



Updated October 22, 2026

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 (OOP) prescription drug costs. In response to the IRA and other 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. The demonstration, originally intended to run for plan years 2025-2027, was terminated by the Trump Administration in 2026. 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 or offer supplemental benefits.

Factors Influencing Medicare Part D Premiums

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 OOP 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 OOP 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](#) that capped the annual base beneficiary premium growth at 6%. The cap is enforced through increased Medicare subsidies paid directly to plan sponsors. The cap is to be held at 6% until 2030, at which point the increased Medicare subsidies permitted to maintain the cap are limited to 80% of the total cost of the plan. Therefore, the BBP may increase by more than 6% in 2030 and subsequent years.

In addition to the IRA, other factors are affecting PDP expenditures. [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 [360 PDPs](#) offered in 2026 compared to 709 offered in 2024, 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

In July 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 for 2025. 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 had three components in 2025: (1) participating PDPs had a \$15 direct subsidy applied to the BBP used in their plan-specific premium calculation, (2) additional subsidies were applied if necessary to cap year-over-year premium increases at \$35, and (3) CMS narrowed the downside of the risk corridors, reducing the share of potential plan losses.

For plan year 2026, CMS altered the parameters of the demonstration to reduce the subsidies available to plans. The direct subsidy applied to plan premiums was lowered from \$15 to \$10. CMS also eliminated the narrowed risk corridors that were available for plans in 2025. Additionally, CMS chose, for the first time, to reject some PDP bids that displayed significant year-over-year premium increases and were outliers in their Part D region. On July 28, 2026, CMS announced that the demonstration would conclude with the end of the 2026 plan year, and that analysis of PDP bids suggested that the additional subsidies were no longer required to stabilize the PDP market.

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.” 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).

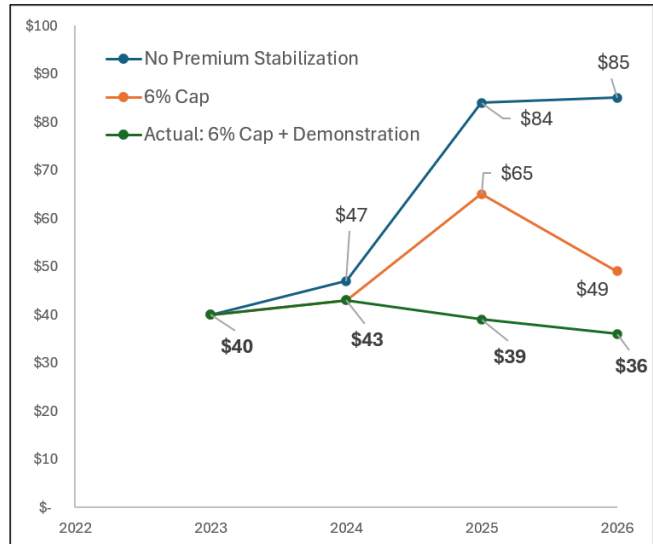
In addition to federal courts, the Government Accountability Office (GAO) has also considered the scope of the Secretary’s authority under Section 402. In 2012, for example, GAO evaluated whether CMS had the authority to implement a Quality Bonus Payment system for MA plans under Section 402(a)(1)(A).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

Demonstration Impact

In 2025, 96% of PDP sponsors chose to participate in the demonstration. CMS has estimated the demonstration cost \$6.2 billion in 2025 and will cost \$3.6 billion in 2026. The majority of the spending in 2025 was on direct premium

subsidies, with 3% of spending attributable to the narrowed risk corridors. As shown in Figure 1, the Medicare Payment Advisory Commission (MedPAC) found that the demonstration subsidies lowered average PDP premiums by \$26 in 2025, and \$13 in 2026, relative to the 6% statutory cap alone.

Figure 1. Average Stand-Alone PDP Premiums Under Alternative Premium Stabilization Scenarios



Source: MedPAC, *July 2026 Databook*, Washington, DC, July 16, 2026, p. 173, https://www.medpac.gov/wp-content/uploads/2026/07/July2026_MedPAC_DataBook_Sec10_SEC.pdf.

Congressional Considerations

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. Some commentators 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, although no lawsuits were brought challenging the demonstration program. After CMS announced the end of the demonstration, over 50 Members of Congress signed a letter requesting that CMS reverse its termination decision.

Congress has broad authority to legislate the administration of the Medicare program. For example, to end the demonstration, it could have enacted a funding prohibition to defund this specific demonstration. Congress could alter the scope of CMS’s authority under Section 402, such as by setting constraints on demonstration length and/or allowed expenditures. Congress could choose not to intervene in the termination of the demonstration or alternatively extend the demonstration. For example, H.R. 10374, the Affordable Premiums for Seniors Act of 2026 (119th Congress), would continue the demonstration, in a manner similar to its parameters in 2026, until the Secretary determines that its termination would not result in an increase in premiums.

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