Inflation Reduction Act: Access Barriers Undermine Affordability

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

The Inflation Reduction Act (IRA) enacted the most significant changes to Medicare Part D since the program's creation.[1] Many of those changes were designed to address a real and longstanding problem: For beneficiaries with serious or chronic conditions, prescription drug costs could be unlimited and financially devastating. The introduction of an annual out-of-pocket (OOP) cap changed that reality. For millions of beneficiaries with high drug spending, the cap provides meaningful financial protection and predictability that did not previously exist.

The IRA also created the Medicare Prescription Payment Plan (MPPP), a voluntary option that allows beneficiaries to spread out OOP prescription drug costs across monthly payments during the plan year. The MPPP is an important companion to the OOP cap. The program is designed to limit OOP costs at the point of sale to improve adherence and help ensure beneficiaries do not abandon medications at the pharmacy counter. Whether it achieves that goal in practice will depend on beneficiary awareness, enrollment processes, and how plan benefit design changes affect the level and timing of cost exposure.

These changes did not happen in isolation; the IRA also fundamentally redesigned the benefit by reallocating financial liability across beneficiaries, plans, manufacturers, and the federal government. While beneficiary liability was reduced at the catastrophic level, the redesign shifted more risk to plans and manufacturers. These changes altered the incentives that underpin plan bidding, formulary construction, cost-sharing design, and utilization management strategies across both standalone prescription drug plans (PDPs) and Medicare Advantage prescription drug (MA-PD) plans.

As plans adjust to these changes, early evidence suggests that beneficiary experience is shifting in ways that were not the focus of the IRA's affordability reforms. While some beneficiaries will realize substantial savings, others are facing higher premiums, less predictable OOP costs earlier in the year, narrower formularies, more aggressive utilization management, and fewer plan choices, especially in standalone PDPs. These effects are disproportionately affecting beneficiaries who rely on standalone PDPs and those with moderate drug spending who may never reach the OOP cap.

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The MAPRx Coalition supported reforms aimed at improving beneficiary affordability and protecting patients from catastrophic drug costs. However, affordability cannot be evaluated solely by looking at annual spending caps or aggregate savings. It must also account for access, predictability, and choice at the point of care, including whether beneficiaries can understand and use tools like the MPPP when they need them. This paper examines how the IRA's Part D redesign is reshaping plan behavior, identifies emerging access and affordability challenges for beneficiaries, and outlines policy considerations to ensure that the promise of the OOP cap and the MPPP is not undermined by new barriers elsewhere in the benefit.

The Milestone of the OOP Cap

The introduction of an annual OOP cap in Medicare Part D marked a major shift in prescription drug affordability for Medicare beneficiaries, particularly those with high and ongoing medication needs. Before the IRA, there was no annual limit on beneficiary OOP spending. Even after reaching the catastrophic phase of the benefit, beneficiaries continued to pay 5% of drug costs, often resulting in ongoing and unpredictable financial exposure.

Beginning in 2025, the IRA established a $2,000 annual OOP cap for Part D, increasing to $2,100 in 2026.[2] According to the Department of Health and Human Services (HHS), while approximately 1.5 million Part D enrollees reached the catastrophic phase in 2022, the new OOP cap was projected to benefit roughly 6.1 million beneficiaries in 2025.[3] This represents a substantial expansion of financial protection and a meaningful improvement in affordability for patients who previously faced unlimited exposure to prescription drug costs.

The MAPRx Coalition advocated for and strongly supports this reform. For beneficiaries living with chronic, complex, and life-threatening conditions, the OOP cap provides critical financial predictability and reduces the risk that costs will undermine treatment adherence. Patient advocates understood that achieving this level of protection would involve tradeoffs, including the possibility of higher premiums. The Congressional Budget Office initially projected a 5% increase in per-enrollee costs, a tradeoff many viewed as acceptable in exchange for removing unlimited OOP liability.[4]

As the program enters the 2026 plan year, early evidence suggests that the benefits of the OOP cap are increasingly being offset by changes in plan behavior. Beneficiaries are facing higher premiums, fewer plan choices, and more aggressive formulary management. These developments risk shifting financial and administrative burden back onto beneficiaries in ways that were not the focus of the IRA's affordability reforms.

IRA Consequences: Access Barriers, Higher Premiums, and Reduced Choice

Under the redesigned Medicare Part D benefit, plan sponsors now bear a larger share of drug costs than they did before the IRA. Most notably, plans are responsible for 60% of drug spending in the catastrophic phase, compared to just 15% before the redesign. This represents a shift in plan exposure and fundamentally changes how risk is managed across the benefit year.

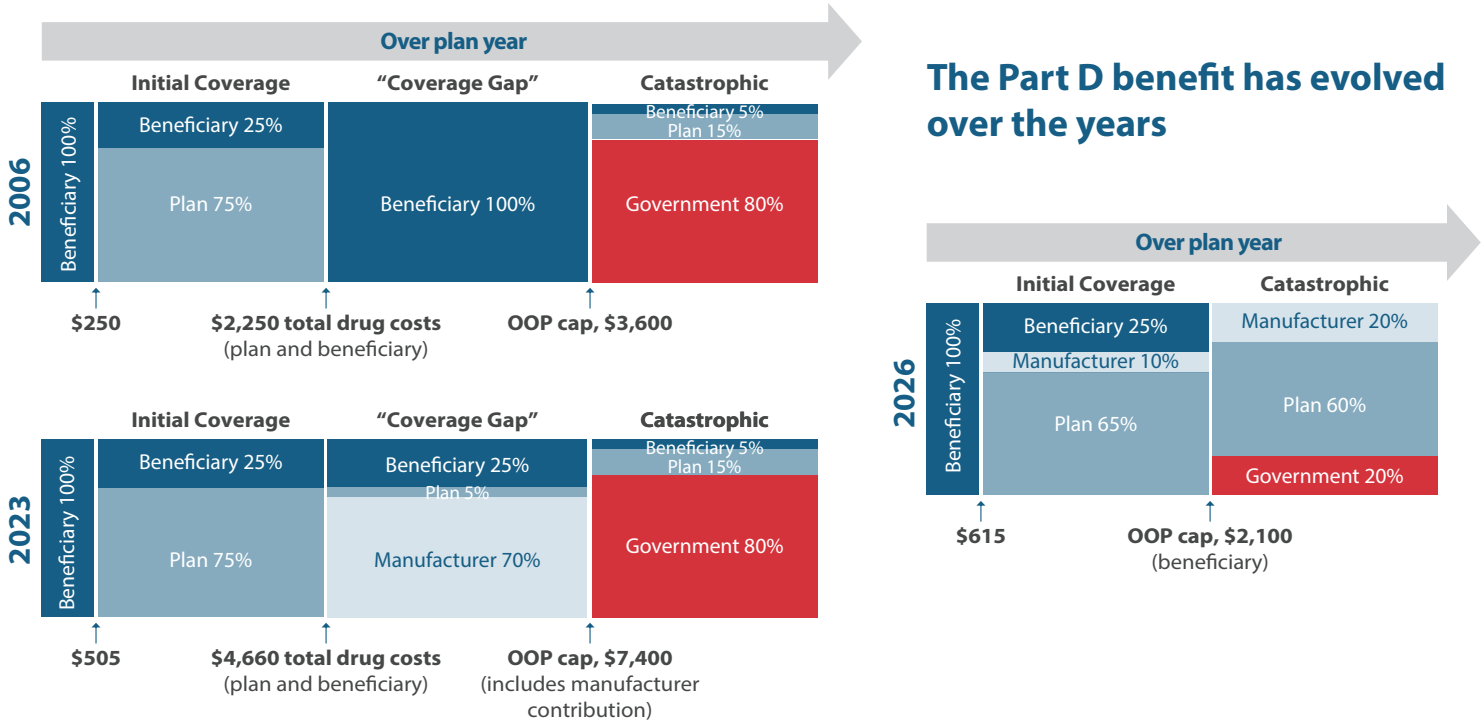
Rather than absorbing most costs only after beneficiaries reach catastrophic coverage, plans must now account for increased liability earlier in the benefit design. This reshaping has altered incentives across plan bidding, benefit design, formulary construction, and utilization management. Plans have strong incentives to control drug spending before beneficiaries reach the annual OOP cap, when plan liability increases most sharply.

These changes are already influencing plan behavior. To manage higher financial exposure, plans are increasingly relying on strategies that limit or control their costs.[5] At the same time, plans are reassessing product offerings, particularly in standalone PDPs, where sponsors have fewer financing tools available to offset rising costs.

While these responses are rational from a plan perspective, they have direct consequences for beneficiaries. Higher premiums, fewer plan options, and increased administrative hurdles at the point of care can erode affordability and access, especially for beneficiaries who rely on standalone PDPs, have moderate prescription drug spending, or live in areas with limited plan competition. Importantly, these effects can occur even for beneficiaries who never reach the annual OOP cap, meaning that aggregate savings at the catastrophic level may coexist with increased financial and administrative burden elsewhere in the benefit.

The sections that follow examine how these incentive shifts are manifesting across the Part D program, including changes in formulary coverage, cost-sharing design, utilization management practices, premium levels, and plan availability. Together, they illustrate how the IRA's benefit redesign, while achieving important affordability gains at the catastrophic level, is reshaping the beneficiary experience in ways that warrant scrutiny and targeted policy response.

Figure 1. Comparison of Part D benefit design, pre-IRA changes vs 2026



Key: IRA – Inflation Reduction Act; OOP – out of pocket.

Fewer Branded Drugs on Formulary

Medicare Part D plans are required to meet minimum coverage standards intended to preserve beneficiary access and choice. Plans must generally cover at least 2 drugs in each therapeutic category and class and must cover all or substantially all drugs in 6 protected classes: antidepressants, antipsychotics, anticonvulsants, antiretrovirals, immunosuppressants, and antineoplastics. These protections are designed to ensure access to therapies for beneficiaries with complex or clinically sensitive treatment needs.

Protected-class status, however, does not dictate how coverage must be structured. Plans retain broad discretion over tier placement, cost-sharing, and the use of utilization management tools such as prior authorization, step therapy, and quantity limits, provided those tools do not amount to a denial of coverage. As a result, a drug may technically be covered while still requiring beneficiaries and prescribers to navigate multiple administrative steps before treatment can begin or continue.

Against this backdrop, early evidence suggests that plans are narrowing branded drug coverage in response to the IRA's redesigned liability structure.[6] While year-to-year changes in formulary composition are expected due to patent expirations and new drug launches, the overall trend across both standalone PDP and MA-PD plans is toward fewer branded products covered on average. This pattern is consistent with plans seeking to manage higher financial exposure through tighter formularies and more selective coverage strategies.

Beneficiaries can receive Medicare Part D coverage through 2 primary pathways:

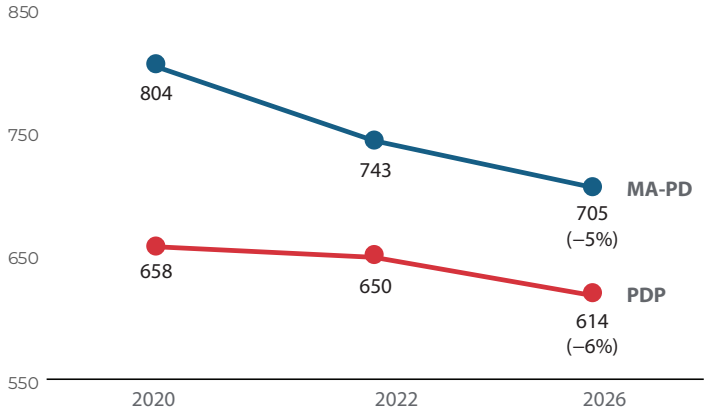
Standalone PDPs:
Plans that cover prescription drugs only and typically serve beneficiaries enrolled in Original Medicare (Parts A and B)

MA-PD plans:
Medicare Advantage plans that bundle medical (Parts A and B) and prescription drug (Part D) coverage in a single plan offered by a private insurer

Because these plan types are financed differently, plan sponsors have different tools available to manage premium pressure and benefit design tradeoffs. These structural differences influence formulary generosity and stability over time.

As shown in **Figure 2**, between 2022 and 2026, standalone PDPs and MA-PD plans reduced the average number of branded products covered by approximately 6% and 5%, respectively.[6] While many beneficiaries primarily use generic drugs, these trends still matter. Reduced branded coverage limits options for patients who cannot tolerate alternatives, require a specific therapy for clinical reasons, rely on branded products where generic substitution is not appropriate, or may benefit from new treatment innovations that have been developed.

Figure 2. Average number of branded products covered by standalone Part D and Medicare Advantage plans, 2020 compared to 2026



Key: MA-PD – Medicare Advantage Prescription Drug Plan; PDP – prescription drug plan.
Source: Cencora Analysis

The persistent gap between PDP and MA-PD formularies also indicates that beneficiaries with Original Medicare may face tighter access to certain branded therapies than those enrolled in Medicare Advantage.

Formulary narrowing translates directly to real-world access challenges. When a plan excludes a drug, beneficiaries may be required to switch from a therapy that has produced stable outcomes to a plan-preferred alternative that may be less effective or have different side effects. If beneficiaries and prescribers pursue coverage through the exceptions and appeals process, treatment can be delayed while administrative requirements are resolved.

In the context of the IRA redesign, tighter formularies represent one of the most direct mechanisms plans use to manage their financial liability. The result is that affordability gains achieved through an annual OOP cap must coexist with narrower coverage and greater administrative burden at the point of care, particularly for beneficiaries who rely on standalone PDPs.

Shifting to Coinsurance

Medicare Part D plans are required to meet actuarial equivalence standards tied to the statutory benefit design. Historically, plans met these requirements primarily through fixed-dollar copays for many drugs, particularly non-specialty branded products. Fixed copays provided beneficiaries with predictable costs at the pharmacy counter and allowed plans to manage affordability without directly tying beneficiary cost-sharing to a drug's list price.

Coinsurance, which requires beneficiaries to pay a percentage of a drug's cost, was traditionally concentrated in specialty tiers. This structure reflected an effort by plans to control costs for those with more significant medication needs while providing predictability for beneficiaries using more common branded therapies. Over time, however, the balance between the use of copays and coinsurance has shifted.

In recent years, plans have increasingly applied coinsurance across a broader range of drug tiers, including preferred and nonpreferred brand drugs that were previously subject to fixed copays. Under coinsurance, beneficiary cost-sharing rises in direct proportion to a drug's price, increasing both the amount paid per fill and the variability of OOP costs over time.

The IRA's redesign of Part D reinforces these incentives. As plan financial liability increases when beneficiaries approach and reach the annual OOP cap, plans have stronger incentives to manage when and how beneficiary spending accumulates over the course of the year and, as a result, manage what treatments beneficiaries take. Shifting from fixed copays to coinsurance allows plans to shift a greater share of costs to beneficiaries earlier in the benefit year before the cap is reached and plan responsibility rises most sharply. Beneficiaries may abandon or employ other strategies to save, such as pill splitting or skipping doses. This further slows progress toward the cap since beneficiaries simply are not taking the medication.

The impact of this shift to coinsurance is uneven across beneficiaries. Some non–low-income subsidy (LIS) beneficiaries with high drug spending will benefit substantially from the annual OOP cap and experience lower total costs over the course of the year.[3] By contrast, beneficiaries with moderate prescription drug spending may face higher and less predictable OOP costs without ever reaching the cap. For these beneficiaries, increased coinsurance can create significant financial pressure early in the year, when deductibles apply and cost-sharing is most pronounced.

For example, in the 2025 AARP Medicare Rx Preferred plan offered by UnitedHealthcare, drugs in the initial coverage phase carried a $47 copay on tier 3, the preferred brand tier.[7] In 2026, that same tier shifts to 15% coinsurance.[8] To a beneficiary, this shift may appear to be a savings, but under this design, a beneficiary will pay more in 2026 than in 2025 for any tier 3 drug priced above approximately $313, even though the drug remains preferred and non-specialty. This illustrates how changes in cost-sharing structure, rather than changes in drug choice, can materially affect what beneficiaries pay at the pharmacy counter.

These higher per-fill costs are most acutely felt early in the benefit year. Beneficiaries must first satisfy the deductible, during which they are responsible for the full cost of their medications, followed by increased cost exposure as coinsurance applies across more tiers and drugs. While the annual OOP cap provides critical protection against catastrophic spending, it does not prevent substantial upfront costs for beneficiaries who never reach the cap.

The MPPP may help beneficiaries manage these early-year costs by smoothing payments over time. However, payment smoothing does not reduce the underlying level of cost-sharing built into plan designs. As plans rely more heavily on coinsurance, beneficiaries may still face higher overall cost exposure, even if those costs are spread across monthly payments.

Taken together, the shift toward coinsurance represents a meaningful change in the beneficiary experience under the redesigned Part D benefit. Drugs may remain on formulary, but access increasingly comes with higher, less predictable, and earlier OOP costs. For beneficiaries with moderate spending or limited financial flexibility, these dynamics can create affordability barriers even in a program that now includes an annual OOP cap.

Additional Barriers to Access

As plan financial liability has increased under the redesigned Part D benefit, utilization management has become a more central mechanism for controlling drug spending. Even when a drug is included on formulary, and beneficiary cost-sharing is defined, access increasingly depends on whether beneficiaries and prescribers can navigate administrative requirements.

Utilization management tools such as prior authorization, quantity limits, and step therapy allow plans to influence utilization without formally excluding a drug from coverage. Plans use these tools to limit utilization, delay initiation of therapy, or steer beneficiaries toward lower-cost alternatives.

The use of utilization management has expanded substantially since the passage of the IRA, particularly for branded drugs. In 2026, nearly half of branded products covered by standalone PDPs and MA-PD plans are subject to prior authorization, with a growing share also subject to quantity limits. As shown in **Tables 1 and 2**, these requirements have increased steadily since 2020 across both types of plans, reflecting a broader shift toward administrative controls as a routine feature of Part D coverage.[6]

For beneficiaries, the impact of expanded utilization management is often felt at the moment care is sought. Prior authorization requirements can delay treatment initiation or continuation while documentation is reviewed. Quantity limits may require repeated physician intervention to maintain therapy.

Table 1. Utilization management requirements for branded products – standalone Part D plans, 2020-2026

Year	2020	2022	2026
Average number of covered drugs	658	650	614
Prior authorization required	38%	43%	46%
Quantity limit required	36%	46%	53%
Step therapy required	1%	1%	1%

Source: Cencora Analysis

Table 2. Utilization management requirements for branded products – Medicare Advantage plans, 2020-2026

Year	2020	2022	2026
Average number of covered drugs	804	743	705
Prior authorization required	33%	39%	44%
Quantity limit required	33%	43%	49%
Step therapy required	2%	1%	1%

Source: Cencora Analysis

Step therapy can force beneficiaries to cycle through plan-preferred treatments before accessing the medication originally prescribed by their clinician. These delays and disruptions can undermine adherence, destabilize disease management, and increase downstream healthcare utilization.

Utilization management also introduces significant transparency challenges. Beneficiaries typically select Part D plans based on visible features such as monthly premiums, deductibles, and formulary drug lists. The specific utilization management rules governing access to covered drugs are far less transparent and difficult to compare across plans. As a result, beneficiaries may enroll in a plan believing a drug is covered, only to discover after enrollment that access requires navigating multiple administrative steps.

These challenges are particularly acute for beneficiaries who rely on standalone PDPs, have limited ability to switch plans midyear, or depend on consistent access to specific medications. In these circumstances, utilization management becomes not just a cost-control mechanism, but a barrier to timely and appropriate care.

The expansion of utilization management completes a pattern emerging under the redesigned Part D benefit. Even when a drug remains covered and annual OOP spending is capped, beneficiaries may still face delays, uncertainty, and administrative burden at the point of care such as phone calls to plans and providers and repeated visits to the pharmacy while working out the utilization management. These dynamics reinforce the need to evaluate affordability not only in terms of annual spending limits, but also in terms of how easily and reliably beneficiaries can access medications when they need them.

Demise of Enhanced PDP Plans

The introduction of an annual OOP cap under the IRA reduced beneficiary financial liability but also diminished the competitive role historically played by enhanced alternative Part D plans. By narrowing the difference between standard and enhanced coverage on an annual basis, the redesign reduced plans' ability to compete through traditional Part D benefit levers, particularly with standalone PDPs.

Enhanced plans have historically served an important function for beneficiaries with moderate prescription drug spending. These plans typically offered lower deductibles, reduced cost-sharing, or other benefit enhancements that helped beneficiaries manage OOP costs throughout the year, even if they never reached catastrophic coverage. Under the redesigned benefit, however, the annual OOP cap diminishes the value of these enhancements while leaving plans with higher financial exposure earlier in the benefit year.

Enhanced plans can offer additional value in 3 primary ways:

Reduced deductible	Lower cost-sharing during the initial coverage phase	Annual OOP limit below the statutory maximum

While all beneficiary spending on deductibles, copays, and coinsurance count toward the statutory OOP cap, plans that offer reduced cost-sharing can still allow some beneficiaries to spend less than the cap over the course of the year. This distinction is particularly important for beneficiaries with moderate drug spending, who may benefit from lower upfront costs without ever reaching the annual limit.

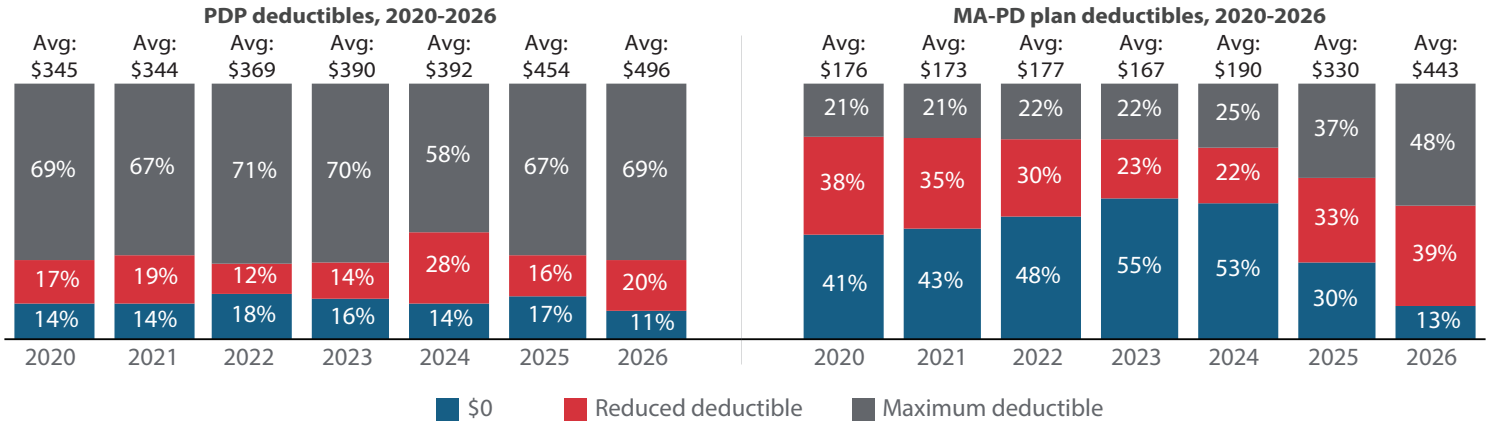
In practice, however, the availability of enhanced PDPs has declined sharply. Between 2025 and 2026, the number of enhanced standalone PDPs fell by 35%, from 271 plans to 177.[6] For beneficiaries enrolled in these plans, these exits require selecting new coverage options, often with higher cost-sharing or fewer enhancements. For beneficiaries who historically relied on enhanced PDPs to manage moderate drug spending, this contraction removes an important affordability option.

Between 2025 and 2026, the number of enhanced standalone PDPs fell by 35%, from 271 plans to 177.[6]

The pattern in MA-PD plans is notably different. Between 2025 and 2026, the number of enhanced MA-PD plans increased by 11%, from 3,741 to 4,134. In 2026, the share of MA-PD plans with the maximum deductible of $615 rose from 37% to 48%.[6] This divergence reflects structural differences between the 2 types of plans. MA-PD plans can use rebate dollars generated through medical benefit bidding to offset Part D cost-sharing or premiums, giving them greater flexibility to maintain or reconfigure enhanced benefits under the redesigned liability structure.

As a result, the IRA redesign is reshaping not only benefit design but also the competitive landscape of Part D. Enhanced coverage options are increasingly concentrated in MA-PD plans, while beneficiaries with Original Medicare face a shrinking menu of standalone PDPs with fewer opportunities to lower costs through benefit enhancements. For beneficiaries who prefer or require Original Medicare coverage, particularly those with moderate prescription drug spending, the erosion of enhanced PDPs represents a meaningful loss of choice and affordability.

Figure 3. Average deductible distribution for PDPs and MA-PD plans, 2022-2026



Key: MA-PD – Medicare Advantage Prescription Drug Plan; PDP – prescription drug plan.
Source: Cencora Analysis

Erosion of Beneficiary Plan Choices

The same financial dynamics driving premium pressure are also reshaping Medicare Part D, narrowing the options available to beneficiaries, particularly those who rely on PDPs.

Some consolidation in Part D predates the IRA. The ability to offer lower premiums, combined with attractive supplemental benefits such as vision, dental, and gym memberships, has driven a long-running shift toward Medicare Advantage, where beneficiaries receive Part D coverage through MA-PD plans. The share of beneficiaries enrolled in MA-PD plans grew from 19% in 2007 to 54% in 2025, and as of December 2025, 59.3 million Medicare beneficiaries were enrolled in Part D.[9-11]

That shift has accelerated under the IRA redesign. Higher plan liability and tighter margins make it increasingly difficult for PDP sponsors to offer competitively priced products. The number of standalone PDPs offered nationally is declining sharply, with the PDP options contracting by approximately 22% in 2026 compared to 2025. In total, this represents an almost 50% decrease in standalone PDP offerings over 2 years.[12] For millions of beneficiaries with Original Medicare with Medigap, this contraction in standalone PDP offerings poses an acute access problem. Medigap policies do not include prescription drug coverage, so standalone PDPs are their only pathway to Part D. MA-PD plans are not always realistic substitutes, particularly in rural regions where plan availability is limited, or where longstanding clinicians may not be part of MA networks. These beneficiaries are effectively captive to a shrinking standalone PDP landscape that may not meet their needs.

The number of standalone PDPs offered nationally is declining sharply, with the PDP options contracting by approximately 22% in 2026 compared to 2025. In total, this represents an almost 50% decrease in standalone PDP offerings over 2 years.[12]

The declining availability of standalone PDPs also significantly impacts the program's most vulnerable enrollees: LIS beneficiaries. LIS enrollees receive additional federal assistance to reduce premiums and cost-sharing, making them particularly sensitive to plan exits, benchmark changes, and formulary disruptions. These beneficiaries often enroll in "benchmark" PDPs, plans priced below a regional subsidy threshold, to receive premium-free coverage. As plan participation contracts, the number of benchmark options has collapsed. In 2026, some states, such as Florida and Texas, will have only 1 premium-free benchmark plan available.[13] Fewer benchmark choices mean more beneficiaries are automatically enrolled in other plans by the Centers for Medicare & Medicaid Services (CMS) because their prior plan is no longer premium-free. Ultimately, fewer benchmark plan options means that there is higher risk of medication disruption and less ability for beneficiaries to select plans that align with their drug needs.

This trajectory undermines one of the foundational promises of the Medicare Modernization Act (MMA): that every beneficiary would have access to at least one viable Part D option. The MMA includes a fallback mechanism requiring CMS to contract with a "fallback" sponsor if no commercial PDPs bid in a region. As participation erodes, the question is no longer academic: What happens if market forces alone cannot sustain meaningful standalone choice?

In short, the IRA's redesign is producing 2 intertwined effects: higher premiums and fewer choices. The same financial pressures that make standalone PDPs more expensive are driving them out of the market altogether, leaving beneficiaries in traditional Medicare and those with LIS fewer, costlier, and often more restrictive options for prescription drug coverage.

Higher Premiums

IRA changes are putting upward pressure on Part D premiums, adding to beneficiary financial burden in a way that is most visible in the PDP landscape. As plan liability increases under the redesigned benefit, premiums become one of the clearest pressure valves. This is especially true for PDPs, which have limited ability to offset Part D premium increases through integrated medical benefits, supplemental rebates, or other financing tools available in Medicare Advantage.

Congress capped growth in the beneficiary base premium, and CMS established a demonstration program intended to limit premium increases. Those steps have helped blunt the immediate impact of premium increases, but they function as temporary stabilizers rather than structural solutions. As those protections sunset, beneficiaries will face higher premiums, with the greatest exposure concentrated among enrollees in PDPs.

Anticipating premium pressure as plans adjusted to the redesign, the IRA also included a temporary cap on growth in the Part D base beneficiary premium (the national benchmark premium used in Part D financing). The law limits annual increases to 6% through 2030. For 2026, the Part D base beneficiary premium is capped at $38.99 by law, compared to an estimated $75.38 without the cap.[14] However, this base beneficiary premium is different from what beneficiaries pay. The 6% cap does not apply to plan-specific premiums, which can still rise depending on each plan's bid relative to the national average and the plan's supplemental premium. As a result, beneficiaries in standalone PDPs may face higher monthly premiums even when the national base beneficiary premium is constrained.

Recognizing acute instability with standalone PDPs during the transition, CMS launched the Part D Premium Stabilization Demonstration beginning in 2025 as a voluntary, temporary set of parameters to moderate beneficiary premium disruption while plans adjusted to the redesigned benefit. For 2026, CMS reduced the uniform base beneficiary premium reduction, increased the year-over-year premium limit from $35 to $50, and eliminated the narrowed risk corridor thresholds.[14]

Taken together, the IRA's 6% cap and the Premium Stabilization Demonstration have moderated premium increases in the near term by putting forth billions of dollars, but they function as transition policies. As plans fully price the redesigned liability profile into bids, and as temporary stabilization parameters are scaled back, premium pressure is likely to remain most visible with standalone PDPs, widening the gap between PDP and MA-PD plan premiums over time.

Looking Ahead: Policy Changes May Not Improve Affordability and Access

Policy changes on the horizon, including Medicare-negotiated pricing under the IRA and the potential introduction of Most Favored Nation (MFN) pricing in Part D, are widely promoted as mechanisms to reduce drug spending. MFN pricing is a policy approach that ties United States drug payment rates to the lowest or average prices paid in a set of other countries. The core idea is that Medicare or other payers should not pay more for a drug than what comparable countries pay for the same product.

While these approaches are expected to generate substantial federal savings, they may not translate into meaningful improvements in beneficiary affordability and could further exacerbate access barriers already emerging in the Part D market. The key issue is how pricing changes alter plan incentives and beneficiary experience.

Under the current Part D system, plan sponsors benefit most from drugs with high list prices that generate substantial manufacturer rebates.[15] These rebates help offset overall plan costs and suppress beneficiary premiums. Plans can also shift a portion of drug costs to beneficiaries through coinsurance, which is calculated as a percentage of a drug's price. Together, these features have historically favored higher-cost, higher-rebate drugs over lower-cost alternatives.

Negotiated Price Ripple Effects

Medicare's new authority to negotiate prices under the IRA disrupts this model by establishing a Maximum Fair Price (MFP) that replaces prior negotiated prices for selected drugs. While negotiated pricing lowers Medicare spending and reduces coinsurance for beneficiaries using those specific drugs, it also changes the economics that have driven formulary and benefit design decisions.

For the 10 Part D drugs selected for negotiation in 2026, beneficiaries are expected to see aggregate OOP savings of approximately $1.5 billion in the first year. However, this total does not reflect the individual patient experience. For many beneficiaries, savings from lower negotiated prices may be offset by broader plan design shifts that limit access and increase beneficiary costs in other ways, including the continued move away from fixed copays toward coinsurance across more drugs and tiers.

Negotiated pricing also eliminates all or most manufacturer rebates for the selected drugs. While this generates federal savings, it removes a key source of plan revenue and incentivizes plans to pursue other strategies to offset revenue losses, including through utilization management and increased beneficiary cost-sharing. With 10 drugs negotiated in 2026 and 15 more scheduled for 2027, plans may respond to reduced rebate revenue by increasing utilization management, adjusting tier placement, narrowing formularies, or raising cost-sharing, even for drugs they are required to cover.

MFN Pricing: Not Ensuring Improved Affordability for Beneficiaries

CMS estimates that while Medicare would save approximately $14.1 billion under the model, beneficiary costs could increase by a net $3.6 billion over its duration.[16]

Proposals to introduce MFN pricing in Part D would further disrupt plan economics without clear beneficiary affordability gains. CMS estimates that while Medicare would save approximately $14.1 billion under the model, beneficiary costs could increase by a net $3.6 billion over its duration.[16]

MFN pricing would apply to a subset of sole-source, rebatable Part D drugs while excluding generics, biosimilars, and drugs already subject to negotiated pricing. If a drug's Medicare net price exceeds an international benchmark, manufacturers would owe rebate payments that accrue to the federal government rather than directly reducing beneficiary costs at the pharmacy counter.

Together, negotiated pricing and potential MFN policies reduce federal drug spending but do not ensure improved affordability or access for beneficiaries. Instead, these changes risk accelerating trends already visible in Part D, including greater reliance on utilization management, increased cost-sharing, and less predictable OOP costs. For beneficiaries, particularly those with moderate drug spending or complex treatment needs, lower government prices may coexist with higher barriers at the point of care.

Challenges Expected to Continue

The issues described in this paper are going to continue; they are not limited to 2025 or 2026. In spring 2025, Cencora conducted a survey of 40 payers to capture their perceptions regarding the IRA's effects and their plans for standalone Part D and Medicare Advantage offerings (see **Figure 4**).[17]

These payer responses suggest that the changes underway in Part D are not viewed as transitional or short-lived. Plans report that higher liability exposure, tighter margins, and increased uncertainty are already influencing benefit design, formulary strategy, utilization management, and decisions about continued participation in the standalone PDP market. Importantly, these responses reflect forward-looking planning assumptions rather than temporary adjustments to early implementation. As sponsors continue to recalibrate their offerings under the redesigned benefit, these dynamics are likely to persist and shape beneficiary experience beyond the initial years of IRA implementation.

Figure 4. Payer responses to the Part D redesign and Medicare drug price negotiations[a]

PREMIUMS

74% of payers surveyed suggested that they will increase PDP premiums in the coming years, with 28% of payers suggesting premium hikes over 10%.

83% of payers surveyed suggested that they will increase MA-PD plan premiums in the coming years, with 30% of payers suggesting premium hikes over 20%.

PLAN SELECTION AND BENEFICIARY CHOICE

23% of payers with Part D plans said they would consider exiting the PDP market in the next few years.

FORMULARY COVERAGE AND UTILIZATION MANAGEMENT

50% The shift to narrower formularies is expected to impact products negotiated by Medicare, with 50% of the surveyed respondents with MA-PD plans (n=35) saying they plan to increase prior authorization and step therapy requirements for these products.

33% of payers said they would place a higher cost-sharing burden on beneficiaries for negotiated products.

Key: MA-PD – Medicare Advantage Prescription Drug Plan; PDP – prescription drug plan.

[a] Cencora surveyed 40 payers, including 17 with standalone PDP offerings and 36 with Medicare Advantage plans.

Evaluating the Tradeoffs of IRA Benefit Design Changes

The introduction of an annual OOP cap and the MPPP represents a meaningful advance in protecting Medicare Part D beneficiaries from catastrophic prescription drug costs. For years, millions of beneficiaries, particularly those with complex or chronic conditions, faced unlimited OOP exposure that could lead to financial hardship and nonadherence to essential therapies. Establishing a fixed annual cap provides an important and predictable financial safeguard, offering greater certainty and stability for beneficiaries who rely on ongoing treatment.

At the same time, achieving this core affordability goal must not come at the expense of access. While the OOP cap addresses catastrophic risk, the redesigned Part D benefit also introduces new pressures earlier in the benefit year. Rising deductibles, greater reliance on coinsurance, narrower formularies, and expanded utilization management can increase upfront and administrative barriers for beneficiaries who may never reach the annual cap. For these beneficiaries, affordability challenges may shift rather than disappear.

This tension underscores the need for active oversight and clear guardrails in the redesigned Part D landscape. As plan liability increases under the IRA, CMS and Congress play a critical role in ensuring that cost-management strategies do not undermine timely, appropriate access to medications or erode beneficiary confidence in the program.

Recent benefit changes have also coincided with growing confusion and dissatisfaction among some beneficiaries. Although Medicare Part D has historically maintained high levels of enrollee satisfaction, increased complexity in plan design and access requirements risks weakening trust in the program. Restoring and maintaining beneficiary confidence requires ensuring that the financial relief promised by the OOP cap and the MPPP is not offset by administrative roadblocks or opaque plan practices.

Recommendations for CMS and Congress

The IRA reforms were intended to improve affordability, but the associated shift in financial liability is already reshaping plan behavior in ways that can affect access, premiums, and plan availability.

CMS and Congress should proactively use their oversight and stabilization authorities to ensure that beneficiaries experience the Part D redesign as reduced financial risk without new access barriers.

The recommendations below focus on preserving meaningful plan choice, aligning plan incentives with access goals, and reducing patient-facing friction, particularly for vulnerable populations.

Beneficiary Protections: Reduce Friction and Strengthen Due Process

- **Establish an ongoing beneficiary and caregiver feedback program** (surveys, task forces, structured interviews) focused on real-world experience with utilization management, pharmacy counter barriers, and OOP costs, including the MPPP, and publish "what was heard/what was changed" annually.
- **Launch a broad MPPP education campaign.** CMS should launch a campaign to educate beneficiaries and other stakeholders who work with beneficiaries about the MPPP.
- **Create a formal CMS process to incorporate beneficiary input** into Part D oversight (formulary design, utilization management, and appeals), including regular touchpoints with patient advocates and public reporting of actions taken.
- **Conduct routine beneficiary focus groups and usability testing** to ensure outreach and education (including plan comparison tools and benefit explanations) meet their objectives, especially for vulnerable populations.
- **Modernize the exceptions and appeals process** by simplifying notices, reducing administrative barriers, strengthening caregiver authorization, improving education, and publishing plan-level performance metrics (denials, overturn rates, timelines) so that delays and inappropriate barriers are visible and correctable.
- **Perform ongoing actuarial-equivalence and formulary-access analytics** to confirm that plans remain aligned with the Part D benefit design and that beneficiary access is not being eroded through increasingly restrictive formularies or utilization management. Ensure that the 6 protected classes are being maintained.

Plan Options: Preserve Meaningful Standalone PDP Choice

- **Stabilize the standalone PDP market with time-limited, targeted premium support** designed to prevent disorderly plan exits and beneficiary disruption, conditioned on access protections (eg, reasonable utilization management, stable formularies, and transparent network design).
- **Set a minimum standard for LIS benchmark choice** and trigger automatic corrective actions when a region/state falls below that threshold (eg, enhanced benchmark subsidies, improved auto-assignment rules, and incentives for additional PDP entry), so LIS beneficiaries are not effectively limited to 1 or 2 viable options.

Plan Incentives and Oversight: Align the Redesigned Liability With Access Guardrails

- **Implement transitional risk protection (eg, risk corridors) tied to IRA redesign volatility**, with clear eligibility rules and guardrails that prevent sponsors from shifting the burden to patients through higher premiums or more restrictive utilization management.
- **Publish a public-facing Part D formulary review playbook** that clearly explains CMS's approval criteria and checkpoints, including how actuarial equivalence is assessed and how CMS evaluates and monitors utilization management (prior authorization, step therapy, quantity limits). Require standardized reporting on utilization management metrics and conduct routine audits to ensure compliance and identify outliers.
- **Require standardized, beneficiary-facing disclosure of MA-PD plan supplemental benefits** (eligibility, limits, and utilization) and publish comparable plan data so beneficiaries can make informed choices and understand what benefits are real and usable, not just advertised.
- **Create enhanced incentives for plans serving high concentrations of LIS and rural beneficiaries**, including targeted subsidies and risk protections tied to access and continuity-of-care performance.
- **Collect, standardize, and publicly report Medicare Part D formulary exceptions and appeal denial data** (by plan, drug class, and denial reason), including turnaround times and ultimate outcomes, to improve transparency and accountability for beneficiary access.

Methodology for Cencora Analysis

Coverage, and utilization management (UM) of branded products were assessed using the Centers for Medicare & Medicaid Services Prescription Drug Plan Formulary and Pharmacy Network Information October files (2020 to 2026). The analysis was restricted to MA-PD plans and PDPs with specialty tiers. UM was categorized as prior authorization (PA), quantity limits (QLs), and step edits. Findings were weighted by plan enrollment, sourced from the Medicare Advantage/Part D Contract and Enrollment Data. Branded drugs were defined based on the multisource indicator from Medi-Span; branded drugs include single-source products and multisource originator products.

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