Executive Summary

Inflation Reduction Act: Access Barriers Undermine Affordability

Medicare Access for Patients Rx™
Convened by Lupus Foundation of America

Enacted in 2022, the Inflation Reduction Act (IRA) introduced significant reforms aimed at reducing the financial burden of prescription drug costs for Medicare Part D beneficiaries. Chief among them is an annual out-of-pocket (OOP) cap, a long-sought protection that improves financial predictability for beneficiaries with significant prescription drug needs as well as the ability to spread out-of-pocket costs over the course of the year through the Medicare Prescription Payment Plan. The MAPRx Coalition strongly supported these reforms and continues to believe they are important steps toward improved affordability.

However, in addition to these reforms, the IRA redesigned the financial structure of Part D by shifting a larger share of liability from the federal government to plans and pharmaceutical manufacturers. As plans absorb this increased risk, early evidence from the 2025 to 2026 transition period shows plan behavior changing in ways that can undermine the promise of patient affordability by limiting access to prescription drugs. These impacts are showing up in higher premiums, fewer plan choices, narrower formularies, more coinsurance, and more utilization management, including for drugs subject to Medicare negotiation.

These trends need additional oversight; without intervention, affordability gains from the OOP cap risk being offset by reduced access.

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Why the Part D Redesign Matters for Beneficiaries

Before the IRA, beneficiaries faced unlimited OOP liability in the catastrophic phase of Part D, paying 5% coinsurance with no annual ceiling. Beginning in 2025, the IRA capped beneficiary OOP spending at $2,000, rising to $2,100 in 2026. Federal estimates suggest more than 6 million Part D enrollees will benefit annually from this protection.[1]

To finance the OOP cap, the IRA reduced the federal share of catastrophic drug spending and increased the share borne by plans and manufacturers. Plans' catastrophic liability rose from 15% to 60%, a shift that changes incentives across the benefit.

Beneficiaries and patient advocates understood there would be tradeoffs, including some premium pressure. What is now clear is that the redesign is reshaping plan behavior faster and more aggressively than many expected, with real consequences for access, affordability at the point of sale, continuity of care, and beneficiary choice.

Early Signals: How Changes in Plan Behavior Reduce Patient Access

Formularies Are Narrowing, Including for Branded Products

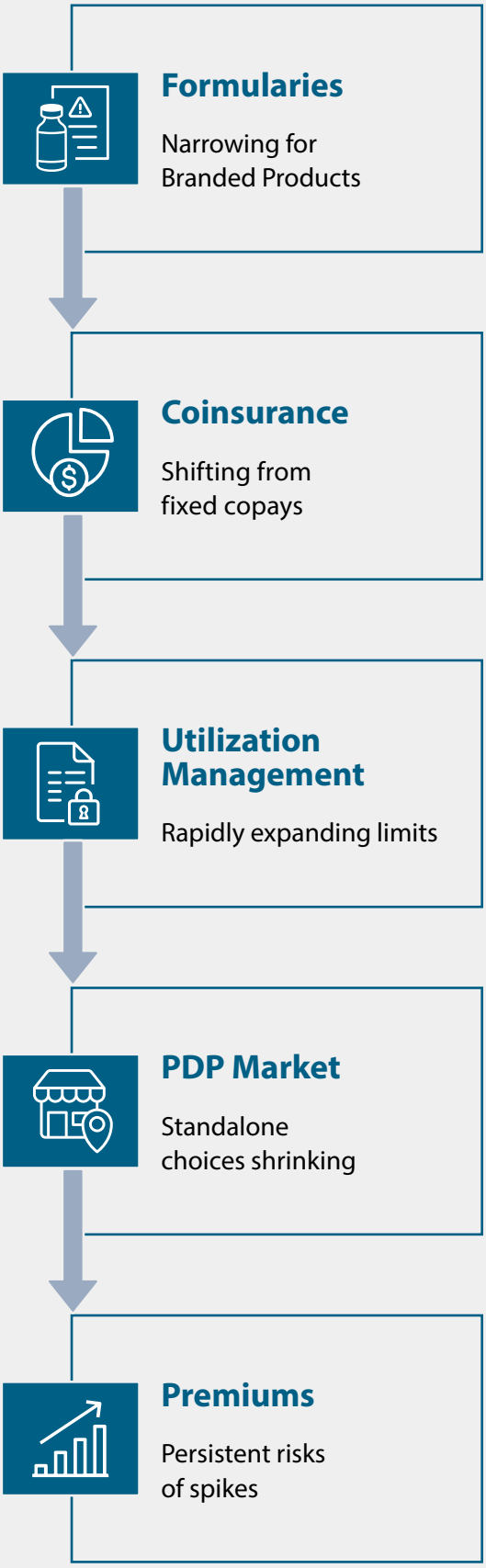
Part D plans have flexibility in formulary design, subject to minimum coverage requirements, including for the 6 protected classes. Recent analyses show a downward trend in the number of branded products covered across both standalone prescription drug plans (PDPs) and Medicare Advantage prescription drug plans (MA-PD plans). Between 2022 and 2026, the average number of branded drugs covered declined by roughly 5% in both markets.

While generic drugs continue to account for a large share of utilization, reduced branded coverage can create significant access challenges for beneficiaries who rely on specific therapies for chronic or complex conditions. When a drug is excluded, beneficiaries may be forced to switch therapies or navigate the exceptions and appeals process, often delaying treatment.

Beneficiaries Are Paying More as Plans Shift From Copays to Coinsurance

While the OOP cap is improving affordability for those with significant prescription drug needs, beneficiaries face increased OOP costs as plans shift cost-sharing requirements from fixed copays to variable coinsurance. Historically, many Part D plans, particularly enhanced plans, relied on fixed-dollar copays that gave beneficiaries predictable costs. In recent years, plans have increasingly expanded percentage-based coinsurance beyond specialty tiers. As a result, prescription costs vary, making it more difficult for beneficiaries to anticipate and manage their prescription drug costs.

The IRA has accelerated this trend. Coinsurance increases beneficiary OOP spending early in the year and slows progress toward the annual cap, reducing the time during which plans carry higher liability. For beneficiaries using higher-priced non-specialty branded drugs, coinsurance can produce per-fill costs that are multiple times higher than prior copays. Beneficiaries with moderate spending may accumulate substantial coinsurance without ever reaching the cap.



Utilization Management Is Expanding, Limiting Access to Treatments

Utilization management tools such as prior authorization, quantity limits, and step therapy are now routine in Part D. By 2026, **nearly half** of covered branded drugs are subject to prior authorization, and roughly half are subject to quantity limits in both PDP and MA-PD plans. These rates represent increases of more than 40% compared to 2020.[2]

Even when a drug appears on a formulary, utilization management can delay or disrupt access, especially for beneficiaries with chronic conditions who depend on timely, uninterrupted treatment. Lack of transparency around these requirements also makes it difficult for beneficiaries to make informed plan choices during open enrollment.

Shrinking PDP Market Is Eliminating Choice for the Beneficiaries Who Need It Most

The financial pressures created by the redesign are reshaping the Part D market, particularly for standalone PDPs. Between 2025 and 2026, the number of standalone PDPs declined by more than 20%, representing nearly a 50% reduction over 2 years. Enhanced PDP offerings have fallen even more sharply.[3]

For beneficiaries in traditional Medicare, especially those with Medigap coverage or those living in rural areas, standalone PDPs are often the only practical pathway into Part D coverage. A shrinking market limits choice, increases the risk of premium spikes, and threatens continuity of care.

The impact is especially acute for low-income subsidy (LIS) beneficiaries, who often rely on benchmark plans for premium-free coverage. In some states, benchmark choice is narrowing to 1 or 2 plans, increasing the likelihood of reassignment, medication disruption, and misalignment between plan design and beneficiary needs.

Premium Increases Remain a Persistent Risk

The IRA included temporary mechanisms intended to limit premium increases, including a statutory cap on increases in the Part D base beneficiary premium and the premium stabilization demonstration by the Centers for Medicare and Medicaid Services (CMS). These measures can moderate short-term volatility, but they do not constrain plan-specific premiums.

As stabilization parameters phase down, premium pressure is expected to remain most visible in the standalone PDP market, widening the gap between PDP and MA-PD plan premiums and accelerating shifts toward Medicare Advantage.

Policy Considerations and Recommended Actions to Improve Beneficiary Access

There is a growing gap between the promise of the OOP cap and what many beneficiaries are experiencing today. The cap meaningfully protects people with the highest drug costs. But for others, the redesign may translate into higher upfront costs, fewer viable plan options, and more administrative hurdles at the point of care.

That combination can increase confusion, disrupt continuity, and contribute to nonadherence, particularly early in the benefit year. Affordability protections should reduce financial risk without creating new access barriers.

The MAPRx Coalition supports the IRA's affordability goals and believes they can be achieved without sacrificing access. CMS and Congress should act now to stabilize the market, align plan incentives with beneficiary access, and strengthen transparency.

Key actions include:

Improve beneficiary-facing transparency about utilization management requirements and real-world access barriers.

Modernize and simplify the exceptions and appeals process, with public reporting on denials, overturn rates, and timelines.

Expand education and outreach on the Medicare Prescription Payment Plan (MPPP) so beneficiaries understand and can use available affordability tools.

Preserve meaningful standalone PDP choice through targeted, time-limited stabilization tools tied to access protections and continuity of care.

Establish minimum standards for LIS benchmark availability and trigger corrective actions when beneficiary choice falls below acceptable thresholds.

Strengthen CMS oversight of formulary design, cost-sharing structures, and utilization management, including standardized reporting and public disclosure of key access metrics.

The IRA reshaped Medicare Part D in ways that beneficiaries are already feeling. Ensuring that its affordability gains are not undermined by new access barriers will require sustained attention, beneficiary-centered oversight, and a willingness to act when data and beneficiary experience show the redesign is falling short.

REFERENCES

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