MILLIMAN REPORT

Expected Impact of Inflation Reduction Act (IRA) Medicare Drug Price Negotiation Program on Medicare Part D Beneficiary Out-of-Pocket Costs

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I. EXECUTIVE SUMMARY

Pharmaceutical Research and Manufacturers of America (PhRMA) engaged Milliman to analyze the impact of the Medicare Drug Price Negotiation Program (MDPNP) enacted by the Inflation Reduction Act of 2022 (IRA) on Medicare Part D beneficiary out-of-pocket (OOP) costs. The IRA introduces several significant changes to Medicare Part D including the MDPNP, a redesigned Part D benefit, inflationary rebate penalties for pharmaceutical manufacturers, Part D premium stabilization, cost sharing caps on insulins and vaccines, and many others. These changes impact Medicare Part D beneficiaries, pharmaceutical manufacturers, plan sponsors, and the federal government in different ways.

This report focuses on the expected impact on beneficiary OOP costs in 2026 directly attributable to the MDPNP, specifically modeling the incremental impact of the MDPNP after implementation of the 2025 Part D benefit redesign and other provisions that will be in place by 2026. The results in this report include two scenarios, a "baseline" scenario which represents expected 2026 OOP costs without the MDPNP and a "with MDPNP" scenario, which represents 2026 OOP costs with MFPs in place.

Based on the results of our analysis, we estimate the MDPNP will cause average annual beneficiary OOP costs to increase by $70, or 12%, for utilizers of MDPNP selected Part D drugs in 2026. Table 1 displays the results of our analysis in total and by income status (i.e., low-income subsidy (LI) beneficiaries and non-low-income (NLI) beneficiaries). The OOP costs shown in Table 1 represent total OOP costs, inclusive of cost sharing for drugs selected for the MDPNP and all other drugs utilized by these beneficiaries. These values do not include any premiums, medical costs, low-income cost sharing subsidies (LICS), or other reductions for cost sharing paid on behalf of the beneficiary through a supplemental benefit.

Table 1
Impact of Medicare Drug Price Negotiation Program on Annual OOP Costs
Utilizers of MDPNP Selected Drugs by Income Status

Beneficiary Income Status	2026 Baseline	2026 with MDPNP	Impact (%)
NLI	$903	$1,007	11%
LI	$43	$54	27%
All	$598	$668	12%

The results in Table 1 are based on key assumptions including estimates of MFPs assigned to each 2026 MDPNP selected drug and benefit designs (i.e., deductibles, copays / coinsurances) of Part D plans in 2026. We modeled results assuming formulary coverage and representative benefits based on current 2024 benefits. However, results are sensitive to benefit designs assumed and benefits in place in 2026 may be different than what is in place in 2024. To sensitivity test the impact of leaner benefits, we replicated our analysis assuming all beneficiaries are enrolled in plans with a defined standard benefit, which includes a full deductible and 25% coinsurance on all tiers. In this scenario, LI beneficiaries experience similar increases in OOP costs, since they are subject to nominal copays, but NLI beneficiaries see OOP savings of 12% on average. Only 2% of NLI beneficiaries are enrolled in defined standard plans in 2024, so the representative benefit scenarios are more likely to reflect what NLI beneficiaries would actually experience. [1]

We assume the prices established by CMS under the MDPNP, called maximum fair prices (MFPs), are equal to our estimates of MFP ceiling prices for drugs selected for the MDPNP. Given the 2026 MFPs are unknown at this time, we are unable to predict actual prices and use this assumption for simplicity, but we expect the findings to directionally hold true at most other prices (provided MFPs are not lower than beneficiary copays). We also assume all 10 drugs selected by CMS for negotiation will be subject to MFPs in 2026.

Increases in OOP costs are driven by beneficiaries paying copays for MDPNP selected drugs. Effective in 2025, as part of the IRA, plan supplemental coverage will contribute to a beneficiary's maximum out-of-pocket (MOOP) limit. As such, lower prices established by the MDPNP will slow a beneficiary's progress toward MOOP, even though the beneficiary continues to pay the same fixed copay. This results in beneficiaries paying additional copays to reach MOOP, resulting in greater total OOP costs. While some beneficiaries paying coinsurance could experience reduced OOP costs, we expect more beneficiaries will experience OOP cost increases, which will outweigh any savings, on average, based on the benefit designs in place as of 2024.

[1] Based on CMS 2024 Part D landscape files: https://www.cms.gov/medicare/coverage/prescription-drug-coverage

- Approximately 3.5 million beneficiaries using MDPNP selected drugs are estimated to experience OOP increases attributable to the MDPNP. These beneficiaries are primarily those with copay benefits, which includes both LI and NLI beneficiaries.

- Approximately 2.2 million beneficiaries using MDPNP selected drugs are estimated to experience no change in OOP costs attributable to the MDPNP. These beneficiaries may have reached MOOP both before and after the MDPNP or may be enrolled in a plan with zero cost sharing.

- Approximately 1.2 million beneficiaries using MDPNP selected drugs are estimated to experience OOP savings attributable to the MDPNP. These beneficiaries are primarily NLI beneficiaries who did not reach MOOP before or after MDPNP implementation.

This report also analyzes the beneficiary OOP cost impacts by Part D plan type, race / ethnicity, aged / disabled status, and End Stage Renal Disease (ESRD) status. We expect average increases in OOP costs for beneficiaries taking an MDPNP selected drug in all three Part D plan types—Medicare Advantage Part D plans (MA-PD), stand-alone prescription drug plans (PDP), and Employer Group Waiver Plans (EGWP). Beneficiaries in EGWPs taking MDPNP selected drugs are expected to see a 29% annual average OOP cost increase, as compared to a 17% increase for those in MA-PDs and 3% for those in PDPs. We find that Black and Asian beneficiaries experience the largest increases in average OOP costs from the MDPNP, likely due to a disproportionate share of LI and MA-PD beneficiaries in these racial / ethnic groups, making these beneficiaries more frequently subject to fixed copays.

II. BACKGROUND

MEDICARE DRUG PRICE NEGOTIATION PROGRAM

The IRA[2] authorizes the Department of Health and Human Services (HHS), delegated to the Centers for Medicare and Medicaid Services (CMS), to determine drug prices for select qualifying single source drugs in Medicare Part B and D. Generally, drugs are selected based on their total gross Medicare spending in prescribed data periods. The maximum fair price (MFP) for each MDPNP selected drug cannot be above the MFP ceiling, prescribed by the IRA as the minimum of the applicable percentage of the non-Federal Average Manufacturer Price (non-FAMP) and, depending on whether the drug is covered under Part D or Part B, the plan-specific enrollment-weighted average price net of direct and indirect remuneration (DIR) or the average sales price (ASP), respectively. Once an MFP is finalized, the price will apply to all Medicare beneficiaries (subject to a 340B drug program nonduplication requirement) in the applicable year(s).

Ten Part D Drugs Selected for Medicare Drug Price Negotiation Program in 2026

For initial price applicability year (IPAY) 2026, CMS announced selection of ten Part D drugs for the MDPNP on August 29, 2023,[3] with MFPs to be announced by September 1, 2024. The selected drugs for 2026 are the focus of this analysis and are displayed in Table 2 below. This table was originally published by CMS in the Medicare Drug Price Negotiation Program fact sheet.[4]

Table 2
2026 Selected Drugs Total Part D Gross Covered Costs and Utilizers[5]

Drug Name	Commonly Treated Conditions	Total Part D Gross Covered Costs* (in $B)	Number of Medicare Utilizers*
Eliquis	Prevention and treatment of blood clots	$16.5	3,706,000
Jardiance	Diabetes; Heart failure	$7.1	1,573,000
Xarelto	Prevention and treatment of blood clots; Reduction of risk for patient with coronary or peripheral artery disease	$6.0	1,337,000
Januvia	Diabetes	$4.1	869,000
Farxiga	Diabetes; Heart failure; Chronic kidney disease	$3.3	799,000
Entresto	Heart failure	$2.9	587,000
Enbrel	Rheumatoid arthritis; Psoriasis; Psoriatic arthritis	$2.8	48,000
Imbruvica	Blood cancers	$2.7	20,000
Stelara	Psoriasis; Psoriatic arthritis; Crohn's disease; Ulcerative colitis	$2.6	22,000
Fiasp / NovoLog	Diabetes	$2.6	777,000

** Data reported by CMS based on the data period of June 2022 through May 2023.*

Table 3 summarizes the most common Part D formulary tier placement and benefit type for each drug selected for the MDPNP, separately by Medicare Advantage and Part D (MA-PD) and standalone Prescription Drug Plan (PDP), based on the 2024 formulary and benefit information released by CMS. In general, tier 5 is virtually always a coinsurance between 25% and 33% and tier 3 can be a copay (up to $47) or a coinsurance (up to 25%), where the latter is common for many PDPs. The tier and benefit type shown in Table 3, below, are weighted by enrollment.

[2] Inflation Reduction Act of 2022: https://www.congress.gov/117/bills/hr5376/BILLS-117hr5376enr.pdf
[3] HHS Announcement: https://www.hhs.gov/about/news/2023/08/29/hhs-selects-the-first-drugs-for-medicare-drug-price-negotiation.html
[4] CMS Fact Sheet https://www.cms.gov/files/document/fact-sheet-medicare-selected-drug-negotiation-list-ipay-2026.pdf
[5] CMS Selected Drug Negotiation List Fact Sheet: https://www.cms.gov/files/document/fact-sheet-medicare-selected-drug-negotiation-list-ipay-2026.pdf

Table 3
2024 Most Common Part D Benefit Design for Drugs Selected for the MDPNP in 2026

	Most Common Tier / Benefit	
Drug Name	**MA-PD**	**PDP**
Eliquis Jardiance Xarelto Januvia Farxiga Entresto	Tier 3 / copay	Tier 3 / coinsurance
Fiasp / NovoLog*	Tier 3 / copay	Tier 3 / copay
Enbrel Imbruvica Stelara	Tier 5 / coinsurance	Tier 5 / coinsurance

* *Insulins are not subject to the same benefits as non-insulins on the same tier and member cost sharing is subject to a maximum copay of $35 / month.*

MFP Ceiling Price Calculation

While the final MFP can be lower than the ceiling, the MFP ceiling generally is the maximum price allowable under the MDPNP per 30-day supply of a given drug. In our analysis of 2026 MDPNP selected drugs, we estimate the ceiling price for each drug using the methodology prescribed in the IRA. Given 2026 MFPs are unknown at this time, we are unable to predict final MFPs and use the MFP ceiling in our analysis for simplicity.

To estimate the MFP ceiling, we (1) determine the discount percentage set by statute based on the age of the drug; (2) apply the discount to the drug's estimated non-FAMP; and (3) compare the discounted non-FAMP to the drug's estimated net price. The ceiling price is defined as the lower of the discounted non-FAMP price and the net price (i.e., Part D plan-specific enrollment-weighted amount).[6] The elements of the ceiling price calculation are defined as:

- Non-Federal Average Manufacturer Price (non-FAMP): The average price paid to the manufacturer by wholesalers (or others who purchase directly from the manufacturer) for drugs distributed to nonfederal purchasers, taking into account any cash discounts or similar price reductions given to those purchasers, but not taking into account any prices paid by the federal government. Non-FAMP does not reflect rebates paid by the manufacturer to third-party payers for most drugs.

- Length of Time Since FDA Approval and Minimum Discount: The minimum discount for a given selected drug off of non-FAMP aligns with the number of years since approval by the U.S. Food and Drug Administration (FDA) to the first day of the price applicability period. The IRA divides minimum discounts into three categories:

  - Short monopoly: Less than 12 years since FDA approval (25% discount off non-FAMP).
  - Extended monopoly:[7] 12 to 16 years since FDA approval (35% discount off non-FAMP).
  - Long monopoly: More than 16 years since FDA approval (60% discount off non-FAMP).

- Average Net Price: For a Part D drug, the plan-specific negotiated price net of all price concessions received by such plan or pharmacy benefit managers (PBMs) on behalf of such plan for the most recent year for which data is available. The net price is calculated for each plan, and then enrollment-weighted across all plans with non-zero claims for the given drug.

[6] Weathering the Reform Storm: https://www.milliman.com/-/media/milliman/pdfs/2022-articles/8-17-22_weathering-the-reform-storm.ashx
[7] Not applicable for drugs selected for 2026; extended monopoly discounts will take effect for selected drugs beginning in 2030.

III. RESULTS

PART D BENEFICIARY OOP COST IMPACTS

We reviewed the 2026 impact of the MDPNP on different cohorts of beneficiaries in this analysis, including:

- Income Status: NLI vs. LI
- Plan Type / Population: Individual MA-PD vs. Individual PDP vs. Employer Group Waiver Plan (EGWP)
- End-stage Renal Disease (ESRD) Status
- Race / Ethnicity
- Aged / Disabled Status

We chose a representative plan design underlying each plan type specific to large national carriers and for all other carriers as well, based on average 2024 Part D plan designs. Whether a plan has a coinsurance or copay benefit on the preferred brand tier is a key determining factor in the magnitude of total NLI patient OOP cost (see Appendix A for more details). There are a variety of benefit offerings in the Part D market, but many PDPs have coinsurance on the preferred brand tier whereas most MA-PDs have historically offered a copay on this tier in almost all cases. This differentiating factor between plan types is a key driver of the results presented in this report. As the IRA introduces new Part D financial dynamics for plans, we may see an increase in the number of Part D plans with coinsurance on brand tiers, though this analysis does not address potential changes in plan designs in future years. In addition to the representative plan designs based on 2024 plan offerings, we also modeled results under a defined standard benefit for comparison. Only 2% of NLI beneficiaries are enrolled in defined standard plans in 2024, so the representative benefit scenarios are more likely to reflect what NLI beneficiaries would actually experience. Results reflect the representative benefit designs except where specifically noted as defined standard.

The results in this report display two scenarios, a “baseline” scenario which represents 2026 OOP costs without the MDPNP and a “with MDPNP” scenario which represents 2026 OOP costs with MFPs (assumed equal to estimated ceilings) in place. We assume all ten selected drugs will have MFPs in place, though it is possible the MFP may not apply if CMS determines that a generic or biosimilar alternative is approved and marketed prior to August 1, 2024. Both scenarios reflect full implementation of the IRA’s Part D benefit redesign.

Patients With OOP Cost Increases

Beneficiaries with the following characteristics are likely to see OOP cost increases:

1. **Utilize a drug selected for the MDPNP:** Beneficiaries must take a drug selected for the MDPNP for their OOP costs to be affected.

2. **MDPNP selected drug is covered on a copay tier and not subject to a deductible:** All LI beneficiaries fall into this category as their cost sharing is exclusively nominal copays with no deductible (as shown in Table A-1). Additionally, NLI beneficiaries with copay benefits are likely to see cost increases as more copays are required to reach MOOP under the MDPNP than prior to its application.

Patients With No OOP Cost Changes

Beneficiaries with the following characteristics are likely to see no change to their OOP costs.

1. **Not utilize a drug selected for the MDPNP:** Beneficiaries not taking any of the selected products will see no impact to OOP costs.

2. **MDPNP selected drug is not subject to cost sharing, or beneficiary reaches MOOP both before and after application of the MDPNP:** Some beneficiaries utilizing MDPNP selected drugs may see no change to their cost sharing if their drugs are covered on a tier that does not require beneficiary cost sharing. This instance is most common on D-SNPs participating in the Value Based Insurance Design (VBID) program.[8]

[8] LI beneficiaries pay the lesser of the nominal copay in Table 4, the actual benefit (e.g., if a $0 generic copay is the plan benefit, the LI beneficiary pays $0 at the POS), and the POS cost of the drug. In most cases, the LI beneficiary pays the nominal copays displayed in Table 4. Approximately 42% of LI beneficiaries are enrolled in dual-eligible special needs plans (D-SNPs) which can coordinate care between Medicare and Medicaid. A trend in recent years among D-SNP sponsors is to provide a benefit through the Value Based Insurance Design (VBID) program which completely waives LI patient pay, meaning the beneficiary pays $0 for all drugs. In 2024, approximately 82% of beneficiaries enrolled in D-SNPs have this benefit. Cost sharing for beneficiaries with this benefit is unaffected by the MDPNP as they pay $0 for all drugs, including those selected for the MDPNP. We adjust for this benefit by reducing the LI OOP cost to $0 for approximately 82% of D-SNP members in our analysis.

Additionally, beneficiaries who satisfy MOOP by paying the full $2,000 (as is typical for utilizers of specialty drugs) both before and after MDPNP will see no change to their cost sharing as their cost sharing continues to be capped at the same amount.

Patients With OOP Cost Savings

Generally, to see OOP cost savings as a result of the MDPNP a beneficiary must have *all* of the following characteristics:

1. **Utilize a drug selected for the MDPNP:** Beneficiaries not taking any of the selected products will see no impact to OOP costs. These beneficiaries may have a change in premium, though premium impact was outside the scope of this analysis.

2. **Qualify as an NLI beneficiary:** LI beneficiaries will typically not benefit from MDPNP because they pay fixed nominal copays regardless of a drug's point of sale (POS) costs.

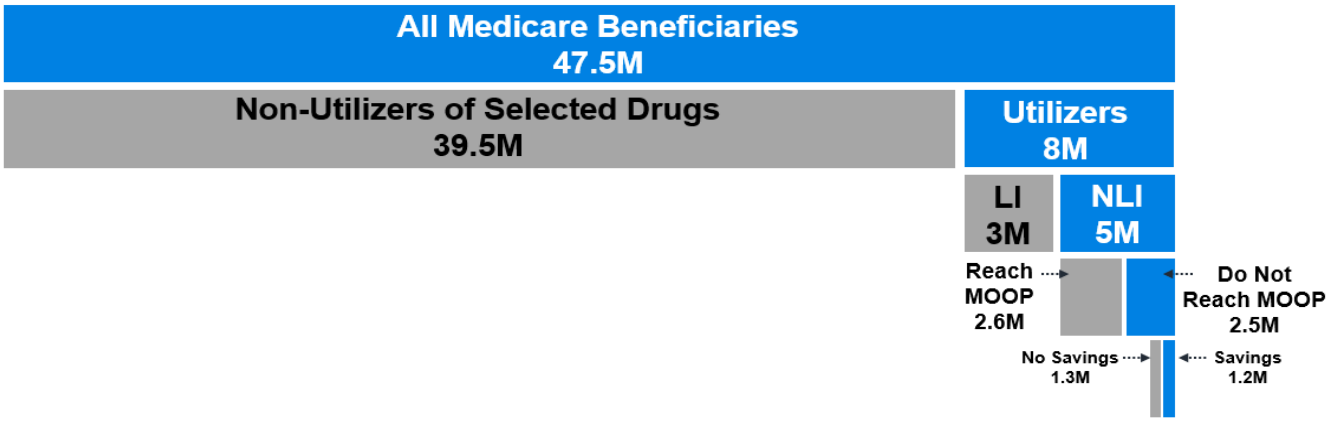
3. **Do not reach MOOP when MDPNP takes effect:** Beneficiaries with gross costs significantly above the MOOP are likely to still reach MOOP after the MDPNP goes into effect. Only those who no longer reach MOOP will have savings attributable to the MDPNP.

4. **MDPNP selected drug is covered on a coinsurance tier or subject to a deductible:** Beneficiaries with copay benefits will typically not see a reduction in OOP costs unless they are subject to a deductible **and** their costs are low enough that they do not reach MOOP. Beneficiaries with coinsurance benefits will generally see more significant savings than those with copays.

There are other less common cases where a beneficiary may see savings, such as cases where a beneficiary only takes one or two scripts of an MDPNP selected product or switches LI eligibility during the year.

Figure 1 below illustrates the estimated number of beneficiaries who satisfy each qualifier.

FIGURE 1: ESTIMATED NUMBER OF BENEFICIARIES BY COHORT



- We estimate approximately 3.5 million beneficiaries will experience cost increases attributable to the MDPNP. These beneficiaries are primarily those with copay benefits (from both income statuses).

- Approximately 2.2 million beneficiaries are estimated to experience no change in cost attributable to the MDPNP. These beneficiaries may have reached MOOP both before and after the MDPNP or be enrolled in a plan with zero cost sharing (such as D-SNPs participating in the VBID).

- Approximately 1.2 million beneficiaries are estimated to experience savings attributable to the MDPNP. These beneficiaries are primarily NLI beneficiaries who did not reach the MOOP before or after the MDPNP implementation. As described above, around 450,000 of these beneficiaries have coinsurance benefits and are expected to see more significant savings than those with copay benefits and a deductible.

OOP COST IMPACTS BY INCOME STATUS

Table 4 displays the average OOP cost impacts by income status. Both NLI and LI beneficiaries see an increase in OOP costs, on average, due to the MDPNP when modeling with representative 2024 benefits.

The findings of this analysis are sensitive to the underlying benefits assumed. Table 4 displays results using representative plan designs by carrier. For contrast, Table 4 also shows OOP impacts by income status based on a defined standard benefit design where the plan design includes a full deductible and 25% coinsurance on all tiers in the initial coverage phase. Nominal copays for LI beneficiaries still apply under the defined standard benefit design, but we assume reductions in nominal copays from VBID do not apply.

Table 4
Impact of the MDPNP on Annual OOP Costs
By Income Status and Benefit Design Scenario

		Utilizers of MDPNP Selected Drugs			All Utilizers**		
Benefits Scenario	**Income Status**	**2026 Baseline**	**2026 with MDPNP**	**Impact (%)**	**2026 Baseline**	**2026 with MDPNP**	**Impact (%)**
Representative	NLI	$903	$1,007	11%	$432	$445	3%
	LI	$43	$54	27%	$39	$41	5%
	All	**$598**	**$668**	**12%**	**$328**	**$337**	**3%**
Defined Standard*	NLI	$1,709	$1,498	-12%	$716	$687	-4%
	LI	$64	$82	29%	$60	$63	5%
	All	**$1,125**	**$995**	**-12%**	**$541**	**$521**	**-4%**

** Defined Standard projection does not reflect the $0 cost sharing D-SNP benefit offered through VBID. Less than 2% of NLI beneficiaries are enrolled in plans with defined standard benefits in 2024.*
*** Utilizers of any Part D covered drugs.*

In both scenarios, LI beneficiaries will pay higher OOP costs after the MDPNP is in effect. NLI beneficiaries also experience an increase in OOP on average using 2024 representative plan designs, however, NLI beneficiaries consistently pay less in OOP costs when using a defined standard benefit design. Since only 2% of NLI beneficiaries are in plans with a defined standard benefit in 2024, the representative benefit scenarios more closely represent what NLI beneficiaries would actually experience.[9]

Seven of the ten MDPNP selected drugs are typically covered on copay tiers in 2024. Based on our analysis, NLI members with copay benefits for brand drugs will typically experience greater OOP costs once the MDPNP is in effect relative to the baseline. This result is driven by three key factors:

- **The POS drug cost does not change the copay.** The copay amount (e.g., $47 for a preferred brand product) is agnostic to the POS cost of the selected drug. This means the beneficiary is insulated from the POS cost of the drug and will pay $47 whether a drug costs $1,000 or $200, for example, in the initial coverage phase.

- **Plan supplemental coverage counts toward MOOP.** Beginning in 2025, beneficiaries progress through Part D benefit phases according to the "greater of" their plan cost sharing and the defined standard cost sharing. When a plan offers an enhanced benefit, the differential between defined standard cost sharing and the plan's actual cost sharing is called plan supplemental coverage, or non-covered plan paid (NPP). Under IRA, any positive NPP will accumulate toward MOOP (in addition to the patient pay), meaning the beneficiary will hit MOOP on the same script they would have under a defined standard benefit even if every claim had cost sharing less than defined standard (e.g., a lower copay). This dynamic translates into many beneficiaries paying less than $2,000 in actual OOP cost upon reaching MOOP beginning in 2025.

  Because the plan supplemental coverage amount scales up or down with the POS cost of the drug, when the POS cost of a selected drug is reduced in the MDPNP scenario, fewer dollars accumulate to the MOOP, and more scripts are required to satisfy the MOOP. Because the beneficiary requires a greater number of claims to hit MOOP before their OOP liability ceases, the beneficiary must pay more copays which increases their total OOP costs relative to the baseline scenario.

[9] Based on CMS 2024 Part D landscape files: https://www.cms.gov/medicare/coverage/prescription-drug-coverage

- **Many beneficiaries using MDPNP selected drugs will reach MOOP.** Even in cases where a beneficiary benefits from reduced OOP costs from a selected drug, they often do not see savings across all of the drugs they utilize. For example, consider a beneficiary who reached the $2,000 MOOP based on $1,500 in OOP cost from a selected product and $500 from other products. Once the MDPNP goes into effect, if the OOP cost for the selected drug dropped to $1,000, then this beneficiary may still reach MOOP based on their other drugs. This beneficiary would only see OOP savings from MDPNP if they have little enough spending on other drugs, such that they no longer reach the MOOP.

The drivers behind LI OOP cost increasing under the MDPNP scenario are very similar to the drivers affecting NLI beneficiaries described above.

- **LI beneficiaries always pay nominal copays prior to the MOOP.** Because LI beneficiaries only pay nominal copays, they are insulated from the POS drug cost, similar to NLI beneficiaries with copays, though this dynamic exists for **all** LI beneficiaries, even those enrolled in plans with coinsurance benefits.

- **LICS counts toward MOOP.** Similar to the dynamic described above with the plan supplemental coverage amounts being a function of the POS cost, LICS is also often a function of the POS cost. The LICS subsidy pays the difference between the plan cost sharing and the LI nominal copay. Many LI beneficiaries are enrolled in defined standard plans or basic plans with coinsurance on brand tiers which drives the LICS subsidy higher. In the MDPNP scenario, the reduction in POS cost of the selected drugs reduces LICS and therefore more claims are required to reach MOOP. This means the LI beneficiary will incur more claims prior to MOOP, and therefore, must pay more nominal copays, which increases their total OOP costs relative to the baseline scenario.

Three of the ten MDPNP selected drugs are most commonly covered on the specialty tier, which is virtually always a coinsurance benefit. Under a coinsurance benefit, NLI beneficiaries who do not reach MOOP would see savings in OOP costs due to lower POS costs resulting from the MDPNP. However, the vast majority of specialty utilizers reach the MOOP with or without the MDPNP and the impact of supplemental coverage accumulating to MOOP is minimized since virtually all plans offer a specialty coinsurance equal to or leaner than defined standard coverage. Therefore, these beneficiaries do not see any impact to OOP costs.

OOP COST IMPACTS BY PLAN TYPE

Beneficiaries in all three plan types (MA-PD, PDP, and EGWP) experience increases in OOP costs on average, with EGWP beneficiaries experiencing the largest increase and PDP beneficiaries experiencing the smallest (as a percentage). This is because many PDPs have coinsurance benefits on Tier 3, the preferred brand tier, where many of the 2026 selected drugs are covered (in 2024).

Table 5 displays the average OOP cost impacts by plan type for both benefit scenarios. On average, beneficiaries would see a reduction in OOP costs under a defined standard benefit design, due to a significant portion of NLI beneficiaries underlying each plan type cohort.

Table 5
Impact of the MDPNP on Annual OOP Costs
By Plan Type and Benefit Design Scenario

		Utilizers of MDPNP Selected Drugs			All Utilizers		
Benefits Scenario	**Plan Type**	**2026 Baseline**	**2026 with MDPNP**	**Impact (%)**	**2026 Baseline**	**2026 with MDPNP**	**Impact (%)**
Representative	MA-PD	$472	$551	17%	$264	$275	4%
	PDP	$743	$764	3%	$385	$387	1%
	EGWP	$570	$735	29%	$362	$388	7%
	All	$598	$668	12%	$328	$337	3%
Defined Standard*	MA-PD	$1,001	$857	-14%	$480	$459	-4%
	PDP	$1,132	$987	-13%	$517	$494	-4%
	EGWP	$1,418	$1,357	-4%	$781	$771	-1%
	All	**$1,125**	**$995**	**-12%**	**$541**	**$521**	**-4%**

** Defined Standard projection does not reflect the $0 cost sharing D-SNP benefit.*

While the majority of EGWPs and individual MA-PD plans have copay benefits on the preferred brand tier, the individual PDP market has diverging benefits on this tier. Standalone PDPs are typically categorized into three archetypes: basic plans, low-premium enhanced plans, and high-premium enhanced plans, where benefits are a key differentiator among plans. Focusing on Tier 3:

- Basic PDPs virtually always offer a **coinsurance** benefit on Tier 3
- Low-premium enhanced PDPs typically offer a **coinsurance** benefit on Tier 3
- High-premium enhanced PDPs always almost offer a **copay** benefit on Tier 3

Figure 2 displays the percentage of NLI utilizers of MDPNP selected drugs who have copay or coinsurance benefits for selected drugs covered on Tier 3. Figure 2 excludes utilizers of MDPNP selected drugs exclusively covered on Tier 5 (the specialty tier), given the benefit is virtually always a coinsurance.

FIGURE 2: PERCENTAGE OF NON-LOW-INCOME UTILIZERS OF DRUGS SELECTED FOR MDPNP BY PLAN TYPE AND TIER 3 BENEFIT TYPE

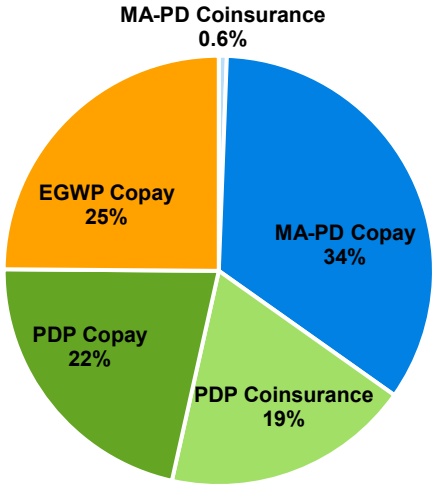
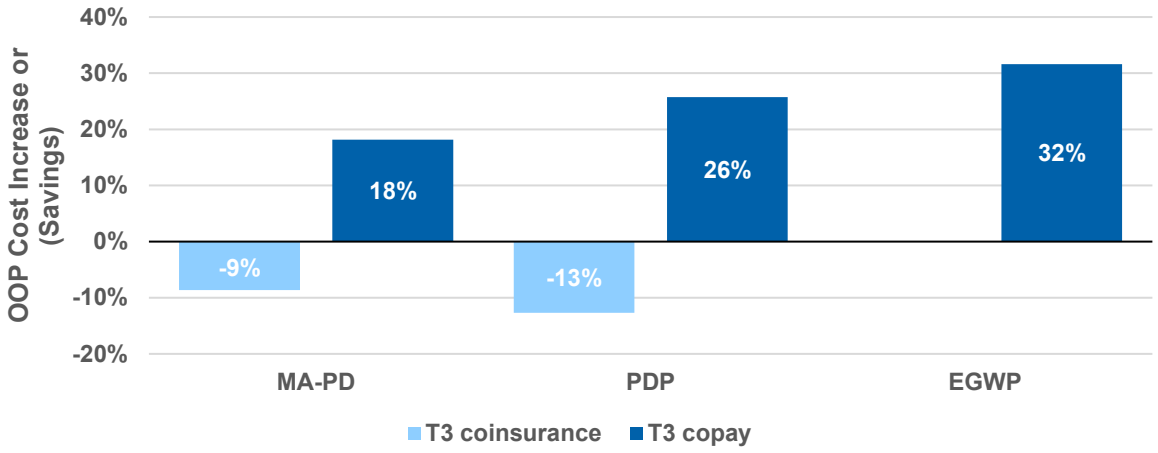


Figure 3 displays the average OOP cost impacts for NLI beneficiaries using MDPNP selected drugs, categorized by the type of Tier 3 benefit (limited to selected drugs covered on Tier 3) in the representative plan design, coinsurance or copay. Similar to Figure 2, above, Figure 3 excludes utilizers of MDPNP selected drugs exclusively covered on Tier 5 (the specialty tier), given the benefit is virtually always a coinsurance.

FIGURE 3: 2026 MDPNP IMPACTS BY PLAN TYPE AND TIER 3 BENEFIT TYPE: NON-LOW-INCOME UTILIZERS



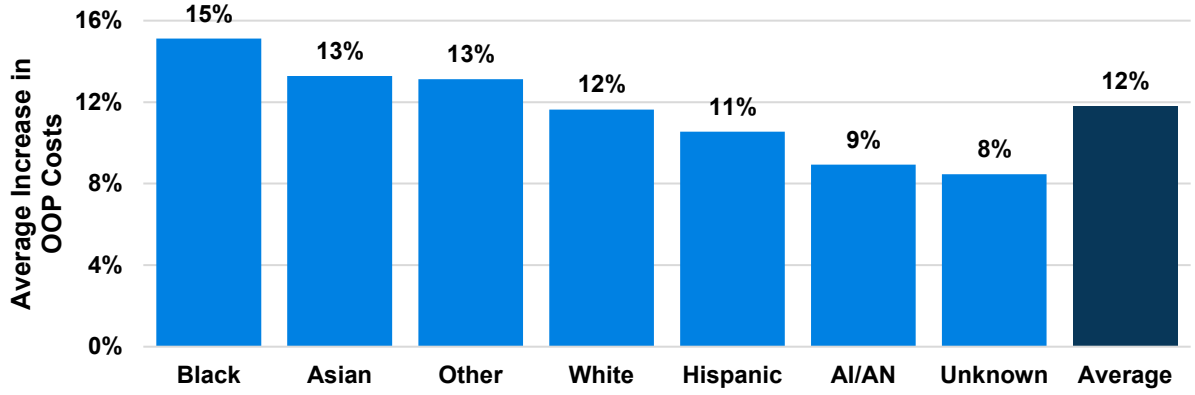
The results above show that OOP cost savings for Tier 3 drugs are only generated for NLI utilizers when the MDPNP selected product is subject to coinsurance, which is the case for 19% of utilizers. In 2024, the PDP market is split between coinsurance or copay Tier 3 benefits, but in aggregate the cost increases attributable to MDPNP selected drug utilizers with copay benefits slightly outweigh the savings generated from those with coinsurance benefits.

As discussed earlier, we assume MFPs are at the estimated ceiling price, but results are directionally similar at other prices. If actual MFPs are lower than the ceiling, beneficiaries with coinsurance benefits would experience greater savings than shown above, while beneficiaries with copay benefits would experience greater OOP increases than shown above, due to a greater number of scripts required to reach MOOP (provided MFPs are not lower than beneficiary copays).

OOP COST IMPACTS BY RACE / ETHNICITY

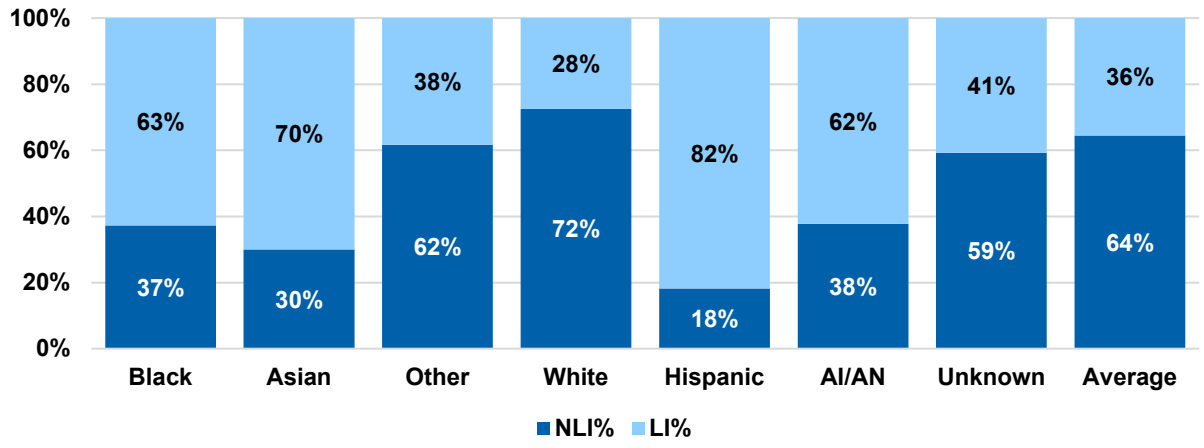
Figure 4 displays the OOP cost impact for MDPNP selected drug utilizers by race / ethnic group. In general, each group sees similar impacts as a percentage of baseline OOP costs, ranging from 8% to 15%. Black and Asian beneficiaries see the largest increases in OOP costs, on average, due to the MDPNP. Approximately 77% of MDPNP selected drug utilizers are white, which is similar to the full Part D population which is approximately 78% white.

FIGURE 4: 2026 MDPNP IMPACTS BY RACIAL / ETHNIC DEMOGRAPHIC GROUP[10]



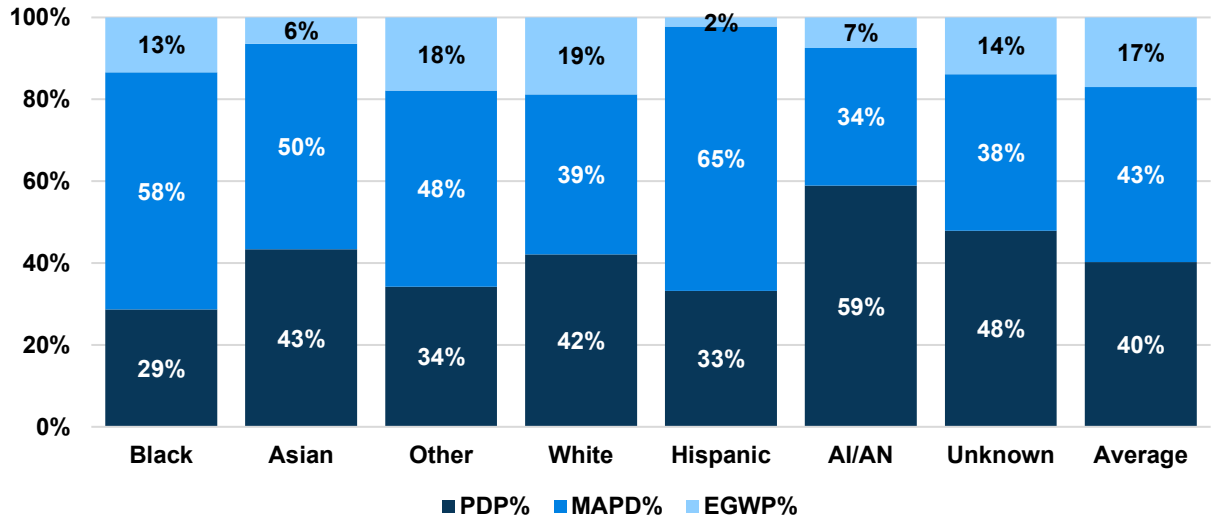
As discussed above, the OOP cost impacts for a particular racial / ethnic group tend to align with the plan benefit design characteristic for the MDPNP selected drug (e.g., copay or coinsurance) and income status. Figures 5A and 5B below show the mix of income status and plan type, respectively, by racial / ethnic group for selected drug utilizers.

FIGURE 5A: INCOME STATUS MAKEUP OF 2026 MDPNP SELECTED DRUG UTILIZERS BY RACE / ETHNICITY



[10] AI / AN refers to American Indian and Alaska Native in Figures 4, 5A, and 5B.

FIGURE 5B: PLAN TYPE MAKEUP OF 2026 MDPNP SELECTED DRUG UTILIZERS BY RACE / ETHNICITY



Among MDPNP selected drug utilizers, Black beneficiaries see the largest percentage increase in OOP costs, on average, due to 63% being LI and 58% enrolled in MA-PD plans, where copays predominate. The combination of these two dynamics leads to this group having the largest OOP cost increases from MDPNP. Asian beneficiaries have a similar pattern, with 70% being LI and 50% enrolled in MA-PD plans. We reviewed OOP cost impacts for each utilizer, plan type, and income status combination and did not observe significant variation by race / ethnicity.

OOP COST IMPACTS BY OTHER DEMOGRAPHIC GROUPS

We also reviewed the impacts of the MDPNP in 2026 for two other demographic groupings: aged / disabled status and ESRD status. Table 6 shows the OOP cost impacts for aged vs. disabled, as well as ESRD vs. non-ESRD status Part D MDPNP selected drug utilizers.

Table 6
Annual OOP Costs Before and After 2026 MDPNP

Part D Status	% of Utilizers of MDPNP Selected Drugs	2026 Baseline	2026 with MDPNP	% Impact
Aged	87%	$653	$730	12%
Disabled	13%	$227	$252	11%
ESRD	2%	$373	$403	8%
Non-ESRD	98%	$601	$672	12%

Both aged and disabled beneficiaries see similar average OOP cost impacts as the overall MDPNP selected drug utilizer average, between 11% and 12%. MDPNP selected drug utilizers with ESRD see slightly lower impacts than those without ESRD, who closely mirror the overall average, likely due to beneficiaries with ESRD being more likely to hit MOOP due to their higher drug costs.

IV. DATA, METHODOLOGY, AND ASSUMPTIONS

This section outlines the data and methodology underlying the results in this report.

DATA SOURCE

We relied on the 2021 CMS 100% Research Identifiable Files (RIF) dataset, which includes claims for all Medicare Part D beneficiaries. This includes beneficiaries in standalone PDPs and MA-PD plans, but excludes PACE plan beneficiaries. Our analysis includes beneficiaries in both the individual and EGWP markets.

CLAIMS PROJECTION AND OUT-OF-POCKET COST CALCULATION

We project claims forward to 2026 using utilization and unit cost trends and calibrated Part D gross costs to values from the 2023 Medicare Trustees Report. We developed a model to adjudicate claims under the 2025 Part D benefit design, using benefit designs derived from average 2024 benefits in the Part D market. For large, national organizations we used formularies and benefit designs based on the particular organization and plan type, whereas all other organizations use an illustrative benefit design based on the most common design by plan type. Because EGWP other health insurance (OHI) wrap benefit designs and formularies are not public, we use MA-PD benefit designs by organization / all other as a proxy. Additionally, because EGWP benefit designs are typically significantly richer than the average MA-PD plan, we reduce the MOOP limit to $1,500 to further reduce the OOP costs for the EGWP members in our analysis.

MFP CEILING CALCULATION

We estimate MFP ceilings using methodology prescribed by CMS in the Medicare Drug Price Negotiation Revised Guidance.[11] We rely on historical gross costs by product and estimate direct and indirect remuneration (DIR) using data from SSR Health, adjusted to reflect estimated Medicare Part D rebates. We assume a relationship between non-FAMP and the wholesale acquisition cost (WAC) of 0.82, based on a 2021 Congressional Budget Office (CBO) report on federal program drug pricing.[12] We use the ceiling price for simplicity. We do not know actual prices at this time and our use of the ceiling price is not intended to be a signal of what actual prices may be.

[11] Medicare Drug Price Negotiation: Revised Guidance: https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf
[12] A Comparison of Brand-Name Drug Prices Among Selected Federal Programs: https://www.cbo.gov/system/files/2021-02/56978-Drug-Prices.pdf

V. CAVEATS, LIMITATIONS, AND QUALIFICATIONS

This report was developed for the Pharmaceutical Research and Manufacturers of America (PhRMA) to understand the 2026 Medicare Part D out-of-pocket (OOP) cost impact of the Medicare Drug Price Negotiation Program (MDPNP) enacted by the Inflation Reduction Act of 2022 (IRA). This information may not be appropriate, and should not be used, for other purposes. We do not intend this information to benefit, and assume no duty or liability to, any third party that receives this work product. Any third-party recipient of this report that desires professional guidance should not rely upon Milliman's work product but should engage qualified professionals for advice appropriate to its specific needs. Any releases of this report to a third party should be in its entirety.

Milliman has developed certain models to estimate the values included in this report. The models are intended to project Part D costs and adjudicate benefits under different benefit designs to estimate 2026 Part D OOP costs. We have reviewed the models, including their inputs, calculations, and outputs for consistency, reasonableness, and appropriateness for the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs).

The models rely on data and information as input to the models. We relied upon certain data and publicly available information, for this purpose and accepted without audit, though we reviewed for reasonability. To the extent that the data and information provided is not accurate or is not complete, the values provided in this report may likewise be inaccurate or incomplete. Actual results will certainly vary due to differences in unit cost and utilization trend, 2026 benefit designs, and actual 2026 maximum fair prices (MFPs) determined by the Centers for Medicare and Medicaid Services (CMS).

Maddie Cline, Michelle Robb, and Katie Holcomb are actuaries for Milliman, members of the American Academy of Actuaries, and meet the qualification standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, the information in this report is complete and accurate and has been prepared in accordance with generally recognized actuarial principles and practices. This report outlines the analysis and opinions of the authors and not necessarily those of Milliman.

APPENDIX A: MEDICARE PART D OOP COSTS

In Medicare Part D, beneficiaries pay a monthly member premium (which may be $0) and cost sharing at the point-of-sale (POS) for prescriptions. This analysis is exclusively focused on cost sharing and does not quantify the impacts of the MDPNP on member premium. Cost sharing, which is set by the Part D plan sponsor, varies by formulary tier.

LOW-INCOME (LI) BENEFICIARY COST SHARING

LI beneficiaries receive "extra help" in Part D in the form of a waived deductible, cost sharing subsidies, and premium subsidies to curb OOP expenses. As such, LI beneficiaries' actual OOP cost sharing (i.e., patient pay) is limited to nominal copays, which vary based on their LI subsidy (LIS) "level" and by drug type. The 2025 LI beneficiary copays are displayed in Table A-1, below.

Table A-1
2025 LI Part D Nominal Copays (Pre-MOOP)*

	Full Dual Eligible Beneficiaries 100-150% FPL (LIS level 1)	Full Dual Eligible Beneficiaries >=100% FPL (LIS level 2)	Institutionalized Beneficiaries (LIS level 3)	Beneficiaries with Waived Cost Share via Part D VBID
Generic Drug	$4.90	$1.60	$0	$0
Brand Drug	$12.15	$4.80	$0	$0

** 2025 CMS Advance Notice https://www.cms.gov/files/document/2025-advance-notice.pdf. LIS level 1 includes beneficiaries designated as level 4 prior to 2024.*

New in 2025, all beneficiaries have a $2,000 maximum out-of-pocket (MOOP) limit. LI beneficiaries are subject to the nominal copays in Table A-1 on each claim before satisfying the MOOP, which is reached via the combination of these nominal copays, LI cost sharing subsidies (paid by the government), and any supplemental drug coverage (paid by the plan).

NON-LOW-INCOME (NLI) BENEFICIARY COST SHARING

NLI beneficiary cost sharing follows the plan design as determined by the Part D plan sponsor.

In 2024, a typical NLI member is enrolled in a Part D plan with copays on generic tiers, either a coinsurance or a copay on brand tiers, and a coinsurance on the specialty tier. One way in which standalone prescription drug plans (PDPs) have historically differed from Medicare Advantage Part D (MA-PD) plans is PDPs will typically offer a coinsurance on the non-preferred brand tier (up to 50%), whereas MA-PD plans will typically offer a copay (up to $100). Many PDPs also offer a coinsurance (up to 25%) on the preferred brand tier, whereas MA-PDs very rarely have a coinsurance on this tier and instead have a copay (up to $47). When a beneficiary is subject to a coinsurance on a brand tier, their OOP costs are typically much higher than if there was a copay in place.

ILLUSTRATIVE PATIENT OOP COST JOURNEY

In the figures below, we provide examples of a patient taking a single MDPNP selected drug under different scenarios to illustrate the cost sharing dynamics we observed in the data. In all three examples, the beneficiary fills one script each month for a $750 brand drug with an MFP of $250 per script.

LI Beneficiary

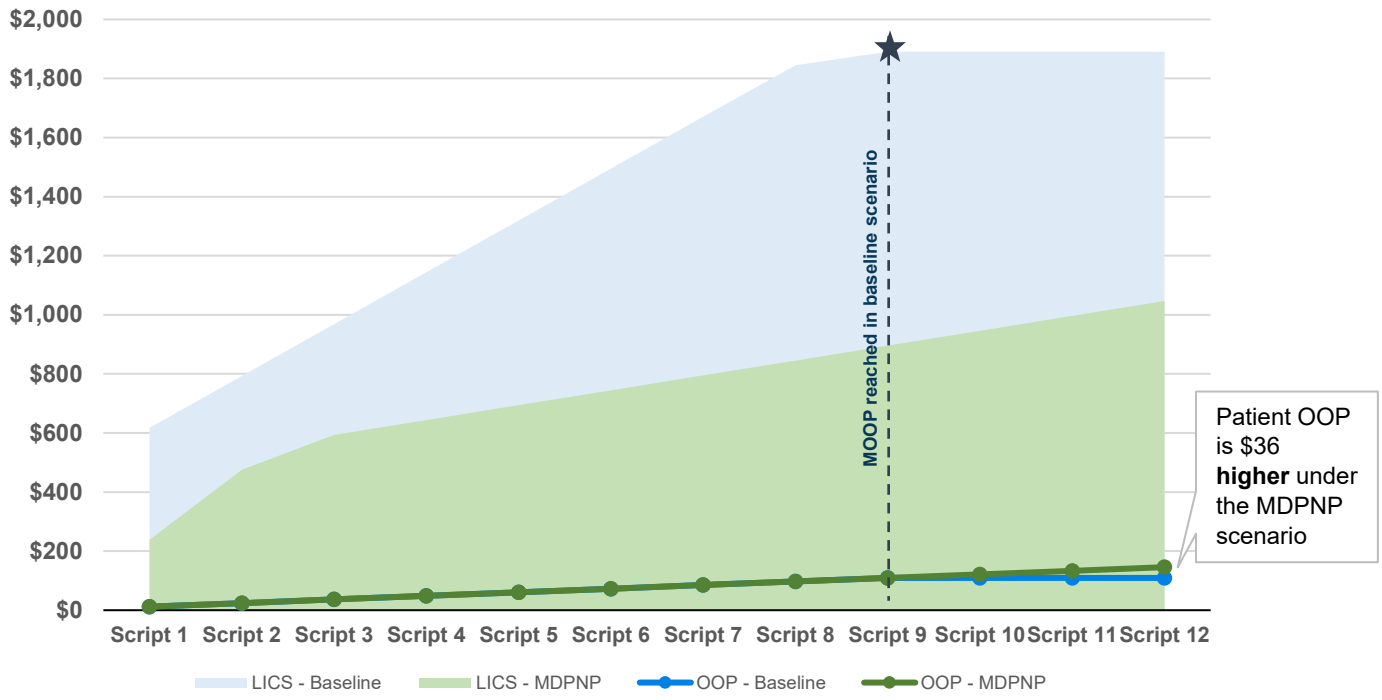
In Figure A-1, we show cost sharing by month for an LI beneficiary. Because the beneficiary is LI, they pay a fixed copay of $12.15 per script regardless of the plan they are enrolled in or what tier the drug is covered on. The plan receives a LICS payment to cover the difference between the plan's benefit design (defined standard[13] in this example) and the LI copay, which is shown as a shaded area.

- At the current cost of $750, the beneficiary pays no deductible, a fixed copay of $12.15 for the first nine months, and then stops paying by the 10th script once their combined OOP and LICS reach the MOOP. Therefore, their total OOP is $12.15 x 9 = $109.35.

[13] The 2025 defined standard benefit design is a $590 deductible, 25% coinsurance, and a $2,000 MOOP. More information on the standard benefit can be found at Weathering the reform storm: The Inflation Reduction Act's changes to Medicare and other healthcare markets (milliman.com)

- At the MFP of $250, the beneficiary still pays no deductible and a fixed copay of $12.15 per script. However, because the drug cost is much lower, the LICS payment is also lower and the beneficiary never reaches the MOOP. As a result, the beneficiary pays their copay for all 12 months, resulting in total OOP of $145.80 ($12.15 x 12) which is an *increase* of $36 over their OOP cost in the absence of the MDPNP.

FIGURE A-1: LOW-INCOME COST SHARING EXAMPLE



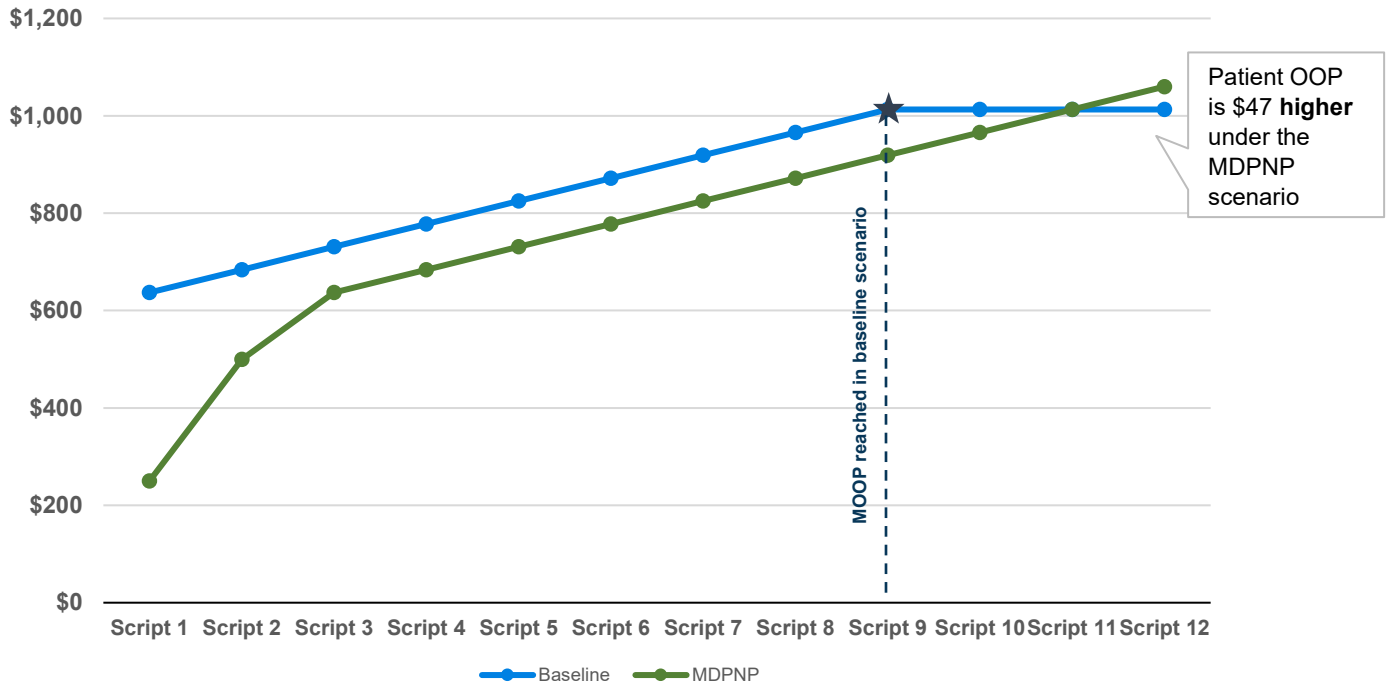
NLI Beneficiary with Copay

In Figure A-2, we show cost sharing by month for an NLI beneficiary with the selected product covered on the preferred brand tier with a $47 copay. We also assume the beneficiary has a $590 deductible.

- At the current cost of $750, the beneficiary progresses through the deductible and their first copay in the first month and then pays their $47 copay for the next eight months, until they reach MOOP in month 9. This beneficiary reaches the MOOP at the same point as the LI beneficiary because all non-basic plan coverage (i.e., the difference between defined standard coverage and the $47 copay) accumulate to the MOOP under the IRA. Therefore, total paid OOP by the beneficiary is $590 + $47 x 9 = $1,013.

- At the MFP of $250, the beneficiary similarly pays the full deductible and then $47 per script. This beneficiary sees lower costs per script in the deductible phase, now needing three scripts to satisfy the deductible rather than just one. However, because the drug cost is lower, the beneficiary does not reach the MOOP, similar to the LI beneficiary example. As a result, the beneficiary continues paying their copay through the end of the year instead of stopping at month 9. This results in three additional copays and a higher total OOP cost compared to what they paid prior to the MDPNP. The lower per script cost in the deductible phase is offset by three additional copays, resulting in total OOP of $1,060 which is an *increase* of $47 (one copay) over their OOP cost in the absence of the MDPNP.

FIGURE A-2: NON-LOW-INCOME COST SHARING EXAMPLE – COPAY BENEFIT

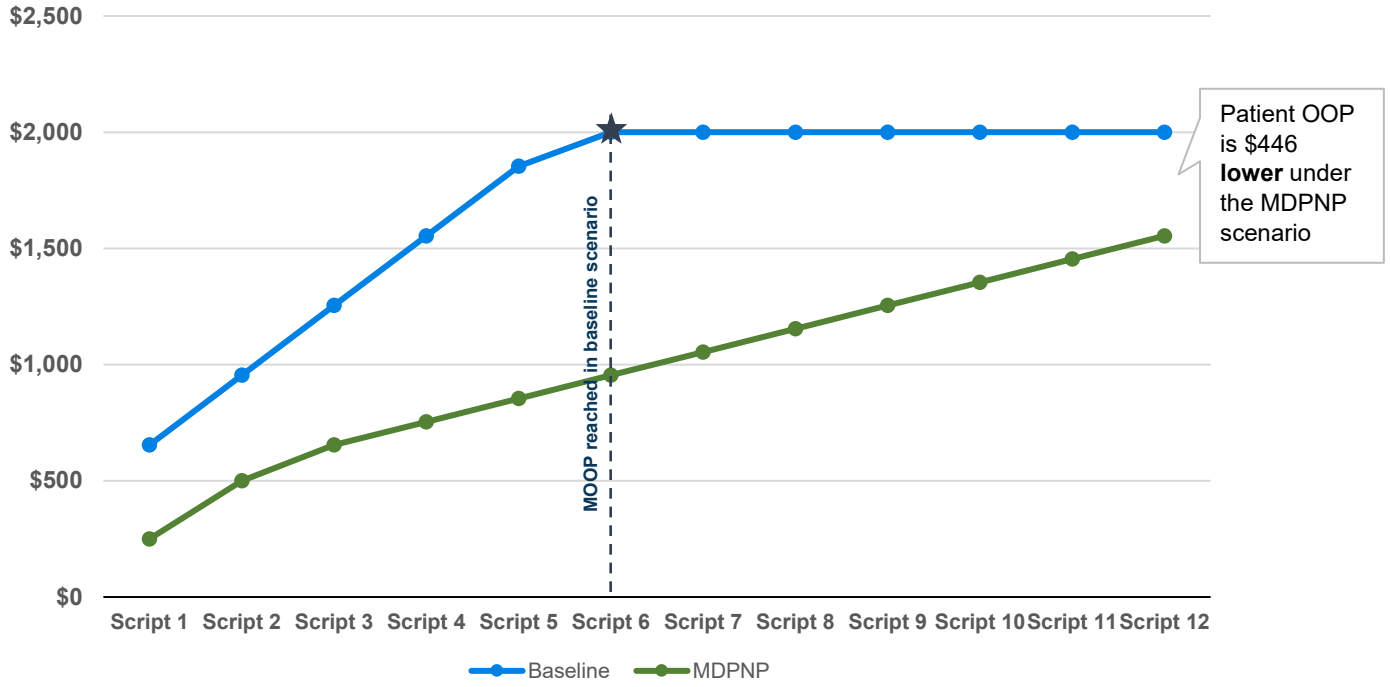


NLI Beneficiary with Coinsurance

In Figure A-3, we show cost sharing by month for an NLI beneficiary with the selected product covered on the non-preferred brand tier with a 40% coinsurance. We also assume the beneficiary has a $590 deductible.

- At the current cost of $750, the beneficiary progresses through the deductible and then pays 40% coinsurance until they reach MOOP in month 6. Therefore, their total OOP is $2,000. Please note, in this example, the beneficiary pays the full $2,000 to reach MOOP since their cost sharing (40%) is greater than the defined standard benefit (25%).
- At the MFP of $250, the beneficiary similarly pays the full deductible and then 40% per script. However, because the drug cost is lower, the beneficiary does not reach the MOOP. Since this beneficiary has a coinsurance benefit, their OOP costs are reduced in line with the drug cost reduction. The beneficiary pays 40% of the lower drug cost. Therefore, their total OOP cost is $1,554, or $590 + ($250 x 12 - $590) x 40%, which is a *decrease* of $446 over their OOP cost in the absence of the MDPNP.

FIGURE A-3: NON-LOW-INCOME COST SHARING EXAMPLE – COINSURANCE BENEFIT



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