MILLIMAN WHITE PAPER

Indirect impacts of the Inflation Reduction Act benefit redesign on Medicare Part D

Reflecting on four years of the IRA and the first two years of the redesigned Part D benefit

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August 2026 marks four years since the Inflation Reduction Act (IRA) was signed into law, and 2026 is the second year of the fully redesigned Medicare Part D benefit. For beneficiaries, some key aspects of the redesign have worked as intended: Cost sharing is capped for the first time, and out-of-pocket spending for patients with the highest prescription drug costs has fallen substantially.[1]

The redesign changed how costs, revenue, and risk are allocated among beneficiaries, plans, pharmaceutical manufacturers, and the federal government, but the mechanisms translating plan bids into plan revenue were not correspondingly revised. The Centers for Medicare and Medicaid Services (CMS) updated the Part D risk-adjustment (RxHCC) model coefficients to reflect the redesigned benefit, but the structure of the model was unchanged: The model continues to predict drug costs from medical diagnoses without using individual beneficiaries' prescription drug history, as has always been the case, and its coefficients are calibrated on claims experience from several years before the payment year. That lag has created challenges in the first few years of the redesign because the change in beneficiary behavior following the redesign is far larger than the year-over-year variation the model normally absorbs.

The direct subsidy calculation itself was not changed by the IRA; it remains the national average monthly bid amount (NAMBA) less the base beneficiary premium (BBP). What changed is the magnitude of both components: Premium stabilization capped annual BBP growth, and the shift in government funding from largely reinsurance to capitation raised the NAMBA substantially. Most of the effects described here follow from that mismatch; a redesigned benefit running on funding mechanics built for the program that preceded it.

Throughout this paper, we provide an objective review of the IRA benefit redesign effects. The final section describes potential adjustments to the funding mechanics discussed here, along with their trade-offs; we do not recommend any particular course of action, and each approach would carry its own consequences. While the IRA includes many provisions affecting Medicare Advantage and Part D, this paper focuses on the benefit redesign and its effects on Part D stakeholders. Specifically, we do not include commentary on the Medicare Drug Price Negotiation Program component of the IRA.

What the redesign delivered

Before 2024, non-low income (NLI) beneficiaries who reached catastrophic coverage paid 5% coinsurance with no annual limit. The IRA eliminated catastrophic phase cost sharing in 2024 and established a lower maximum out-of-pocket (MOOP) limit in 2025 ($2,000, indexed to $2,400 in 2027), converting an open-ended liability for beneficiaries into a capped and more predictable one. Premium stabilization, which caps annual growth in the BBP at 6% through 2029, also held beneficiary premium growth well below the growth in underlying program costs over the same period.

1. Feller, M., Gill, M., & Pierce, K. (October 2, 2025). MOOP there it is: In 2025, Part D beneficiaries are spending $1,200 on average to satisfy the $2,000 out-of-pocket maximum. Milliman. Retrieved September 1, 2026, from https://www.milliman.com/en/insight/moop-2025-part-d-beneficiaries-spending.

The law was designed to reduce beneficiary costs, which may have partially contributed to recent increases in prescription drug utilization (discussed below), suggesting beneficiaries are now filling prescriptions they may have previously been going without. Higher utilization for some must be offset by increased federal spending and/or higher premiums and cost sharing for other beneficiaries. The MOOP is most valuable to the share of NLI beneficiaries whose annual drug spending would otherwise have exceeded it, while the larger share of NLI beneficiaries who do not reach MOOP have generally seen higher deductibles, more brand coinsurance, and leaner formularies as plans absorbed the cost of the redesigned benefit. The redesign therefore redistributed costs among beneficiaries while it reduced costs for high utilizers.

Where the funding mechanics did not keep pace

DRUG TREND AND MOOP ACCUMULATION

Part D gross costs have grown sharply over the past two years, driven in part by glucagon-like peptide-1 (GLP-1) and specialty drug utilization concentrated among NLI beneficiaries, the population most directly affected by the redesign. Between 2023 and 2025, gross costs grew 37% for NLI beneficiaries compared to just 5% for low income (LI) beneficiaries, whose actual cost sharing was minimally impacted by the IRA.[2] Because the trends of NLI and LI beneficiaries have historically been of similar magnitude, a trend divergence of that size suggests a behavioral response from the NLI population. Emerging 2026 experience continues to show a gap, and it is not yet clear if the two populations' trend patterns will converge again.

The high trend increases were at least partially driven by the redesign's improvement in NLI affordability, and one important detail of how the MOOP is calculated may have also contributed to this effect. A change in accumulation toward the MOOP allowed beneficiaries to reach MOOP without actually spending the full $2,000 out of pocket. Milliman analysis of 2025 claims found that NLI beneficiaries reaching catastrophic coverage did so with actual out-of-pocket spending well below the nominal limit, roughly $1,200 on average.[3] Under the "greater-of" accumulation rule, beneficiaries enrolled in enhanced plans progress toward the MOOP based on the higher of the cost sharing of the plan benefit design and the cost sharing that would apply under the defined standard benefit.[4] This is impactful because defined standard cost sharing is generally higher than what many beneficiaries pay in an enhanced plan, and roughly 90% of NLI beneficiaries are enrolled in enhanced plans. In most cases, those beneficiaries accumulate toward the MOOP faster than their own spending would suggest, leading to many satisfying MOOP having paid well under the nominal limit.

Plans responded to the new design through a combination of benefit and formulary changes.[5] To address both increasing plan costs and the gap between actual NLI out-of-pocket spending and the MOOP value, a large number of Part D plans added or increased deductibles and moved brand tiers from copays to coinsurance in 2025 and 2026.[6]

2. Feller, M., Holcomb, K., & Robers, J. (March 31, 2026). Milliman MedIntel Part D trend insights: Drug costs continue rising through 2025, with Q4 growth moderating from midyear peaks. Milliman. Retrieved September 1, 2026, from https://www.milliman.com/en/insight/medintel-part-d-trend-insights-q4-2025.

3. Feller, M., Gill, M., & Pierce, K. (October 2, 2025), op. cit.

4. Karcher, J., Magnusson, J., & (Klein) Robb, M. (August 27, 2024). Out of whose pocket? Many beneficiaries will spend less than expected to reach the IRA's new $2,000 out-of-pocket spending limit. Milliman. Retrieved September 1, 2026, from https://www.milliman.com/en/insight/out-of-whose-pocket-inflation-reduction-act.

5. Feller, M. Harris, J., Jian-ya, L., & Gruenhaupt, M. (December 13, 2024). Prescribing a Part D formulary for the new IRA world. Milliman. Retrieved September 1, 2026, from https://www.milliman.com/en/insight/prescribing-part-d-formulary-new-ira.

6. Cates, J., Friedman, J., & Yen, I. (March 10, 2026). State of the 2026 Medicare Advantage industry: General enrollment plan valuation and selected benefit offerings. Milliman. Retrieved September 1, 2026, from https://www.milliman.com/en/insight/medicare-advantage-general-enrollment-2026-update.

RISK ADJUSTMENT

The RxHCC model assigns coefficients based on age, gender, income status, institutional status, disability status, and medical diagnoses—prescription drug history is not used for imputing conditions. Consider three beneficiaries with a Type 2 diabetes diagnosis: one with no drug use, one using generic metformin, and one using a GLP-1. Their Part D costs differ significantly, but all three carry the same diabetes coefficient and generate the same risk-adjusted revenue, all else equal. The model also assigns a demographic score to every beneficiary regardless of diagnoses, so a plan receives risk-adjusted revenue for a beneficiary with no recorded conditions, even when that beneficiary has no prescription drug use at all.

No risk-adjustment model predicts costs accurately for every individual. The RxHCC model is designed to be accurate for the population average, and CMS publishes predictive ratios each year showing how prediction varies across cost deciles. That limitation was a more easily managed risk prior to the implementation of the IRA, when risk-adjusted payments (i.e., the direct subsidy) were a much smaller component of total Part D revenue and most federal funding flowed through reinsurance, which is trued up to actual experience. Post-IRA, the direct subsidy has increased substantially, while reinsurance is reduced, meaning the divergence between drug costs and revenue has become a larger risk for plans.

The risk-adjustment model is prospectively renormalized to a 1.0 projected average each year. As a result, the total paid across all beneficiaries and plans is generally appropriate, but some plans are overcompensated, and some plans are undercompensated compared to their relative risk. Two key fundamental limitations exist with the current RxHCC model:

1. The 2027 RxHCC model is calibrated on 2024 prescription drug data, before the majority of the significant increase in NLI trends relative to LI trends occurred. The normalization factor implicitly assumes LI and NLI costs grow at the same rate, but to the extent this is not the case, risk scores are likely too high for LI populations and too low for NLI populations, on average, relative to their actual risk.
2. Within any condition, the model is likely to overfund beneficiaries using no- or low-cost therapies and underfund plans for beneficiaries using high-cost therapies, as the diabetes example above illustrates. This dynamic has always existed, where the model "fails at the tails," but the financial risk for plans is amplified in 2025 and beyond due to the increased proportion of Part D revenue that is risk adjusted as opposed to pass-through costs trued up at year-end.

The impact of the first limitation should diminish in 2028, assuming CMS recalibrates the 2028 RxHCC model on 2025 Part D claims. The second is structural and will not be resolved without substantive model revisions.

NEGATIVE PREMIUMS

A plan's Part D basic premium is equal to its risk-adjusted basic bid less the direct subsidy, which is then combined with any supplemental premium to form the total Part D member premium. When the direct subsidy exceeds the bid, the calculated basic premium is negative, which can be offset by the supplemental premium, but under current bid submission rules, the total Part D premium cannot be negative. The direct subsidy has grown quickly under the redesign, reaching $254.72 per member per month for calendar year (CY) 2027, compared with $29.58 in CY 2024. Milliman modeling, using 2025 claims for every plan in the country projected to 2027, estimated a significant number of plans would have negative calculated 2027 premiums before any corrective adjustments.[7]

7. Milliman analysis of CMS's 100% Research Identifiable Files (RIF), accessed under data use agreements with CMS; CY 2025 claims projected to CY 2027 and re-adjudicated at the claim level under the CY 2027 benefit design for every plan in the market to forecast CY 2027 bid amounts by plan.

Three forces drive this, and they behave differently over time:

1. Because the current RxHCC model does not fully reflect recent differences in LI and NLI cost trends, plans serving primarily
   LI beneficiaries tend to receive more risk-adjusted revenue than their costs warrant, while plans serving primarily NLI beneficiaries tend to receive less. This contributes to lower bids for LI-heavy plans and higher bids for NLI-heavy plans. Because NLI-heavy plans make up a large share of the calculation,[8] their higher bids raise the NAMBA, and the direct subsidy paid to every Part D plan rises with them, so plans serving predominantly LI populations receive a subsidy calibrated to a market whose risk-adjusted costs grew faster than their own.
2. Similarly, the overfunding of low- and non-utilizers contributes to lower calculated bids for plans enrolling lower-cost beneficiaries regardless of income mix. This will not correct itself via the expected use of 2025 prescription drug data in the forthcoming 2028 RxHCC model calibration.
3. Premium stabilization, the IRA's 6% annual cap on BBP growth, raises the direct subsidy for every plan uniformly (on a 1.0 risk score basis). Absent the cap, the direct subsidy would have been $36 and $53 lower per member per month in 2026 and 2027, respectively, based on published CMS data on uncapped BBP. The delta has increased, and may continue to do so, because the NAMBA has increased by more than 6% annually.

A plan with negative premium has few options: Margin limits restrict how much of the excess the plan may retain, and a negative Part D premium is not permitted to offset a positive Part C premium. The remaining option is to spend the excess through Part D benefit enhancements. During the CY 2027 bid cycle, CMS directed renewing plans in this situation to reduce cost sharing to a threshold defined as 70% of the defined standard benefit's out-of-pocket cost (OOPC) value (as measured by CMS's OOPC model), with margin flexibility beyond that point.[9] As discussed in the previous section, enhancing benefits reduces the amount a beneficiary has to spend to satisfy the MOOP and increases adverse selection risk on those plans, meaning they may be more likely to attract beneficiaries whose costs exceed the revenue the risk model provides for them. This risk falls on the plans whose initial projections assumed the lightest utilization. Conversely, for basic standalone prescription drug plans (PDPs), which cannot add supplemental benefits by statute, the only permitted remedy was to raise margin until the premium reaches $0, increasing the cost of coverage to the government while delivering no additional value to the beneficiary, all else equal.

The same flexibility was not available to every plan. Plans that were new in 2027 were excluded from the 70% threshold and the margin flexibility that came with it, which CMS clarified in its May 28, 2026, actuarial user group call. A new plan with a negative calculated premium therefore had to resolve it entirely through Part D benefit enhancement, while an established plan in the same market could enhance to the 70% OOPC threshold and take the remainder in margin. A new plan sponsor facing that requirement may need to offer richer benefits than comparable incumbent plans, potentially increasing selection risk and making market entry less attractive.

These negative premium remedies can also feed back into the direct subsidy that caused them. When a plan increases margin or enriches benefits to reach a $0 premium, part of that increase flows into the NAMBA, and a higher average raises the direct subsidy paid to every plan, which can push additional plans into negative positions. Margin increases were constrained by the aggregate margin rules, and benefit enhancements do not translate into the NAMBA as directly as margin does. Since the BBP is already above the cap, whatever increase in NAMBA does occur flows through to the direct subsidy, so the greater cost is borne almost entirely by the federal government.

8. The national average monthly bid amount (NAMBA) calculation excludes certain plan types, namely special needs plans (SNPs) that are heavily low-income and employer group waiver plans (EGWPs).

9. Centers for Medicare and Medicaid Services. (April 16, 2026). CY 2027 actuarial bid user group call weekly announcements. Retrieved September 1, 2026, from https://www.cms.gov/files/document/cy-2027-actuarial-bid-call-weekly-announcements.pdf-0.

MARKET INSTABILITY

Standalone PDP offerings fell from 464 in 2025 to 360 in 2026, a 22% reduction following a 35% reduction the year before, and the top five carriers now cover roughly 96% of PDP enrollment. Both trends predate the IRA: Standalone offerings had been declining and enrollment concentrating for more than a decade, and carriers began exiting after the IRA was enacted but before the redesign took effect. The redesign did not start these trends, but it does not appear to have slowed them, and it is one contributor among several, alongside broader Medicare Advantage and Part D market dynamics over the same period.[10]

CMS created the Part D Premium Stabilization Demonstration for PDPs, a voluntary program under which participating standalone plans received a subsidy to limit year-over-year premium increases in 2025 and 2026. The demonstration was separate from the IRA's premium stabilization provision, which caps growth in the BBP program-wide. CMS also rejected standalone PDP bids in 2026 that failed to address large year-over-year premium increases, indicating CMS viewed the pace of premium change in the standalone market as a concern.[11] On July 28, 2026, CMS announced this additional premium stabilization mechanism would not be in place for 2027, which would have been its third and final year under the original design, which will contribute to increased premiums in 2027.[12,13]

Selection pressure is acute in the PDP market because PDPs compete largely on premium. Beneficiaries with limited drug needs can easily move to the lowest premium plan, while those on high-cost therapies are less willing to move because a new plan may not cover their drug or may apply utilization management differently. Plans therefore face a potential outcome that the lowest-premium plan in a market attracts a disproportionate share of beneficiaries with low or no prescription drug costs, for whom the risk model provides more revenue than their costs warrant, while competing plans retain beneficiaries with higher prescription drug costs for whom it provides less. Plans respond by adding deductibles, moving brand drugs to coinsurance, narrowing formularies, and applying more utilization management levers. While these changes are rational responses to keep premiums from rising, they collectively reduce the actuarial value of coverage available in the market, and changes made through a formulary are far less visible to a beneficiary at enrollment than changes in estimated out-of-pocket costs. Plan exits compound the selection effect: When higher-premium plans exit the market, their beneficiaries migrate elsewhere, and lower-premium plans may not be priced to adequately absorb an influx of beneficiaries with higher prescription drug costs.

These pressures have also affected the Medicare Advantage Prescription Drug (MA-PD) market through the interaction between Part C rebates and Part D premiums. A large number of individual MA-PD products are designed around an overall $0 premium value proposition, so increases in the Part D premium component generally need to be absorbed by Part C benefits, a flexibility that standalone PDPs do not have. As Part D costs and premiums rise, more of the Part C rebate may be needed simply to preserve the overall $0 premium position, leaving fewer dollars available for supplemental benefits such as dental, vision, hearing, or other non-Medicare-covered benefits. This creates a trade-off that is less visible than a premium increase: Beneficiaries may continue to see $0 premium MA-PD options, but with reduced supplemental benefit value or higher medical cost sharing. Recent analyses have noted that average Part D premiums remain substantially higher in standalone PDPs than in MA-PDs, reflecting MA-PD sponsors' ability to use rebates to buy down the drug premium.[14]

10. Collin, D., Hamilton, J., & Klaisner, J. (October 24, 2025). Continued concentration and sustained stabilization: A 2026 Medicare prescription drug plan market overview. Milliman. Retrieved September 1, 2026, from https://www.milliman.com/en/insight/concentration-stabilization-medicare-pdp-2026.

11. Centers for Medicare and Medicaid Services. (July 28, 2025). 2026 Medicare Part D bid information and Part D Premium Stabilization Demonstration parameters.

Retrieved September 1, 2026, from https://www.cms.gov/newsroom/fact-sheets/2026-medicare-part-d-bid-information-and-part-d-premium-stabilization-demonstration-parameters.

12. Centers for Medicare and Medicaid Services. (July 28, 2026). Medicare Part D 2027 national average monthly bid amount information. Retrieved September 1, 2026, from https://www.cms.gov/newsroom/fact-sheets/medicare-part-d-2027-national-average-monthly-bid-amount-information.

13. Brooks, J. (July 28, 2026). Annual release of Part D national average monthly bid amount and other Part C & D bid information. Centers for Medicare and Medicaid Services. Retrieved September 1, 2026, from https://www.cms.gov/files/document/july-28-2026-parts-c-d-announcement.pdf.

14. Cubanksi, J., & Damico, A. (June 11, 2026). Medicare Part D enrollment, premiums, and cost sharing in 2026. KFF. Retrieved September 1, 2026, from https://www.kff.org/medicare/medicare-part-d-enrollment-premiums-and-cost-sharing-in-2026/.

The result may also tilt the relative value proposition between MA-PD and Original Medicare paired with Medigap and a standalone PDP. The Medigap plus PDP combination preserves broader provider access and more-predictable medical cost sharing but requires both Medigap premium and a standalone PDP premium. As PDP premiums rise, and particularly as temporary PDP premium stabilization support ends after 2026, that combination becomes more expensive, while MA-PD plans can often maintain a $0 total premium by reallocating Part C rebate dollars. That does not mean MA-PD has become uniformly preferable; network constraints, utilization management, and medical cost sharing remain important considerations. But from a monthly premium perspective, the differential has widened in a way that could make MA-PD appear relatively more attractive to beneficiaries who are sensitive to premium cost.

A recalibration of the RxHCC model for 2028 may introduce its own transition risk. Large year-over-year movements in risk scores change plan revenue independently of any change in the underlying population, and plans that priced benefits against one set of risk scores may need to adjust benefits materially when the next model takes effect. CMS limits on year-over-year cost sharing increases constraint on how quickly those adjustments can be made for some plans, which can leave sponsors choosing between absorbing the change or exiting.

THE 2030 BASE BENEFICIARY PREMIUM RESET

A significant transition is scheduled for 2030. The BBP was originally defined as 25.5% of the sum of the NAMBA and federal reinsurance. The IRA premium stabilization capped BBP growth at 6% per year through 2029, but in 2030 the statute resets the BBP percentage, if necessary, so that the BBP increase is no more than 6%, subject to a floor of 20% and a cap at the statutory 25.5%. Because the capped BBP has fallen well below what its calculated share of program cost would be in the absence of IRA premium stabilization (from 16.8% in 2025 to 11.2% in 2027), that reset may produce a large single-year increase in beneficiary premiums and a corresponding single-year decrease in the direct subsidy. Plans would need to absorb the increase in basic Part D premium through margin or benefits within one bid cycle. The new BBP percentage calculated for 2030 will also be used in subsequent years.

FEDERAL COST

Part D is largely financed by the federal government, and under the current funding structure most changes in Part D cost flow through to federal expenditures rather than being absorbed elsewhere. Two mechanics in the current structure make that relationship especially direct:

1. First, utilization-driven trend flows into higher bids, and with the cap on BBP growth, that increase flows entirely into the direct subsidy. Assuming beneficiaries generally continue therapies they have started, this level of spending persists, creating a new baseline rather than a temporary spike in spending levels. While cost increases are not all IRA-driven, such as growth in GLP-1 use and new therapies entering the market, the Congressional Budget Office's (CBO's) recent updates indicate that the redesigned Part D benefit has cost materially more than originally projected.

   CBO initially estimated that the IRA's Medicare Part D drug provisions would reduce federal deficits by $129 billion over 2022 through 2031, with savings from negotiation and inflation rebates more than offsetting the cost of the Part D redesign. CBO now states that the Part D redesign has been significantly more expensive than expected because prescription drug use increased more than anticipated, and the combined drug provisions are now projected to increase deficits over that period.[15] Separately, CBO reported that 2025 Part D bids alone implied $10 billion to $20 billion of additional federal spending relative to its earlier projections, before the additional cost of the temporary premium stabilization subsidies.[16]

15. Congressional Budget Office. (July 29, 2026). Developments in CBO's projections for Medicare Part D. Retrieved September 1, 2026, from https://www.cbo.gov/publication/62549.

16. Congressional Budget Office. (October 2, 2024). Developments in Medicare's prescription drug benefit. Retrieved September 1, 2026, from https://www.cbo.gov/system/files/2024-10/Arrington_et_al_Letter_PartD_0.pdf.

2. Second, where the risk model pays a plan more than its costs warrant, that excess is not recovered. Plans resolve it within the bid, either by enriching benefits or by increasing margin, and both routes carry federal cost forward: Richer benefits induce additional utilization, and higher margins raise the NAMBA and therefore the direct subsidy paid to every plan in the following cycle. Federal interventions to manage the resulting instability, such as the PDP Premium Stabilization Demonstration, add further cost attributable to the same funding mismatch.

These mechanics also work in the other direction. Where the risk model provides less revenue than a plan's costs warrant, the plan absorbs the difference, leading to higher bids, and to the extent that the 2028 recalibration reduces the misalignment, the federal cost associated with it should decline as well.

Areas that could be addressed

These outcomes trace to a small number of mechanics: the risk model's calibration lag and level of granularity, the greater-of MOOP accumulation rule, the $0 premium floor, and the mechanics driving the direct subsidy. We describe categories of potential adjustments to these mechanics and their trade-offs. We do not endorse or oppose any of them. Some of these sit within existing administrative discretion; others would require demonstration or waiver authority at a minimum, while others likely require congressional action.

Each would create its own set of incentives and potential unintended effects, and each would require analysis well beyond the scope of this paper before being adopted.

RISK ADJUSTMENT

Recalibrating the 2028 RxHCC model on 2025 prescription drug experience will capture much of the shift in spending patterns between LI and NLI populations, though emerging 2026 trends still show divergence. CMS could go further by projecting calibration data forward using drug- or class-specific trend assumptions and by reflecting maximum fair prices closer to the year in which they take effect. Each of these steps introduces new judgment into the model, and projecting data forward requires trend assumptions that may themselves prove wrong.

Incorporating prescription drug claims as a predictor could also help. The Department of Health and Human Services Hierarchical Condition Categories (HHS-HCC) model used in the individual exchange market has 10 drug-imputed conditions alongside medical diagnoses, and a similar approach could work here without a wholesale change in model type. We cite that model only as an example of using drug information as a predictor, not as a recommendation to adopt its broader risk-transfer design. The principal objection to using drug data as a predictor is that it has the potential to reward plans for higher utilization; that concern would need to be accounted for in any model change. Another potential enhancement would be finer granularity within existing categories, such as separate brand and generic utilizer factors, which could also improve predictive power.

MOOP ACCUMULATION

MOOP accumulation is a second mechanic that could be revisited. Under the current greater-of rule, beneficiaries in enhanced plans accumulate toward the MOOP based on defined standard cost sharing when that exceeds what they actually pay. Accumulating to the MOOP using amounts actually paid by the beneficiary and/or cost-sharing subsidies would reduce the gap between the nominal limit and actual beneficiary spending. Beneficiaries in enhanced plans would face additional cost sharing but would still be capped at MOOP.

NEGATIVE PART D PREMIUMS

Several approaches would let the program recognize favorable funding positions without requiring plans to spend the excess on benefit enhancements:

- Permitting negative Part D premium to stand and applying it as a credit against the beneficiary's other Medicare premiums (Part C and Part B, in the case of MA-PDs, and Part B in the case of PDPs), which would remove the need for many of the remedies described above. This would require a mechanism for crediting premiums across parts of the Medicare program and would direct revenue to beneficiaries in plans whose funding advantage may reflect risk model inaccuracy rather than efficiency. This change would require congressional action. It would also interact with sequestration, since the direct subsidy is a federal payment while beneficiary premiums are not, so the mechanics of any credit would need to be worked out carefully.
- Directing excess Part D funding to Part C supplemental benefits or Part B premium buydowns for MA-PD plans, which reaches beneficiaries without triggering the accumulation dynamics, but is unavailable to standalone PDPs. This could blur the separation between Part C and Part D funding and would require waiver authority or congressional action.
- Permitting higher Part D margins to be offset by lower or negative Part C margins, keeping total plan margin within existing aggregate rules. This delivers no specific value to beneficiaries, but it keeps the plan financially neutral in total and provides more flexibility to keep benefit designs as originally planned.
- Permitting plans to return excess capitation to the Part D account of the Supplementary Medical Insurance (SMI) Trust Fund. This reduces federal spending but provides no direct benefit to enrollees and would need to be structured so that plans are not penalized for operating efficiently. Making this a usable option, rather than a voluntary donation, would likely require congressional action.
- Allowing enrollment capacity limits to be requested after the bid deadline as a safety valve for plans placed into outlier benefit positions. This would protect plans pushed into positions their capital cannot absorb at the expense of restricting beneficiary access to plans that may otherwise be attractive.
- Applying flexibilities consistently across new and renewing plan benefit packages so that entry into a market does not subject new carriers to selection risk that incumbents can avoid.

BBP CAP

As described earlier, the 6% cap on BBP is temporary, and a drop in the direct subsidy (all else constant) is expected in 2030 when the BBP calculation is reset. Phasing the reset in over several years would avoid the single-year step while still moving the beneficiary share back toward its statutory level. A phased approach would have trade-offs, including continued federal support above the level the statute contemplates during the phase-in period.

Conclusion

The IRA redesign delivered meaningfully on its objective of capped, predictable out-of-pocket costs for beneficiaries, particularly for those taking high-cost medications, beginning in 2024. The same period has also brought higher drug trends, changes in benefit and formulary design, continued consolidation in the PDP market, and a large volume of negative calculated premiums requiring adjustments in the bid process. These outcomes have several causes beyond what is described in this paper, including drug pipeline and utilization trends that would have emerged under any benefit design. However, it is clear the increased richness of the benefit (particularly for utilizers of high-cost drugs) has led to a significant portion of the high trend levels. The issues discussed here also relate to funding mechanisms that were not updated alongside the benefit, most notably a risk-adjustment model whose accuracy now carries significantly greater financial consequence than when it was designed. With the 2028 recalibration and the 2030 premium reset ahead, and multiple IRA bid cycles now completed, there is both the data and the opportunity to examine these mechanics going forward.

Qualifications

The authors are members of the American Academy of Actuaries and meet the qualification standards for rendering the actuarial opinions contained herein. This paper reflects the views of the authors and does not necessarily represent the views of Milliman, Inc. Nothing herein is intended as legal advice or as a recommendation for or against any specific legislative, regulatory, or administrative action. We have relied on data provided by CMS without audit.

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