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Medicare Part D Premium Stabilization Demonstration

Introduction

Medicare Part D is a voluntary federal program that provides outpatient prescription drug coverage to 54 million beneficiaries. Premiums for Part D plans are influenced by various factors, including plan costs, federal subsidies, and beneficiary enrollment choices. The Inflation Reduction Act (IRA; P.L. 117-169) redesigned the Part D benefit to lower out-of-pocket prescription drug costs. In response to the IRA and other contributing factors, the Centers for Medicare & Medicaid Services (CMS) announced a new Part D Premium Stabilization Demonstration (the demonstration) in July 2024, intended to reduce premiums and plan sponsors' liability. This In Focus provides an overview of the demonstration, its impact on premiums, CMS's statutory authority to create the demonstration, and considerations for Congress.

Overview of the Medicare Part D Benefit

Medicare Part D coverage is provided by private health payers (*plan sponsors*) that contract with CMS to offer stand-alone prescription drug plans (PDPs) or Medicare Advantage (MA) plans with drug coverage (MA-PDs). Each calendar year, CMS releases guidance detailing the standard Part D benefit, which includes specifications on annual deductibles, enrollee cost-sharing, and an out-of-pocket maximum. Plan sponsors submit annual bids to CMS that project the cost of providing either the standard benefit or an actuarial equivalent in a given region. If the actual plan costs differ from the projected costs, the plan's responsibility for any upside or downside risk is outlined through specified risk corridors.

In addition to the annual deductibles and coinsurance defined in the standard benefit, many Medicare Part D enrollees pay a plan-specific monthly premium. This monthly premium is calculated by CMS and is derived from the plan costs in annual bids. CMS derives the base beneficiary premium (BBP) as 25.5% of the National Average Monthly Bid Amount (NAMBA), adjusted for government reinsurance subsidies. Reinsurance subsidies are paid to plans on behalf of an enrollee to offset costs exceeding a certain threshold. Premiums may vary widely between MA-PDs and PDPs, with MA-PDs generally offering lower premiums because MA plans are required to use any MA rebates they earn to lower patient cost-sharing.

Factors Influencing Medicare Part D Premiums in 2025

Congress made a number of changes to the Medicare Part D standard benefit via the IRA. Prior to the enactment of the IRA, the Part D standard benefit contained four phases: a deductible phase, an initial coverage phase, a coverage gap (doughnut hole), and a catastrophic phase. Enrollees and their plans were responsible for some degree of cost-sharing in each phase, but Medicare paid 80% of the costs via reinsurance once a beneficiary reached the catastrophic phase.

The IRA redesigned the Part D standard benefit by eliminating the coverage gap phase, reducing enrollee cost sharing in the catastrophic phase, lowering the catastrophic threshold, and reducing Medicare reinsurance in the catastrophic phase to a maximum of 40% of total costs. These reductions in enrollee out-of-pocket costs and Medicare reinsurance payments, as well as other IRA measures (such as the $35 cap on co-pays for insulin and the new Medicare Prescription Payment Plan), shift the upfront cost of providing the standard Part D benefit to plan sponsors while reducing out-of-pocket expenses for enrollees. To limit the amount of the increased cost to plan sponsors that is passed on to Medicare enrollees through premium increases, the IRA included a premium stabilization provision which capped the annual BBP growth at 6%. The cap is enforced through increased Medicare subsidies paid directly to plan sponsors.

In addition to the IRA, other factors also impact PDPs. CMS has altered the Part D risk-adjustment model it uses to set payments to reflect the Part D redesign and separate PDP and MA-PD scoring, which will differentially affect payment amounts to plans. Another influence on plan premiums is increased spending on high-cost drugs such as GLP-1 agonists which drive up overall plan costs and impact premium calculations. CMS selected three GLP-1 drugs (Ozempic, Wegovy, and Rybelsus) for negotiation under the Medicare Drug Price Negotiation Program. Negotiated prices for those drugs are not scheduled to go into effect until CY2027. An ongoing decline in number of PDPs since 2014, with a decrease of 26% in plan offerings between 2024 and 2025 alone, has made the PDP market more vulnerable to large enrollment shifts when plan availability or benefits change, particularly for certain low-income subsidy eligible individuals who are automatically enrolled in PDPs based on regional benchmarks.

Premium Stabilization Demonstration

On July 29, 2024, CMS released the Part D Bid information for 2025 and announced a further stabilization measure: the Voluntary Part D Premium Stabilization Demonstration for PDPs using its authority in Section 402(a)(1)(A) of the Social Security Act. After reviewing CY2025 bids, CMS found a 179% increase in NAMBA relative to 2024, raising concerns about PDP enrollment market disruptions.

The voluntary three-year demonstration, which is scheduled to begin in CY2025, has three components to lower Part D premiums: (1) participating PDPs will have a $15 direct subsidy applied to the BBP used in their plan-specific

premium calculation; (2) additional subsidies will be applied if necessary to cap year-over-year premium increases at $35; and (3) CMS will narrow the downside of the risk corridors, reducing the share of potential plan losses.

Table 1 displays how the demonstration could alter plan premiums and subsidy payments. The first row in the table represents a plan-specific premium in 2024, with the second row providing the 2025 premium for the same plan in the absence of the demonstration. The first alteration to the initial premium is the application of the $15 direct subsidy, which can initially result in negative premiums. If the year-over-year change in the premium still exceeds $35 after the initial $15 subsidy, subsequent subsidies are applied until the $35 growth cap is met. No premium can be less than $0, referred to below as the "$0 Premium Floor."

Table 1. Two Examples of PDP Premiums under Premium Stabilization Demonstration

	Ex. 1	Ex. 2
CY 2024 Premium	$10.00	$10.00
Pre-Demonstration CY 2025 Premium	$65.00	$13.00
Application of $15 Direct Subsidy	$50.00	-$2.00
Increase YOY post-subsidy	$40.00	$0.00
Application of $35 Cap on YOY Increase	$45.00	N/A
Initial Demonstration Premium	$45.00	-$2.00
Application of $0 Premium Floor	$45.00	$0.00
Final Post-Demonstration Premium	$45.00	$0.00
Total Direct Subsidy	$20.00	$13.00

Source: CRS analysis of CMS Demonstration FAQ document. Examples are for hypothetical basic PDPs with no supplemental Part D premium and a basic Part D premium before income adjustments.

Demonstration Authority and Selected Legal Issues

CMS cited Section 402(a)(1)(A) of the Social Security Act as the authority for the demonstration. Under Section 402(a)(1), the Secretary of Health and Human Services (Secretary) may create "experiments and demonstration projects" for a variety of purposes, including to determine whether certain Medicare payment changes would "increas[e] the efficiency and economy of health services." In order to carry out demonstrations, under Section 402(b), the Secretary may waive compliance with other Medicare payment requirements "insofar as [they] relate to reimbursement or payment on the basis of reasonable cost," or "to reimbursement or payment only to such services or items as may be specified in the experiment." Before establishing a demonstration project, the Secretary must obtain "advice and recommendations" from relevant, competent specialists. A few appellate courts have considered challenges to certain prior Section 402 demonstration projects involving Medicare reimbursement or payments to providers. Those courts upheld the relevant projects, rejecting arguments that they exceeded the Secretary's waiver authority under Section 402(b).

In addition to federal courts, the Government Accountability Office (GAO) has also considered the scope of the Secretary's authority under Section 402. In 2012, for example, GAO evaluated whether CMS had the authority to implement a Quality Bonus Payment system for MA plans under Section 402(a)(1)(A). In concluding that the Secretary likely did not have the authority to conduct the program, GAO noted several structural flaws in the program's design, including that it was not structured in a way that would encourage MA plans to increase their efficiency or economy. As part of its analysis, GAO observed that federal courts have yet to weigh in on the particular criteria that CMS must meet under Section 402(a)(1)(A).

Considerations for Congress

The Congressional Budget Office has estimated that the temporary subsidies provided through the demonstration will increase federal spending in 2025 by $5 billion. After applying the demonstration measures to participating PDPs, CMS announced that "the average total Part D beneficiary premium is projected to decrease by $7.45 in 2025." CMS estimates that approximately 99% of enrollees in a PDP will be covered by a participating sponsor. Under certain conditions, additional plan sponsors can join the program in subsequent years. Premium subsidy amounts and risk corridors for CY2026 will be determined after CMS reviews the CY2026 bids submitted by sponsors.

Since CMS announced the premium stabilization demonstration, the program has received attention from stakeholders as well as some Members of Congress. For example, in a 2024 letter to CMS, several House Members expressed concern about the demonstration's financial impact and asked CMS for greater transparency on the program's rationale. Additionally, several chairs and ranking members of relevant committees have requested that GAO review the program, citing concerns over both legal authority and expense. Some commentators have questioned the legality and timing of CMS's announcement, which came in August 2024, after plans had already submitted their contract bids for the next plan year. To date, it does not appear that a lawsuit has been brought challenging the demonstration program.

Congress has broad authority to legislate the administration of the Medicare program. To the extent that Congress is dissatisfied with the premium stabilization demonstration specifically, it could enact a funding prohibition to defund this specific demonstration. If Congress were more generally concerned about the scope of CMS's authority under Section 402, it could amend the statute to clarify the criteria and parameters for eligible demonstration projects, such as by setting constraints on demonstration length and/or allowed expenditures. Alternatively, if Congress wanted the premium stabilization program to be permanent, it could codify CMS's demonstration in the SSA. Several codified reforms to Medicare payment systems had their origins in Section 402 demonstrations.

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