IRA Reforms to Medicare Part D Reinsurance Are Associated with Plan Exits and Higher Premiums

Paul H.S. Kim
Michigan State University

Colleen Carey
Cornell University & NBER

Abstract: The 2022 Inflation Reduction Act (IRA) altered the financing of prescription drug purchases for more than 55 million Medicare beneficiaries. Prior to 2025, the federal government contributed 80% of expenditure after a beneficiary hit a threshold, but beginning in 2025 this share is reduced to 20%. We study the effect of the reinsurance reforms on exit, premium, and benefit design for free-standing Part D plans. We find that after the IRA reforms, previous reinsurance payments became a strong predictor of plan exit. In a first look at the 2025 Premium Stabilization Demonstration, we find that plans with higher pre-IRA reinsurance were more likely to receive the Demonstration's targeted subsidy. However, we show that plans with higher pre-IRA reinsurance increased premiums substantially in 2024 and 2025, even after the Demonstration subsidies. Finally, we find no significant relationship between pre-IRA reinsurance and benefit design outcomes (e.g., coverage, out-of-pocket cost). Together, our findings highlight the role of reinsurance reform in recent Part D market volatility.

Introduction

Medicare Part D uses a public-private partnership to provide prescription drug coverage to older adults and individuals with disabilities. Private plan sponsors administer drug coverage, collecting federal subsidies and beneficiary premiums.. At the point of sale in a pharmacy, prescription drug costs are shared between Medicare beneficiaries and plan sponsors.

The original Part D benefit included a federal reinsurance program through which the government mitigated plan sponsors' financial risk for high-cost enrollees. Once an enrollee's out-of-pocket spending exceeded a defined ("catastrophic") threshold, plan sponsors paid only 15% of remaining drug costs, while the federal government covered 80%, and beneficiary cost-sharing covered 5%.

While reinsurance only made up less than 20% of total Part D spending in its early years (e.g., 17% in 2008), rising drug list prices, combined with the structure of the Part D benefit design, led to a rapidly expanding role for federal reinsurance in covering overall drug spending (1–3). Since 2020, reinsurance has accounted for nearly 50% of total Part D spending, shrinking the liability share of plan sponsors (4).

As the liability share of plan sponsors shrank, their incentive to negotiate lower drug prices may have weakened. Under Part D, plans or their pharmacy benefit managers determine the formulary design - that is, which drugs are covered and at what cost to enrollees. This formulary design is shaped by negotiations with drug manufacturers, where favorable formulary placement is traded for price concessions. However, as plans' share of liability for total spending fell, plans retained a smaller portion of any savings achieved through price concessions or decreased utilization. This dynamic has raised concerns that the program's design may inadvertently contribute to higher overall drug prices (5,6), leading to an increasingly large share of spending incurred beyond the catastrophic threshold (7,8).

Partly in response to these concerns, the 2022 Inflation Reduction Act (IRA) significantly restructured the Part D benefit. The law altered beneficiary cost-sharing and shifted financial liability from the federal government and the beneficiaries to plan sponsors. In 2024, the IRA

eliminated the beneficiary's 5% coinsurance above the catastrophic threshold and raised plan liability to 20%. In 2025, the benefit was fully redesigned: plan sponsors now cover 60% of costs above the threshold, while the rest is covered by manufacturers and the government reinsurance. The law also lowered the threshold for catastrophic coverage to a $2,000 annual out-of-pocket cap, making it more likely that beneficiaries reach it (9). Collectively, these reforms substantially increased plan sponsors' financial liability while strengthening beneficiary protection against high drug costs.

In light of these significant changes, Centers for Medicare and Medicaid Services (CMS) introduced the Premium Stabilization Demonstration for stand-alone prescription drug plans (PDPs) beginning in 2025. The Demonstration introduced two additional subsidies to mitigate the impact of plan liability changes on enrollee premiums. The first was a universal increase in the direct subsidy by up to $15, provided the premium remained non-negative. The second was a targeted subsidy for plans proposing premium increases exceeding $35 that capped premium increases at $35 (10,11).

These reforms have coincided with noticeable changes in insurer behavior. Recent evidence points to a substantial number of plan exits following the IRA's implementation in 2024 (12), as well as shifts in formulary design and cost-sharing structures (13–17). In this paper, we examine how insurers responded to the increased liability resulting from the IRA's changes to the federal reinsurance structure. We leverage plan-level variation in pre-IRA reinsurance exposure to determine how the reinsurance reform affected plans' exit decisions, premiums, and reliance on the Premium Stabilization Demonstration.

Study Data and Methods.

Data

We use the publicly-available Q1 Quarterly Prescription Drug Plan Formulary, and Pricing Information files and Part C & D Plan Crosswalk files published by CMS to measure Part D plan participation, premium, and formulary outcomes for 2020-25. We use the Part D Payment files to measure plan-level reinsurance payments and direct subsidy per-member-month (PMPM) for 2020-23. We focus on PDPs, excluding Medicare Advantage Part D plans and employer group waiver plans. We note that 99% of PDP enrollees were in plans that participated in the Premium Stabilization Demonstration in 2025, implying that participation was nearly universal, although there is no public data on participation that would allow us to differentiate between participating and non-participating plans (18).

Exposure

Our analysis examines differences in post-IRA outcomes among plans with different exposure to the reinsurance reforms. We proxy exposure to the reinsurance reforms using each plan's 2023 PMPM reinsurance payment. This measure captures a plan's reliance on federal reinsurance before the IRA reforms. It serves as a useful proxy for two reasons.

First, 2023 reinsurance payments are a strong predictor of what reinsurance payments would have been in 2024-2025 absent the IRA, i.e., *counterfactual 2024-25 reinsurance payments*. In the 2020-23 Part D Payment files, reinsurance amounts are highly correlated within a plan across time, with plan fixed effects accounting for 88% of the variation in yearly reinsurance payments to plans. This high correlation is driven by the fact that consumers exhibit inertia in plan choice, so a high-cost individual is likely to continue to incur reinsurance payments for the same plan year after year (19,20).

Second, the IRA reform to plan liability is proportional to *counterfactual reinsurance payments* in 2025. Specifically, in 2023, spending in the catastrophic zone (where reinsurance applied) was equal to the reinsurance payment divided by 0.8. Plan liabilities in the catastrophic zone increase under the IRA from 15% of spending to 60% in 2025. Thus, we can write the change in plan liability induced by the IRA reinsurance reforms as:

$$\Delta Plan\ liability^{IRA\ reins} = (0.6 - 0.15) * catastrophic\ zone\ spending^{25}$$

$$= (0.6 - 0.15) * \frac{counterfactual\ reinsurance\ payments^{25}}{0.8} \approx (0.6 - .15) * \frac{reinsurance\ payments^{23}}{0.8}$$

In the second line, we substitute catastrophic zone spending in 2025 with its equivalent under the pre-IRA benefit design (i.e., reinsurance payments would have been 80% of catastrophic zone spending). The final approximation holds because, as we argued above, reinsurance payments in 2023 are a strong predictor of 2025 reinsurance payments in a counterfactual without the IRA. While other IRA provisions (such as the reduction in the OOP threshold) increased liability broadly, our measure isolates the heterogeneous changes in plan liability induced by the reinsurance reforms.

Outcomes

We report five measures describing PDP market characteristics between 2020 and 2025. First, we report the total number of plans offered across all PDP markets and the total number of plans exiting each year (i.e., not continuing from the previous year). We also report three statistics averaged across PDP markets: the number of plans being offered, the number of distinct plan sponsors, and the Herfindahl-Hirschman Index (HHI) as a measure of market concentration.

We consider five measures of plan financial characteristics. The first is the average monthly premium (for beneficiaries not receiving the low-income subsidy). Starting in 2025, monthly premiums are reported net of additional subsidies from the Demonstration. To contextualize the Demonstration's targeted subsidy, we count the number of plans with premium increases of $35. The next measures are the average PMPM direct subsidy and the average PMPM reinsurance payment. Premiums, a direct subsidy subject to risk adjustment, and reinsurance sum to total payments to plans and, equivalently, total plan liabilities.

We further examine four measures of benefit design. *Mean coverage* represents the share of drugs covered (on-formulary) from the set of drugs covered by any Part D plan in that year. *Mean OOP* represents enrollees' average cost-sharing for the same set of drugs when being dispensed prior to the initial coverage limit (2020-24) or the out-of-pocket maximum (2025). OOP is set to the average point-of-sale price for the drug in cases where the plan does not cover the drug. *Mean price* reports the average point-of-sale price for the same fixed set of drugs; again, price is set to the average price in cases where the plan does not cover the drug. This publicly-available price does not reflect price concessions specific to this plan-drug that reduced prices by an average of 23% in 2021 (21). Our fourth outcome is the share of covered drugs in the plan requiring prior authorization. We compute these outcomes separately for all drugs and for 300 drugs with an average 30-day price exceeding $1000. Further detail is provided in the Appendix.

Sample

We describe aggregate market statistics and study exits using all PDPs available in any year 2020–2025. For our analysis of premium, the Demonstration, and benefit design outcomes, we use a "2025 plans" panel. This panel represents 473 PDPs that existed in 2025 and could be

crosswalked to non-missing 2023 plan-level average reinsurance data, as well as their parent plans in all preceding years.

We measure the IRA impact beginning in 2024. The IRA was signed in August 2022, after Part D contracts had been finalized for 2023 (18). In 2024, plans faced a small increase in reinsurance liability and positioned themselves for the larger 2025 reforms.

Methods

We first measure the association between 2023 reinsurance payments and receipt of the Demonstration's targeted subsidy that capped premium increases at $35. We report the share of plans with premium increases equal to exactly $35, our proxy for targeted subsidy receipt, plotted against a histogram of 2023 reinsurance payments.

Next, we use the full sample of plans in an event study to describe the relationship between reinsurance payments and plan exit before and after the IRA reforms. The dependent variable is an indicator for plan exit (set to 1 in the first year that a plan does not continue). The independent variable is plan's reinsurance payments in the previous year (i.e., the final year for exiters), interacted with calendar year indicators. Because 2024 reinsurance payment data are unavailable, we use 2023 reinsurance levels for plans exiting in 2025.

Finally, we evaluate whether plans with greater pre-IRA reinsurance exposure systematically altered premiums or benefit design after the IRA. Using the 2025 plans panel, we estimate an event-study model that interacts 2023 reinsurance payments with year indicators. The event-study model also controls for year and plan fixed effects. The coefficients represent the differential change in the outcome in a given year for each additional dollar in 2023 reinsurance payments. We hypothesize that if the Demonstration fully offset the increased liabilities of plans with high 2023 reinsurance, we should see no association in the event study between reinsurance exposure and 2025 premiums.

To focus on plan decisionmaking, we use plan-years (unweighted) as our unit of observation. Weighting by each plan's 2023 enrollment better represents typical enrollee experience, and weighted specifications of Exhibits 1, 2, and 4 are available in the Appendix Exhibits A1-3. Additionally, Appendix Exhibit A8 presents robustness to a risk-standardized version of our primary reinsurance measure, as well as a discussion of its interpretation.

Results

We begin by presenting our outcome measures over the years 2020-25 to show the evolution of market and plan measures. Exhibit 1 shows that since the IRA took effect in 2024, there have been widespread plan and insurer exits from stand-alone PDP markets, confirming recent results (22). Prior to 2024, each market averaged over 20 plans offered by about 8 sponsors. By 2025, this declined to 12.2 plans and 5.2 sponsors per market, raising market concentration from an average HHI of 2,830 to nearly 3,500.

Exhibit 1: PDP Market Statistics and Plan Characteristics, 2020-2025

	2020	2021	2022	2023	2024	2025
Market Statistics						
Total # of plans	959	1007	776	814	719	474
# of plan exits	0	18	18	4	62	140
Mean # of insurers/market	8.3	8.2	7.9	8.0	7.0	5.2
Mean # of plans/market	24.6	25.8	19.9	20.9	18.4	12.2
Mean HHI/market	2851	2783	2817	2859	3081	3437
Plan Characteristics						
Mean Premium	$40.9	$41.5	$47.7	$49.3	$59.8	$64.3
# of plans with $35 premium increase	0	0	1	0	0	117
Mean Direct Subsidy	$14.8	$7.8	$2.9	$1.6	-	-
Mean Reinsurance Payment	$82.9	$88.6	$101.3	$107.5	-	-
Mean Coverage	0.52	0.52	0.52	0.52	0.52	0.54
Mean OOP (pre-ICL)	127	134	137	146	187	259
Mean Drug Price	202	213	221	235	282	354
Mean Prior Authorization	0.23	0.24	0.25	0.25	0.26	0.26
Number of Plans in Each Panel						
2025 plans	756	791	579	580	579	473

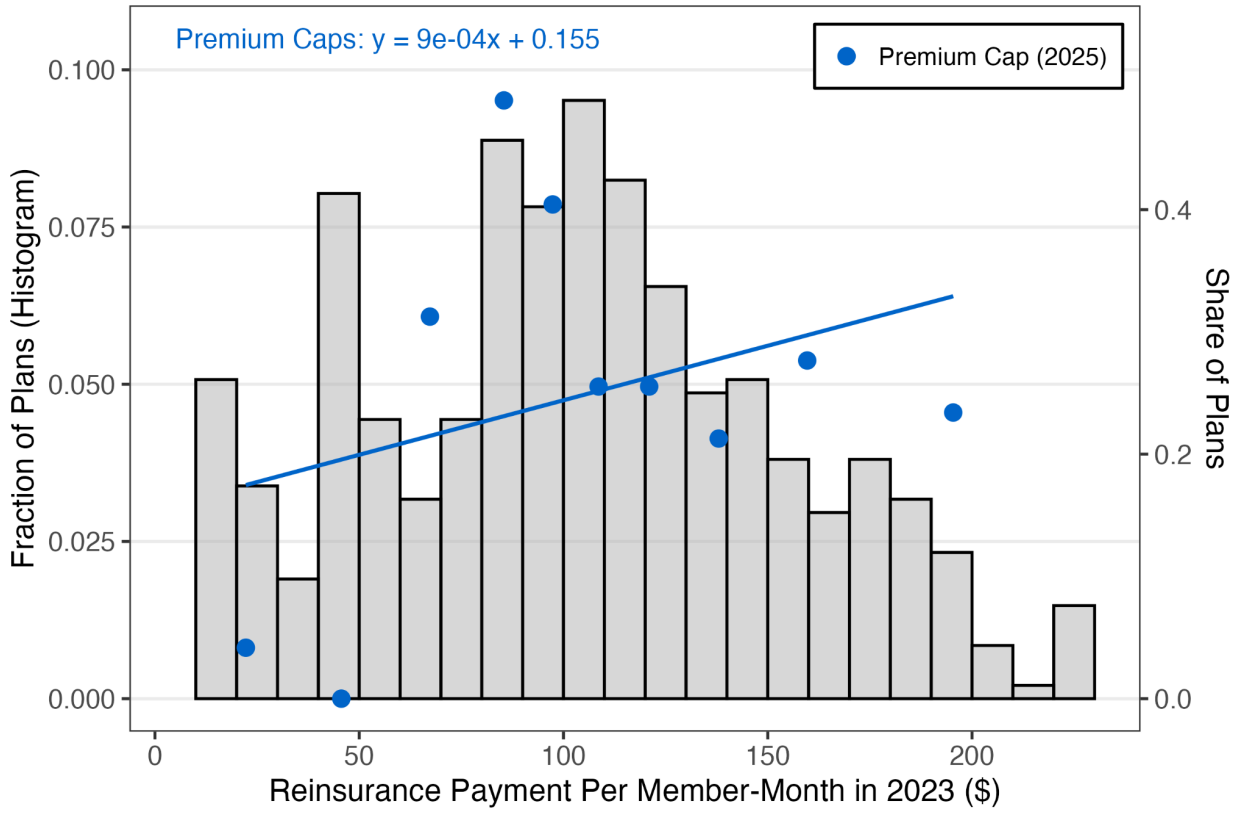
Source/Notes: SOURCE: Q1 Quarterly Prescription Drug Plan Formulary and Pricing Information Files (2020-25), Part D payment files (2020-23). NOTES: Summary statistics for the "universe" plan panel (all plans offered); benefit design outcomes are unavailable for 58 plans in 2020 and 33 plans in 2024 . Mean plan characteristics are averaged across all PDP plans. Mean market statistics are averaged across PDP regions. "-" signifies that the statistic is not yet available from the source. Premium in 2025 is net of additional subsidies in the Premium Stabilization Program.

Exhibit 1 also describes plan characteristics over time. Premiums averaged $45 in the years 2020-23, and increased by 40% in 2025, even after the Demonstration's additional subsidies. Approximately a quarter of 2025 plans have a $35 premium increase (which was observed only once over the years 2020-24), implying that about a quarter of plans qualified for the targeted subsidy (See Appendix Exhibit A5 for the distribution of premium increases in 2025.) Average drug coverage is approximately stable, as is use of prior authorization. Growth in average OOP costs and drug prices accelerated from approximately 8% per year in 2020-23 to 33% and 26%, respectively, in the IRA post-period (13).

Exhibit 1 also shows the dominant role of reinsurance in plan finances prior to the IRA reforms. In 2023, plans received an average of $158 in total payments PMPM to cover their share of prescription drug purchases, with more than two-thirds of those payments received under the pre-IRA reinsurance.

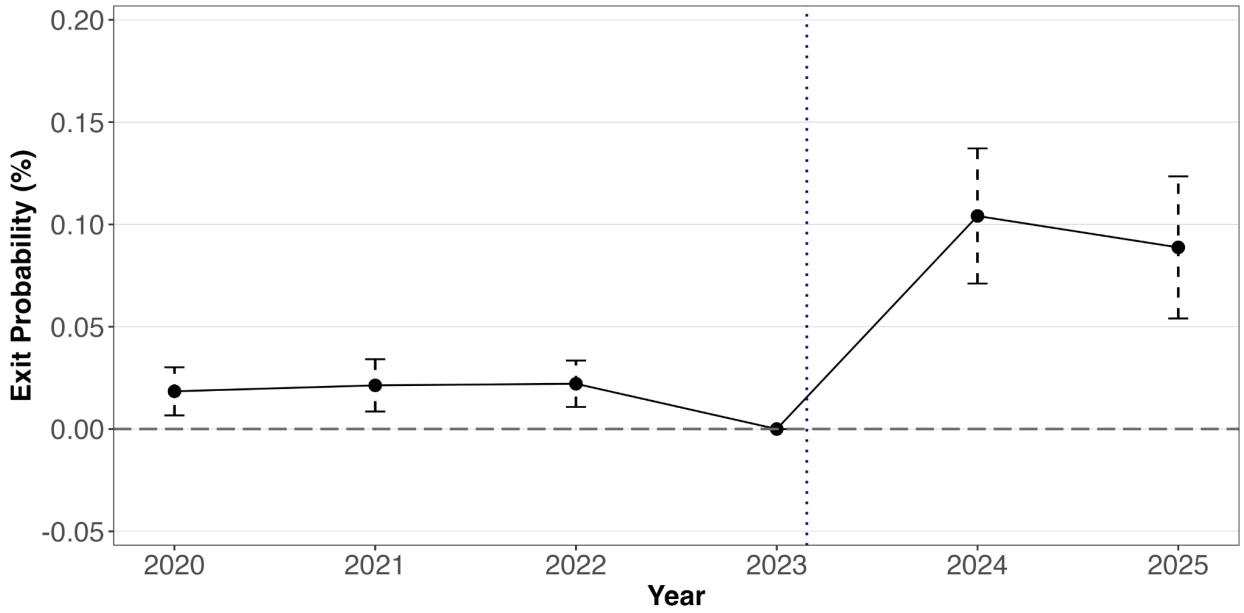
Exhibit 2 reports the distribution of our exposure measure, 2023 reinsurance payments. There was wide variation around the mean of $108 PMPM, with an interquartile range of $93 PMPM.

Exhibit 2: Distribution of 2023 Plan Reinsurance Payments & Share of Plans Hitting Premium Cap in 25.



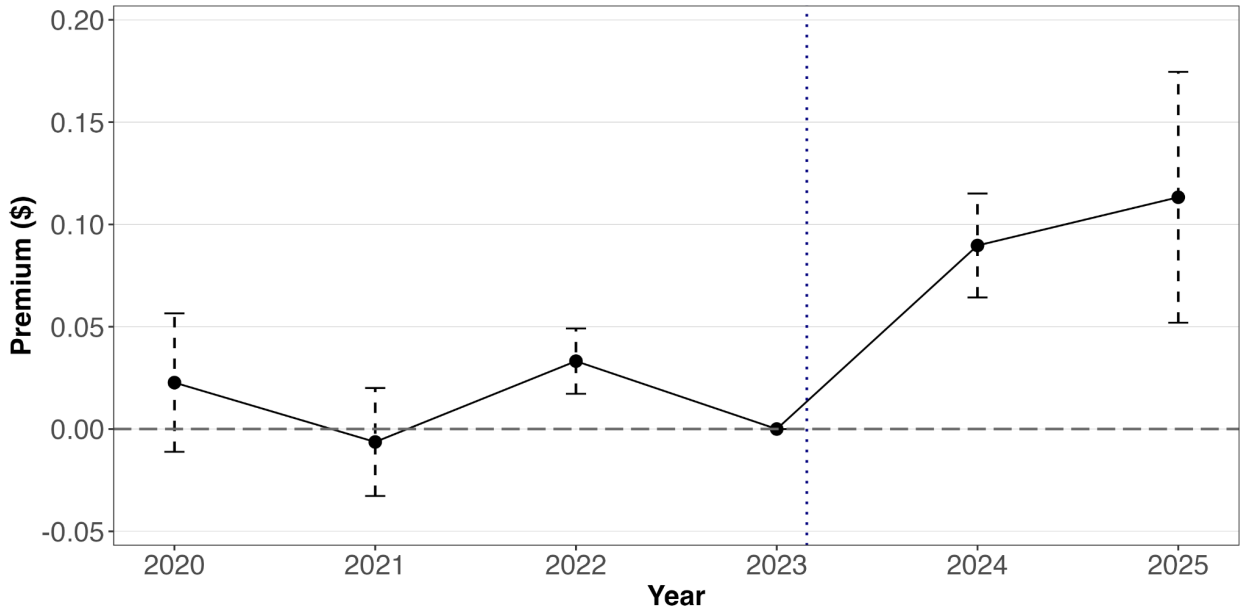
Source/Notes: SOURCE: Q1 Quarterly Prescription Drug Plan Formulary and Pricing Information Files (2023-25), Part D payment files (2023), Part D plan crosswalk files (2023-2025). NOTES: The sample includes all plans in 2025 that could be linked to a 2023 parent plan with non-missing reinsurance payment. The distribution was plotted using the 2025 PDP's 2023 plan-level per-member-month reinsurance payment. The binned scatterplot was plotted by computing the share of plans in each decile of the plan-level reinsurance payment that had 2024-2025 premium change capped at $35. Plan's 2024 premium is defined as the minimum premium amongst all 2024 parent plans associated with the given 2025 plan, consistent with CMS's Premium Payment Demonstration definition. The line of best fit was computed using each 2025 plan as a unique observation.

Exhibit 3: Plan Exit by Prior Year's Reinsurance Exposure.



Source/Notes: SOURCE: Q1 Quarterly Prescription Drug Plan Formulary and Pricing Information Files (2019-24), Part D payment files (2019-2023), Part D plan crosswalk files (2019-2025). NOTES: This figure reports event study coefficients estimating the impact of a $1 increase in a plan's average reinsurance payment in the prior year on the probability of plan exit. Coefficients are plotted relative to the 2023 baseline. Reinsurance exposure is defined as the plan's average per-member-month reinsurance payment in the prior year. The model includes fixed effects for parent organization, year, and PDP region.
Standard errors are clustered at the PDP region level. Error bars represent 95% confidence intervals.

Exhibit 4: Plan Premiums by Pre-IRA Reinsurance Exposure.



Source/Notes: SOURCE: Q1 Quarterly Prescription Drug Plan Formulary and Pricing Information Files (2020-25), Part D payment files (2023), Part D plan crosswalk files (2020-2025). NOTES: This figure reports event study coefficients estimating the premium response to a $1 increase in reinsurance exposure. Reinsurance exposure is defined as the plan's average per-member-month reinsurance payment in 2023. All estimates are plotted relative to the 2023 baseline. The model includes fixed effects for plan and year. Standard errors are clustered at the plan level based on 2023 plan ID. Error bars represent 95% confidence intervals.

Exhibit 2 also illustrates the association between pre-IRA reinsurance and receipt of the Demonstration's targeted subsidy. The least-squares line suggests each $100 in 2023 reinsurance payment was associated with a 8.9 percentage point increase in the probability of a $35 premium increase. The positive correlation is robust to controlling for market and plan fixed effects and other plan characteristics (see Appendix Exhibit A4).

Exhibit 3 reports an event study analyzing the relationship between plan exit and reinsurance payments in the previous year. The results indicate that prior reinsurance exposure became a much stronger predictor of exit following the IRA. Relative to the pre-IRA period, a plan with $100 higher 2023 reinsurance was 8-10 percentage points more likely to exit in 2024-25.

Finally Exhibit 4 reports our event study for premium. In the pre-IRA period of 2020-2022, we find that plans with higher levels of 2023 reinsurance had similar trends to plans with lower 2023 reinsurance. However, plans with higher reinsurance disproportionately raised premiums in the years 2024–25. The event study coefficients imply that a plan with $100 higher 2023 reinsurance payments had monthly premiums that were $9 ($11) higher in 2024 (2025).

Event studies for benefit design outcomes are reported in Appendix Exhibit A6. The event study coefficients report the impact of a $100 difference in 2023 reinsurance payments. We find no strong evidence that higher reinsurance plans disproportionately changed coverage, OOP, price, or prior authorization in 2024–25 relative to lower reinsurance plans. Results are similar when weighted by enrollment or when examining outcomes for high-priced drugs.

Discussion

We examine how the IRA's reduction in reinsurance, and corresponding increase in plan liabilities, affects plan characteristics in Medicare Part D. Since plan reinsurance is highly serially correlated, we posit that plans with high 2023 reinsurance had greater exposure to the IRA reinsurance reforms. We find that plans with higher 2023 reinsurance were more likely to receive a targeted subsidy under the Demonstration. Despite this support, plans with higher 2023 reinsurance were significantly more likely to exit in 2024–25 relative to their pre-reform baseline. Among surviving plans, premiums for higher reinsurance plans followed parallel pre-trends relative to lower reinsurance plans in 2020–22, but diverged significantly in 2024–25. However, plans with higher reinsurance levels did not differentially alter benefit design outcomes in 2024–25.

Our results indicate that the reduction in reinsurance played a key role in the volatility in Part D since the IRA. More than 28% of 2023 PDPs chose to exit in 2024-25, suggesting that the post-IRA Part D market will likely be more concentrated. Our findings suggest that high reinsurance was not previously a strong predictor of exit, but beginning in 2024 exiting plans were disproportionately those with high exposure to the reinsurance reforms. Notably, the Demonstration was announced in July 2024, which was likely too late to deter exits in 2024 or 2025.

Our finding that exits are linked to reinsurance payments has implications for the near-term stability of the PDP market. Estimates suggest that 4-11% of PDP enrollees experienced plan exit in 2024 and 2025 (12). We show that these individuals were disproportionately from plans with high reinsurance payments, suggesting they are disproportionately high-cost individuals. The new plans chosen by these individuals may find them unprofitable under the new benefit

design and may need to raise bids (and therefore premiums) to account for their expense. These dynamics may explain ongoing stress in the 2026 Part D market (23,24).

In a first look at the Premium Stabilization Demonstration, we find that plans with high levels of reinsurance were more likely to hit the premium increase cap, suggesting that they benefited from the Demonstration's targeted subsidy. However, we also show that plans with high levels of reinsurance disproportionately raised premiums in 2024 and 2025, even including the Demonstration subsidies in 2025. Our results suggest that the program was not sufficiently targeted to prevent premium increases among plans most exposed to the reinsurance reforms.

Our results further suggest that the Part D risk adjustment, while recalibrated for the restructured benefit design, may not have fully offset the heterogeneous increases in plan liability. Risk adjustment and reinsurance target different points of the spending distribution, and the Part D risk adjustment methodology has been optimized to explain plan liabilities after pre-IRA reinsurance. Had the risk adjustment model fully compensated plans for the shift in liability, we would find no relationship between pre-IRA reinsurance and post-IRA outcomes. Instead, we find that plans with higher prior reinsurance increased exit rates and premiums after the IRA relative to pre-IRA trends. Crucially, these relationships persist even when standardizing reinsurance by risk score (see Appendix Exhibit A8), implying that structural liability shifts, rather than enrollee risk profiles alone, drove these differential plan responses.

We do not find any evidence that plans with higher reinsurance exposure responded to reinsurance reforms by differentially altering benefit design outcomes (coverage, OOP costs, price, or prior authorization) relative to plans with lower exposure, perhaps because that benefit design is more tightly constrained by statute and CMS regulations (e.g., coverage breadth and actuarial value requirements). However, our results do not indicate how the utilization of high-cost drugs is likely to change now that plans bear a greater liability share; when available, the Part D Event microdata can reveal changes in utilization and the effects of harder-to-observe formulary design elements like the stringency of prior authorization.

Finally, the reinsurance reform was part of a bundle of IRA policies aiming to ensure lower drug prices, either through enhanced plan incentives or centralized negotiation. We cannot yet assess how the reinsurance reforms affected plan-negotiated pricing due to data limitations. In addition, our study ends in 2025, before the phase-in of centrally-negotiated prices for certain drugs which may improve plans' financial picture in the longer run.

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