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Advising the Congress on Medicare issues

Structural differences between the Part D PDP and MA–PD markets

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Presentation roadmap

1. Background on the Part D program
2. Concerning trends in Part D and policies that may contribute to those trends
3. Factors that may affect costs and payments for PDPs and MA-PDs
4. Part D redesign and trends in the PDP market
5. Discussion

Background on the Part D program

- The Part D program relies on competition among private plans
- Plans vary by premium, cost sharing, formulary, and pharmacy network
- Two markets with distinct structures:
  - Stand-alone PDPs for FFS beneficiaries
  - MA-PDs, combining medical and drug coverage, for MA enrollees
- Part D market is highly concentrated, with most large firms offering plans in both markets. In 2024, the 5 largest firms* accounted for:
  - 75% of all Part D enrollees nationally
  - Over 80% of the state's total Part D enrollment in many states

Note: PDP (prescription drug plan), FFS (fee-for-service), MA-PD (Medicare Advantage prescription drug [plan]).
* The 5 largest organizations varied across states, but large national insurers were also dominant at the state level.

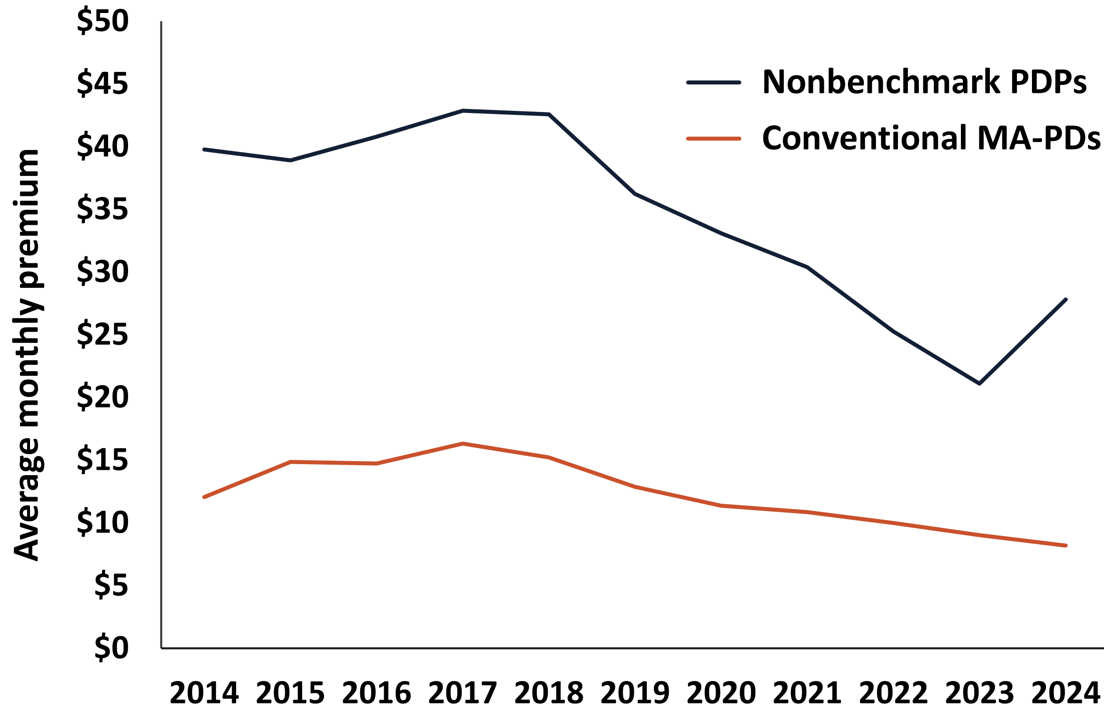
Background on the Part D program (cont.)

- Consistent with the shift from FFS to MA in the broader Medicare program, Part D's enrollment has also shifted from PDPs to MA–PDs
- While Part D is just one piece of the complex choice faced by Medicare beneficiaries, the lack of (relatively attractive) PDP options could be consequential in driving beneficiaries' choice between MA and FFS

Note: FFS (fee-for-service), MA (Medicare Advantage), PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]).

Concerning trends for the PDP market

#1. Average basic premiums for PDPs have exceeded those of MA–PDs



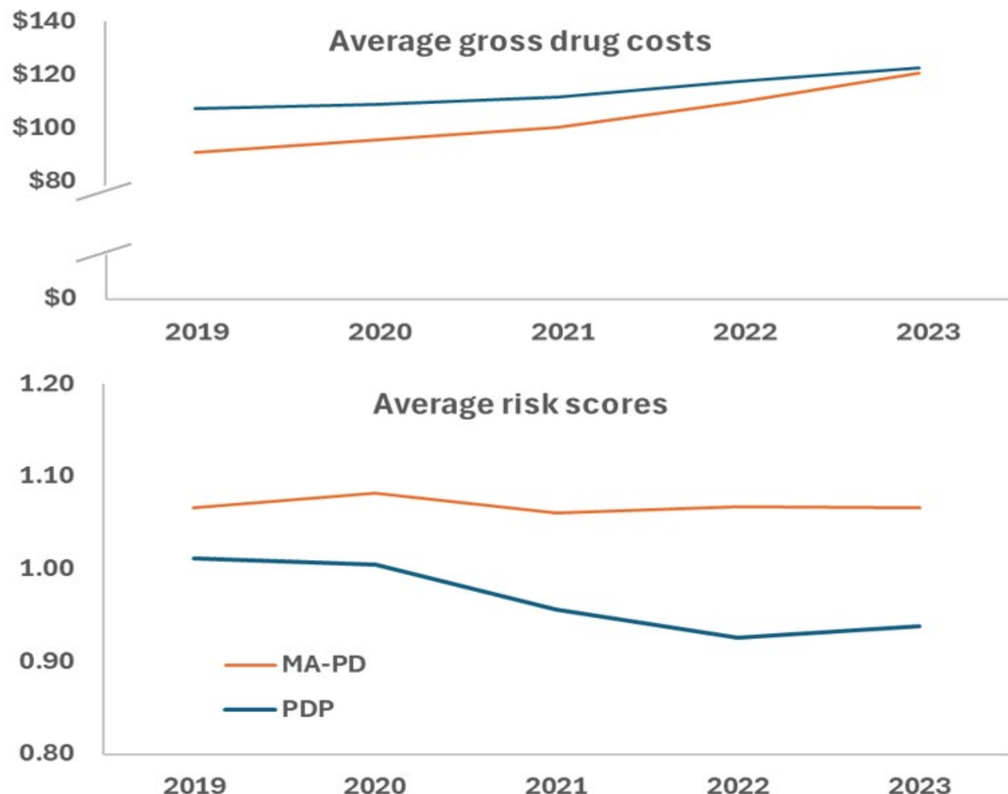
Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), LIS (low-income subsidy). Premiums weighted by enrollment in the month of July.
Source: Part D premium and enrollment files from CMS.

#2. Number of PDPs offered has declined in recent years

- Affects the availability of "benchmark" plans:
  - Premium free for LIS enrollees
  - Default plans for LIS enrollees who otherwise would not have enrolled in a Part D plan
  - In 2025, on average, 4 PDPs qualified as benchmark plans per PDP region, down from 10 in 2014

Concerning trends for the PDP market (cont.)

#3. PDPs, on average, had higher gross costs but lower average risk scores than MA–PDs



#4. PDPs were more likely to incur losses compared with MA-PDs*

- Related to diverging trends in gross costs and risk scores?
  - Risk scores directly affect payments to plans
  - Payment accuracy requires alignment of costs and payments, in the aggregate

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]), LIS (low-income subsidy).
* Calculation of profits/losses in risk corridors excludes profit margins included in plan bids.

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

Why does the stability of the PDP market matter?

- Stability of the PDP market is important for FFS beneficiaries
- Currently, enrolling in a stand-alone PDP is the only way FFS beneficiaries can obtain Part D drug coverage
- Premium-free PDPs, or benchmark plans, serve an important role in ensuring that FFS beneficiaries who receive the LIS have drug coverage at no cost*

Note: PDP (prescription drug plan), FFS (fee-for-service), LIS (low-income subsidy), MA (Medicare Advantage).
* Some LIS beneficiaries pay nominal copays (set in law) when they fill their prescriptions.

MA and Part D policies: MA–PDs have an additional funding source (MA rebates) to enhance Part D offerings

- MA rebates allow MA–PDs to:
  - Charge low, or $0, premiums without lowering their bids
  - Subsidize the costs of supplemental Part D benefits
- PDPs do not have any additional funding source; their bids and the full expected costs of any supplemental benefits determine enrollee premiums
- Rebate-financed benefits provide financial protection and more generous coverage for MA–PD enrollees but could also affect competition in the Part D market

Note: MA–PD (Medicare Advantage Prescription Drug [plan]), MA (Medicare Advantage), PDP (prescription drug plan).

MA and Part D policies: MA–PDs have an additional opportunity to adjust their Part D premiums

- MA–PDs may reallocate the MA rebate amount in their bids after the national average bid and LIS benchmark amounts are announced:
  - Allows MA–PDs to achieve their target basic Part D premium or LIS benchmark amount
  - Ensures that MA–PD enrollees receive the full value of MA rebates
  - May help stabilize premiums across years, ensure premium-free status for LIS, and maximize LIS premium revenue
- PDPs do not have this additional opportunity (or funds)
  - PDPs that miss the LIS benchmark may lose their LIS enrollees or receive lower premium revenue*

Note: MA–PD (Medicare Advantage Prescription Drug [plan]), MA (Medicare Advantage), LIS (low-income subsidy), PDP (prescription drug plan).
* PDPs that bid too high relative to the LIS benchmark but within the de minimis amount ($2) must waive the "excess" premiums to maintain premium-free status for LIS enrollees. PDPs that bid below the LIS benchmark will not be maximizing their premium revenue.

MA and Part D policies: MA–PDs can offer D–SNPs that limit enrollment to beneficiaries who receive the LIS

- Ability to offer separate plans for LIS enrollees may offer advantages because:
  - LIS enrollees face little or no cost sharing and typically pay no premiums, so they face different financial incentives than non-LIS enrollees
  - Differences in incentives may affect how plans design their formularies and benefits for LIS beneficiaries (e.g., D–SNPs use defined standard benefit)
- PDPs cannot perfectly limit enrollment by LIS status
  - May face greater challenges in balancing the need to offer an attractive benefit (e.g., with copays) while managing spending to keep premiums low

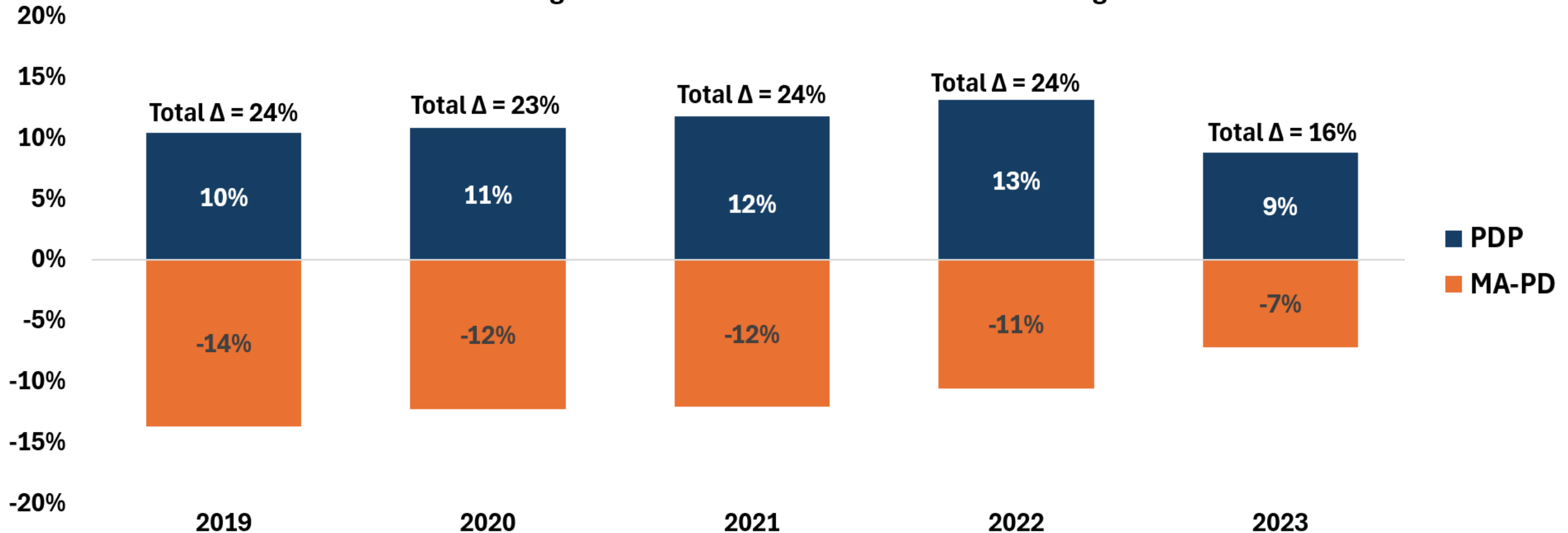
Note: MA (Medicare Advantage), MA–PD (Medicare Advantage Prescription Drug [plan]), D–SNP (dual-eligible special-needs plan), LIS (low-income subsidy), PDP (prescription drug plan).

Assessing the relationship between costs and payments for PDPs and MA–PDs

- We use risk-standardized costs to compare the alignment of costs to payments between MA–PDs and PDPs
  - Risk-standardized costs reflect actual beneficiary costs standardized for a beneficiary with average expected costs
  - For a given beneficiary, a higher risk score will result in lower risk-standardized costs
- On average, MA–PDs have lower costs relative to what is predicted by their risk score while PDPs have higher costs relative to what is predicted by their risk score

Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). Risk scores adjust payments to Part D plans.

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



Note: MA–PD (Medicare Advantage–Prescription Drug [plan]), PDP (prescription drug plan). "MA–PD" includes both conventional MA–PDs and special-needs plans. "Costs" reflect a plan's gross benefit liability before accounting for postsale rebates and discounts. In 2023, there was a noticeable drop in the magnitude of the difference in the average risk-standardized costs between MA–PDs and PDPs, which may, in part, be due to the uptick in spending for an antidiabetic drug which tended to be more generously covered by MA–PDs.

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

Factors driving differences in risk-standardized costs for PDPs and MA–PDs

- Differences in how plans manage benefit spending
  - Cost-sharing tiers to encourage the use of lower-cost drugs
  - Utilization management tools
- Differences in diagnostic-coding behavior
  - Differences in MA and FFS may translate to coding-intensity differences for MA–PDs and PDPs
- Other factors that affect the relationship between spending on medications and payments to plans

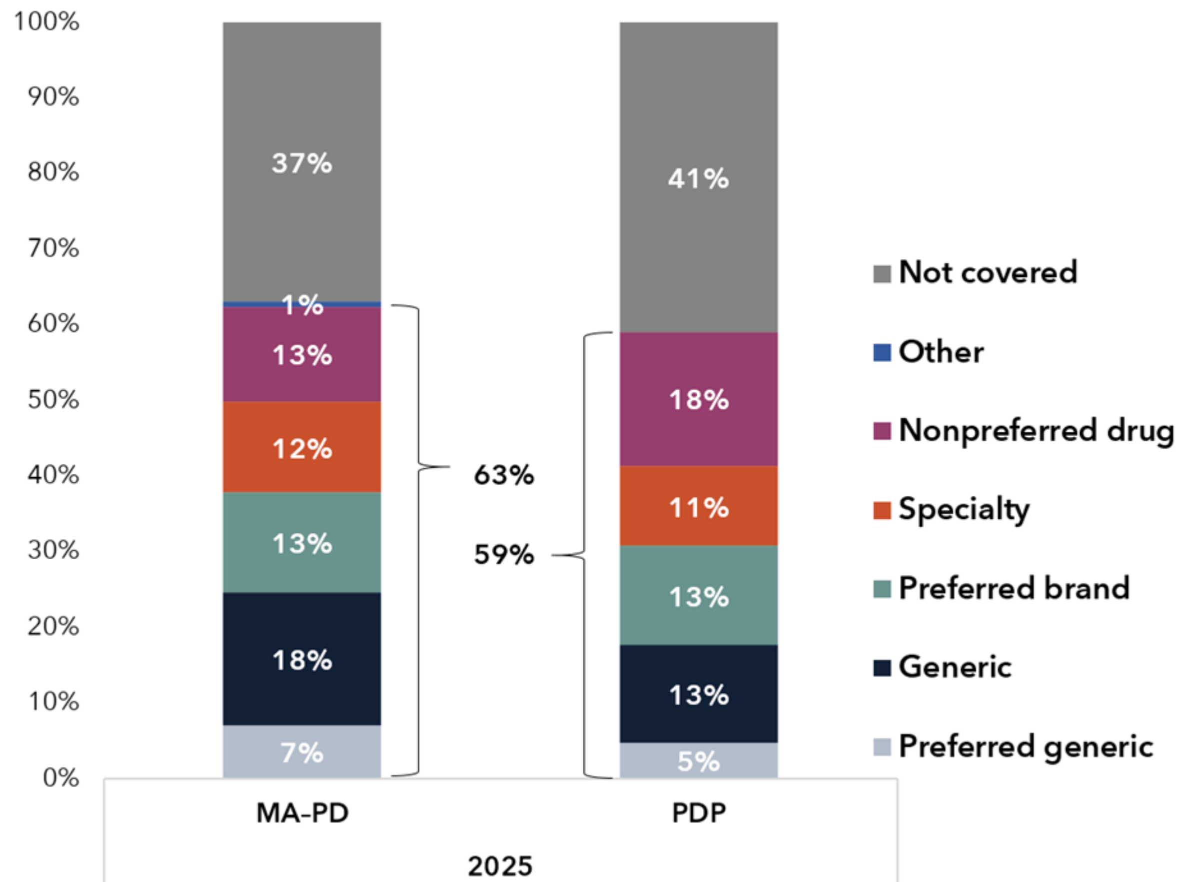
Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan).

Could formularies explain some of the difference in costs between MA–PDs and PDPs?

- Plans may use formularies to manage spending and encourage use of lower-cost products through:
  - Product coverage
  - Tier placement
  - Utilization management
- Compared formularies for MA–PDs* and PDPs in 2024 and 2025 to assess plan generosity and benefit management, including:
  - All Part D–eligible products
  - Subset of products with the highest spending (high cost and highly utilized)
  - The 50 most frequently filled generics
  - Select brands with generic availability

Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan). * Analysis included conventional MA–PDs only (excludes special-needs plans).

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

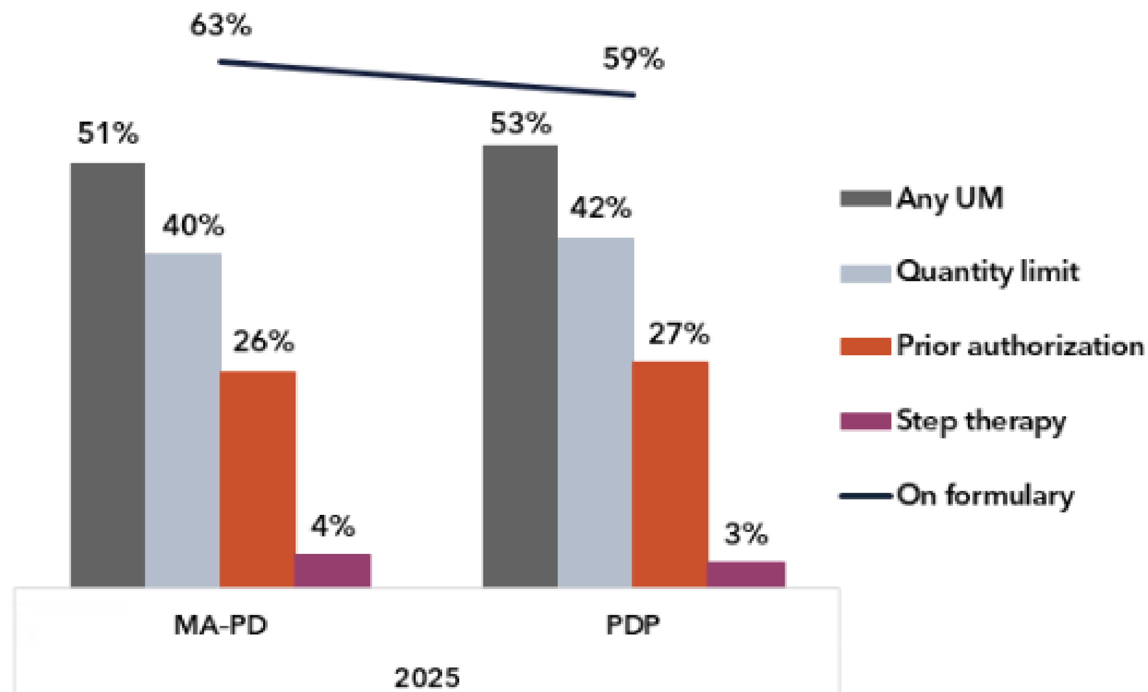


- MA–PDs cover more products and place more products on lower cost-sharing tiers
- Both plan types cover a smaller share of products in 2025 than in 2024, but coverage for MA–PD enrollees continued to be more favorable

Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan).

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

MA–PDs were slightly less likely than PDPs to use utilization management tools



- Both MA–PDs and PDPs apply UM to roughly half of covered products in 2025
- Quantity limits (QLs) are the most common type of UM used for both plan types; QLs increased in 2025 more than other types of UM

Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan), UM (utilization management). Shares of products "on formulary" in this chart represent the share of all products at the active-ingredient level eligible for coverage under Part D. The shares of products with any UM applied, and each type of UM, are calculated as a share of products covered by plan type and year.

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

Part D’s RxHCC risk-adjustment model adjusts payments to Part D plans

- Like the CMS–HCC model used in MA, the RxHCC model uses:
  - Demographic and diagnostic information to predict an enrollee’s costs
  - Diagnoses grouped into condition categories (ranked into hierarchies)
  - Diagnoses from physician and inpatient & outpatient hospital records in MA encounter or FFS claims data
- Differences in diagnostic coding between FFS and MA
  - FFS: Little incentive to code diagnoses
  - MA: Financial incentive and infrastructure to code more diagnoses
- Substantial overlap (82%) of diagnoses in CMS–HCC and RxHCC models
  - Coding differences between MA and FFS translate to MA–PD and PDP differences

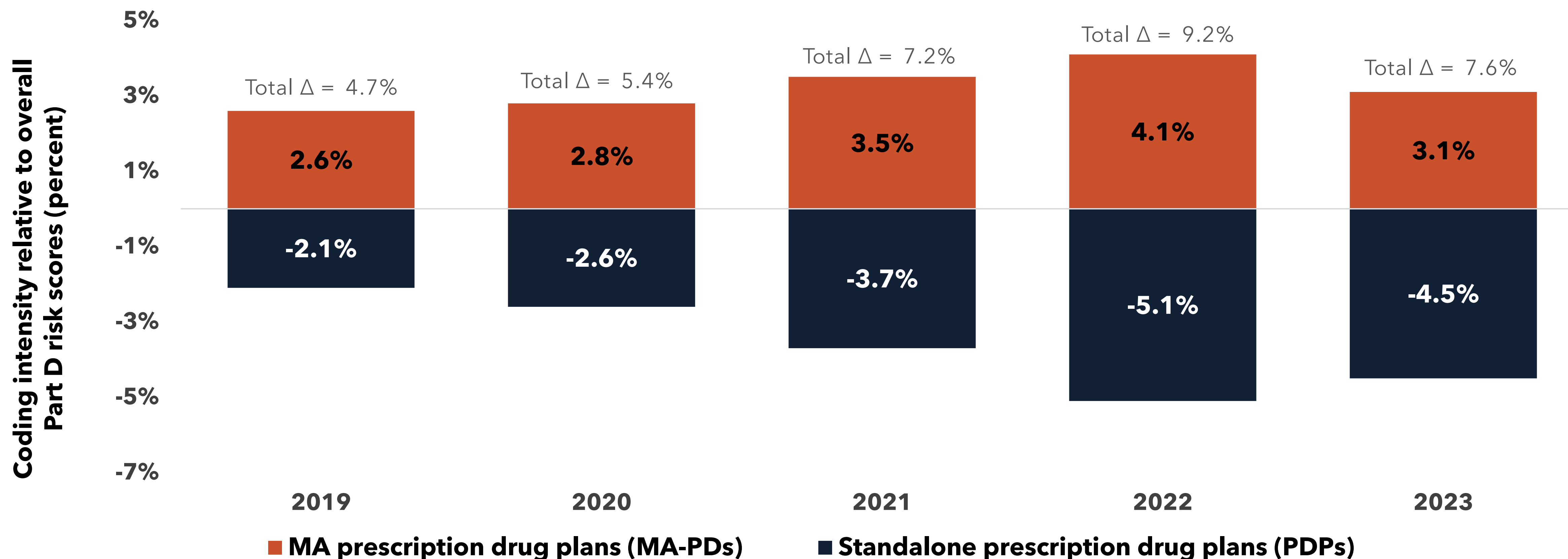
Note: RxHCC (prescription drug hierarchical condition category), CMS–HCC (CMS hierarchical condition category), MA (Medicare Advantage), FFS (fee-for-service). Plans take insurance risk for total capitated payments (direct subsidy plus enrollee premium). CMS risk adjustment accounts for the premium paid by enrollees. The CMS–HCC model is normalized across FFS beneficiaries.

Estimating coding intensity in Part D

- We adapted MedPAC's DECI method of estimating coding intensity in MA for Part D plans by:
  - Addressing differences in the share of enrollees in Part D risk-model segments for LIS, non-LIS, and institutionalized beneficiaries
  - Estimating demographic risk scores using gross Part D–plan liability
  - Estimating coding intensity separately for MA–PDs and PDPs relative to the whole Part D population
- The RxHCC model is normalized across all Part D enrollees
  - Coding differences do not affect overall Part D spending but can generate different payments and premiums across plans for similar enrollees

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

Estimated coding intensity increased Part D risk scores for MA–PDs and decreased scores for PDPs, 2019–2023



Note: MA–PD (Medicare Advantage–prescription drug [plan]), PDP (stand-alone prescription drug plan). 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 as their risk scores are not based on diagnostic coding.

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

What explains the difference in risk-standardized costs between MA–PDs and PDPs?

- Our findings suggest that MA–PDs did not achieve lower costs by applying more UM tools to the drugs used by their enrollees
- Differences in coding intensity do explain a portion of the recent differences in risk-standardized costs between MA–PDs and PDPs
- Persistence of large difference between MA–PDs and PDPs even after accounting for differences in coding intensity suggests other factor(s) are at play
- We will continue to monitor the risk-standardized costs and CMS's recent application of separate normalization factors for MA–PDs and PDPs

Note: MA–PD (Medicare Advantage Prescription Drug [plan]), PDP (prescription drug plan), UM (utilization management).

Part D redesign and trends in the PDP market

- Part D–covered drugs are paid for through:
  - Cost sharing when beneficiaries fill prescriptions
  - Enrollee premiums and Medicare (taxpayers') subsidies
- Two key IRA changes increased the portion of spending that is risk adjusted:
  - Shifted spending from cost sharing to enrollee premiums and Medicare's capitated direct subsidy
  - Shifted Medicare's payments from cost-based reinsurance to capitated direct subsidy
- Increase in benefit costs and plans' insurance risk heightens the importance of Part D's risk adjustment

Note: IRA (Inflation Reduction Act of 2022).

Part D redesign and trends in the PDP market–cont.

- For 2025, national average bid amount rose by nearly 180%†
- Large increases and variation in PDP bids led CMS to implement the Part D Premium Stabilization Demonstration
  - Even with the demonstration, enrollee premiums for individual PDPs varied widely
- Average enrollee premiums for MA–PDs decreased slightly, remained below that of PDPs
  - Ability to use MA rebates to lower Part D premiums and the opportunity to adjust their MA rebate allocation may have helped to keep premiums stable
  - Plans with higher risk scores relative to their costs will have lower risk-standardized bids and premiums

Note: PDP (prescription drug plan), MA–PD (Medicare Advantage Prescription Drug [plan]). The national average bid is the enrollment-weighted average of plan bids that reflect plans' expected benefit liability, net of postsale rebates and discounts and including required administrative costs and profit margin.
* Relative to the national average bid amount for 2024, which reflected plans' projected benefit costs for 2024. Some of the increase can be explained by higher-than-expected spending growth in 2023, thus preceding the planned implementation of the benefit redesign in 2025 (https://www.cbo.gov/publication/60974).

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

Discussion

- Questions
- Feedback or comments on material
- This material will be published as an informational chapter in our June 2025 report to the Congress

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