to adjust their premiums after the LIS benchmarks are announced nearly guarantees their ability to qualify as a premium-free plan for LIS enrollees and to receive the maximum LIS premium subsidy amount.

However, PDPs intending to qualify as benchmark plans may need to submit lower bids (and therefore accept lower payments from Medicare) to increase their likelihood of qualifying as benchmark plans. PDPs that qualify as a benchmark plan in one year may

unintentionally miss the LIS benchmark in a subsequent year. If that happens, the plan would not qualify as premium-free and would likely lose some or all of its enrollees who receive the LIS; or if the plan misses the LIS benchmarks by a de minimis amount (less than $2 per member per month), it would have to waive the "excess" premium to remain premium-free, thereby forgoing payment. In contrast, MA–PDs can offer a premium-free plan without forgoing any payment and without a de minimis limit on the amount of rebate reallocation, as long as the reallocation achieves the low-income premium subsidy amount. Even when PDPs do bid below the benchmark, to the extent that their bids result in basic premiums that are different from the LIS benchmarks, their premium revenue is lower than the revenue based on the maximum LIS premium subsidy amount. In general, because PDPs do not have additional funds or the opportunity to adjust their bids to achieve the intended premiums for their basic plans, they may face greater uncertainty in constructing their bids relative to their MA–PD counterparts.

When structuring benefits specifically for enrollees with the LIS, MA–PDs can offer D–SNPs to restrict enrollment to beneficiaries with the LIS

Managing spending for enrollees with and without the LIS using the same formulary and benefit design can be challenging. Because beneficiaries who receive the LIS face little or no cost sharing, widely used strategies to manage spending and utilization—such as tiered cost sharing—are generally not effective for the LIS population. For beneficiaries without the LIS, on the other hand, tiered cost sharing is generally preferable to a benefit design that applies a uniform coinsurance amount, as is the case with Part D's defined standard benefit. With tiered cost sharing, plans typically use copays rather than coinsurance for some of the preferred drug tiers, allowing predictability in out-of-pocket (OOP) costs for beneficiaries without the LIS.

PDPs intending to qualify as a benchmark plan must keep their premiums below the LIS benchmark without relying on tiered cost sharing (beyond the statutory copays that set different amounts for brand-name drugs and generic drugs) and therefore must use other strategies to manage benefit spending. For example, we have found that benchmark plans tend to have narrower formularies (Medicare Payment Advisory Commission 2024a). Plans may also rely more heavily on utilization-management tools, such as prior authorization and quantity limits. However, these strategies may make their benefit less attractive to beneficiaries without the LIS.

Another challenge in serving both LIS and non-LIS populations in the same plan may relate to the trade-off plans face in setting their premiums. Part D's LIS covers eligible beneficiaries' basic premium (up to the LIS benchmark amount), so it would be in the plan's interest to maximize revenue for enrollees with the LIS by setting the basic premium equal to the LIS benchmark amount. However, because premiums are the most salient feature for beneficiaries, particularly for those without the LIS, PDPs must also balance the incentive to maximize per enrollee revenue with the need to keep their premiums competitive (i.e., low).

While the goal of offering D–SNPs may be related to their ability to provide dually eligible (for Medicare and Medicaid) beneficiaries with benefits that are tailored to meet their distinct care needs, such as better coordination with long-term care service providers, with D–SNPs, MA–PDs can also limit enrollment to beneficiaries who receive the LIS (because D–SNPs are open only to dually eligible beneficiaries, all of whom receive the LIS). It is easier to maximize the revenue that plans receive for each enrollee when LIS enrollees are segmented into separate plans from other enrollees (Medicare Payment Advisory Commission 2022). D–SNPs' ability to limit enrollees to those who receive the LIS is likely to provide them with competitive advantages over PDPs—for example, by allowing them to more effectively tailor their drug benefits. The additional opportunity to adjust their MA rebate allocations after the LIS benchmarks are announced, discussed above, allows D–SNPs to maximize their revenues by setting their premiums at (or very close to) the benchmarks. In turn, their competitive advantages may contribute to the decline in the number of benchmark PDPs.

Separately, MA–PDs can typically offer conventional MA–PDs, nearly all of which are enhanced-benefit plans, with comparatively low premiums (including supplemental premiums that tend to be attractive to beneficiaries without the LIS). By charging a premium for the supplemental benefit, these plans are likely to be able to discourage beneficiaries who receive the LIS from enrolling since Part D's LIS can only cover the

basic premiums. While qualifying as a benchmark plan may allow PDPs to gain more enrollees with the LIS, PDPs do not have the ability to restrict their enrollees in the way that D–SNPs can. In addition, because ex ante, PDPs do not know whether they will qualify as a benchmark plan, even those that are bidding to qualify as a benchmark plan may still need to offer an attractive benefit to both groups.

This situation could affect how plans design their formularies and structure their benefits to attract enrollees. While PDPs and conventional MA–PDs typically use tiered cost-sharing structures, and conventional MA–PDs largely use a low or no deductible, nearly all D–SNPs offer a defined standard benefit with a standard deductible and coinsurance throughout the benefit phases (Medicare Payment Advisory Commission 2024a). The difference in benefit design is likely driven by the fact that LIS enrollees face, at most, statutorily defined nominal copayments; thus, use of the defined standard benefit is unlikely to affect their decision to enroll in D–SNPs. PDPs serving both beneficiaries with and without the LIS, on the other hand, likely face a greater challenge in balancing the need to offer an attractive formulary and benefit with the need to keep their premiums competitive, while at the same time attempting to maximize revenues for the low-income premium and cost-sharing subsidies. In turn, these formulary and benefit design decisions may affect plans' benefit costs and bids that are the basis for premiums charged to their enrollees.

Factors that may affect relative costs and payments for PDPs and MA–PDs

In this section, we discuss the sizable difference in risk-standardized costs between MA–PDs and PDPs, which in turn may affect the profitability of plans in these two markets. We also discuss factors that may contribute to that difference.

We first show that PDPs had much higher risk-standardized costs than MA–PDs in recent years. We then show results from our analysis of formulary coverage and application of utilization-management tools by MA–PDs and PDPs to assess whether MA–PDs achieved lower risk-standardized costs by applying more restrictions to the drugs used by their enrollees. We did not find any evidence to support that theory. Next, we examined diagnostic coding practices among MA–PDs and PDPs to see whether there are systematic differences in coding intensity that affect the ability of Part D's risk-adjustment model to accurately predict costs. We found that a portion of the recent differences in risk-standardized costs between MA–PDs and PDPs can be explained by differences in coding intensity.

Average risk-standardized costs for MA–PDs are substantially below those of PDPs

Our analysis of the Part D data found that, on average, enrollees in MA–PDs have lower costs relative to the expected costs based on their risk score. Table 4-2 shows the average gross plan cost standardized to a 1.0 risk score ("risk-standardized cost"). Between 2019 and 2023, the average risk-standardized costs for MA–PDs were consistently below the overall average (across all Part D enrollees) by between 7 percent and 14 percent, while the average risk-standardized costs for PDPs consistently exceeded the overall Part D average by between 9 percent and 13 percent. The double-digit difference in the average risk-standardized costs between the two markets persisted during this period.

In 2023, the difference in the average risk-standardized costs between MA–PDs and PDPs dropped significantly (from over 20 percentage points before 2023 to 16 percentage points in 2023). The decrease in 2023 may have been due, at least in part, to the "unanticipated rapid growth in the use of antidiabetic drugs," which includes a class of drugs called glucagon-like peptide-1 receptor agonists (GLP-1s) (Boards of Trustees 2024). Between 2022 and 2023, Medicare's gross Part D spending for GLP-1 products grew from about $5.7 billion to $13.2 billion, or by 130 percent (Office of Inspector General 2025).[20]

In 2023, the average gross plan liability for MA–PD enrollees, both with and without the LIS, grew faster than for PDP enrollees (Figure 4-13, p. 200). Because MA–PDs had more generous coverage of GLP-1s than PDPs, the uptick in use may have disproportionately affected MA–PDs relative to PDPs (Assistant Secretary for Planning and Evaluation 2024a).[21] These changes in trends for enrollees with and without the LIS combined caused overall average costs for PDPs and MA–PDs to converge (despite the diverging trends

TABLE 4–2

Average risk-standardized gross plan costs for MA–PDs are substantially below those of PDPs, 2019–2023

	2019	2020	2021	2022	2023
Risk-standardized gross plan cost per member per month					
All Part D	$97	$99	$105	$113	$120
MA–PD	83	87	92	101	112
PDP	107	110	118	128	131
Percentage difference in the risk-standardized gross plan costs					
MA–PD relative to all Part D	–13.7%	–12.3%	–12.1%	–10.6%	–7.2%
PDP relative to all Part D	10.4	10.8	11.8	13.1	8.8
Absolute percentage point difference between MA–PDs and PDPs	*24.1*	*23.2*	*23.9*	*23.7*	*16.0*

Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this table, "MA–PD" includes both conventional MA–PDs and special-needs plans. Figures are calculated on unrounded numbers.

Source: Part D prescription drug event data, Part D risk-score file, and Medicare enrollment files from CMS.

among the LIS enrollees and a modest narrowing of the difference among the enrollees without the LIS).[22] In turn, that convergence in the cost trends for PDPs and MA–PDs has decreased the average difference in risk-standardized costs. Still, a 16 percentage point difference in average risk-standardized costs in 2023 is substantial.

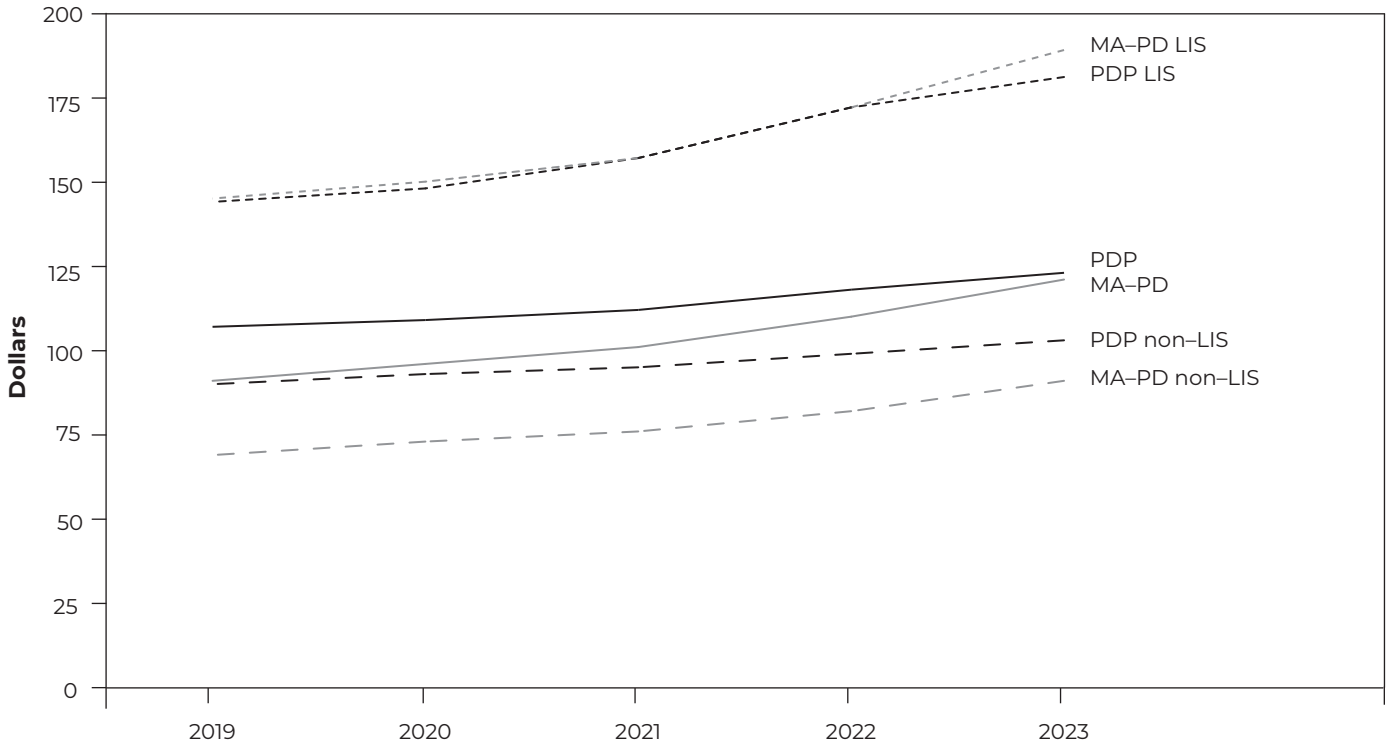
Several factors may contribute to the difference between MA–PDs and PDPs in the risk-standardized costs. For example, there could be differences in how effectively plans manage benefit spending, such as through the use of formulary tiering and utilization-management tools. As noted above, the two types of plans might differ in coding intensity. Trends for average risk scores that are not consistent with the trends in actual average costs, as described above, suggest that differential coding intensity between MA–PDs and PDPs may be contributing to the difference in risk-standardized costs in the two markets. Risk-standardized costs could also be affected by other systematic differences in the spending tendencies of MA–PD enrollees relative to PDP enrollees that are not captured by Part D's risk-adjustment model for reasons other than coding intensity.

Differences in MA–PD and PDP formularies suggest more generous coverage among MA–PDs

Differences in formulary design may explain some of the difference in risk-standardized costs between the two plan types. For example, MA–PDs may be achieving lower costs by excluding higher-cost products from their formularies, by placing them on higher copayment tiers, or by applying more utilization-management tools.

We conducted an analysis of Part D plan formularies in 2024 and 2025 to assess differences in formulary generosity between conventional MA–PDs (which exclude SNPs) and PDPs, both immediately before and in the first year of implementation of the IRA's redesigned benefit structure.[23] Based on average coverage rates, tier placement, and the frequency with which utilization-management tools are used for all Part D products, as well as various subsets of products, MA–PDs appear to have more generous formularies, on average, than PDPs. That finding is consistent with nearly all conventional MA–PDs being enhanced plans that must provide a richer benefit than basic plans, which are more common among PDPs. These metrics suggest that beneficiaries enrolled in MA–PDs, on

FIGURE 4–13 **Average gross plan cost per enrollee per month by plan type and LIS status, 2019–2023**



Note: LIS (low-income subsidy), MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes both conventional MA–PDs and special-needs plans.

Source: Part D prescription drug event data and Medicare enrollment files from CMS.

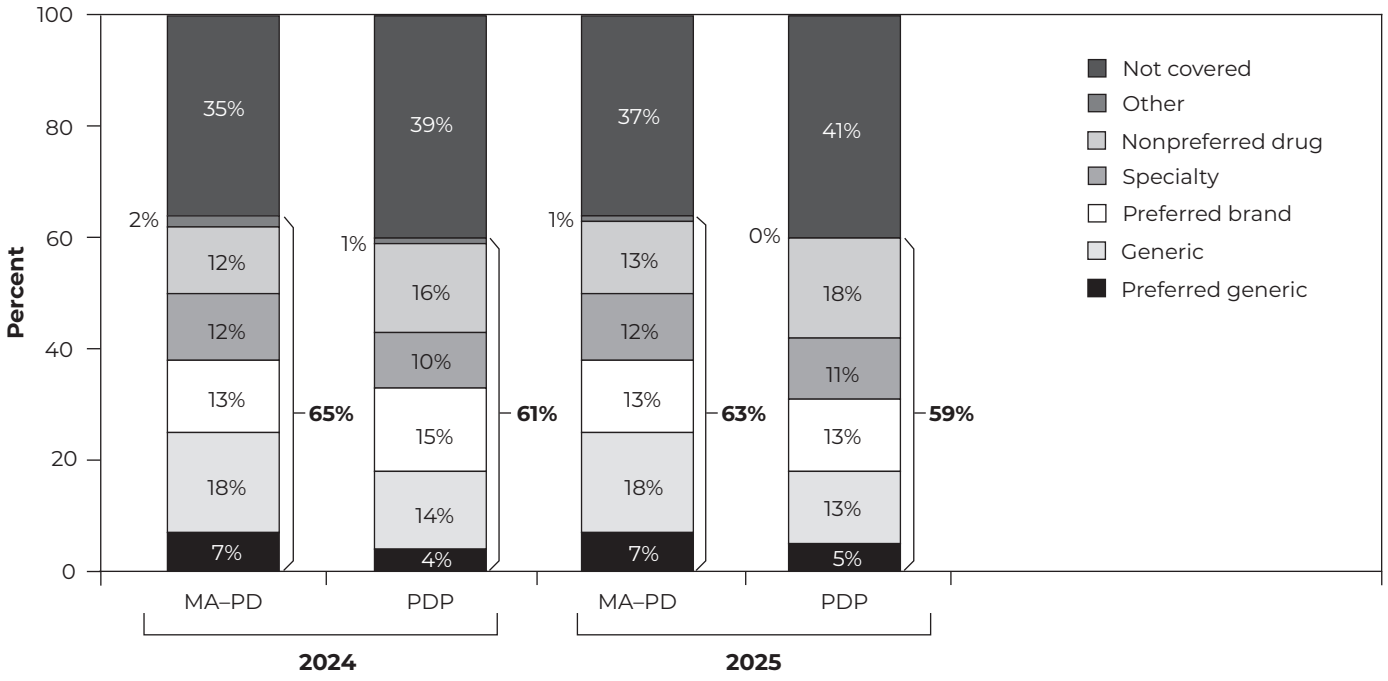
average, have moderately greater and easier access to medications than PDP enrollees, as well as lower OOP costs. Thus, it does not appear that MA–PDs use formularies and utilization-management tools to more aggressively manage their enrollees' spending. In other words, the findings of our formulary analysis do not help explain why MA–PDs have had lower risk-standardized costs than PDPs in recent years. Instead, formulary differences could largely reflect other aspects of the market related to MA plans' ability to use rebates to provide more generous coverage.

Across all Part D products, MA–PDs cover more products than PDPs, on average, and place covered products on lower tiers

We first compared average coverage rates for all Part D–eligible products for MA–PDs and PDPs in 2024 and 2025. We weighted the coverage rates by plan enrollment in the first half of 2024, meaning that the rates can be interpreted as the percentage of drugs that the average beneficiary has available on their plan's formulary. For this section of the analysis, a drug product is defined at the active-ingredient level, meaning that a drug is considered covered for a beneficiary if at least one formulation of an active ingredient (for example, a particular dose or type of packaging) is included on the formulary, whether brand name or generic. We classified products into tiers using the lowest tier for which any version of the product was included on the plan's formulary.[24] Lower tiers indicate more generous coverage of a drug because beneficiaries typically pay less in cost sharing for products on lower tiers (Medicare Payment Advisory Commission 2024a).

FIGURE 4–14

Coverage rates and tier distribution, all products, 2024 and 2025



Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes conventional MA–PDs only, not special-needs plans. The total share of drug products covered is equal to the sum of the shares of drugs covered on each formulary tier; the totals are shown by brackets for each plan type and year. A drug product is defined at the active-ingredient level, meaning that a drug is considered covered for a beneficiary if at least one formulation of an active ingredient is covered on the formulary. Components may not sum to total due to rounding.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and 2024 enrollment data for MedPAC.

Our analysis found that the average MA–PD enrollee had a somewhat larger share of drug products available on their plan's formulary and on lower-cost tiers relative to the average PDP enrollee in both 2024 and 2025; both findings indicate more generous coverage for beneficiaries (Figure 4-14). Both MA–PDs and PDPs are covering a smaller share of products in 2025 (63 percent and 59 percent, respectively) compared with 2024 (65 percent and 61 percent, respectively), but MA–PDs again have a larger share of products on formulary and on lower cost-sharing tiers.

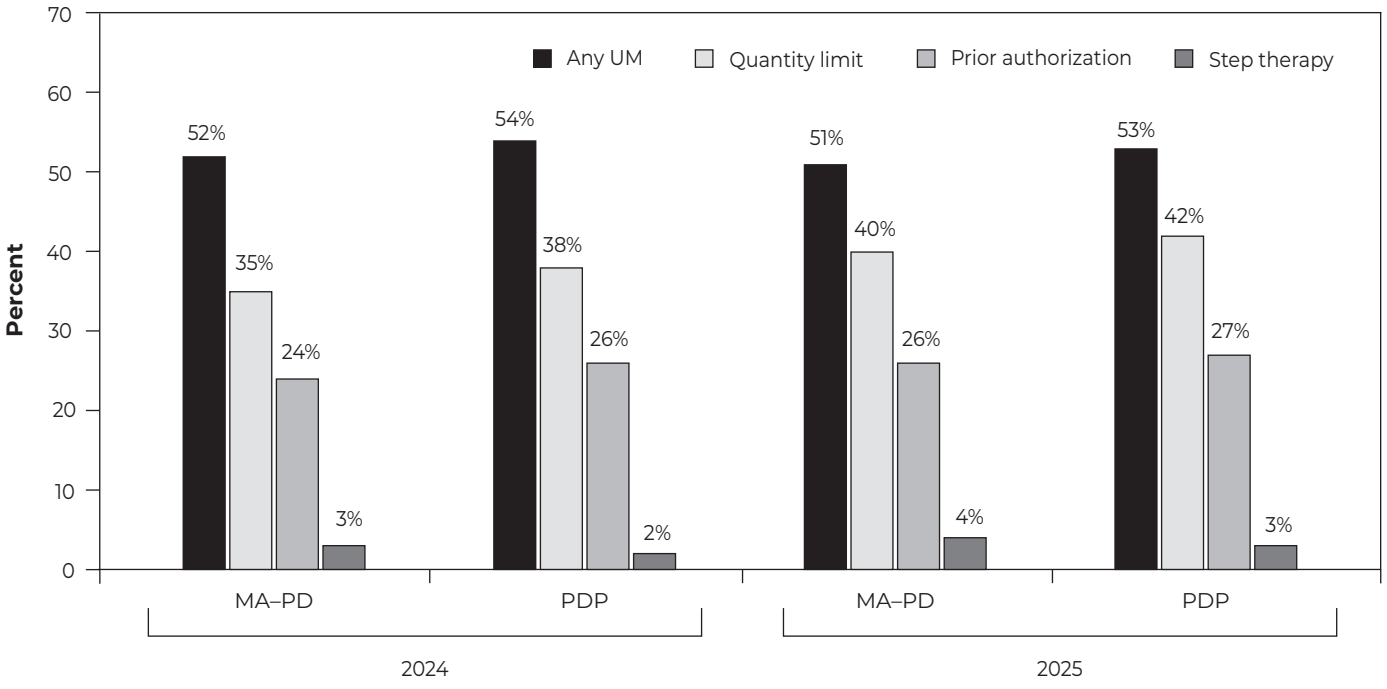
Across all Part D-eligible products, MA–PD enrollees on average had access to 25 percent of products on generic tiers, including 18 percent on the preferred generic tier, in both 2024 and 2025, compared with PDP enrollees who had access to just 18 percent of products on either generic tier in both years (Figure 4-14).

MA–PD enrollees will also find fewer products on the nonpreferred tier (12 percent in 2024 and 13 percent in 2025 compared with 16 percent in 2024 and 18 percent in 2025 for PDP enrollees, on average). PDP enrollees have a slightly smaller share of products on the specialty tier in each year compared with MA–PD enrollees, on average. PDPs had more products on the preferred-brand tier in 2024, but in 2025 the shares of products on the preferred-brand tier are equal between MA–PDs and PDPs.

As with our other analyses, we also examined formulary differences between nonbenchmark PDPs with both benchmark PDPs and conventional MA-PDs. Coverage among nonbenchmark PDPs was slightly more generous than benchmark PDPs, in terms of overall coverage rates (60 percent vs. 58 percent in 2025) and tier placement, with 32 percent of covered products

FIGURE 4–15

Utilization-management rates as a share of on-formulary drugs, all Part D–covered products, 2024–2025



Note: UM (utilization management), MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes conventional MA–PDs only, not special-needs plans. The shares of products listed as "on formulary" in this chart represent the share of all products at the active ingredient level that are covered on the average beneficiary's formulary. The shares of products with any UM applied, and each type of UM, are calculated as shares among the products covered on plan formularies.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and 2024 enrollment data for MedPAC.

on the generic tiers, compared with 27 percent among benchmark PDPs and 30 percent of covered products listed as nonpreferred compared with 31 percent among benchmark PDPs. Still, nonbenchmark PDPs are not as generous in terms of coverage or tier placement as conventional MA–PDs.

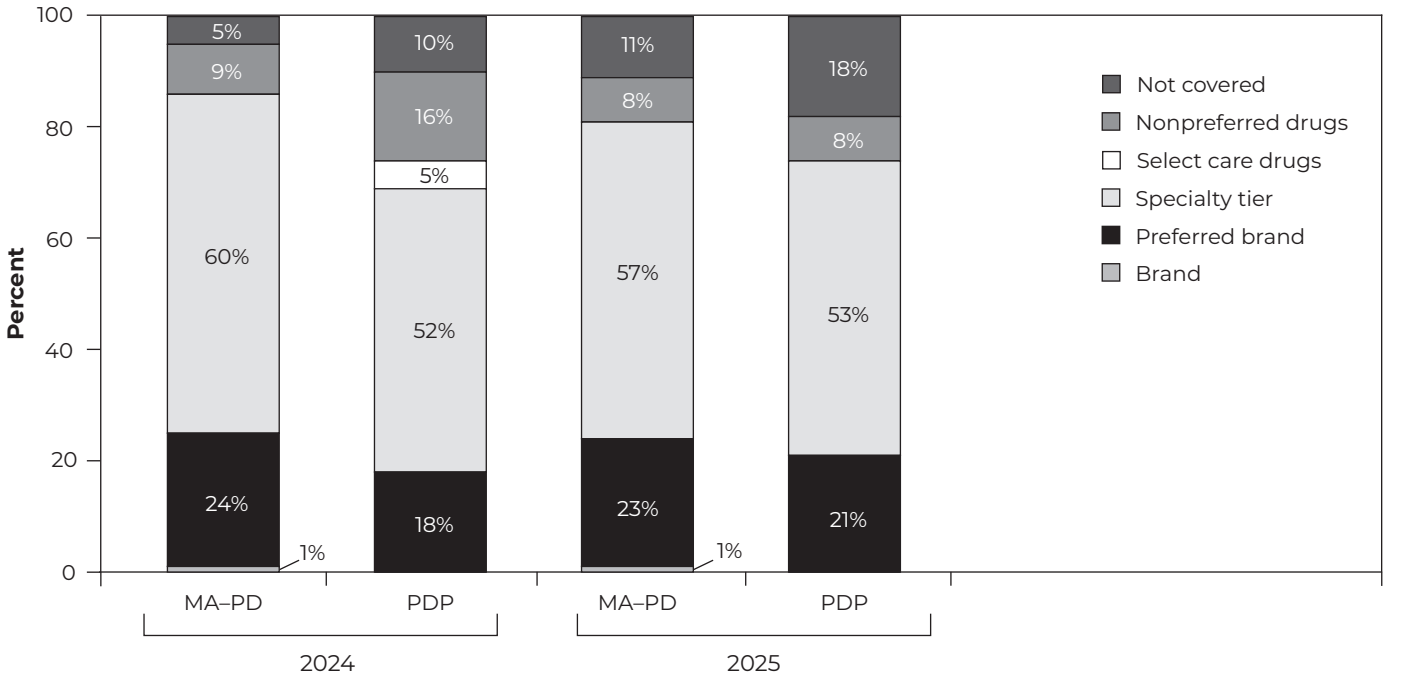
In addition to having a greater share of products covered, MA–PD enrollees on average were slightly less likely to face access restrictions for their covered products, with an average of 52 percent and 51 percent of products, in 2024 and 2025 respectively, having any form of utilization management (UM) applied, compared with 54 percent and 53 percent of products facing restrictions for PDP enrollees in these years (Figure 4-15).

Quantity limits (QLs) are the most used UM tool among both MA–PDs and PDPs, and each plan type increased their use by about 5 percentage points in 2025 to 40 percent and 42 percent, respectively, among all covered products (Figure 4-15). Prior authorization (PA) is required for roughly one-fourth of covered products, with PDP enrollees having 1 percentage point to 2 percentage points more products subject to PA. On average, across all products, step therapy (ST) is rarely used, though both MA–PDs and PDPs increased its use by 1 percentage point in 2025 to 4 percent and 3 percent, respectively.

Notably, despite each of the three types of UM use increasing in 2025 for both plan types, overall UM use by all types decreased 1 percentage point from 2024 to 2025. This decline could mean that while fewer products have any UM applied, more products are seeing the application of more than one type of UM, such as PA and, even after being authorized, the imposition of QLs.

FIGURE 4–16

Top 20 high-cost, high-utilization products in 2024, coverage rates, and tier distribution



Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes conventional MA–PDs only, not special-needs plans. Products were selected based on the highest total gross drug costs among both MA–PDs and PDPs in the first six months of 2024 with an average gross cost per fill of at least $1,000 and at least 20,000 fills for each plan type. Figures in each column may not sum to 100 percent due to rounding.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and prescription drug event data and enrollment data for 2024 for MedPAC.

Nonbenchmark PDPs also use UM tools at a slightly higher rate than conventional MA–PDs, applying UM to 53 percent of all covered products.

Products with high total spending were largely placed on specialty tiers and had higher-than-average rates of utilization management

We next considered a subset of products whose coverage is likely to be important to enrollees: products that are both high cost and highly utilized. We identified products that had an average price (as measured by gross cost per fill) of at least $1,000 and selected the 20 drugs with the highest gross spending and at least 20,000 fills for each plan type in 2024.[25] Those 20 products were among the top 24 products, ranked by total gross spending, for MA–PDs and the top 33 for PDPs.

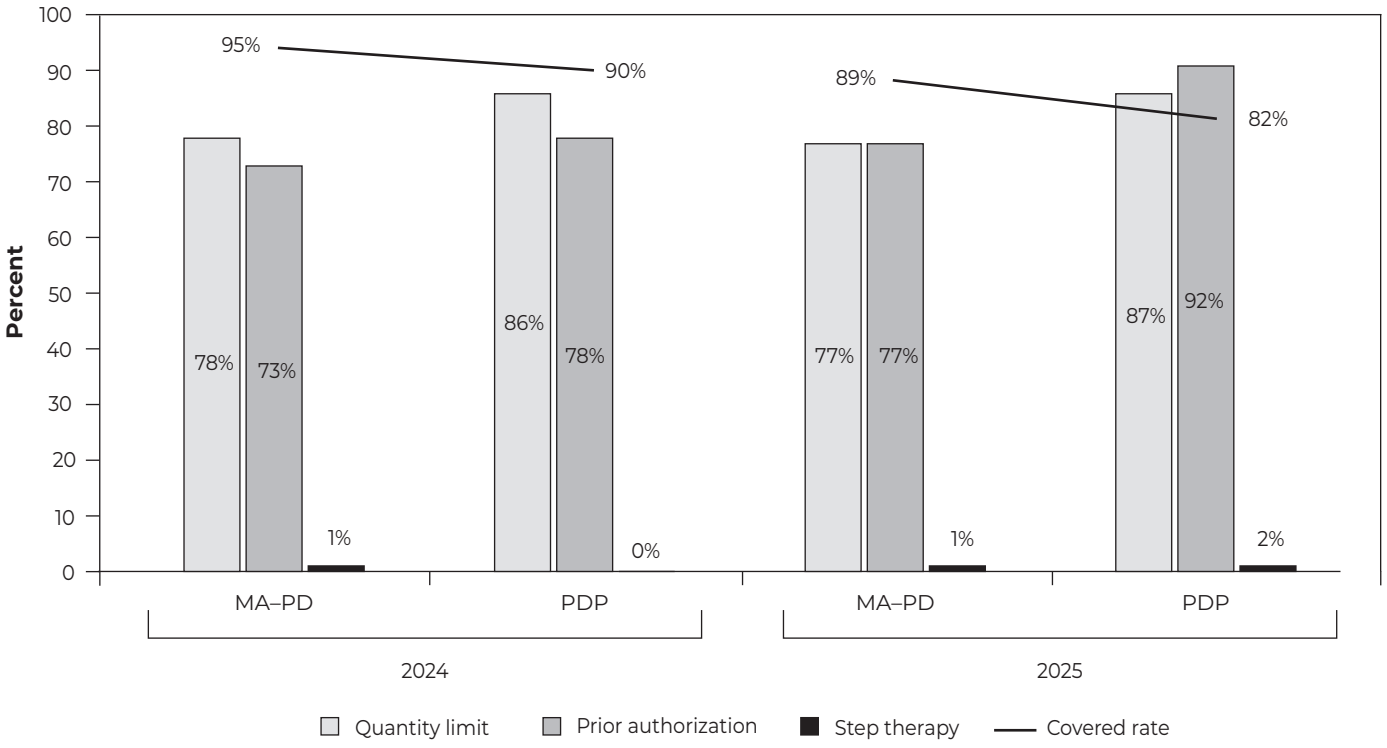
These products, in 2024, accounted for 4.1 million fills and $8.5 billion in total gross spending for MA–PDs and 4 million fills and $9.2 billion in total gross spending for PDPs. The average gross spending per fill, weighted by fills in 2024, was $2,080 for MA–PDs and $2,302 for PDPs. Seven of these products have been selected for negotiation under the Medicare Drug Price Negotiation Program.[26] There are just two generic products among these top 20, both oncology medicines, including lenalidomide (the generic of Revlimid, which is also on the list and accounted for higher gross drug costs) and abiraterone (generic Zytiga).

These products on average had high levels of coverage for both MA–PDs and PDPs, with the average MA–PD enrollee having 95 percent of these products available on their formulary in 2024, compared with 90 percent of products for PDP enrollees (Figure 4-16).

In 2024, MA–PD enrollees were more likely to find these products covered on the preferred-brand tier (24 percent) than PDP enrollees (18 percent),

FIGURE 4–17

Top 20 high-cost, high-utilization products in 2024, coverage and utilization-management rates



Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes conventional MA–PDs only, not special-needs plans. Products were selected based on highest total gross drug costs among both MA–PDs and PDPs in the first six months of 2024, with an average gross cost per fill of at least $1,000 and at least 20,000 fills for each plan type.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and prescription drug event data and enrollment data for 2024 for MedPAC.

and MA–PD enrollees had just 9 percent of these products placed on the nonpreferred tier on average compared with 16 percent for PDP enrollees. MA–PD enrollees did have a larger share of these products on the specialty tier in 2024 (60 percent on average), compared with 52 percent for PDP enrollees.

In 2024, only two products had coverage rates below 90 percent for MA–PDs; in 2025, this increased to four products, and tier placement for these products changed very little, on average, across MA–PDs between the two years.[27] PDPs, on the other hand, were less likely to cover these products in both 2024 and 2025 and had more noticeable changes in tier placement. In 2024, 3 of these 20 products had coverage rates below 90 percent; in 2025, 8 of them are covered on average for fewer than 90 percent of PDP enrollees.[28]

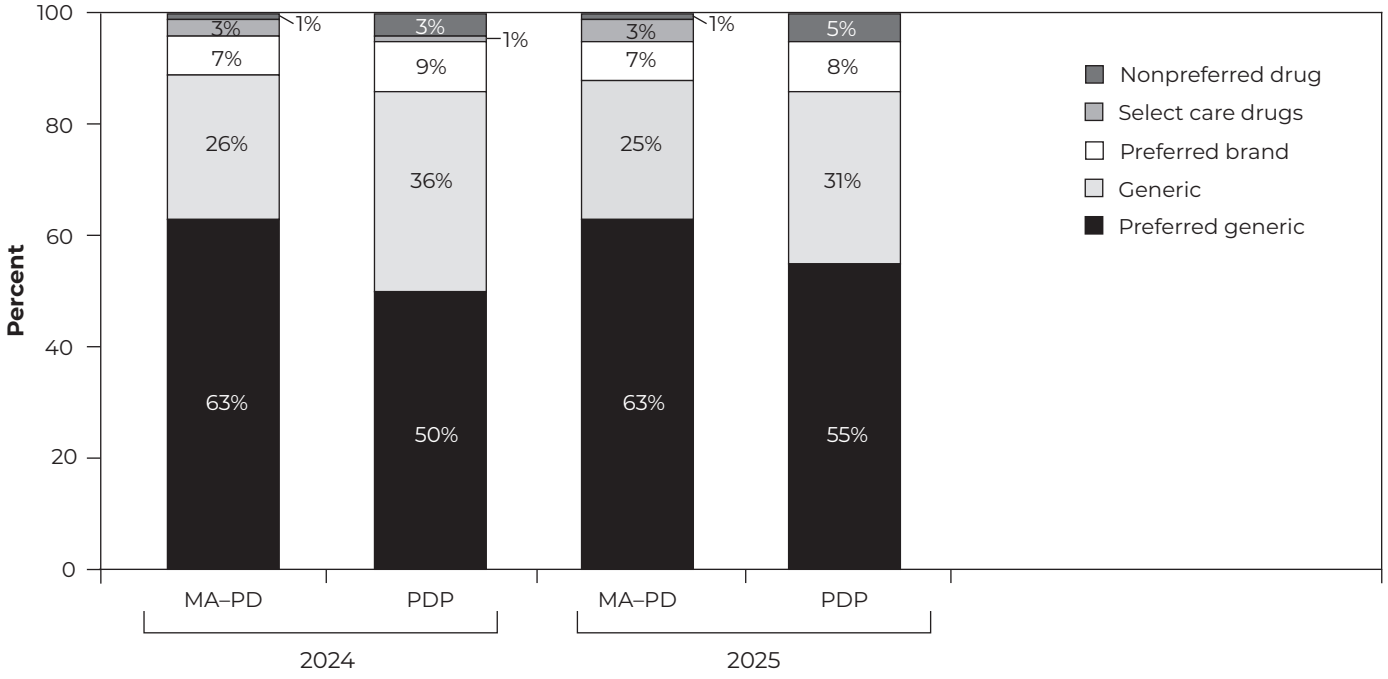
A handful of these products experienced particularly large drops in coverage rates. Across both MA–PDs and PDPs, Revlimid, Enbrel SureClick, Ingrezza, and Otezla experienced declines in coverage of between 18 percentage points and 35 percentage points. Among PDPs, Trulicity, Humira, and Rybelsus have also seen significant decreases in coverage rates in 2025 among PDPs.

All of these products had some amount of UM applied, except one.[29] On average, MA–PDs used UM tools for these products less frequently than PDPs in both 2024 and 2025.

QLs applied to 78 percent of the products for the average MA–PD enrollee and 73 percent of products for the average PDP enrollee, more than twice the rate of QLs applied across all products on average (Figure

FIGURE 4–18

Tier distribution for the top 50 generic products by fills, 2024



Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes conventional MA–PDs only, not special-needs plans. These products were the top 50 products that were among each plan type's most filled generics in the first six months of 2024.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and prescription drug event data and enrollment data for 2024 for MedPAC.

4-17). Similarly, rates of prior authorization (PA) were roughly three times higher for these products than the average rate for all products in 2024 (73 percent to 78 percent compared with 24 percent to 26 percent) and increased even more in 2025. As was true among all products, average rates of ST were very low.

Use of QLs was virtually unchanged from 2024 to 2025 for both plan types, though MA–PDs and PDPs both increased use of PA; PDPs increased PA use by 15 percentage points, so on average PDP enrollees will face PA for 92 percent of these products in 2025.

Most commonly filled generic products had near-universal coverage, primarily on generic tiers

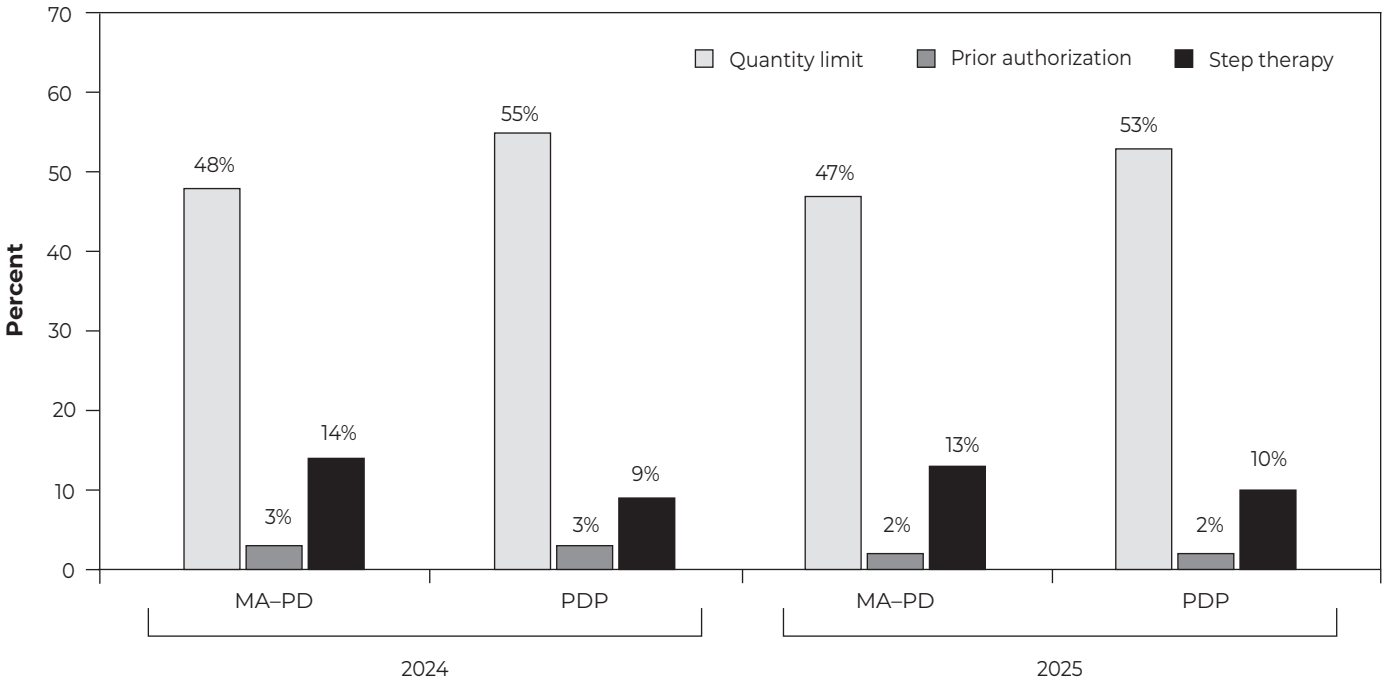
Next in our analysis, we considered the most frequently used generics, selecting the top 50 products that were among each plan type's most filled generics: These products were among the top 59 most utilized for MA–PD enrollees and the top 56 for PDP enrollees.[30] These products had an average coverage rate of 100 percent for both plan types in 2024.[31] The fill-weighted average gross spending for these 50 products per fill in 2024 was $9.99 for MA–PDs and $11.04 for PDPs.

While total coverage on generic tiers was roughly equal between MA–PDs and PDPs, MA–PDs currently have a higher share of such products on the preferred-generic tier (63 percent compared with 55 percent for PDPs in 2025) and a smaller share of products on the nonpreferred tier (1 percent compared with 5 percent among PDPs) (Figure 4-18, p. 205).

QLs were applied to roughly half of these products, on average, in 2024, with more products subject to QLs among PDP enrollees (55 percent) than MA–PD enrollees (48 percent) (Figure 4-19). However, unlike

FIGURE 4–19

Share of products subject to utilization management among top 50 generic products by fills in 2024



Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes conventional MA–PDs only, not special-needs plans. These products were the top 50 products that were among each plan type's most filled generics in the first six months of 2024.

Source: Acumen LLC analysis of Part D formulary files for 2024 and 2025 and prescription drug event data and enrollment data for 2024 for MedPAC.

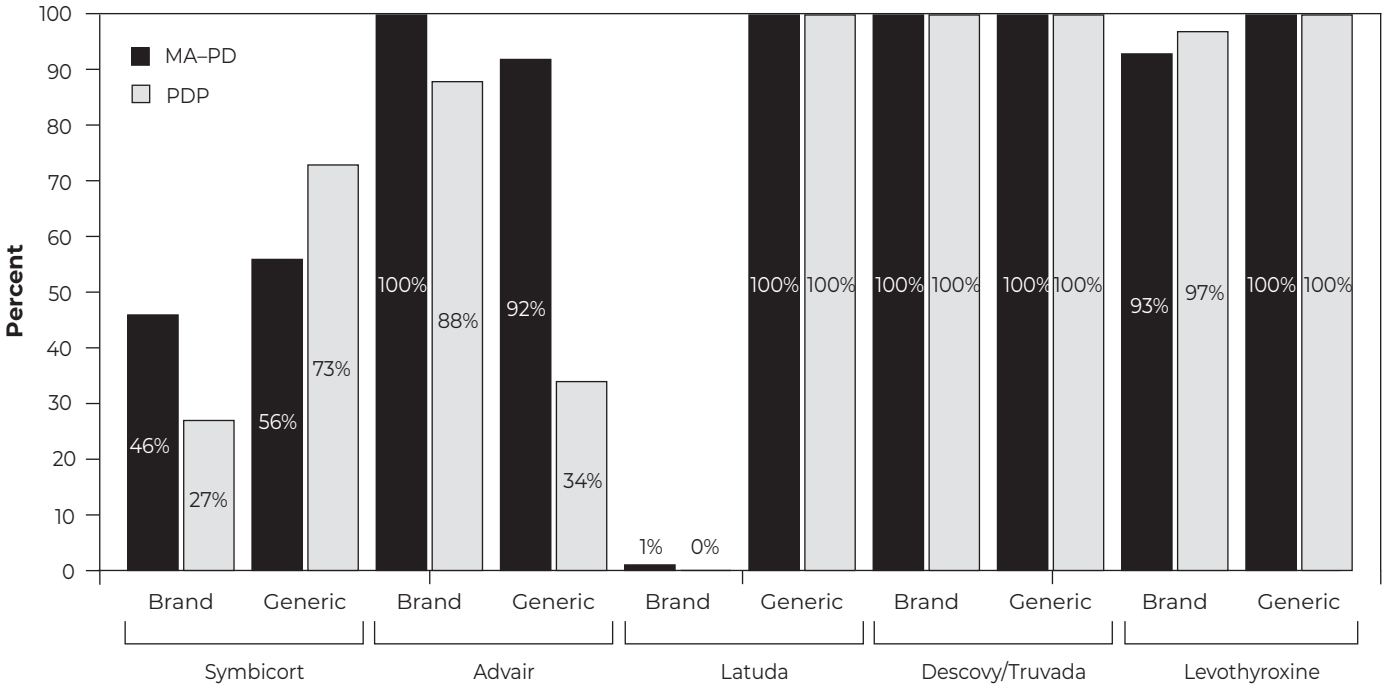
all products overall and the top 20 products with high costs and high utilization, PA rates for these products are quite low (3 percent for both plan types in 2024 and 2 percent in 2025, compared with an average of roughly 25 percent for all products); ST use is more common (roughly 10 percent or more for both plan types in 2024 and 2025, compared with an average of 3 percent for all products among both plan types). PA rates for these products were equal for MA–PDs and PDPs in each year, while MA–PDs had a higher rate of ST use than PDPs in each year (14 percent vs. 9 percent in 2024 and 13 percent vs. 10 percent in 2025). The relatively high rates of ST among these generic products are surprising because ST is usually considered a tool to encourage use of a lower-cost product before trying a more expensive product, yet these products all had an average gross cost per fill of less than $35. Further, despite the use of step therapy, these products were still among the most utilized. We do not have an explanation for the relatively high use of ST at this time.

Formulary preference for some brands remains despite generic availability

One more area of interest in this analysis was frequent plan coverage of brand-name products despite generic availability. For example, in recent years we have discussed the high coverage rates of Symbicort, Advair, Humira, and Descovy/Truvada, despite the availability of less expensive generic or biosimilar products (Medicare Payment Advisory Commission 2025, Medicare Payment Advisory Commission 2023). We found that some preference for these brand-name products still exists in 2025, even for products with authorized generics (AGs), which are generic versions of products that are manufactured by or on behalf of the same manufacturer of the brand-name

FIGURE 4–20

Average coverage rates for selected multiple-source drugs, 2025



Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes conventional MA–PDs only, not special-needs plans.

Source: Acumen LLC analysis of Part D formulary data for 2025 and enrollment data for 2024 for MedPAC.

product (Figure 4-20). For example, the AG of Advair HFA, the most commonly used Advair product by number of fills, is covered only for 12 percent of MA–PD enrollees and 14 percent of PDP enrollees, while the branded version is covered for roughly 60 percent of all PDP and MA–PD enrollees (data not shown). The AG of Advair Diskus, by contrast, is covered more favorably than the brand and at a similar rate as the other generic version, among both MA–PDs and PDPs in 2025.

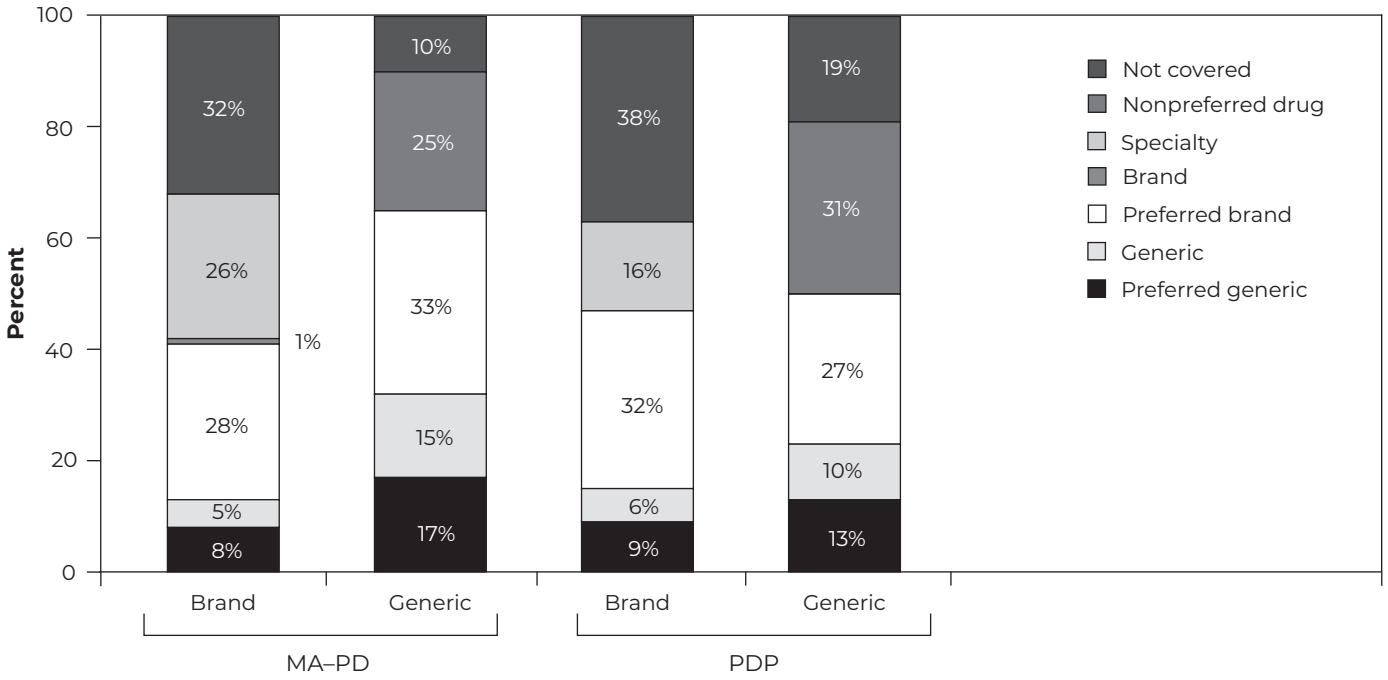
However, if we also consider tier placement and the use of UM, a fuller picture emerges. For many of these products, plans have placed the branded and generic versions on the same tiers, with some branded products on generic tiers and some generics being mostly placed on a brand tier (Figure 4-21, p. 208). In fact, the generic version of Descovy/Truvada is on the nonpreferred tier for 85 percent of MA–PD enrollees and 100 percent of PDP enrollees, while the branded versions are on the specialty tier for 93 percent of MA–PD enrollees and 100 percent of PDP enrollees. The AG of Advair HFA, when it is covered, is primarily on the nonpreferred tier, while the branded product is almost exclusively on the preferred-brand tier.

The application of UM tools also places generics for several of these products at a disadvantage, particularly among PDPs. PDPs are applying some form of UM to the generic versions of these products for 80 percent of their enrollees, but only 57 percent of enrollees will face UM for the branded version. MA–PD plans apply UM roughly equally across the brand and generic versions of these products.

The findings of our analyses are consistent with the findings of other studies examining Part D coverage rates, tier placement, UM, and OOP costs from recent years. For instance, Joyce and colleagues found that prior to the IRA, PDPs were slightly more likely to

FIGURE 4–21

Coverage and tier placement for select products, 2025



Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes conventional MA–PDs only, not special-needs plans.

Source: Acumen LLC analysis of Part D formulary data for 2025 and enrollment data for 2024 for MedPAC.

exclude products from coverage, and the use of UM tools increased for both plan types from 2011 through 2020 (Joyce et al. 2024).

One study found that despite lower expenditures for basic coverage relative to PDPs, in 2019, MA–PDs covered 81 percent of drugs within a class, on average, compared with 74 percent of products covered per class in PDPs. MA–PDs were also found to cover slightly more excluded drugs (such as vitamin supplements and cough and allergy relief products) than PDPs, though the difference is not enough to explain MA–PDs' higher costs for supplemental coverage (Ippolito and Vabson 2024).

Several studies have found that PDPs were using coinsurance at greater rates than MA–PDs, even before the benefit changes of the IRA began to take effect (Axelsen et al. 2024, Cubanski and Damico 2024, Trish et al. 2025), and greater coinsurance rates are associated with higher patient OOP costs (Trish et al. 2025). Another study found that MA–PD enrollees, on average, had 24 percent lower OOP costs than PDP enrollees in 2019, largely as a result of MA–PD sponsors' ability to use MA rebates to provide supplemental coverage to lower enrollees' cost-sharing liabilities (Ippolito and Vabson 2024).

MA plans' ability to document additional diagnosis codes may contribute to higher Part D risk scores

Under Part D, Medicare's subsidy takes the form of two distinct payments: (1) capitated payments called the "direct subsidy" and (2) cost-based reinsurance payments that cover a portion of an individual's drug spending above the benefit's OOP limit. As explained above, Medicare's direct-subsidy payments are risk adjusted to reflect the expected costliness of each enrollee, using the prescription drug hierarchical

condition category (RxHCC) risk-adjustment model. The model uses demographic information and documented medical conditions to predict an enrollee's Part D costs, similar to the way the CMS hierarchical condition category (CMS–HCC) risk-adjustment model adjusts payments to MA plans based on expected costs under Part A and Part B (see text box on Part D's risk-adjustment model, pp. 210–211).

Because the CMS–HCC model uses FFS Medicare claims data to estimate the size of the model coefficients, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic-coding patterns. When MA plans submit more diagnoses for a beneficiary, the payment to the plan increases. This financial incentive to submit more diagnosis codes generally does not exist in FFS Medicare, particularly for physician and outpatient services, which tend to be paid based on procedure codes and account for the majority of diagnoses used in risk adjustment.

MA plans cover the Part A and Part B benefit and have contractual relationships with physicians and hospitals that are the source for diagnostic data used in risk adjustment for MA and Part D payments. Therefore, MA plans can influence diagnostic-coding behavior by offering those providers financial incentives to document more diagnosis codes, such as through pay-for-coding programs, in which plans pay physicians to document more diagnoses, or through subcapitation, in which a portion of higher payments generated by greater coding intensity is retained by subcapitated providers. PDPs do not have such relationships and cannot influence diagnostic-coding behavior in the same way. Furthermore, MA plans have several tools that are unavailable in FFS Medicare to code more diagnoses, including the use of health risk assessments and chart reviews (Medicare Payment Advisory Commission 2025). PDPs do not have a mechanism for using these kinds of tools.

Given the overlap of diagnostic-data sources (physician and hospital claims and encounters) and conditions in the CMS–HCC and RxHCC models, the effects of coding intensity are directly linked between the two risk-adjustment models. Specifically, for the 82 percent of RxHCC model diagnoses that are also included in the CMS–HCC model, higher MA diagnostic-coding intensity relative to FFS transfers directly into higher MA–PD coding intensity relative to PDPs.

Estimating differences in coding intensity between MA–PDs and PDPs

For the past several years, the Commission has evaluated the effects of coding intensity on the CMS–HCC risk scores that are used to pay MA plans for providing services covered under Part A and Part B. To conduct this analysis, we use the demographic estimate of coding intensity (DECI) method that is described in our March 2025 report (see Appendix 11-B). The method compares MA and FFS CMS–HCC risk scores and controls for differences in age, sex, Medicaid eligibility, and institutional status using a separate risk score based on only those demographic factors. The method implicitly assumes that MA enrollees have similar rates of health conditions when compared with FFS Medicare beneficiaries with similar demographic characteristics.

Our analysis of the effects of coding intensity in Part A and Part B shows that MA risk scores relative to FFS have increased over time and were about 17 percent higher than FFS risk scores for similar beneficiaries in 2023 due to coding intensity before accounting for CMS's adjustment for coding intensity (Medicare Payment Advisory Commission 2025). Several studies using a variety of methods and data sources have produced estimates of MA coding intensity relative to FFS that are consistent with our estimates (Congressional Budget Office 2017, Geruso and Layton 2020, Government Accountability Office 2013, Hayford and Burns 2018, Jacobs and Kronick 2018, Kronick and Chua 2021, Kronick and Welch 2014). These results support the assumption that MA enrollees and FFS Medicare beneficiaries with similar demographic characteristics have similar rates of health conditions. Given the overlap in data sources and diagnoses used in the CMS-HCC and RxHCC risk models, we believe that the assumption of similar rates of health conditions is valid for RxHCCs, but we also note that this is the first known study assessing coding intensity in Part D and therefore there are no other studies currently available for comparison.

Evaluating the effects of coding intensity in Part D differs from our analysis of MA coding intensity. Because the RxHCC risk-model coefficients are estimated using all enrollees with Part D coverage (enrollees in both MA–PDs and PDPs), we estimate the effects of coding intensity separately for MA–PDs and PDPs relative to the overall Part D population. Although

Part D's risk-adjustment model

Direct-subsidy payments are calculated based on plan bids that reflect plans' expected basic-benefit costs for an enrollee with average expected costliness. These direct-subsidy payments are adjusted by risk scores—an index of beneficiaries' expected cost—that increase Medicare's payments to plans for beneficiaries who are expected to have higher Part D spending based on their demographics and recorded diagnoses, and vice versa. The goal of risk adjustment is to accurately adjust payments to plans for the expected costs of their enrollees, thereby limiting plan incentives to engage in risk selection (i.e., attracting or avoiding enrollees with certain conditions).

The prescription drug–hierarchical condition category (RxHCC) model uses demographic information (age, sex, disability, institutional status, and eligibility for low-income subsidies) and certain diagnoses to adjust payments to Part D plans. The diagnostic information comes from physician, inpatient hospital, and outpatient hospital records in Medicare Advantage (MA) encounter data or fee-for-service (FFS) claims data in the same manner that codes are used in the CMS hierarchical condition category (CMS–HCC) model that adjusts payments to MA plans.[32]

Diagnoses included in the RxHCC model are grouped into condition categories, which are ranked into hierarchies for similar conditions (e.g., diabetes with and without complications). A diagnosis needs to be submitted just once per year for a given RxHCC to count for a beneficiary, and only the highest-ranked RxHCC in a hierarchy counts for beneficiaries with multiple RxHCCs in a hierarchy.

This method of calculating risk scores is similar to the CMS–HCC model used to risk adjust payments to MA plans. Notably, the sources of diagnostic information used in the CMS–HCC and the RxHCC models are the same, and there is substantial overlap in the diagnoses used in the two models. We found that about 82 percent of the diagnoses used in the RxHCC model were also used in the CMS–HCC model in each of the years between 2019 and 2023.[33]

Each demographic and RxHCC component in the model has a coefficient that represents the expected gross plan costs (the portion of gross drug spending for which plans bear insurance risk) associated with that component.[34] The sum of these dollar-value coefficients is converted to a risk score by dividing by average gross plan costs for the Part D basic benefit. A risk score of 1.0 represents an enrollee with average costliness. Higher risk scores result in

(continued next page)

RxHCC risk scores are based on the overall Part D population, higher MA coding intensity relative to FFS Medicare would still provide MA–PDs with advantages over PDPs if higher coding intensity translates to higher RxHCC risk scores for enrollees in MA–PDs. However, those differences in coding intensity generally do not increase Part D program spending, unlike in MA, where coding intensity that is higher than in FFS increases payments to MA plans.

To apply the DECI method to RxHCC risk scores, for enrollees in MA–PDs, PDPs, and the overall Part D population, we calculated average RxHCC risk scores and average demographic risk scores separately for enrollees with institutional status, those eligible for the LIS, and those not eligible for the LIS. Then we calculated average RxHCC and demographic risk scores for MA–PDs, PDPs, and Part D overall using the share of all Part D enrollees in each group as weights. Finally, we calculated separate DECI estimates for MA–PD and PDP enrollees using the formula in Figure 4-22 (p. 212).

Up to this point, the calculation of MA–PD and PDP coding intensity includes only "continuing" enrollees

Part D's risk-adjustment model (cont.)

higher direct-subsidy payments. A "normalization factor" is applied to keep the average beneficiary risk score at 1.0 by offsetting year-to-year changes in the average risk score.

The RxHCC model differs from the CMS–HCC model in two important ways. First, the normalization factor for the RxHCC model is calculated across all Part D enrollees, so a 1.0 risk score is maintained across enrollees in both MA–PDs and PDPs. As a result, differential changes in risk scores across enrollees in MA–PDs and PDPs are, by themselves, budget neutral for Medicare (though they could have distributional implications across plans). In 2025, CMS began applying separate normalization factors for MA–PDs and stand-alone prescription drug plans (PDPs) to "more accurately reflect Part D costs in each of these two sectors" (Centers for Medicare & Medicaid Services 2024c). The agency noted that the RxHCC model has historically overpredicted costs for MA–PDs and underpredicted costs for PDPs. That means that, on average, the RxHCC model historically produced risk scores that reflect expected spending that is higher than actual spending for MA–PDs and reflect expected spending that is lower than actual spending for PDPs. The separate normalization factors for 2025 (0.955 for PDPs and 1.073 for MA–PDs) 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 Part D enrollees. In contrast, the normalization factor for the CMS–HCC model is calculated across fee-for-service (FFS) beneficiaries and maintains a 1.0 risk score only among FFS beneficiaries. Because the CMS-HCC normalization factor accounts only for FFS risk-score trends over time, greater increases in MA risk scores relative to FFS result in higher Medicare payments to MA plans (i.e., higher MA coding intensity is not budget neutral for Medicare's Part C payments to plans).

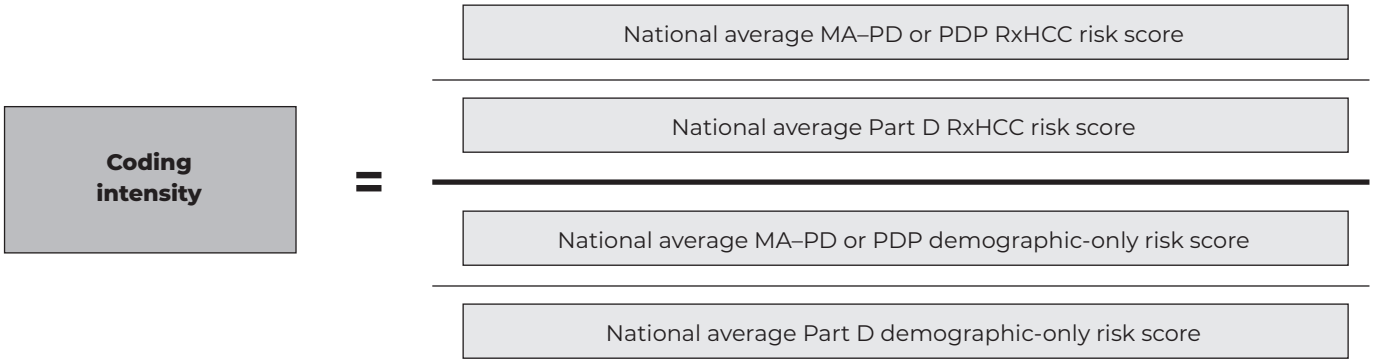
Second, RxHCC model coefficients are estimated using gross plan costs rather than net plan costs, which reflect postsale rebates and fees that can vary by plan and across therapeutic class. As a result, the accuracy of the RxHCC model coefficients reflecting relative plan costs for different demographic and condition components can vary across plans and therapeutic classes (Medicare Payment Advisory Commission 2021). These postsale rebates and fees have grown rapidly, accounting for 31 percent of gross spending in 2022, up from 11 percent in 2010. In contrast to the RxHCC model that uses data for PDPs and MA–PDs, in MA, the CMS-HCC risk-adjustment model coefficients are estimated using FFS claims data and therefore reflect FFS prices for items and services. ■

who have an RxHCC risk score that includes diagnostic information. ("New enrollees" to Medicare have a risk score that is based only on demographic information.) The last step in the calculation is to incorporate the effect of new enrollees, for whom we attribute no coding-intensity effect because their risk scores do not include diagnostic information. The continuing and new-enrollee group weights are based on the share of enrollees and the average risk score for enrollees in each status. Figure 4-23 (p. 213) shows the MA–PD and PDP coding-intensity estimates for 2019 through 2023.

Our estimates show that, relative to the overall Part D population, differences in coding intensity produced higher risk scores for MA–PD enrollees and lower risk scores for PDP enrollees on average. In the aggregate, MA–PD risk scores were about 4.7 percentage points higher than PDP risk scores due to coding intensity in 2019, increasing to about 9.2 percentage points higher in 2022 before falling to 7.6 percentage points higher in 2023. A new RxHCC risk-adjustment model was introduced in 2023, which may contribute to the reduced impact on coding intensity in 2023.

FIGURE 4–22

DECI method estimates coding intensity as the ratio of two ratios



Note: DECI (demographic estimate of coding intensity), MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan), RxHCC (prescription drug–hierarchical condition category).

Source: MedPAC adaptation of methods published in Kronick and Chua 2021.

Prior to 2025, higher MA–PD coding intensity resulted in higher payments to MA–PDs and lower payments to PDPs because the RxHCC model was normalized to a 1.0 risk score across the whole Part D population. Starting in 2025, CMS uses separate normalization factors for MA–PDs and PDPs, based on historical MA–PD and PDP risk-score trends that will account for the difference in projected risk scores in the two markets. However, systematic differences between PDPs and MA–PDs in coding would still compromise the ability of the RxHCC model to accurately predict costs because the coefficients from the model are estimated based on the pooled population of MA–PD and PDP data. In turn, those inaccuracies affect enrollee premiums and payments to plans.

Coding differences may affect Part D plan bids and premiums

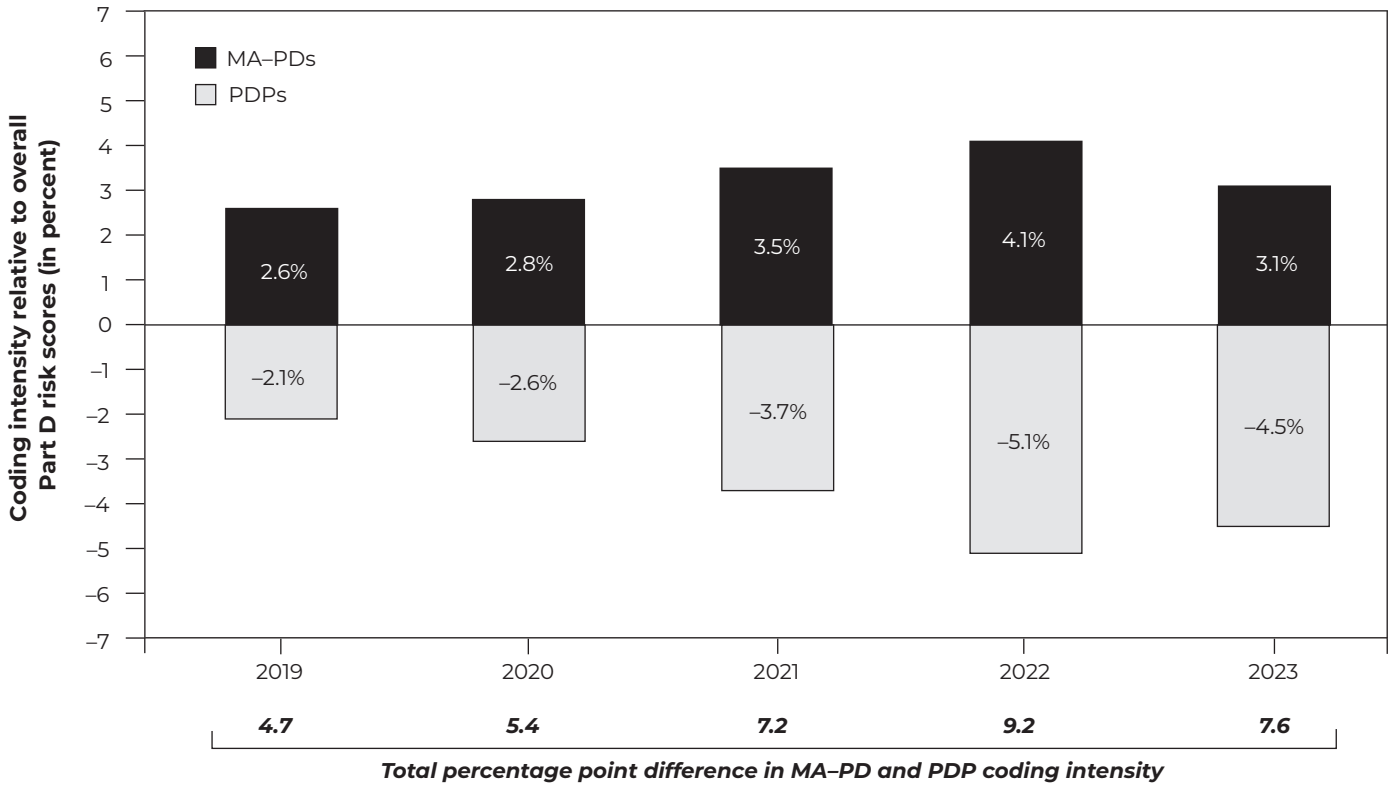
Increases in a plan's risk scores due to higher coding intensity are offset by a reduction in risk scores for plans with lower coding intensity. Higher or lower risk scores due to relative coding intensity can affect plan payments through their bids and therefore can affect enrollee premiums. Prior to 2025, when a single normalization factor was used for Part D risk scores, differences in coding intensity between MA–PDs and PDPs contributed to payment and premium differences in the MA–PD and PDP markets. Starting in 2025, separate MA–PD and PDP normalization factors are intended to eliminate the risk-score differences between MA–PD and PDP markets, but differences in coding intensity across plans within each market will remain and can have similar effects on plan payments and enrollee premiums.

We illustrate how coding differences mechanically affect plan bids and enrollee premiums using a hypothetical example in which we assume that higher coding intensity by Plan A results in an average risk score for that plan that is 10 percent higher (a risk score of 1.10) than the overall average (Table 4-3, p. 214). Because the RxHCC is normalized to 1.0 across both plans, the average risk score for Plan B would necessarily be lower than 1.0 (in this example, 0.90). For simplicity, we also assume that the average expected basic-benefit cost per enrollee is the same ($50) for both Plan A and Plan B. Risk-standardized plan bids (standardized to a 1.0 risk score) are then equal to the average expected cost divided by the average risk score, or $45 and $56 for Plan A and Plan B, respectively.

CMS calculates the national average monthly bid amount (NAMBA) as the enrollment-weighted average

FIGURE 4–23

Estimated impact of coding intensity on Part D risk scores was positive for MA–PDs and negative for PDPs, 2019–2023



Note: DECI (demographic estimate of coding intensity), MA–PD (Medicare Advantage prescription drug [plan]), PDP (prescription drug plan). PDPs provide drug coverage for beneficiaries in fee-for-service Medicare who choose to enroll. Most beneficiaries in Medicare Advantage are enrolled in MA–PDs. In this figure, "MA–PD" includes both conventional MA–PDs and special-needs plans. All estimates account for any differences in age, sex, low-income subsidy eligibility, and institutional status between MA–PD and PDP enrollees. New enrollees are constrained to have no coding intensity because their risk scores are not based on diagnostic coding.

Source: MedPAC analysis of CMS enrollment and risk-score files.

of the standardized bid across all Part D plans. The NAMBA is used to set the base beneficiary premium (BBP), which reflects the enrollees' share of the total basic-benefit cost, including reinsurance. The risk-standardized plan bid (RSPB) is calculated by dividing the average expected basic benefit cost by the average risk score. In this example, $50 divided by 1.10, or $45, would be Plan A's RSPB and $50 divided by 0.90, or $56, would be Plan B's RSPB.

A plan's enrollee premium and direct-subsidy amounts are both affected by the plan's risk score. This is because the RSPB is the basis for calculating both the premium and the direct-subsidy amount:

Enrollee premium

= BBP + (RSPB − NAMBA)

= $30 + ($45 - $51), or $25, for Plan A

= $30 + ($56 - $51), or $35, for Plan B

Direct subsidy per enrollee

= RSPB × average risk score − premium

= $45 × 1.10 − $25, or $25 for Plan A

= $56 × 0.90 − $35, or $15 for Plan B

TABLE 4–3

Hypothetical example of the effects of coding difference on plan payments and profitability

	Plan A	Plan B	All Part D	
				Overall average amounts
Average expected basic benefit cost per enrollee (plan bid)	$50	$50		$50
Part D market share	50%	50%		100%
Average risk score	1.10	0.90		1.00
Plan bid standardized to a 1.0 risk score (RSPB)	$45	$56	NAMBA	$51
Enrollee premium	25	35	BBP	30
Direct subsidy per enrollee (RSPB × average risk score – premium)	25	15		21

Note: RSPB (risk-standardized plan bid), NAMBA (national average monthly bid amount), BBP (base beneficiary premium). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. A plan bid reflects the plan's average expected cost of providing the basic benefit to their enrollees. "Direct subsidy" is a capitated payment made by Medicare to Part D plans, calculated as a share of the national average of plan bids. This example assumes that neither plan faces any reinsurance. Figures are rounded to the nearest whole number.

That is, because of higher coding intensity, the enrollee premium for Plan A is $25, or $10 below the premium for Plan B, which is $35. For the direct-subsidy calculation, higher coding intensity translates to $10 in higher direct-subsidy amounts for Plan A ($25) compared with Plan B ($15).

The IRA redesign may amplify the effects of current policies and other differences between PDPs and MA–PDs

Financing of Part D's prescription drug spending is divided between spending paid in premiums (including the portion subsidized by Medicare) and costs paid either OOP by beneficiaries or by Medicare's LIS at the point of sale when beneficiaries fill their prescriptions.[35] The Medicare program subsidizes premiums through the capitated direct subsidy and through cost-based reinsurance for a portion of spending above the annual OOP threshold. Importantly, plans serve as a pass-through for these payments, retaining a portion of them for their administrative costs and profits. The ultimate costs of prescription drug spending are borne by beneficiaries through their monthly premiums and cost sharing when they fill prescriptions and by taxpayers through Medicare's subsidies.

One key change made by the IRA concerns the shift in financing of prescription drug spending from cost sharing paid by beneficiaries when they fill prescriptions to premiums (paid by enrollees and Medicare). That shift was largely achieved by imposing an annual limit on cost sharing paid by beneficiaries. To the extent that the annual OOP cap induces greater utilization of drugs, that would put upward pressure on premiums. (The uncertainty around the magnitude of that utilization effect may account for some of the variation in bids submitted by Part D plans.)

Shift toward premium financing does not, by itself, imply that beneficiaries are paying more in total for prescription drugs. It largely represents a shift from cost sharing paid at the POS to premiums paid by all enrollees (and subsidized by Medicare). This change effectively spreads costs from a small number of beneficiaries with high drug spending to the broader Part D population and to taxpayers who subsidize Part D's benefit costs. In fact, due to the manner in which the IRA and the subsequent demonstration (discussed below) capped enrollees' share of increases in premiums, in 2025, average enrollee premiums were expected to remain stable (Centers for Medicare & Medicaid Services 2024a). At the same time, as a result of changes

TABLE 4–4

Changes in Part D national average monthly bid amount, base premium, and average subsidies, 2024–2025

	2024	2025	Change (in percent)
Total expected basic-benefit cost	$154	$220	42%
National average monthly bid amount	64	179	179
Medicare's average expected reinsurance	90	40	–55
Base beneficiary premium	35	37	6
Uncapped BBP	39	56	42
Medicare's total subsidy	120	183	53
Medicare's average direct subsidy	30	143	382

Note: BBP (base beneficiary premium). Under Part D, basic benefits offered by plans must use the standard benefit defined in law or, if using an alternative benefit structure, must be actuarially equivalent to the standard benefit. Medicare subsidizes the costs of Part D's basic benefits through direct subsidy (a capitated payment to plans calculated as a share of the adjusted national average of plan bids) and individual reinsurance (a cost-based payment to plans for a portion of drug spending above the annual out-of-pocket limit). Medicare's total subsidy is the amount of total expected basic-benefit costs that are paid by Medicare through these subsidies. Percentage changes were calculated on unrounded figures.

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

made by the IRA, in 2025, cost sharing paid at the POS, particularly among those with high drug spending, is expected to decrease (Assistant Secretary for Planning and Evaluation 2024b).

Another key change made by the IRA shifted more of the insurance risk to plans by increasing the share of basic benefit costs that plans are paid on a capitated basis (Medicare's direct subsidy) while reducing the share that is paid based on actual costs (Medicare's reinsurance). This change, combined with the shift toward premium financing described above, heightens the importance of Part D's risk adjustment for determining accurate plan premiums and subsidies.

As we describe below, the increase in bids for 2025 (relative to the 2024 average bid amount) is significantly larger than the amount CMS expected based on changes made by the IRA. In 2023, CMS estimated that the IRA changes will roughly double gross plan liability, and many, including CMS, expected Part D's risk adjustment to take on much greater importance (Centers for Medicare & Medicaid Services 2023, Robb et al. 2024). Some of the increase can largely be explained by higher-than-expected spending growth in 2023 and thus preceded the planned implementation of the benefit design in 2025 (Congressional Budget Office 2024, Medicare Payment Advisory Commission 2025).

At the same time, the IRA's changes may further amplify the diverging trends between MA–PDs and PDPs that arise from certain aspects of MA and Part D policies and other differences between the two markets. Because MA–PDs have additional tools, including MA rebates and higher coding intensity, available to lower enrollee premiums, the Part D redesign may make MA–PDs relatively more attractive to beneficiaries and contribute to the ongoing shift from FFS to MA.

For 2025, Medicare's average direct subsidy rose by nearly fivefold to $142.67, up from just under $30 in 2024 (Centers for Medicare & Medicaid Services 2024b).[36] As described above, the NAMBA, which is used to determine the level of Medicare's capitated direct subsidy for the Part D benefit and the premiums enrollees will pay, rose by nearly 180 percent, while expected reinsurance declined by 55 percent (Table 4-4).

The announcement of the national average bid amount was accompanied by the unveiling of a new voluntary

Risk corridors used for participating PDPs under the Part D Premium Stabilization Demonstration

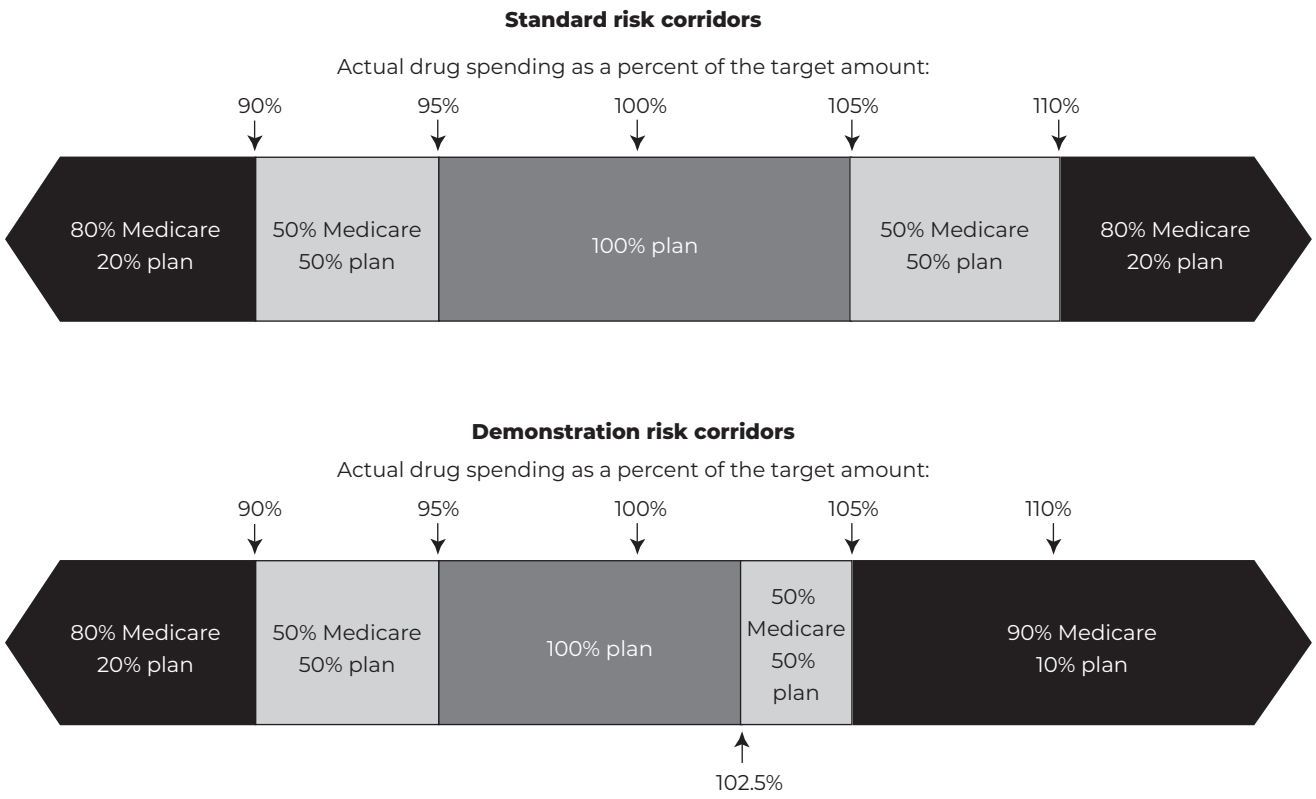
One of the mechanisms Part D uses to share the insurance risk that plans bear is through a protection provided by Part D's risk corridors. Risk corridors limit a plan's overall losses or profits (beyond the amounts assumed in plan bids) by financing some of the higher-than-expected costs (or recouping excessive profits). The "standard" risk corridors are symmetric in that the same thresholds and risk-sharing percentages apply to both losses and profits (Figure 4-24).

For example, if a plan's costs are between 5 percent and 10 percent above the target amount (TA), the losses incurred in the risk corridors are split 50/50 between Medicare and the plan (i.e., Medicare makes payments to the plan for 50 percent of the losses incurred above 105 percent of the TA). Similarly, if costs are between 5 percent and 10 percent below the plan's TA, Medicare recoups 50 percent of the excess profits.

(continued next page)

FIGURE 4–24

Risk corridors under the Part D Premium Stabilization Demonstration differ from the standard risk corridors



Note: "Target amount" is equal to the plan bid minus administrative costs and profits. Risk corridors limit a plan's overall losses or profits (beyond the amounts assumed in plan bids) by financing some of the higher-than-expected costs or recouping some of the excessive profits.

Source: MedPAC depiction of Part D's risk corridors.

Risk corridors used for participating PDPs under the Part D Premium Stabilization Demonstration (cont.)

Risk corridors that apply to stand-alone prescription drug plans (PDPs) participating in the Part D Premium Stabilization Demonstration ("the demonstration") are different from the standard risk corridors in that they provide more generous protection from losses while maintaining the same risk-sharing thresholds and percentages for profit sharing. For losses, plans are at full risk (i.e., 100 percent of the cost) for costs up to 2.5 percent above their TAs, rather than up to 5 percent above their TAs under the standard risk corridors. In addition, under the demonstration, Medicare will reimburse plans for 90 percent of the losses above 105 percent of their TAs, instead of the 50 percent that applies for losses between 105 percent and 110 percent of the TA and 80 percent above 110 percent of the TA under the standard risk corridors. These changes to the risk corridors are expected to increase Medicare's costs because Medicare will finance more of the losses while allowing plans to keep a larger share of their profits (relative to the share of losses they assume) in the risk corridors. ■

nationwide demonstration, the Part D Premium Stabilization Demonstration for 2025, which would reduce monthly enrollee premiums for participating PDPs by up to $15 (Centers for Medicare & Medicaid Services 2024b). The demonstration requires participating PDPs to limit the annual increase in their total monthly premiums (i.e., the sum of the Part D basic and Part D supplemental premiums) to no more than $35 and provides more generous protection from losses under Part D's risk corridors (see text box on the risk corridors used under the demonstration). The Congressional Budget Office expects that the additional subsidies paid to PDPs under the demonstration would increase federal spending for Part D by roughly $5 billion in 2025 (Swagel 2024).

According to CMS, all PDPs (with the exception of 36 EGWPs) are participating in the demonstration, which has kept the average PDP premiums stable (with a slight decrease in the average total monthly premiums of $1.63 for PDPs) (Centers for Medicare & Medicaid Services 2024a).[37] The average total monthly premiums for MA–PDs (after the application of MA rebates) also declined (by $2.06), which is notable because MA–PDs were not eligible to participate in the premium stabilization demonstration. Even with the demonstration, average monthly premiums for PDPs remained substantially above those of MA–PDs.

Further, some have raised concerns about how increased plan liability under the redesigned benefit will affect plan formularies. In particular, some have argued that because PDPs will be under greater financial pressure (without MA rebates to help finance the increased basic benefit costs), they may respond by changing benefits and formularies to make their plans less generous (Axelsen 2024, Manatt 2024). This consequence, in turn, may affect both plan participation and beneficiary enrollment in the PDP market.

Our analysis of changes in formularies under the first year of the redesigned benefit shows a general tightening of plan formularies for both PDPs and MA–PDs. The magnitude of average changes, however, appears to be generally consistent with the trends over the last several years, in which we have observed a general uptick in the use of coinsurance on brand-name drugs as well as in the use of utilization-management tools. As a result, it is difficult to determine the extent to which the benefit redesign has accelerated the trend toward tighter formularies. ■

Endnotes

1 As a result of the changes made by the IRA, beginning in 2024, the annual increase in the base premium is limited to no more than 6 percent. When this provision is binding (as has been the case in 2024 and 2025), the beneficiary's share of Part D benefit costs is less than 25.5 percent; as a result, Medicare's subsidy rate can be higher than the 74.5 percent specified in law.

2 See Endnote 1.

3 See Endnote 1.

4 Between 2006 and 2010, the average number of stand-alone PDPs offered per region ranged from 42 to 55.

5 MA–PDs may vary based on either the medical or drug coverage they offer, as well as the supplemental benefits provided under MA. Thus, the figure for the number of MA–PD offerings may not reflect the number of truly unique drug coverage options, but rather the various combinations of different medical and drug benefits that are covered.

6 The five largest firms operating in the Part D market in 2024 included UnitedHealth Group, Centene, Humana, CVS Health, and Elevance Health. In 2014, the five largest firms included the three insurers that were among the largest in 2024 (UnitedHealth Group, Humana, and CVS Caremark). The other two were Aetna, which was subsequently acquired by CVS Health, and WellCare Health Plans, which was acquired by Centene in 2020. The analysis excludes employer group waiver plans, which are open only to retirees of the employers that sponsor such plans.

7 In 2024, the five largest firms (in each PDP region) accounted for 80 percent of the region's total conventional MA–PD and SNP enrollment in 21 and 25 PDP regions, respectively, up from 19 and 13 PDP regions, respectively, in 2014.

8 The HHI approaches zero when a market is occupied by a large number of firms of relatively equal size and reaches its maximum of 10,000 points when a market is controlled by a single firm. The U.S. Department of Justice generally considers markets in which the HHI is between 1,000 and 1,800 points to be moderately concentrated and considers markets in which the HHI is in excess of 1,800 points to be highly concentrated (Department of Justice and Federal Trade Commission 2023).

9 The definition of a firm used here (11 firms in 2024 and 7 firms in 2025) differs from the definition used for reporting the number of sponsoring organizations in the market-concentration analysis above, which is based on unique counts of parent organizations that sponsor Part D plans, as reported to CMS in the Part C and Part D data submissions.

10 Because of the salience of the premiums in choosing among Part D plan options, beneficiaries may not always choose a Part D plan that is the "best option" for them from the financial perspective when considering out-of-pocket costs, including premiums and cost-sharing liabilities (Abaluck and Gruber 2011).

11 The average Part D premium for PDPs reflects the effects of the Part D Premium Stabilization Demonstration, which provided additional subsidies to limit the annual increase in premiums for individual PDPs in 2025. It does not, however, reflect the effects of any enrollment changes for the 2025 benefit year.

12 Part D law includes a contingency plan to ensure that FFS beneficiaries have a minimum of two Part D options (which may not be offered by the same plan sponsor) and must include at least one PDP, which would by default qualify as a benchmark plan. When that minimum requirement is not met in any given region, the law allows the Secretary to approve plan(s) that administer Part D's prescription drug benefit without taking insurance risk (or assuming only limited insurance risk).

13 At least seven of these regions included among their two benchmark plans a PDP that was terminated effective December 31, 2024, after being under CMS sanction for failing to maintain a Part D summary plan-rating score of at least 3 stars. Plans that are under CMS sanction may not receive auto-enrollment of LIS beneficiaries.

14 The range for the share of enrollees with the LIS reflects the 10th and 90th percentiles of the distribution.

15 TAs exclude administrative costs and profits that are 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.

16 The overall average TA dropped from about $70 per month in 2012 to just under $30 per month in 2022. On average, plans with lower TAs were more likely to have risk-corridor losses compared with plans that had higher TAs. This pattern was generally true for all plan types.

17 For MA plans, the addition of the prescription drug benefit may allow for more targeted selection by "setting generous

cost-sharing rules for drugs taken by beneficiaries that tend to have below-average medical expenses conditional on their diagnosis" (Han and Lavetti 2017). Lavetti and Simon show that MA plans design drug formularies that are significantly different from stand-alone Part D plans in ways that encourage advantageous selection (with respect to HCCs) (Lavetti and Simon 2018).

18 MA plans can also use rebates to reduce cost sharing for Part A and Part B services, cover services not covered by Medicare (including dental, vision, and hearing services), or reduce beneficiaries' Part B premiums.

19 The sponsors of MA–PDs may decrease or increase Part D supplemental premiums to adjust for excessive or insufficient rebate allocation to achieve the target amount for their Part D basic premiums. However, sponsors may not make any other modifications to the benefit design, pricing of the Part D basic benefit, the supplemental benefit, administrative costs, or margin that is built into their initial bids. Limited changes may be allowed to the supplemental benefit if the total Part D premium would be negative without such change (according to Appendix E of the Instructions for Completing the MA BPT for Contract Year 2025).

20 GLP-1 products included in the analysis by the Department of Health and Human Services' Office of Inspector General included both self-injectable drugs (Ozempic and Mounjaro) and oral medication (Rybelsus).

21 Part C's star-rating system for Medicare Advantage plans includes a measure of how well blood sugar level is controlled among enrollees with diabetes. Because a plan's performance on Part C's star-rating measures directly affects bonus payments that plans receive under the quality-bonus program, MA–PDs may have different incentives for covering GLP-1 medications than PDPs.

22 Before 2023, average gross plan cost for LIS enrollees in MA-PDs and PDPs was nearly identical, differing by one dollar or less in most years. In 2023, however, spending grew more rapidly among MA-PD enrollees, resulting in a difference in the average gross plan liability exceeding $8 per enrollee per month. In contrast, for enrollees without the LIS, because the average gross plan liability among enrollees in MA-PDs had been consistently below that of PDP enrollees before 2023, the faster growth in spending among the MA-PD enrollees in 2023 has resulted in a narrowing of the difference in spending between MA-PD and PDP enrollees (from nearly $20 in most years to $12 in 2023).

23 SNPs were excluded because they are much more likely to use the defined standard benefit that uses 25 percent coinsurance for all products rather than multiple tiers with varying cost-sharing rates; further, most SNP enrollees receive the LIS and are therefore required to pay only nominal copay amounts set in law, making any cost-sharing differentiations that do exist less likely to influence beneficiary choice of product relative to beneficiaries without the LIS.

24 Specifically, a product was assigned to the lowest tier to which at least one national drug code of a product was placed on a plan's formulary.

25 These 20 products, in order of total gross drug costs, include Ozempic, Mounjaro, Trulicity, Revlimid, Humira Pen, Biktarvy, lenalidomide, Jakafi, Xtandi, Ingrezza, Invega Sustenna, Enbrel SureClick, Rybelsus, Creon, Dupixent, Rinvoq, Xifaxan, Vraylar, Otezla, and abiraterone. For this analysis, different strengths of a drug are considered together such that a "product" is defined as all drugs with the same active ingredient, route of administration, dosage form, and brand name.

26 Products selected for negotiation among this subset include Enbrel, which was selected for negotiation in 2026, and Ozempic, Rybelsus, Otezla, Vraylar, Xifaxan, and Xtandi, which were selected for negotiation in 2027.

27 In 2024, among these 20 products, Revlimid and Ingrezza had average coverage rates below 90 percent among MA–PDs; in 2025, average coverage rates for Enbrel SureClick and Otezla also dropped below 90 percent among MA–PDs.

28 In 2024, the three products with average coverage rates below 90 percent for PDPs were Revlimid, Ingezza, and Creon; in 2025, coverage rates among PDPs also fell below 90 percent for Trulicity, Humira Pen, Rybelsus, Enbrel SureClick, and Otezla.

29 Creon had no UM among PDPs and a very small share of plans applying ST among MA–PDs (affecting 2 percent to 3 percent of MA–PD enrollees).

30 For this analysis, different strengths of a drug are considered together such that a "product" is defined as all drugs with the same active ingredient, route of administration, and dosage form.

31 These products accounted for more than 160,000 fills and $1.6 billion in total gross drug costs among MA–PDs and 156,000 fills and $1.7 billion in total gross drug costs for PDPs during the first half of 2024.

32 Both MA encounter and FFS claims data are used for beneficiaries who switch between MA and FFS enrollment during a calendar year. MA encounter records are submitted

by plans and contain information about Medicare-covered services that an enrollee receives from a health care provider. CMS conducts risk-adjustment data validation audits to ensure that diagnoses recorded in the encounter data are supported by evidence in the patient's medical record, but the scope of the audits has been limited so far.

33 The analysis compared the version of the RxHCC model (V05) used between 2017 and 2022 and the new version of the RxHCC model in use since 2023 (V08) to the version(s) of the CMS–HCC models used in each of the corresponding years between 2019 and 2023.

34 "Gross plan costs" refers to all gross drug spending covered under Part D's basic benefit—excluding reinsurance payments—before the application of postsale rebates and discounts. The RxHCC model has five segments for continuing enrollees (community non-low-income beneficiaries ages 65 and over, community non-low-income beneficiaries under age 65, community low-income beneficiaries ages 65 and over, community low-income beneficiaries under age 65, and beneficiaries who live in institutions) and three segments for new enrollees (low-income beneficiaries, non-low-income beneficiaries, and beneficiaries who live in institutions). CMS estimates a separate set of coefficients for each model segment.

35 Pharmaceutical manufacturers also pay for a portion of prescription spending through mandatory discounts (Medicare Payment Advisory Commission 2024b).

36 The IRA policy to cap the annual increase in the BBP to no more than 6 percent limited the BBP for 2025 to $36.78 rather than $55.98. When the 6 percent cap is binding, as has been the case for 2024 and 2025, the policy automatically increases Medicare's subsidy rate. (Based on the data released in July 2024, the subsidy rate would be 83 percent in 2025, rather than the 74.5 percent specified in law.)

37 CMS calculated the average premium across Medicare beneficiaries who pay full premiums (i.e., the average excludes over 14 million beneficiaries who receive the LIS).

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