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

Commissioned by Pharmaceutical Research and Manufacturers of America (PhRMA)

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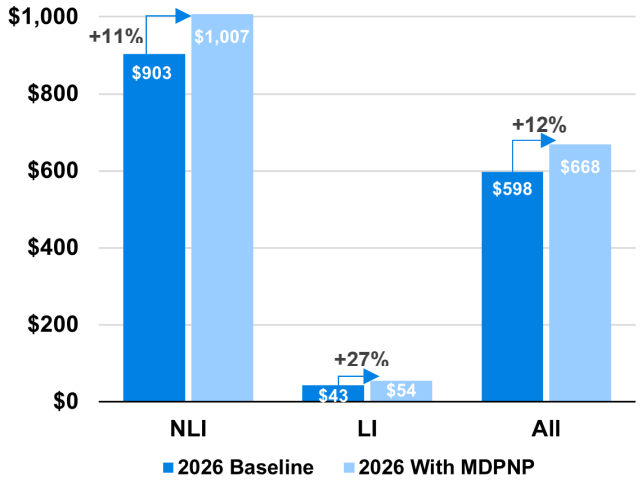
Pharmaceutical Research and Manufacturers of America (PhRMA) engaged Milliman to analyze the impact of the Medicare Drug Price Negotiation Program (MDPNP) enacted by the Inflation Reduction Act of 2022 (IRA) on Medicare Part D beneficiary out-of-pocket (OOP) costs. The IRA introduces several significant 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 study 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. This brief provides a summary of results; the full report can be found here. Key findings of the study include:

- Beneficiaries utilizing MDPNP selected drugs are more likely to see their OOP costs increase than decrease. The MDPNP increases OOP costs for beneficiaries with copays by slowing progression towards the maximum out-of-pocket limit (MOOP) under the IRA adjudication rules. For this reason, all low income (LI) beneficiaries, most MA-PD and employer group waiver plan (EGWP) beneficiaries, and some PDP beneficiaries are expected to see higher OOP costs.
    - Approximately 3.5 million beneficiaries taking MDPNP selected drugs are estimated to experience cost increases attributable to the MDPNP. They are primarily those with copay benefits (both LI and NLI).
    - Approximately 2.2 million beneficiaries taking MDPNP selected drugs are estimated to experience no change in OOP costs. These beneficiaries may have reached MOOP both before and after the MDPNP or be enrolled in a plan with zero cost sharing.
    - Approximately 1.2 million beneficiaries taking MDPNP selected drugs are estimated to experience OOP savings attributable to the MDPNP. They are primarily NLI beneficiaries who do not reach the MOOP before or after the MDPNP implementation.
- Overall, we estimate the MDPNP will increase average annual beneficiary OOP costs by $70 (or 12%) for utilizers of MDPNP selected Part D drugs in 2026. We estimate average annual OOP costs will increase by $11 (or 27%) for LI beneficiaries and $104 (or 11%) for NLI beneficiaries.
- We expect the impact to vary by plan type, primarily due to differences in benefit design. Beneficiaries in EGWPs taking MDPNP selected drugs are expected to see a 29% average annual OOP cost increase, compared to a 17% increase for MA-PD members and 3% increase for PDP members.
- We also expect different demographic groups to have different OOP cost impacts due to their income status, average costs, and plan enrollment. Among beneficiaries utilizing MDPNP selected drugs, Black and Asian beneficiaries are expected to have larger increases in OOP costs than people in other racial / ethnic groups, likely due to a disproportionate amount of these beneficiaries being LI and enrolled in MA-PDs.

The results (as summarized in Figure 1) include two scenarios, a “baseline” scenario, which represents expected 2026 OOP costs without MDPNP and a “with MDPNP” scenario, which represents 2026 OOP costs with maximum fair prices (MFPs) in place.

Figure 1: Expected Impact of MDPNP on annual OOP costs for utilizers of MDPNP selected drugs, by income status



Our analysis is based on several key assumptions. We assume MFPs will equal estimated MFP ceiling prices. Given the 2026 MFPs are unknown at this time, we are unable to predict actual prices, but we expect the findings to directionally hold true at other prices (provided MFPs are not lower than beneficiary copays). This assumption is used for simplicity and is not intended to signal what actual prices may be.

We modeled results assuming formulary coverage and benefits similar to 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. Under defined standard benefits, LI beneficiaries experience similar results since they are subject to nominal copays, but NLI beneficiaries experience OOP savings of 12% on average. However, given that only 2% of NLI beneficiaries are enrolled in plans with a defined standard benefit in 2024, which have a full deductible and 25% coinsurance on all tiers in the initial coverage phase, the representative scenario more closely reflects what NLI beneficiaries would actually experience.

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 the methodology prescribed by CMS in the Medicare Drug Price Negotiation Revised Guidance.[1] 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.[2]

Caveats, Limitations, and Qualifications

This report was developed for the Pharmaceutical Research and Manufacturers of America (PhRMA) to understand the 2026 Medicare Part D OOP cost impact of the MDPNP enacted by the 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.

[1] Medicare Drug Price Negotiation: Revised Guidance: https://www.cms.gov/files/document/revised-medicare-drug-price-negotiation-program-guidance-june-2023.pdf

[2] A Comparison of Brand-Name Drug Prices Among Selected Federal Programs: https://www.cbo.gov/system/files/2021-02/56978-Drug-Prices.pdf

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