Preventing Collapse: Policy Solutions to Strengthen Medicare's Standalone Part D Plan Market

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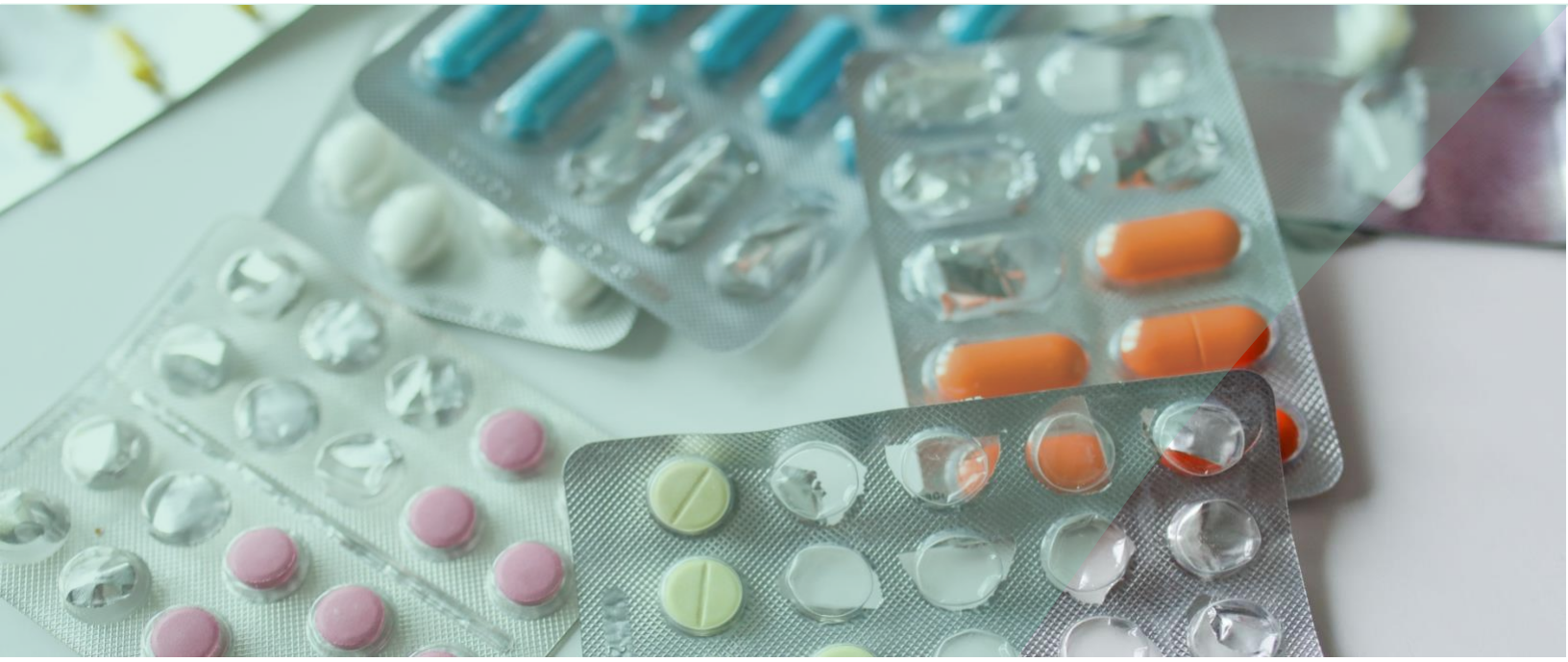

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Executive Summary

The Medicare Part D standalone prescription drug plan (PDP) market is approaching a breaking point. Since the program's 2006 launch, enrollment has shifted steadily away from PDPs toward Medicare Advantage prescription drug plans (MA-PDs), driven by structural payment asymmetries and active steering by plan sponsors who use PDPs as a feeder channel into more profitable MA products. Plan availability has contracted sharply in parallel: the number of PDPs offered nationwide has fallen by more than 60% over the past five years, and market share has consolidated among a handful of large sponsors. This contraction disproportionately affects rural beneficiaries and those with complex health needs who depend on Traditional Medicare and lack comparable MA-PD options in their area.

Left unaddressed, these dynamics risk a self-reinforcing "death spiral" – shrinking enrollment, evolving risk dynamics, and further sponsor exits – that leave millions of Traditional Medicare beneficiaries with fewer, more expensive prescription drug coverage options.

This paper offers and discusses three policy options to stabilize the PDP market for Medicare beneficiaries:

- **A federally-facilitated PDP,** activated administratively through existing fallback authority or established through new legislation, to serve as an independent, nationwide competitor;
- **Migration of prescription drugs from Part D into the Medicare Part B benefit**, integrating pharmacy and medical benefits in Traditional Medicare analogous to the Medicare Advantage/MA-PD model; and
- **A requirement that MA sponsors offer companion standalone PDPs** as a condition of MA participation, ensuring a PDP option exists in every service area.

Each pathway carries distinct tradeoffs in policy, implementation, financing, and market impact. Of the three, the paper finds that activating the existing fallback authority could offer the most feasible near-term solution, while a federally-sponsored PDP established through new legislation – potentially leveraging Medicare's drug price negotiation program – may offer the most durable market impact. None of the three options, on their own, resolves the underlying structural drivers of PDP market erosion; each must be paired with broader reforms addressing the underlying structural dynamics that contribute to market asymmetries between MA and PDP, to comprehensively stabilize the market and preserve affordable prescription drug coverage for beneficiaries in Traditional Medicare.

Background

In 2003, the Medicare Modernization Act (MMA) created Medicare's prescription drug benefit, called Part D, to provide voluntary coverage for prescription drugs through private plans to people with Medicare. The Centers for Medicare & Medicaid Services (CMS) effectuated enrollment in 2006 with beneficiaries either choosing to enroll in standalone prescription drug plans (PDPs) if they were enrolled in Fee-for-service (FFS) or "Traditional Medicare" (Parts A and B), or to enroll in Medicare Advantage prescription drug plans (MA-PDs), which bundles coverage with medical coverage offered through private plans, known as Medicare Advantage (MA or Part C).[1]

In the past two decades, the Medicare Part D market has grown substantially, with enrollment increasing from 21.8 million beneficiaries in 2006 to 56.1 million in 2026.[1] Over time, the enrollment has steadily shifted away from PDPs toward MA-PDs. This corresponds with an overarching enrollment shift from FFS to MA, driven by a range of factors that extend beyond drug cover.[2] As of February 2026, PDPs accounted for 44% of enrollment compared to 72% at the start of the program, while MA-PD enrollment has grown, 28% to 56% during the same period.[1] These shifts are driven by both structural advantages MA-PDs hold over PDPs and active steering by plan sponsors,[3] who leverage PDPs as "feeders" for enrollment into their more profitable MA products.

***EXHIBIT 1:* Two distinct markets, not intended to compete directly: PDPs and MA-PDs**

PDPs and MA-PDs are commonly perceived as competing products within the Part D market. However, the two plan types have significant structural differences that make direct competition inherently asymmetric. Given that Medicare Advantage (MA) financing cross-subsidizes MA-PDs, PDPs are competing with not just MA-PDs but MA more broadly. Given that the differences between the two plans are tied to the broader Medicare financing architecture, creating fair competitive conditions across the two product lines would require broader Medicare reform to address issues in Medicare Advantage.

Table 1: Structural differences between PDPs and MA-PDs

	PDPs	MA-PDs
Enrollment eligibility	FFS/Traditional Medicare enrollees	Medicare Advantage enrollees
Benefit design	Outpatient prescription drug coverage **only**	Outpatient prescription drug coverage **bundled with medical coverage and supplemental benefits offered as one plan**
Financing structure	Part D direct subsidy (capitated payments per enrollee), federal reinsurance for catastrophic spending and beneficiary premiums	Part D direct subsidy (capitated payments per enrollee), federal reinsurance for catastrophic spending, beneficiary premiums, **and MA rebates (which can be used to further buy down beneficiary premiums or beneficiary cost-sharing)**

Alongside the declining PDP enrollment, there has been a downward trend in the number of PDPs available, and market share has consolidated among a small number of large plan sponsors. The total number of PDPs offered across the 34 PDP regions shrunk by more than 60% over the past 5 years, declining from 1,007 to 360.[4] For beneficiaries enrolling in 2026, there remain only 8-12 PDP options offered by 4-6 parent organizations.[5] Similarly, the availability of Benchmark PDPs[2] has also fallen to 1-4 plans per state (88 nationwide), with 321 counties across 2 states having only 1 benchmark PDP plan available.[6]

Contraction of the PDP market through plan sponsor exits and declining plan availability has significant implications for beneficiaries in Traditional Medicare who depend on PDPs for prescription drug coverage. In particular, PDPs serve as a critical option for individuals in rural areas given the limitations of MA provider networks, and individuals with complex health needs given higher utilization of prior authorization under MA.[7] On average, rural counties have less than half the

[1] A small number of beneficiaries receive drug coverage through other means, including group plans such as employer/union retiree plans that receive Part D subsidy payments.

[2] Premium-free plans available for individuals with low income and limited assets, referred to as the low-income subsidy [LIS].

number of MA-PD plan options compared to their urban counterparts,[8] leaving nearly 6 in 10 (58%) Part D beneficiaries in rural areas enrolled in PDPs, compared to 41% in urban areas.[9] Reduced plan availability and concentration of plan sponsors limit beneficiaries' ability to find plans that best match their drug needs and budget priorities. A less competitive market also reduces incentives for remaining plan sponsors to offer robust formularies or lower cost-sharing. This market dynamic is particularly concerning for individuals eligible for the low-income subsidy (LIS),[3] whose access to Benchmark PDPs has narrowed to as few as 1 plan in some states. PDP market contraction is thereby undermining a coverage pathway specifically designed to protect the most financially vulnerable Medicare beneficiaries.

Over time, a combination of interacting, structural market dynamics – including MA-PD access to MA rebates;[4] vertical consolidation of insurers, pharmacy benefit managers (PBMs), and pharmacies; evolving risk dynamics; and cost liability structures – has placed increasing and outsized financial pressure on PDP sponsors, compared to MA-PDs. The impact of these market pressures may have been accelerated by the Inflation Reduction Act (IRA) of 2022, which included the most significant changes to the Part D benefit since its inception (several of which took effect in 2023, 2024, and 2025). Redesign under the IRA included enriching the Part D benefit by eliminating beneficiary cost-sharing in the catastrophic phase (2024), introducing a $2,000 maximum out-of-pocket cap (2025), and shifting more financial liability to plan sponsors and manufacturers, to address perverse incentives for plans sponsors and manufacturers to favor higher drug prices. These changes were more easily absorbed by MA-PDs, given their structural financial advantages over PDPs (e.g., access to MA rebates).

To limit premium increases associated with enhancements to the Part D benefit, the IRA established a temporary 6% cap on year-over-year increases in the base beneficiary premium. In addition, CMS implemented the Part D Premium Stabilization Demonstration in 2025 providing direct subsidies to PDPs to limit premium increases.[11] Without the demonstration in place, it is estimated that premiums would have doubled on average between 2024 and 2025.[12] Although both of these premium stabilization measures have been effective in keeping PDP premiums relatively stable since 2024, they are temporary: the demonstration will be discontinued at the end of 2026[13] and the IRA 6% cap effectively expires at the end of 2029.[14]

The recent decision by CMS to voluntarily discontinue the demonstration early[13] accelerates the need to address persistent PDP market challenges. While the 6% cap will continue to limit premium increases until 2030, the withdrawal of the demonstration is likely to accelerate market exits and impact beneficiary affordability. Without the premium stabilization demonstration in place, larger premium increases are expected[5] for 2027 compared to recent years. Moreover, following the effective loss of the 6% cap at the end of 2029, a sharp spike in Part D premiums is expected. The base premium is projected to increase by 48% to $68.93 in 2030, up from $46.44 in 2029.[15] This underscores pressing concerns around the near-term affordability and sustainability of the PDP market.

The combined impact of the shifting enrollment from Traditional Medicare to MA; ongoing market contraction and vertical integration; IRA implementation; and the expiration of temporary premium stabilization measures makes this a critical moment to identify sustainable policy solutions that ensure affordable prescription drug coverage for beneficiaries enrolled in Traditional Medicare. This paper aims to identify concrete policy solutions to bring stability, ensure affordability, and maintain choice for beneficiaries in Part D, including key regulatory, legislative, and implementation considerations.

[3] Individuals with low income and limited assets are eligible for federal subsidy that lowers the cost of prescription drugs. The CMS-defined annual resource limit that qualifies beneficiaries for the LIS benefit in CY 2026 is $16,590 for an individual and $33,100 for a married couple.[10]

[4] MA rebates are payments generated when MA-PD bids for benefits under Parts A and B are below county-specific benchmarks. Rebate dollars must be reinvested in beneficiary benefits.

[5] Plan-specific premiums will only be announced closer to open enrollment.

Key Challenges

The contraction of the PDP market is not the result of any single policy failure, but rather a set of interacting dynamics. This paper raises three primary dynamics affecting market conditions and unpacks the underlying mechanisms behind each.

Asymmetric Payment Architecture: MA-PDs have access to MA rebates, which serve as an additional financial lever to manage premiums and benefit design that is not available to PDPs. While these rebates are partially financed by Part B premiums paid by both MA and FFS beneficiaries, FFS beneficiaries structurally excluded from the benefits they fund given that rebate dollars are reinvested in MA beneficiary benefits only.[3] In Part D, MA rebates can be used to make MA-PD coverage more appealing to beneficiaries (typically through lower or no premiums, lower cost-sharing in the form of co-pays, and/or more generous formularies).[16] The practical impact is substantial. In 2026, 75% of MA-PD beneficiaries paid no premium for Part D coverage, and the average enrollment-weighted[6] monthly premium for MA-PDs was $8, compared to $36 for PDPs.[17] However, MedPAC estimates for 2021 to 2024 found that without MA rebates, average MA-PD premiums would have exceeded those of PDPs.[16] Additionally, cost-sharing structures for PDP plans are more often centered around coinsurance rather than co-pays – a more attractive structure for beneficiaries – compared to MA-PDs. In 2026, 97% and 100% of PDP enrollees pay coinsurance for preferred and non-preferred brands, respectively, compared to 56% and 89% for MA-PD enrollees.[18] With no equivalent mechanism to MA rebates, PDPs are structurally unable to remain price-competitive while offering comparable benefits, making PDPs a less attractive option for beneficiaries and a less lucrative market for plan sponsors.

Growing trends of vertical integration (i.e. consolidation within a single corporate entity) of commercial insurers, PBMs, and pharmacies may enable MA-PDs to more easily leverage profit opportunities than PDPs, further widening the competitive gap between the two.[19] Through consolidating ownership across the drug supply chain, integrated companies are able to shift profits across the supply chain by inflating or deflating prices at any point in the process, potentially circumventing regulations designed to prevent market exploitation. Specifically, because pharmacy profits are not subject to the Medical Loss Ratio (MLR) requirements that cap MA plan sponsor profits at 15%, integrated plan sponsors have a financial incentive to inflate prices paid to their own pharmacies – effectively shifting profits from their regulated insurance arm to their unregulated pharmacy subsidiaries. This practice, known as strategic transfer pricing, can lead to anticompetitive behavior and is challenging to detect under current reporting and regulatory standards.

Recent research provides evidence of strategic transfer pricing in the Part D market. Following the implementation of minimum MLR requirements in 2014, plan sponsors increased prices paid to affiliated pharmacies by 9.5% per claim relative to non-affiliated pharmacies, generating an estimated $1.2 billion in additional Part D drug spending between 2014 and 2016 – 25% of which was borne by Medicare.[19] The scale of vertical integration in the Part D market makes this a significant concern – by 2025, 4 of the 5 largest firms[7] (accounting for 73.5% Part D enrollees) were vertically integrated in some form.[20,21]

Strategic transfer pricing is more easily adopted within MA-PDs than PDPs: the broader MA financing structure gives integrated plan sponsors additional revenue streams (such as MA rebates) to offset higher internal drug costs, while standalone PDPs lack equivalent cross-subsidization mechanisms and cannot as readily absorb these costs without a corresponding impact on premiums. This creates a structural incentive for the vertically integrated firms to prioritize MA-PDs over standalone PDPs, contributing to ongoing consolidation and contraction in the PDP market.

[6] The enrollment-weighted average includes all MA-PD beneficiaries, including those who paid no premium.

[7] The Cigna Group (Cigna Healthcare-Express Scripts), CVS Health (Aetna-CVS), Humana (Humana-Center-Well), UnitedHealth Group (United Health-Optum), and Centene (not vertically integrated; contracts PBM services to Express Scripts since 2024).[20] In 2025, the Cigna Group sold it's Medicare business to Health Care Service Corporation (HCSC).

Evolving Risk Dynamics: Historically, standalone PDP enrollees have had higher risk-standardized drug spending – that is, spending relative to enrollees' measured risk scores[8] – than MA-PD enrollees.[22] Past MedPAC analyses found that lower risk-standardized costs in MA-PDs cannot be fully explained by tighter formularies or higher use of utilization management tools, such as prior authorization or step therapy.[22] These analyses suggest that lower risk-standardized costs in MA-PDs are substantially attributable to differences in coding intensity, rather than underlying differences in enrollee health status. MA plans have strong financial incentives and greater administrative capacity to extensively document diagnoses that increase risk-adjusted payments, which inflates MA-PD risk scores related to enrollee's actual clinical profiles.[23] In addition, MedPAC found evidence of favorable selection into MA over Traditional Medicare, which would independently contribute to a less healthy PDP risk pool, though the magnitude of that effect – net of coding intensity – is difficult to isolate from the available analyses.[24] These analyses are based on data that predate significant changes CMS has made to the Part D risk adjustment methodology. The changes, implemented in 2025[25] and upcoming 2027,[26] are designed to directly address risk pool distortions described above. No data is available yet on how CMS efforts will prevail in closing the gap. This is now an open empirical question rather than a settled finding.

Uncompensated Cost Exposure: The risk corridors[9] for Part D plans have remained largely unchanged[10] since 2008.[27] Historically, risk corridor payments have reflected net losses for Part D plans since 2018,[22,27] highlighting that these corridors may be mismatched to current drug cost structures, such as more high-cost biologics and specialty medications. CMS, notably, implemented risk adjustment changes, as noted above, to address the risk corridor losses that applied to plan years 2025 and 2027; however, results will not be available until later this year for the first of these changes. The shifting landscape of drug costs is evident in the growing number of Part D enrollees that reach the catastrophic phase of the benefit (532,000 in 2023 compared to 33,000 in 2010[23]). Although the rising trends in prescription drug prices affect both PDPs and MA-PDs, MA-PDs have been structurally better equipped to absorb the financial impact while PDPs have been consistently more likely to incur losses compared to MA-PDs.[22]

Compounding this existing vulnerability, redesign under the IRA shifted additional financial liability onto Part D plan sponsors. The primary changes included: elimination of beneficiary cost-sharing in the catastrophic phase in 2024, introducing an annual maximum out-of-pocket cap for beneficiary cost sharing in 2025, reducing federal reinsurance contributions from 80% to 20% in the catastrophic phase in 2025, and capping the annual growth in the base beneficiary premium at 6% through 2029.[28] MA-PD plan sponsors can more easily absorb this increase in financial liability, compared to PDPs, through cross-subsidization under MA financing structures. To partially offset these shifts in plan sponsor liability, the IRA also replaced the Coverage Gap Discount Program with the Manufacturer Discount Program.[28]

The three structural dynamics described above contribute to a self-reinforcing cycle that accelerates contraction in the standalone PDP market through the compounding effects of market erosion. Competitive advantages that draw beneficiaries to the MA market contribute to declining enrollment in PDPs. As enrollment declines and beneficiaries increasingly migrate toward MA-PDs, the remaining PDP risk pool becomes smaller and higher cost, placing additional upward pressure on premiums. Higher premiums, in turn, further reduce PDP competitiveness relative to MA-PDs, particularly given the latter's ability to leverage MA rebates and integrated financing structures to enhance benefits while maintaining lower premiums. These pressures create increasingly difficult conditions for plan sponsors to sustain standalone offerings, contributing to market exits, reduced plan availability, and greater market concentration among a smaller number of firms, which may further weaken competition within the PDP market. Over time, this cycle of declining enrollment, shrinking risk pools, rising premiums, and reduced insurer participation each compound the underlying structural disadvantages facing the standalone PDP market.

[8] Risk scores are numerical values that capture relative risk of enrollees based on demographic and health-related factors, such as diagnoses.
[9] Risk corridors for Part D plans are risk-sharing mechanisms whereby Medicare shares in plan gains and losses, designed to protect Part D plans from unexpected cost volatility.
[10] Risk corridors for PDPs participating in the Part D Premium Stabilization Demonstration differ from standard risk corridors and better protection plans against losses.

These challenges may be leading the Part D standalone market toward a "death spiral," which is defined in the insurance market as a self-reinforcing cycle of adverse selection and premium increases that ultimately causes a market to collapse or become nonviable. One of the key structural characteristics of this cycle is that either premiums cannot keep pace with the rising cost of the insured population, or when they do, the increase itself accelerates exits. As with the standalone PDP market thinning, the fewer competitive plan sponsors and reduced competitive pressure on premiums has reduced plan choice, further discouraging enrollment by healthier beneficiaries. The standalone market still may not have the appropriate risk-mitigation mechanisms — reinsurance and risk corridors — so it has become vulnerable to this deteriorating pool over time. In other words, the Part D market's own dynamics have worsened the underlying problem.

Policy options

Stabilizing the Part D market will require a comprehensive approach that addresses each of the structural dynamics and their interconnected, reinforcing nature discussed above – asymmetric payment architecture, evolving risk dynamics, and structural uncompensated cost exposure. This paper focuses on policy options through direct market intervention. The authors acknowledge that the policies proposed in the paper would need to be complementary and coupled with policies that address each of the individual dynamics, and ultimately, target reducing the competitive gap between PDPs and MA-PDs. The literature reflects ongoing work to identify reform measures to address the payment asymmetries associated with the application of MA rebates to Part D premiums, incongruities associated with current risk adjustment methodologies, and the recalibration of financial liability through risk corridors and risk-sharing arrangements.

This paper argues that direct market intervention is required to avoid market failure (i.e. certain regions having no PDP availability) in the near term. Established literature on price competition in insurance markets, including health insurance markets, suggests that a minimum of three independent competitors is typically required to support meaningful price competition.[29,30] The applicability of this threshold in the Part D market was endorsed by experts engaged through this work (by the authors of this paper), with independent competitors defined at plan sponsors level (i.e. independent parent organization). Proactive intervention – rather than waiting for further market contraction – is needed to preserve sustainable competitive conditions before they erode to the point at which market-based remedies are no longer viable. The three independent competitor threshold is therefore used as the working definition for erosion of competitive market conditions in this paper.[11] Many regions are nearing this threshold, with PDP offerings ranging from 4-6 parent organizations across regions in 2026.[1] Within the LIS segment, many regions have already crossed the threshold, with only 1-4 PDPs available across regions.[1]

The underlying objective of the direct market intervention policy options discussed below is to improve and ensure sustainable access to affordable prescription drug coverage for beneficiaries enrolled in Traditional Medicare through stabilization of the market. At minimum, this requires that the intervention delivers lower premiums than the prevailing standalone PDP market offers, maintains a formulary sufficiently robust to meet the prescription drug needs of the Traditional Medicare population, and offers cost-sharing structures aligned with beneficiary preferences and utilization patterns. The intervention must also be designed to operate durably across market cycles, rather than as a temporary corrective. This paper considers three alternative pathways for direct market interventions, summarized as follows and with detail in Table 2:

- **Establish a federally-facilitated PDP,** with benefits established by the federal government;
- **Migrate prescription drug coverage to Medicare Part B**; or
- **Require MA sponsors to offer PDP companion plans,** whereby MA participation is conditional on the offering of a standalone PDP in matched service areas.

[11] The three-competitor threshold used in this paper refers specifically to the minimum number of independent plan sponsors in a market required to sustain price competition and should be distinguished from the separate literature on "meaningful choice" as it relates to beneficiary decision-making. Plan meaningful-difference standards are important constructs of the Part D program but are outside the scope of this paper's focus on market-structure intervention.

Table 2: Summary of intervention pathways

	Federally-facilitated PDP	Drug Coverage Migrated to Part B	PDP Companion Plans
Overview	PDP with benefit design, formulary parameters, and beneficiary protections established by CMS. Available nationwide to Traditional Medicare beneficiaries as a stabilizing market presence.	Prescription drug coverage is migrated into Medicare Part B and automatically available to all Part B enrollees. The standalone Part D market is wound down.	All MA plan sponsors are required to offer a standalone PDP in the same service areas where they offer MA-PDs (i.e. PDP Companion Plans), as a condition of MA participation. Design parameters would ensure the companion plan operates as a viable option rather than a shell offering.
Statutory basis	*Administrative or legislative:* Administrative activation of the existing fallback authority (§1860D-11(g)) modernized using demonstration or model authority with waivers (§402 or §1115A) to pilot the model, adapted for current market dynamics; or legislatively through statutory amendment or new legislation. *The fallback authority requires CMS to make a fallback PDP available to beneficiaries in any region where no private PDP is offered.*	Statutory amendment to SSA definition of Part B services (§1861(s)) to include outpatient prescription drugs under a separate, new benefit category. Parallel amendments to other aspects of the statute may be required. *This approach integrates pharmacy benefits with medical coverage, similarly to MA and commercial insurance.*	Demonstration or model authority with waivers to pilot the intervention, or new legislation to condition MA participation on the offering of a standalone PDP in matched service areas.
Plan sponsor	CMS defined benefit is administered by a non-governmental entity selected through competitive bid separate from current Part D bidding process (as written under §1860D-11(g)); or directly by CMS. Substantial expansion of federal capacity since 2003 supports the case for direct federal administration, which has the potential to yield savings through federal negotiating power and elimination of plan sponsor administrative costs. Non-interference clause waiver required to enable direct federal negotiation with manufacturers, PBMs, and pharmacies. *The Limited Income Newly Eligible Transition (LI NET) program[31] provides operational precedent for a single national contractor[12] administering a federally-defined Part D benefit under CMS oversight. Precedent for direct federal administration exists across several adjacent programs, including*	Traditional Medicare or MA – drug coverage is included under Part B or MA plan sponsor. *Precedent for direct federal administration of outpatient drug coverage exists in Part B's current treatment of certain vaccines, oral anti-cancer drugs, immunosuppressives, and drugs 'furnished incident to a physician's service'.*	Existing MA plan sponsors operating MA-PDs in the service area, without any new contracting requirements. *Exemptions could be considered for certain types of MA plan sponsors that are structurally unsuited to offer standalone PDPs, such as provider integrated delivery systems that have an exclusive medical group with a closed network and have never participated in the PDP market.*

[12] CMS currently contracts with Humana to administer the LI NET program.

	Federally-facilitated PDP	Drug Coverage Migrated to Part B	PDP Companion Plans
	the Medicare Administrative Contractor (MAC)[32] infrastructure for FFS claims processing, the Medicare Transaction Facilitator (MTF)[33] for pharmacy claims data exchange and effectuation of maximum fair price payment under the Medicare Drug Price Negotiation Program.		
Geographic scope	National scope to avoid structural cross-subsidy risk (whereby private sponsors retain profitable regions and cede unprofitable ones while benefiting from program-level parameters such as national average bid), and strengthen negotiating leverage with pharmacies, PBMs, and manufacturers. Expansion to national scope would require amendment to current fallback authority.	National, in line with Part B definition and uniform coverage requirements.	Mirrors MA footprint by definition. Risk of coverage gaps in areas without existing MA presence.
Benefit design	Defined standard benefit or actuarially equivalent design, set by CMS. *Design variant for consideration: offer an enhanced plan to enrich the benefit for competitive positioning. Would require amendment to current fallback authority.*	Standardized benefit set in statute consistent with other Part B benefits and maintain the current Part D deductible and catastrophic threshold. *Consider a statutory definition of covered outpatient drugs (e.g., self-administered drugs approved by FDA that are reasonable and necessary), with the specific list defined through CMS annual rulemaking or quarterly guidance.*	Defined standard benefit or actuarially equivalent design at minimum, with additional design parameters required to prevent the companion plan from operating as a shell offering or a feeder channel to the MA-PD. *A marketing non-discrimination requirement, that ensures PDPs are presented with equal prominence to MA-PD options in marketing materials and broker scripts, could serve as a mechanism to prohibit companion PDPs being leveraged as "feeder" channels to MA-PDs.*
Formulary & cost-sharing	*Contractor or CMS:* The formulary could be designed and administered by a third party (aligning to standard Part D formulary requirements) or by CMS directly. Design directions for consideration: improve generic affordability through low or fixed-dollar generic cost-sharing or automatic price-driven generic substitution; cost-sharing structures that favor copays to improve predictability and transparency of beneficiary out-of-pocket costs; and least-costly-alternative policy where clinically appropriate. Lowering generic cost-sharing would erode the cross-subsidy currently offsetting	Covered outpatient drugs defined based on statutorily set benefit definition (as above). Cost-sharing is uniform and established, at no more than current Part B and Part D cost-sharing. The same design directions considered for the federally-facilitated plan apply. *Cost-sharing for migrated drugs would remain subject to the IRA annual out-of-pocket cap. Adaption should be considered to ensure beneficiary protections remain intact (e.g., extending the cap to a combined Part B/Part D basis for migrated drugs, or adopting a monthly out-of-*	Standard Part D formulary and cost-sharing requirements. Additional parameters, potentially via CMS's existing non-discriminatory formulary design authority[37], needed to prevent the companion plan from being structured as less attractive than the sponsor's MA-PD. *Design directions for consideration: a formulary comparability floor tied to the sponsor's own MA-PD formulary for overlapping drug classes, layered on CMS's existing non-discriminatory formulary design authority; and a cost-sharing ceiling capping*

	Federally-facilitated PDP	Drug Coverage Migrated to Part B	PDP Companion Plans
	brand costs, therefore requiring paired adjustments to brand reimbursement or dispensing fees to protect plan economics. *The list of drugs to treat chronic conditions published by the Internal Revenue Service (IRS)[34] and the CMS Innovation Center's Medicare $2 Drug Model offer precedents for defining eligible generics and structuring low or zero cost-sharing.* *The Veterans Administration National Formulary (administered directly)[35] and Tricare Uniform Formulary (administered via contracted PBM)[36] demonstrate operationally workable models for federal formulary administration at scale, using federal clinical committees and competitive contracting in select therapeutic classes to negotiate manufacturer discounts beyond statutory pricing floors.* *A transparent PBM model (if third-party administered) could be promoted through the bidding process.*	*pocket cap in lieu of the Medicare Prescription Payment Plan).* *Given that Medigap plans currently cover Part B coinsurance, migrating drugs to Part B could shift a portion of beneficiary drug cost exposure onto Medigap issuers, which could in turn prompt Medigap premium increases.* *To promote use of high value, generic drug use and increase affordability for beneficiaries, apply first dollar coverage for generic and low-cost drugs to manage chronic disease with nominal copays.*	*companion PDP cost-sharing at a specified multiple of the sponsor's MA-PD cost-sharing for comparable drug tiers.*
Pharmacy network	At minimum, standard Part D network adequacy requirements apply. Network design should prioritize broad access, with terms that ensure economic viability for independent and rural pharmacies. For a CMS-administered plan, CMS could directly reimburse pharmacies on a cost basis (e.g., defined dispensing fee plus National Average Drug Acquisition Cost [NADAC]) by leveraging existing federal payment infrastructure, which would improve transparency and offers more favorable terms to independent pharmacies. *Potential to partner with non-governmental entities such as Blueberry Pharmacy, Mark Cuban Cost Plus Drugs or Amazon Pharmacy to facilitate a low-cost model.*	Any-willing-pharmacy participation, enabling broad and nationwide access. CMS directly reimburses pharmacies, building on existing Medicare infrastructure (e.g., MAC and MTF). *Reimbursement could be a cost-based model or build on the Medicaid model whereby pharmacies are paid Actual Acquisition Cost (AAC) plus dispensing fee whereas Medicare would invoice manufacturers for rebates.*	Standard Part D network adequacy requirements apply. Additional parameters needed to prevent the companion plan from being structured as less attractive than the sponsor's MA-PD.

	Federally-facilitated PDP	Drug Coverage Migrated to Part B	PDP Companion Plans
Program integrity	Aligned with existing Part D frameworks to minimize administrative complexity and preserve beneficiary protections consistent with the broader Part D program.	Aligned with existing Part B oversight frameworks. Coordination with residual Part D program elements, if any (e.g., MA-PD), needed to prevent dual coverage and payer-of-last-resort disputes.	Aligned with existing Part D frameworks. Enforcement of the conditionality requirement would result in restrictions on MA participation in service areas where the companion offering requirement is not met.
Financing and risk	Federal government bears claims risk. If contracted, plan sponsor receives cost-reimbursement plus performance-based management fee tied to performance measures established by CMS. If CMS-administered, CMS pays pharmacies and manufacturers directly and absorbs administrative costs. Premium share could align with the 25.5% standard (as in fallback authority) or the federal government could cover a higher share of costs via subsidy, improving affordability but increasing federal fiscal exposure. *If made permanent, the Part D premium stabilization demonstration could serve as an ongoing subsidy mechanism that protects premium affordability.*	Federal government bears full claims cost under Part B, and Part B premiums would account for drug coverage. The federal government could cover a higher share of drug costs via subsidy, improving affordability but increasing federal fiscal exposure. *If some of the Part D market remains (e.g., MA-PD), the migration of beneficiaries to Part B may impact the Part D risk pool: a smaller but still-costly residual Part D population could paradoxically raise per-capita risk scores if migrated drugs are disproportionately utilized by lower-risk-score enrollees.*	Operates under existing Part D risk corridor and risk-sharing framework, therefore inheriting the structural dynamics that have driven PDP exits. Companion plan must remain competitive with the corresponding MA-PD despite the structural advantage MA-PDs hold through rebate application. In the absence of broader MA reform, the differential could be constrained through direct premium constraints or cross-subsidization mechanisms.
Implementation considerations	Administrative activation of the fallback authority combined with demonstration or model authority offers a viable near-term pathway, given the time-sensitive trajectory of PDP market contraction and the longer timelines associated with statutory amendment. Meaningful expansion of CMS operational scope will require time and resources. While CMS would build upon existing operational infrastructure for direct coordination of pharmacy claims data, manufacturer payments and rebates, and dispensing entity payments, additional capacity development will be required to tailor existing systems to and operationalize additional elements such as real-time claims adjudication.	Longer implementation timeline associated with statutory changes of this scale. Operational expansion related to pharmacy payment infrastructure under Part B will require time and resources. Transition considerations for current Part D enrollees will need to be modelled and transition plans developed.	While operational implementation would leverage existing regulatory and administrative infrastructure, new operational capacity would need to be built to implement the design of the conditionality structure. Effectiveness will be highly dependent on parallel progress on broader structural reforms, particularly MA rebate reform.

A federally-facilitated PDP is the most likely feasible pathway for near-term implementation that delivers meaningful market impact. The federally-facilitated PDP would add an independent competitor to the PDP market, and federal negotiating power has the potential to yield cost savings through securing favorable drug pricing. This would add an affordably priced PDP, designed to meet Traditional Medicare beneficiary needs to the market, restoring competitive conditions, and exerting downward pressure on premiums offered by remaining private sponsors.

The ability to activate this pathway administratively via the existing fallback authority positions it as the most feasible intervention in the short term. In contrast, establishing the federally-facilitated plan legislatively would likely take longer to implement. This is because of the extended timeline associated with establishing new legislative authority – by which time the PDP market may have deteriorated beyond the point at which market-based remedies remain viable – as well as the substantial expansion of CMS operational scope and capacity required for direct federal administration.

The introduction of a federally-facilitated PDP may, however, pose a risk of crowding out remaining PDP sponsors. If the plan delivers materially lower premiums without paired reforms addressing the broader competitive gap between PDPs and MA-PDs, market exits by remaining PDP plan sponsors may accelerate. Smaller and beneficiary-oriented sponsors would likely be the first to exit, leaving the market polarized between the federally-facilitated PDP and the largest vertically integrated sponsors. It is possible the market has already reached this point. While the crowding-out risk is notable, should it materialize, the federally-facilitated plan could preserve a baseline of affordable coverage for beneficiaries in Traditional Medicare, which is the underlying objective of the intervention and central to CMS's mandate, even where a competitive market structure cannot be fully preserved.

Migration into Part B is the most transformative pathway; however, it would likely require an extended implementation timeline compared to federally-facilitated PDP, as well as raise additional questions around transitions for current Part D enrollees. Migrating outpatient prescription drug coverage into Part B would establish uniform access to prescription drug coverage for all Traditional Medicare beneficiaries through intentionally dissolving the PDP market. This would potentially remove market competition challenges and asymmetries between PDPs and MA-PDs entirely, as well as strengthen the competitive balance between MA and Traditional Medicare, including if designed such that parts of the Part D (e.g., MA-PDs) remain intact. Migration into Part B may also eliminate the complexities beneficiaries face in navigating the Part D market (plan comparison and choice, penalties, etc.).

This pathway may, however, require a longer implementation timeline to overcome the following aspects: the substantial scale of legislative amendment required across multiple sections of the Social Security Act, the high operational capacity CMS would need to build to administer coverage and payment under Part B, and adjacent market disruptions (e.g., current PDP plan sponsors loss of business line and/or facing higher competition against MA lines, and Medigap issuers facing increased cost exposure).

The MA companion PDP is the least likely pathway to meaningfully restore competitive conditions in the standalone market. While MA companion PDPs have the potential to improve PDP availability across the market, coverage gaps would persist in service areas where no MA organization operates, leaving beneficiaries in those areas without an additional standalone PDP option. Without broader MA rebate reform or design-level cross-subsidization, driving down premiums would be challenging. The companion plan would likely also operate at a structural competitive disadvantage relative to the sponsor's MA-PD offering, with the risk that the companion plan is positioned and resourced as a continued “feeder” channel toward the MA-PD rather than as a meaningful coverage alternative, which may result in gaming. Lastly, this reform would most likely face sustained industry opposition, extending the timeline of statutory amendment if ever achieved.

Recommendations

A federally-facilitated PDP offers the most feasible near-term solution. Administrative activation via the existing fallback authority would allow for meaningful market impact in the short term, which this paper argues is required to avoid collapse of the standalone Part D market. The impact of the discontinuation of the Premium Stabilization Demonstration and the expected spike in PDP premiums in 2030, together with ongoing market contraction, highlight the need for timely implementation. The use of demonstration or model authority with waivers would also allow for CMS to test the implementation and impact of the plan to ultimately determine whether it is a sustainable long-term solution. Given that new legislative authority would enable a more tailored design, it is worth considering that policymakers could start with the administrative federally-facilitated PDP as an immediate relief, and then work toward a more permanent long-term solution – whether that is a federally-facilitated PDP or migration of the Part D drugs into Part B.

Implementation of the federally-facilitated plan via the fallback authority would require modernization for current marketplace dynamics. As discussed in the preceding sections of this paper, there have been considerable changes to the Part D program and the market since 2003 when statutory language was drafted and passed for the fallback option, including the addition of §1115A authority. As a result, there are a few considerations to take into account on when CMS may exercise demonstration or model authority, through §402 or §1115A, to adapt the fallback authority to current marketplace dynamics. Either authority would allow CMS to test how best to administer a federally-facilitated plan, raise implementation questions, and develop the operational capacity required for long-term durability and oversight before scaling the program. Two specific areas in particular warrant attention.

First, the existing "trigger" for the fallback option under MMA, as written in current statute, is calibrated to the point at which a given region has no PDP plan availability.[13] Under the working definition adopted in this paper, intervention should occur as regions approach the three-competitor threshold at the plan sponsor level, rather than waiting for competitive conditions to deteriorate to market failure. An expansion of the activation trigger would therefore be required to achieve the goal of restoring competitive market conditions. In addition, the existing trigger is open to gamification by MA organizations who may choose to continue providing a shell PDP offering to avoid the instatement of a federally-facilitated plan, to ensure that the more profitable MA-PD offerings remain as the only attractive available option.

Second, the fallback option is only to be made available on a region-specific basis, and the statutory language explicitly prohibits a national plan.[14] However, region-limited activation risks may create a structural cross-subsidy whereby private plan sponsors retain profitable regions and cede unprofitable regions to the federally-facilitated plan, while continuing to benefit from program-level financial parameters, including the national average bid and benchmark calculations, calibrated across the full Part D population. Through scale, national scope would also strengthen the contracted plan's negotiating power with pharmacies, PBMs, and manufacturers, supporting more favorable pricing and discount arrangements than a region-limited footprint. It should therefore be considered to expand the geographic scope of the federally-facilitated plan to a national offering.

Realizing the objectives of the intervention hinge both on the final design of the plan and broader market reforms. The final design of the federally-facilitated plan will shape affordability and attractiveness to beneficiaries relative to other available plan options, with affordability largely hinging on the plan sponsor's ability to negotiate favorable terms with manufacturers, pharmacies, and other supply chain participants, to drive down the underlying cost of coverage. While federal negotiating power may result in lower drug prices for the plan, delivering a meaningfully lower premium than the prevailing standalone PDP market would be challenging without additional federal subsidies, given that a richer, more attractive benefit would likely increase costs.

[13] Under §1860D-3, the fallback plan must be offered if there are less than two prescription drug plans available, only one of which must be a PDP.
[14] §1860D-3

While the proposed direct market intervention addresses the compounding effects of market erosion, it does not resolve the underlying structural dynamics driving PDP market contraction. The intervention would need to be packaged with additional reforms addressing broader market challenges, including rising drug prices and the various structural drivers of competitive imbalance between MA and PDPs, to comprehensively address the erosion of the Part D standalone market.

Conclusion

The standalone Medicare Part D market is approaching a death spiral in which the interaction of asymmetric payment architecture, evolving risk dynamics, and structural uncompensated cost exposure has produced a self-reinforcing cycle of declining enrollment, shrinking risk pools, and reduced plan participation. Without intervention, this cycle is likely to continue, further limiting beneficiary choice and reducing competitive pressure on premiums. This dynamic is expected to intensify by 2030, as the temporary measures currently stabilizing the market – the premium stabilization demonstration and the IRA's 6% premium cap – expire. This underscores the need for near-term market intervention.

Direct market intervention offers a pathway to preserving access to affordable prescription drug coverage for beneficiaries. While the proposed direct market intervention pathways would address the compounding effects of market erosion, they are not designed to resolve the underlying structural dynamics driving PDP market contraction. This will require complementary policies addressing MA reforms to undertake the structural dynamics identified in this paper.

Of the three direct market intervention pathways considered in this paper, establishing a federally-facilitated plan via administrative activation of the fallback authority offers the most likely feasible route for near-term implementation. Administrative activation of the fallback authority, paired with demonstration or model authority to modernize the activation trigger and expand the plan's geographic scope, would allow CMS to pilot the federally-facilitated plan and its ability to restore competitive conditions to the PDP market. If expanded (through new legislation) to be administered by CMS rather than a contractor, the plan could leverage learnings from the Medicare negotiations of drug prices with manufacturers and bring lower premiums and more affordable options for beneficiaries. Alongside broader structural reforms, the federally-facilitated plan could stabilize the standalone PDP market and ensure that beneficiaries retain access to an affordable prescription drug coverage option.

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