Polygon Health Analytics

A Beginner's Guide to Medicare Drug Price Negotiation Under the Inflation Reduction Act

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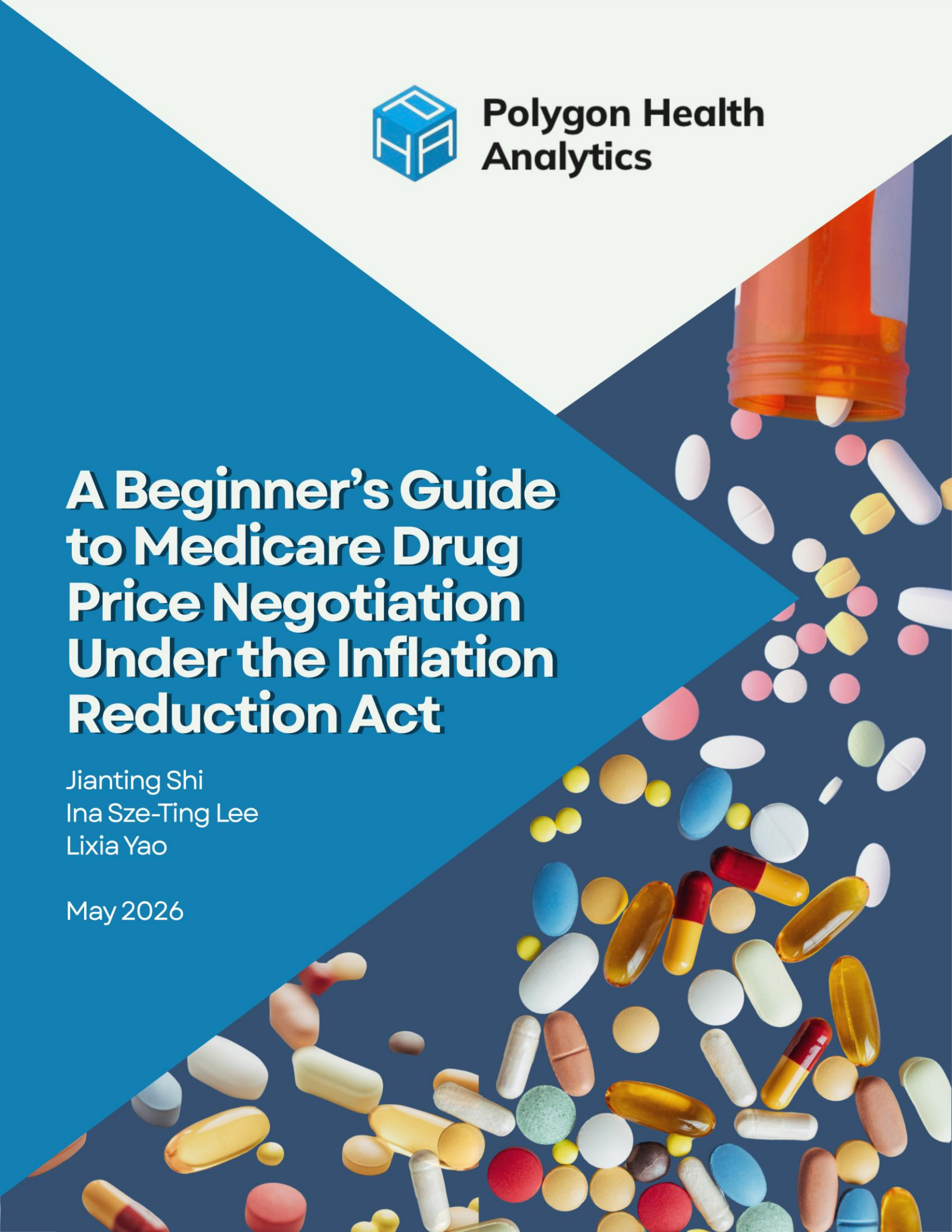

Table of Contents

List of Abbreviations

Abbreviation	Definition
AMP	Average Manufacturer Price
ASP	Average Sales Price
BLA	Biologics License Application
CMS	Centers for Medicare & Medicaid Services
DPP-4	Dipeptidyl Peptidase-4
FDA	U.S. Food and Drug Administration
GENEROUS	Generic Effective Negotiated Unit Rebate Optimizing Strategy
HHS	Department of Health and Human Services
HTA	Health Technology Assessment
IPAY	Initial Price Applicability Year
IRA	Inflation Reduction Act
LOE	Loss of Exclusivity
MFP	Maximum Fair Price
MFN	Most Favored Nation
NDA	New Drug Application
NDC	National Drug Code
Non-FAMP	Non-Federal Average Manufacturer Price
OBBBA	One Big Beautiful Bill Act
OECD	Organisation for Economic Co-operation and Development
PDE	Prescription Drug Event
PDP	Prescription Drug Plan
PBM	Pharmacy Benefit Manager
QALY	Quality-Adjusted Life Year
QSSD	Qualifying Single-Source Drug
R&D	Research and Development
VC	Venture Capital

Chapter 1. The Inflation Reduction Act of 2022 and Medicare Drug Price Negotiation

1.1 Pre-IRA Medicare Drug Spending and Affordability Pressures

Prescription drug prices in the United States are among the highest in the world, and concerns about affordability have grown over the past two decades. According to an analysis of 2022 IQVIA MIDAS data, U.S. manufacturer gross prices for prescription drugs averaged 278% of those in 33 peer Organization for Economic Co-operation and Development (OECD) countries, while gross prices for brand-name originator drugs averaged 422% of those in peer countries.[1] For many Americans—particularly older adults and people with chronic conditions—these high prices have contributed to substantial financial strain and growing pressure on government health programs.

At the same time, the United States spends about 18% of its gross domestic product on health care, the highest among high-income countries.[2] According to National Health Expenditure data from the Centers for Medicare & Medicaid Services (CMS) released in early 2026, total U.S. health care spending reached $5.3 trillion.[3] Medicare's actuaries estimate that spending on Part D benefits will reach $141 billion in 2026, accounting for 11% of total Medicare benefits spending, with Part B drugs adding further costs.[4] This growth has been driven in part by expanded use of high-cost specialty medications and rising launch prices for new therapies. For example, Medicare Part D spending on selected diabetes drugs increased more than threefold between 2019 and 2023.[5] Policymakers increasingly viewed this trajectory as fiscally unsustainable, heightening concerns about long-term federal exposure.

Medicare is the federal health insurance program for people 65+, certain people with disabilities, and individuals with End-Stage Renal Disease. It is divided into parts that cover different types of services.

Part A (Hospital Insurance)	Part B (Medical Insurance)	Part C (Medicare Advantage)	Part D (Outpatient Prescription Drug Benefit)
Covers inpatient hospital care, skilled nursing facility services, hospice care, and limited home health services under qualifying conditions. Free for most.	Covers physician visits, outpatient care and preventive services, as well as some outpatient drugs (e.g., provider-administered injectables/infusions). Requires monthly premium.	Combines Part A and Part B benefits through *private plans* that contract with Medicare and typically include outpatient prescription drug coverage.	An *optional* program for outpatient prescription drug coverage, offered by private insurance plans approved by Medicare. Each has its own list of covered drugs (formulary) and varied cost like premiums, deductibles, and copayments.

Alongside these fiscal pressures, beneficiary cost burden further intensified policy debate. Prior to the Inflation Reduction Act (IRA), Medicare Part D imposed no hard annual cap on beneficiaries' out-of-pocket drug spending.[4] As a result, patients using high-cost therapies could face thousands of dollars in annual out-of-pocket liability, particularly those with chronic conditions requiring continuous treatment.[6] This open-ended exposure became increasingly salient as drug prices rose and more beneficiaries reached the catastrophic phase of the Part D benefit—a final phase that, once beneficiaries incurred approximately $8,000 in annual drug spending to enter, required them to continue paying 5% coinsurance with no upper limit. Over time, concerns about beneficiary affordability reinforced broader policy concerns about the sustainability and equity of the Medicare drug benefit.

These affordability concerns were shaped in part by the institutional design of Medicare Part D. Enacted in 2003 and implemented in 2006, the program was structured as a market-based system in which private plans develop formularies and negotiate price concessions from drug manufacturers, often through pharmacy benefit managers (PBMs).[7] Unlike other federal programs, such as the Veterans Health Administration or Medicaid, which rely on direct price regulation or statutory rebates, Congress included a statutory "noninterference clause" in Part D, prohibiting the Department of Health and Human Services (HHS) from intervening in negotiations among private plans, manufacturers, and pharmacies.[8] This framework relied on competition among private plans rather than direct federal negotiation or price-setting, and supporters argued that the decentralized approach would promote pharmaceutical innovation while maintaining robust beneficiary access to medicines.

Spending pressures in Medicare, however, were not limited to Part D retail drugs. Medicare also pays for many provider-administered drugs under Part B, including infused or injected therapies delivered in physician offices and hospital outpatient departments.[9] Many of the costliest Part B drugs are specialty biologics used to treat cancer, autoimmune diseases, and other serious conditions. Part B drug spending is highly concentrated in a small number of these products, including therapies such as Keytruda.[10]

Because Part B drugs are typically purchased by providers and administered at physician offices and hospital outpatient departments, Medicare generally reimburses providers after acquisition—an approach known as "buy-and-bill,"[11] paying the benefits under Average Sales Price (ASP) plus a 6% add-on, often reduced by sequestration, in addition to a separate payment for drug administration.[10] While this model is intended to align reimbursement with market prices and preserve access, it has raised concerns about spending growth and prescribing incentives because the add-on increases with the drug's price.[12,13]

After decades of debate over Medicare's limited authority to influence drug prices, Congress granted the program a limited drug price negotiation authority through the IRA.[14] For the first time, CMS can directly negotiate prices for a select set of high-cost drugs covered by Medicare.[15] The IRA also established inflation-based rebate requirements, requiring manufacturers to pay rebates when drug prices rise faster than inflation.[16] Together, these reforms mark a major federal policy shift aimed at moderating Medicare drug price growth. Key milestones in Medicare drug pricing policy and IRA implementation are summarized in **Figure 1.1**.[17]

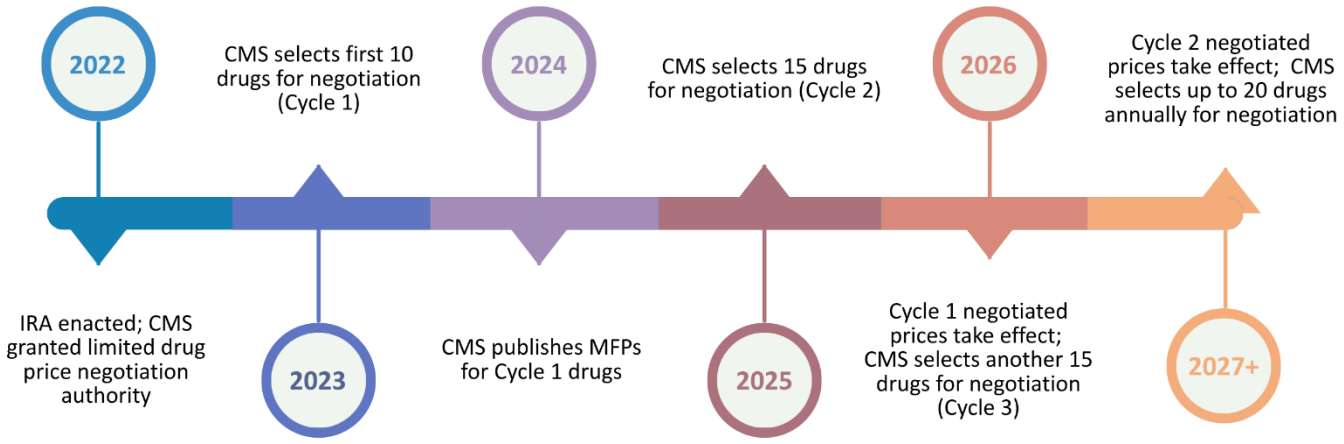

Figure 1.1. Timeline of Medicare Drug Pricing Policy and IRA Implementation

1.2 Conceptual Framework of Medicare Drug Price Negotiation Under the IRA

1.2.1 How the Negotiation Program Works

The IRA establishes a Medicare Drug Price Negotiation Program under which HHS, through CMS, may negotiate prices directly with manufacturers for a limited number of prescription drugs. Rather than imposing broad price regulation, the IRA creates a targeted form of administered bargaining focused on high-spend drugs that lack generic or biosimilar competition. Each year, CMS selects only a limited set of eligible high-expenditure drugs for negotiation; therefore, most Medicare-covered drugs remain priced under the existing market-based system.[18]

The goal of this process is the Maximum Fair Price (MFP), a ceiling price on what Medicare will pay for a selected drug during the applicable period. Although framed as a ceiling, the MFP could function as the effective transaction price for many selected drugs because plans and beneficiaries have limited leverage to negotiate lower prices. The statute also limits how low the MFP can be by tying it to specified price benchmarks and the drug's time on the market. Within these bounds, CMS and manufacturers engage in a structured exchange of offers and counteroffers.[14] The MFP remains in effect until CMS determines that a generic or biosimilar version of the drug is approved or licensed and is marketed.[19]

1.2.2 Which Drugs Are Eligible for Negotiation

Eligibility is limited to single-source, brand-name small-molecule drugs and biologics that lack marketed generic or biosimilar competition and have been on the market for a minimum period. Selection is further limited to drugs with high Medicare spending, and the number of negotiated drugs is phased in over time.[14] Together, these design features and the statutory exclusions described below ensure that negotiation initially applies to a narrow subset of Medicare-covered products.

The exclusions are applied to orphan drugs, low-spend Medicare drugs, and plasma-derived products.[20] The orphan drug exclusion applies to a drug or biologic approved only for one or more rare-disease (orphan)

indications and not approved for any non-orphan use across its forms and strengths. The low-spend exclusion removes products whose combined Part D Prescription Drug Event (PDE) expenditures and/or Part B allowed charges (inclusive of cost sharing) do not exceed the $200 million statutory threshold (subject to adjustments based on the Consumer Price Index for All Urban Consumers). The plasma-derived product exclusion relies on FDA labeling and related information to identify biologics derived from human blood or plasma. Recently, AbbVie has challenged the application of this exclusion, suing HHS for selecting Botox in the latest negotiation cycle and arguing that Botox qualifies as a "plasma-derived product" exempt from the IRA negotiations.[21]

The eligibility rules are designed to avoid disrupting markets where competition is expected to lower prices, while focusing negotiations on drugs that drive Medicare spending. Small-molecule drugs generally become eligible after at least 7 years on the market, whereas biologics become eligible after at least 11 years (**Figure 1.2**). Negotiated prices take effect two years after selection, implying an effective lag of roughly 9 years for small molecules and 13 years for biologics from initial launch.[22] The longer biologics timeline aligns with the Biologics Price Competition and Innovation Act, which bars biosimilar submissions for 4 years and biosimilar approvals for 12 years after first licensure.[23] Taken together, these design choices reflect a legislative effort to target high-spend drugs while limiting potential disruption to pharmaceutical innovation and beneficiary access.

More discussion and details on eligibility and selection, the negotiation process, and early implementation outcomes are covered in Chapters 2 and 3.

Small-Molecule Drugs	Biologics
• Chemically synthesized, low-molecular-weight compounds • Typically have relatively simple, well-characterized structures and established, scalable manufacturing processes • Example: *Eliquis,* an oral anticoagulant used to prevent and treat thromboembolic events	• Large, structurally complex molecules produced in living systems • Typically require more complex and costly manufacturing, characterization, and regulatory oversight than small-molecule drugs • Examples: insulin aspart (*NovoLog*) and monoclonal antibodies such as adalimumab (*Humira*)

Figure 1.2. Key characteristics of small-molecule drugs and biologics[24]

1.2.3 How This Differs from Negotiation in Other Countries

Although the statute uses the term "negotiation," the IRA's approach differs in important ways from drug pricing systems in many peer countries. In those systems, governments often have greater leverage in price negotiations through coverage and formulary tools, such as preferential placement or exclusion, that allow payers to withhold reimbursement when a drug's price is deemed excessive relative to its value.[25] Peer countries also employ a broader toolkit to shape prices and spending, including allowing payers to decline reimbursement when a drug's price is judged excessive relative to its value, including health technology

assessment (HTA), reference pricing, and rebate arrangements. As summarized in **Table 1.1**, these mechanisms can further strengthen payer negotiating power.[26-31]

Table 1.1. Common Drug Pricing and Reimbursement Approaches in Selected Peer Countries

Approach	How It Works	Example Countries
HTA / pharmaco-economic assessment	Coverage and pricing/reimbursement decisions informed by evaluation of clinical benefit relative to cost	UK (National Institute for Health and Care Excellence), Australia (Pharmaceutical Benefits Advisory Committee), Sweden (Dental and Pharmaceutical Benefits Agency)
Therapeutic (internal) reference pricing	Reimbursement level benchmarked to prices of therapeutically similar products within defined reference groups	Germany (Festbetrag system), Netherlands
International reference pricing (external benchmarking)	Prices benchmarked against those in peer countries, often used as an input into pricing or negotiation decisions, particularly at launch (role varies by country)	Many EU/OECO countries (e.g., France, Italy, Spain)
Rebates, claw-backs, and price concessions	Mandatory or negotiated manufacturer rebates or post-purchase price concessions, often confidential	UK, Germany
Risk-sharing / performance-linked arrangements	Agreements that tie payment or rebates to utilization, budget impact, or real-world clinical outcomes	Italy (outcomes-based managed entry agreements); UK (primarily discount-based patient access schemes, with limited outcomes-linked use)

Medicare operates under different institutional constraints. As a social insurance program with statutory coverage requirements and beneficiary protections, it has limited ability to use formulary exclusion as a bargaining tool, particularly for drugs in protected classes.[25] Instead, the IRA relies on mandatory participation and enforcement mechanisms to bring manufacturers to the negotiating table. Manufacturers that refuse to negotiate face substantial excise taxes or must withdraw their products from Medicare and Medicaid.[14]

From an economic perspective, some policymakers and researchers argue that negotiated prices should reflect therapeutic value while still allowing manufacturers to earn returns sufficient to sustain research and development (R&D).[22] Although government involvement in drug price setting is common internationally, the tools and legal frameworks vary widely. The IRA, therefore, represents a distinct U.S. approach shaped by Medicare's statutory design and institutional constraints.[25]

Chapter 2. The IRA Drug Price Negotiation Implementation in Cycles 1 and 2

The statutory authority for CMS to negotiate prescription drug prices marks a major break from the Medicare Modernization Act's "non-interference" framework, under which the federal government was barred from directly negotiating drug prices. As of January 2026, the Medicare Drug Price Negotiation Program transitioned

from a contested mandate into an operational policy tool, with the first set of negotiated MFPs coming into effect for ten high-expenditure medications.[32]

CMS generated the cycle 1 selected-drug list through a structured, statute-driven process laid out in its revised guidance issued June 30, 2023.[24,33] A similar framework applies in subsequent cycles.[19] The program, therefore, unfolds in two key phases: (1) drug selection and (2) price negotiation. First, CMS publishes the selected-drug list, then conducts formal negotiations with participating manufacturers to establish the final MFPs.

2.1 Drug Selection Process

CMS outlines the drug-selection methodology in **Figure 2.1**, which has three steps: (1) identify qualifying single-source drugs (QSSDs), (2) determine which QSSDs are negotiation-eligible, and (3) select the final set of drugs for negotiation. This process narrows the pool to high-spend Medicare drugs that meet the IRA statutory criteria. Drugs selected in earlier cycles are excluded from the eligibility pool in subsequent cycles.

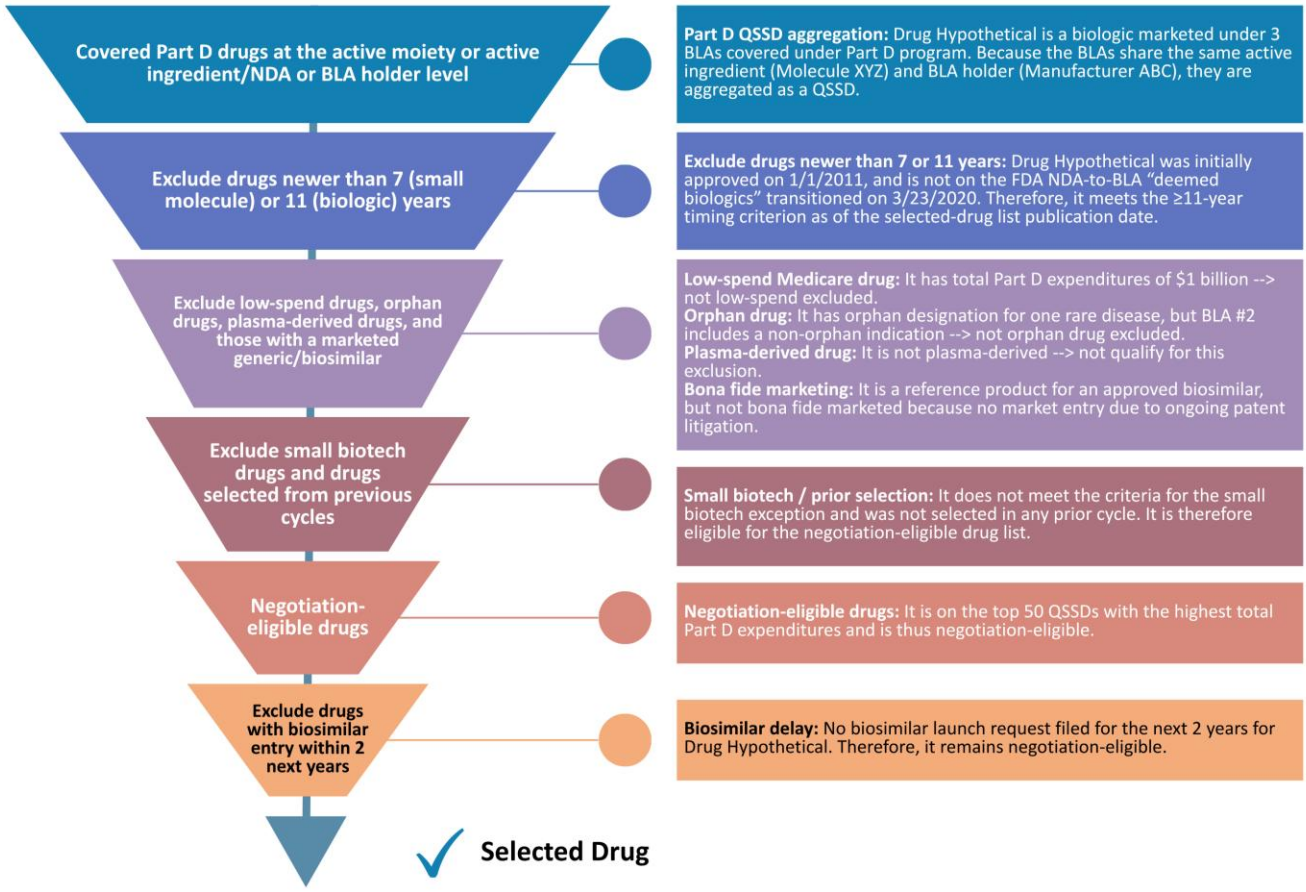

Figure 2.1. Drug Selection Process for IRA Drug Price Negotiation.[34]

2.1.1 Identification of QSSDs

A QSSD covered under Medicare Part D may be a small-molecule drug or a biologic. Reflecting scientific and regulatory differences between these product types, the statue applies different time-on-market thresholds before CMS may initiate assessment: at least 7 years after approval for small-molecule drugs and 11 years for biologics. Because negotiated prices take effect roughly two years after selection, the biologic threshold can place MFP implementation near the end of the 12-year biologic exclusivity period. By contrast, small-molecule drugs generally receive a 5-year new chemical entity exclusivity period that delays generic entry.[35]

CMS determines whether a drug remains "single-source" by integrating FDA Orange Book and Purple Book records with Part D PDE and Average Manufacturer Price (AMP) data to verify bona fide generic or biosimilar market entry. Evidence of marketed generic or biosimilar competition for the same active ingredient excludes a product from negotiation. In making this determination, CMS aggregates all dosage forms and strengths that share the same active ingredient and the same New Drug Application (NDA) or Biologics License Application (BLA) holder into a single analysis unit, including repackaged or authorized generics.

Statutory implementation also applies three exclusions when identifying QSSDs: orphan drugs, low-spend Medicare drugs, and plasma-derived products. Two contextual considerations are particularly relevant. First, the program is designed to focus on drugs with substantial Medicare budget impact; both the statute and CMS guidance emphasize ranking and selecting from high-spend drugs after exclusions are applied. Second, orphan drugs and plasma-derived products operate in policy environments where legislators and regulators have long sought to protect fragile development incentives and address supply vulnerability.[33,36,37]

2.1.2 Identification of Negotiation-Eligible Drugs

After applying the statutory exclusions, CMS calculates total Medicare Part D expenditures for each QSSD using PDE data at the NDC-11 level. Spending is measured over the 12-month period preceding the selection announcement and then aggregated to the QSSD level.

CMS then applies the Small Biotech Exception, using the statutory thresholds and the reference-year data specified in the guidance. This exception reflects a policy judgment that negotiation should focus on high-expenditure drugs marketed by large, diversified manufacturers, while avoiding disproportionate financial and innovation impacts on smaller biotechnology firms that typically rely on limited product portfolios. Drugs qualifying for this exception are excluded from negotiation. CMS then ranks the remaining QSSDs by total Part D expenditures and designates the 50 highest-spending products as negotiation-eligible for the relevant Initial Price Applicability Year (IPAY).

2.1.3 Final Selection of Drugs for Negotiation

The IRA allows CMS to defer selection of certain biological products when biosimilar market entry is expected within two years of publication of the selected drug list. Biological products meeting this criterion—based on defined evidentiary standards and timelines—are removed from immediate selection. After applying statutory exclusions and biosimilar-entry delays, CMS formally selects the highest-ranked remaining negotiation-eligible drugs for negotiation: 10 drugs for cycle 1 (IPAY 2026) and 15 drugs for cycle 2 (IPAY 2027).[24,38]

2.2 Drug Price Negotiation Process

Once CMS publishes the selected-drug list, the negotiation phase proceeds as a structured sequence of submissions and offer exchanges governed by statutory deadlines and backed by penalties for non-participation. Across IPAY 2026 and IPAY 2027, the core sequence is consistent: participation agreement → evidence submission → initial offer and counteroffer → negotiation meetings and revised offers → final MFPs → publication of MFPs → publication of an explanation.[32]

Manufacturers provide "manufacturer-specific" information, including narratives on R&D and production or distribution, federal financial support, sales and market data, and patent and exclusivity status. In parallel, public and clinical stakeholders provide evidence on therapeutic alternatives, clinical benefits, unmet needs, and impacts on specific populations. CMS has formalized these engagement channels through mechanisms such as patient roundtables and clinician town halls.[32]

At the center of this phase is the MFP, which serves as the Medicare payment amount for a selected drug and as a policy signal of how therapeutic value is operationalized within statutory constraints. CMS describes the negotiated prices for IPAY 2026 and IPAY 2027 as MFPs that take effect January 1 of the relevant IPAY.[32]

The MFP is not unconstrained. The IRA sets an upper-bound ceiling, defined as the lower of (a) the enrollment-weighted negotiated net price for Part D drugs, net of price concessions including rebates, or (b) a percentage of a drug's non-federal average manufacturer price (non-FAMP), with the permitted percentage declining as time since approval increases (75%, 65%, then 40% across specified age bands). This ceiling structure is central to ongoing debate over the extents to which the program reflects negotiation versus bounded price setting.[18]

Within that ceiling, CMS anchors its initial offer in therapeutic comparators. CMS guidance describes a four-part approach: identify therapeutic alternatives; use available pricing information as a starting point; adjust for clinical benefit; and incorporate manufacturer-specific economic information to reach the initial offer.[18] CMS's IPAY 2026 negotiated-prices fact sheet similarly describes an offer-counteroffer process and notes that CMS developed initial offers consistent with statute and guidance.[32]

The statute also places limitations on how much comparative effectiveness evidence may be used in the MFP negotiation process, particularly by restricting the use of quality-adjusted life years (QALY)-based methods. These methods could lead to the perception that extending the lives of elderly, disabled, or terminally ill individuals is inherently of lower value compared to extending the lives of younger or non-disabled individuals.[18] These constraints shape both the technical method and the broader public debate.

Finally, the principal transparency mechanism is the MFP explanation. CMS describes these explanations as summaries of the information that most influenced CMS's offers and its consideration of counteroffers, with redactions applied to protect proprietary information under the confidentiality policy.[39] This combination of narrative disclosure and confidentiality redaction has become a standing feature of post-selection governance and a recurring point of contention over what can be independently verified about a price called "fair".[38,40]

2.3 Selection and Negotiation Outcomes

2.3.1 The 2026 IPAY Negotiation Results

CMS launched Cycle 1 in 2023, with negotiated prices taking effect in 2026, providing a baseline for evaluating early program performance. The ten drugs selected for IPAY 2026 accounted for $50.5 billion in gross covered Part D prescription drug costs during the selection window (June 1, 2022 to May 31, 2023), representing about 19% of total Part D expenditure for that year.[32] Approximately 8.247 million Part D enrollees used at least one of the selected drugs during the same period.[41]

These medications treat high-prevalence conditions, such as diabetes, heart failure, autoimmune disease, and cancer, which broadens the reach of any negotiated savings. For example, Medicare reported $16.5 billion in gross Part D spending on Eliquis during the selection window. Some products also have very high per-user spending (e.g., Imbruvica and Stelara), consistent with their specialty use profiles (**Table 2.1**).

Table 2.1. IPAY 2026 & 2027 Selected Drug List and MFP Facts.

IPAY	Drug (active ingredient)	Manufacturer	Primary indication	Total gross Medicare Part D spending	Medicare Part D users	Gross spending per user	MFP (30-day supply) for IPAY year	List price for selection baseline year	% discount (vs. list price baseline)
2026	Eliquis (apixaban)	BMS	Prevention and treatment of blood clots	$16,482,621,000	3,706,000	$4,448	$231	$521	56%
	Jardiance (empagliflozin)	BI	Diabetes; heart failure	$7,057,707,000	1,573,000	$4,487	$197	$573	66%
	Xarelto (rivaroxaban)	JNJ	Prevention and treatment of blood clots; risk reduction for coronary/peripheral artery disease	$6,031,393,000	1,337,000	$4,511	$197	$517	62%
	Januvia (sitagliptin)	MSD	Diabetes	$4,087,081,000	869,000	$4,703	$113	$527	79%
	Farxiga (dapagliflozin)	AZ	Diabetes; heart failure; chronic kidney disease	$3,268,329,000	799,000	$4,091	$178.50	$556	68%
	Entresto (sacubitril/valsartan)	NVS	Heart failure	$2,884,877,000	587,000	$4,915	$295	$628	53%
	Enbrel (etanercept)	AMGN	Rheumatoid arthritis; psoriasis; psoriatic arthritis	$2,791,105,000	48,000	$58,148	$2,355	$7,106	67%
	Imbruvica (ibrutinib)	ABBV/JNJ	Blood cancers	$2,663,560,000	20,000	$133,178	$9,319	$14,934	38%
	Stelara (ustekinumab)	JNJ	Psoriasis; psoriatic arthritis; Crohn's disease; ulcerative colitis	$2,638,929,000	22,000	$119,951	$4,695	$13,836	66%
	Fiasp/NovoLog (insulin aspart)	NVO	Diabetes	$2,576,586,000	777,000	$3,316	$119	$495	76%
2027	Ozempic/Rybelsus/Wegovy (semaglutide)	NVO	Type 2 diabetes; cardiovascular disease; obesity/overweight	$14,426,566,000	2,287,000	$6,308	$274	$959	71%
	Trelegy Ellipta (fluticasone furoate/umeclidinium/	GSK	Asthma; chronic obstructive pulmonary disease	$5,138,107,000	1,252,000	$4,104	$175	$654	73%
	Xtandi (enzalutamide)	AST	Prostate cancer	$3,159,055,000	35,000	$90,259	$7,004	$13,480	48%
	Pomalyst (pomalidomide)	BMS	Kaposi sarcoma; multiple myeloma	$2,069,147,000	14,000	$147,796	$8,650	$21,744	60%
	Ibrance (palbociclib)	PFE	Breast cancer	$1,984,624,000	16,000	$124,039	$7,871	$15,741	50%
	Ofev (nintedanib)	BI	Idiopathic pulmonary fibrosis	$1,961,060,000	24,000	$81,711	$6,350	$12,622	50%
	Linzess (linaclotide)	ABBV	Chronic idiopathic constipation; irritable bowel syndrome with constipation	$1,937,912,000	627,000	$3,091	$136	$539	75%
	Calquence (acalabrutinib)	AZ	Chronic lymphocytic leukemia/small lymphocytic lymphoma; mantle cell lymphoma	$1,614,250,000	15,000	$107,617	$8,600	$14,228	40%
	Austedo/Austedo XR (deutetrabenazine)	TEVA	Chorea in Huntington's disease; tardive dyskinesia	$1,531,855,000	26,000	$58,918	$4,093	$6,623	38%
	Breo Ellipta (fluticasone furoate/vilanterol)	GSK	Asthma; chronic obstructive pulmonary disease	$1,420,971,000	634,000	$2,241	$67	$397	83%
	Tradjenta (linagliptin)	BI	Type 2 diabetes	$1,148,977,000	278,000	$4,133	$78	$488	84%
	Xifaxan (rifaximin)	BHC	Hepatic encephalopathy; irritable bowel syndrome with diarrhea	$1,128,314,000	104,000	$10,849	$1,000	$2,696	63%
	Vraylar (cariprazine)	ABBV	Bipolar I disorder; major depressive disorder; schizophrenia	$1,085,788,000	116,000	$9,360	$770	$1,376	44%
	Janumet/Janumet XR (sitagliptin/metformin)	MSD	Type 2 diabetes	$1,082,464,000	243,000	$4,455	$80	$526	85%
	Otezla/Otezla XR (apremilast)	AMGN	Oral ulcers in Behçet's disease; plaque psoriasis; psoriatic arthritis	$994,001,000	31,000	$32,065	$1,650	$4,722	65%

For IPAY 2026, CMS reported the negotiated MFPs as substantial discounts from 2023 list prices, ranging from 38% to 79%. CMS and other analyses projected meaningful reductions in beneficiaries' out-of-pocket spending and additional savings for the Medicare program[41-43].

At the same time, the statute's ceiling framework constrains how low MFP can go. Under the non-FAMP ceiling, drugs that have been marketed longer face deeper statutory discount bands.[20] This structural feature helps distinguish the IRA model from traditional PBM negotiation, which relies more heavily on coverage leverage and rebate contracting.

2.3.2 Escalating the Intervention: The 2027 IPAY Negotiation Results

The second negotiation cycle, which targets 15 additional drugs for IPAY 2027 (**Table 2.1**), reflects a more aggressive government posture. Announced in late 2025, the results indicate a net savings of 44%, or $12 billion, relative to 2024 spending on these drugs.[44] This exceeds the 22% net reduction reported for the inaugural IPAY 2026 cycle. One driver of the larger savings may be the mix of products in the 2027 list, including oncology and other specialty drugs that historically carried lower rebates in the commercial market (often under 10%), compared with roughly 25% on average across other classes.[45]

The IPAY 2027 list includes heavy-hitters such as the Ozempic family of GLP-1 medications (used in type 2 diabetes and cardiovascular disease) as well as multiple high-cost oncology drugs.[18,46] Collectively, these 15 drugs accounted for $42.5 billion in gross Medicare Part D costs between November 2023 and October 2024, representing approximately 15% of total program spending over that period.[47]

Early results across diabetes therapies demonstrate a deliberate effort to reset pricing in high-utilization classes. Across diabetes drugs selected in IPAY 2026 and IPAY 2027, negotiated price reductions ranged from 66% for Jardiance to 85% for Janumet/Janumet XR. An analysis by the Office of Inspector General, HHS found that Medicare Part D spending on ten selected diabetes drugs rose sharply from $7.7 billion in 2019 to $35.8 billion in 2023 and projected further growth to $102 billion by 2026.[5] Together, these trends help explain why diabetes therapies emerged as an early focus: they combine high utilization, high spending, and limited federal leverage on price before IRA.[5]

Chapter 3. The 2028 Cycle: Integrating Part B and New Selection Realities

The Medicare Drug Price Negotiation Program has entered a new phase with the launch of the IPAY 2028 cycle.[48] This third iteration is not simply a larger round of price setting; it reshapes the program in three ways: (1) it brings Medicare Part B provider-administered drugs into negotiation for the first time, (2) it introduces a formal renegotiation pathway for previously selected drugs, and (3) it incorporates statutory changes enacted in the One Big Beautiful Bill Act (OBBBA) of 2025.[49-51] Together, these changes shift the program's center of gravity beyond high-volume Part D retail drugs towards more complex, high-priced therapies, especially biologic products used in oncology and immunology, which are often covered under Part B.[52-54]

3.1 Evolving Selection Realities and the IPAY 2028 Cohort

On January 27, 2026, CMS announced 15 drugs for the third negotiation cycle (**Table 3.1**), along with Tradjenta, the first drug selected for the program's new renegotiation process.[54,55] This cohort is historically significant because it includes, for the first time, drugs payable under Part B alongside those covered under Part D. The selected products accounted for an estimated $27 billion in total Medicare spending during the statutory evaluation period (November 1, 2024 through October 31, 2025).[48] This represents roughly 6% of combined Part B and Part D spending over the same window, illustrating how concentrated Medicare drug spending is among a relatively small set of products.[52,54,56]

Table 3.1: Comprehensive List of Selected Drugs for IPAY 2028 Negotiation.

Drug (active ingredient)	Manufacturer	Primary indication	Total gross Medicare spending	Medicare users	Gross spending per user	Coverage type
Trulicity (dulaglutide)	LLY	Type 2 diabetes; cardiovascular disease or multiple cardiovascular risk factors	$4,898,378,000	617,000	$7,939	Part D
Biktarvy (bictegravir+emtricitabine+ tenofovir alafenamide)	GILD	HIV-1 infection	$3,904,486,000	101,000	$38,658	Part D
Orencia (abatacept)	BMS	Psoriatic arthritis; rheumatoid arthritis	$2,450,065,000	72,000	$34,029	Part B & D
Cosentyx (secukinumab)	NVS	Plaque psoriasis; psoriatic arthritis	$2,327,442,000	40,000	$58,186	Part B & D
Erleada (apalutamide)	JNJ	Prostate cancer	$1,947,504,000	19,000	$102,500	Part D
Kisqali (ribociclib)	NVS	Breast cancer	$1,578,679,000	17,000	$92,863	Part D
Entyvio (vedolizumab)	TAK	Crohn's disease; ulcerative colitis	$1,483,348,000	37,000	$40,090	Part B & D
Verzenio (abemaciclib)	LLY	Breast cancer	$1,428,714,000	15,000	$95,248	Part D
Botox (onabotulinumtoxinA)	ABBV	Chronic migraine; overactive bladder; spasticity; other movement disorders	$1,143,070,000	390,000	$2,931	Part B & D
Lenvima (lenvatinib)	EIS	Thyroid cancer; endometrial cancer; liver cancer; kidney cancer	$1,088,498,000	10,000	$108,850	Part D
Xolair (omalizumab)	Roche	Asthma; chronic spontaneous urticaria	$1,077,271,000	40,000	$26,932	Part D
Rexulti (brexpiprazole)	OTS	Major depressive disorder; schizophrenia; agitation associated with dementia	$1,075,274,000	119,000	$9,036	Part D
Xeljanz/XR (tofacitinib)	PFE	Psoriatic arthritis; rheumatoid arthritis; ulcerative colitis	$1,013,332,000	22,000	$46,061	Part D
Anoro Ellipta (umeclidinium+vilanterol)	GSK	Chronic obstructive pulmonary disease (COPD)	$812,772,000	281,000	$2,892	Part D
Cimzia (certolizumab pegol)	UCB	Crohn's disease; plaque psoriasis; psoriatic arthritis; rheumatoid arthritis	$786,790,000	38,000	$20,705	Part D

The IPAY 2028 list appears to place greater weight on Part D protected-class drugs. Six selected drugs fall into protected classes—four antineoplastics, one antipsychotic, and one antiretroviral—compared with one in Cycle 1 and five in Cycle 2. Under longstanding Part D rules, plan sponsors must cover "all or substantially all" drugs in these protected classes, limiting formulary exclusion as a bargaining tool and potentially contributing to higher spending in these categories.[57,58]

In that context, negotiated pricing may be particularly consequential. When plans have limited ability to exclude products within a class, negotiated MFPs can substitute for competitive mechanisms that may be weaker in these segments. Looking back at Cycles 1 and 2, negotiated discounts reportedly increased from

levels often in the single digits to substantially larger reductions, generating significant savings in areas where private-market leverage has been structurally constrained.

What Is Part D Protected Classes?

- **Most Part D plan can design their formularies** (with CMS requirements) and choose which drugs to cover.
- **Exception**: For six "protected classes," plans must cover all or substantially all drugs (with limited exceptions).
- **The six protected classes are**: immunosuppressants (for transplant rejection), antidepressants, antipsychotics, anticonvulsants, antiretrovirals (HIV/AIDS), and antineoplastics (cancer drugs, including many oral oncology agents).

Beginning in 2026, Part D plans are required to include drugs with an applicable negotiated MFP on formularies. CMS also expects plans to provide "meaningful access" and use annual formulary review to scrutinize benefit designs that may disadvantage selected drugs. This includes situations where a plan places a selected drug on a non-preferred tier; assigns it to a higher tier than a non-selected drug in the same class; requires use of an alternative brand before the selected drug; or applies more restrictive utilization management (e.g., step therapy or prior authorization) than for a comparable non-selected drug. CMS may require plans to justify such differences on clinical grounds and in compliance with statutory and regulatory standards.[59,60]

3.2 Integrating Medicare Part B and the Shift to Comprehensive Expenditure Tracking

Bringing Part B drugs into negotiation is the most substantial operational change in IPAY 2028.[48] Unlike Part D drugs, which are typically dispensed through retail or mail-order pharmacies, Part B drugs are generally administered in clinical settings such as infusion centers and hospital outpatient departments. Historically, many Part B drugs have been paid under a "buy-and-bill" model, with reimbursement based on ASP plus an add-on (often referenced as ASP + 6%) and separate payment for administration.[61]

A key methodological shift in the IPAY 2028 final guidance is the inclusion of Medicare Advantage encounter data when calculating total expenditures for drug selection.[48] Earlier approaches contemplated relying primarily on fee-for-service claims in the Original Medicare program,[19,33,48] but stakeholders argued that this would omit a substantial share of utilization, given that over 50% of Medicare beneficiaries are enrolled in Medicare Advantage in 2026, and the percentage of share is expected to rise to 64% by 2034, according to CBO projections.[49-51,62]

Under the final approach (**Table 3.2**), CMS identifies Part B units administered to Medicare Advantage enrollees using encounter records and assigns standardized dollar values to those units using fee-for-service payment limits (e.g., ASP-based limits) or, where applicable, Outpatient Prospective Payment System rates.[63,64] This normalization allows Part B drugs to be ranked alongside Part D drugs in the combined expenditure-based "Top 50" list.[48,54,64] Under this methodology, four Part B drugs with substantial utilization were selected for IPAY 2028: Botox, Cimzia, Orencia, and Entyvio.[65]

Table 3.2. Data Sources Used for Drug Selection by IRA Negotiation Cycle

	Cycles 1 & 2 (IPAY 2026–2027)	Cycle 3 and Beyond (IPAY 2028+)
Primary data scope	Original Medicare only	Original Medicare + Medicare Advantage
Part D data source	Prescription Drug Event (PDE) data from Original Medicare	PDE data (Original Medicare) + Medicare Advantage prescription drug encounter data
Part B data source	Not included in selection	Fee-for-service Part B claims plus Medicare Advantage encounter data, normalized to FFS payment rates
Population reflected	Fee-for-service Medicare beneficiaries only	Full Medicare population across delivery models
Spending measure	Gross covered Part D spending in Original Medicare	Combined gross Part D and Part B spending across Original Medicare and Medicare Advantage

3.3 The OBBBA and Its Impact on the Orphan Drug Exclusion

IPAY 2028 is the first cycle conducted under statutory modifications enacted in the OBBBA (signed July 4, 2025). While the IRA established the negotiation program, the OBBBA recalibrates key eligibility rules, particularly those governing orphan drugs, therefore narrowing the pool of drugs that can be selected in future cycles.[64]

3.3.1 Expansion of the Orphan Drug Exclusion

As discussed in Chapter 2, under the IRA, a drug was exempted from negotiation only if it was designated and approved as an orphan drug for a single rare disease and had no other approved indications. This "sole orphan" requirement was criticized for potentially discouraging manufacturers from pursuing additional rare disease indications for existing therapies.[50] The OBBBA modifies this exclusion by extending the exemption to drugs designated for one or more rare diseases, provided that all approved indications remain for rare conditions (**Table 3.3**). This change has immediate implications for certain high-expenditure products (e.g., Brukinsa, which treats multiple rare lymphomas) that might have otherwise become eligible for selection.[49] Additionally, it increases the strategic importance of whether and when a manufacturer seeks approval for a non-rare indication, as this decision can alter a drug's eligibility status under the revised framework.[50]

Table 3.3: Comparison of IRA vs. OBBBA Provisions

Policy Dimension	IRA	OBBBA	Regulatory Implication
Orphan Drug Exclusion	Limited to a single rare-disease indication.	Expanded to multiple rare indications (if all rare).	Expands protection for orphan-designated products.
Eligibility "clock"	Starts at first FDA licensure/approval.	Starts at first approval for a non-rare indication.	Delays negotiation for drugs that later expand beyond rare conditions.
R&D Tax Treatment	Amortized over 5 years.	100% immediate deduction.	Improves near-term liquidity for manufacturers.
Selection Scope	Part D initially; Part B included in IPAY 2028.	Maintains scope but narrows the future eligibility pool via orphan changes.	Focuses selection more heavily on broad-market, non-orphan drugs.

3.3.2 Recalibration of the Eligibility "Clock"

The OBBBA has also adjusted how the eligibility clock is calculated for drugs that initially qualify for the orphan exclusion but later receive a non-rare indication.[49,63] Under the IRA, eligibility thresholds are tied to time since first approval/licensure (7 years for small molecules; 11 years for biologics). Under the OBBBA, if an orphan drug (e.g., Keytruda and Opdivo) later obtains a non-rare indication, the 7- or 11-year clock begins after approval date of that first non-rare indication, rather than the original approval date (**Figure 3.1**).[49-51,66,67] This adjustment can significantly delay eligibility for some widely used therapies and could reduce long-term savings relative to projections based on the original IRA timelines.

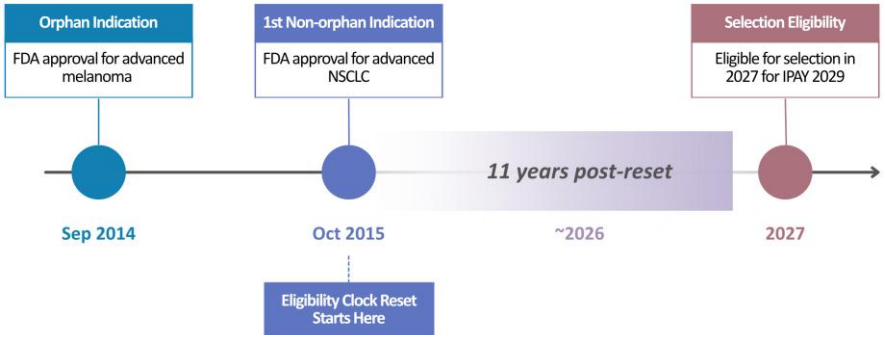

Figure 3.1. Keytruda Eligibility Timeline.

3.4 Renegotiation Framework: First Application to Tradjenta

IPAY 2028 also introduces renegotiation, a mechanism intended to update MFPs in response to current market conditions and clinical context.[48,63] Under this framework, CMS may identify previously selected drugs (from cycle 1 and 2) that remain without generic or biosimilar competition and are eligible for a revised MFP if specific criteria are met. These criteria can include changes in monopoly status (e.g., transition to a "long-monopoly" category after 16 years on the market) or a new indication that could materially affect the drug's value assessment.[48,55,63]

For IPAY 2028, CMS selected Tradjenta (linagliptin) for renegotiation, aiming for further cost reduction.[54,55] Tradjenta is a dipeptidyl peptidase-4 (DPP-4) inhibitor for type 2 diabetes and was selected for negotiation in Cycle 2. Its selection for renegotiation appears consistent with the program's criteria, given its time-on-market since its original approval (May 2, 2011) and the potential relevance of evolving evidence and class dynamics.[56,65]

Chapter 4. Policy Updates Since 2022

The IRA introduced the most significant federal drug pricing reforms in decades, but the negotiation program has not evolved in isolation.[68] Since 2022, the drug-pricing landscape has been shaped by implementation decisions, agency guidance, litigation, and parallel affordability and supply-chain initiatives.

4.1 IRA Implementation After 2022

Although the IRA statute established the negotiation framework, many operational details have been defined through post-2022 agency action.[69] As a result, this period has been characterized less by new legislation and

more by regulatory interpretation and implementation. In practice, three forces have shaped program evolution: (1) iterative CMS guidance, (2) litigation, and (3) interactions with other IRA provisions, especially Part D redesign and inflation rebates.[68,70]

A central feature has been CMS's ongoing release and revision of Medicare Drug Price Negotiation Program guidance. These documents clarify eligibility definitions, manufacturer data submission requirements, compliance expectations, and procedures for implementing MFPs. CMS has updated guidance as implementation has progressed and stakeholder feedback has been incorporated.[19,33,48] This iterative approach reflects the complexity of translating statutory language into operational policy.

Implementation has also continued amid legal challenges. Manufacturers and industry groups have raised statutory and constitutional arguments, including claims related to compelled speech, takings, and administrative authority. The Congressional Research Service reported that these lawsuits had not halted implementation at the time of review, but they introduced uncertainty regarding how negotiation authority may ultimately be interpreted.[20]

Two additional IRA provisions materially affect incentives:

- Part D redesign, including the $2,000 annual out-of-pocket cap and revised catastrophic-phase liability, redistributes financial responsibility across beneficiaries, plans, manufacturers, and the federal government. Because plans now bear greater liability for high-cost drugs, incentives for formulary management and price negotiation may be strengthened.[71]
- Inflation-based rebates penalize price increases above inflation and operate independently of negotiation.

Together, negotiation, benefit redesign, and inflation rebates create a layered policy structure in which multiple mechanisms constrain prices simultaneously.

Finally, Congress enacted the OBBBA in 2025, modifying selected provisions of the IRA negotiation. While Chapter 3 addresses these changes in detail, their enactment underscores that the negotiation framework continues to evolve through both regulatory and legislative channels.

4.2 Other Moving Parts in Drug Pricing Policy

While IRA implementation remains the anchor of recent reform, policymakers have pursued additional approaches to affordability and supply-chain incentives. These efforts generally do not amend IRA authorities, but they influence the environment in which pricing and access decisions occur.

4.2.1 International Reference Pricing and Most-Favored-Nation (MFN) Concepts

International reference pricing, often described as MFN pricing, links U.S. prices to those in peer countries. Since 2022, MFN has re-emerged less as a single nationwide statutory proposal and more as a recurring policy framework reflected in executive actions and agency models. Legal scholarship notes that large-scale price regulation implemented through executive or administrative authority may face judicial scrutiny.[75]

Recent executive actions have emphasized MFN principles, and some agency models incorporate international price comparisons.[79] For example, the Generic Effective Negotiated Unit Rebate Optimizing Strategy (GENEROUS) Medicaid model uses international benchmarks to inform supplemental rebates in participating states.[78] These initiatives do not replace IRA negotiation, but they reflect continued federal interest in global price comparisons.

4.2.2 PBM Reform and Supply-Chain Regulation

PBMs manage prescription drug plan (PDP) benefits for insurers and employers and serve as intermediaries in the prescription drug supply chain. Their primary functions include negotiating rebates and discounts with drug manufacturers, managing drug formularies, assembling pharmacy networks, processing and adjudicating pharmacy claims, designing drug benefits, and conducting utilization management (e.g., prior authorization, step therapy).[80]

Through these activities, PBMs influence drug spending, including through formulary design, utilization management, price negotiation, and pharmacy network management (**Figure 4.1**). Market concentration and vertical integration have prompted scrutiny of competition and transparency.[81]

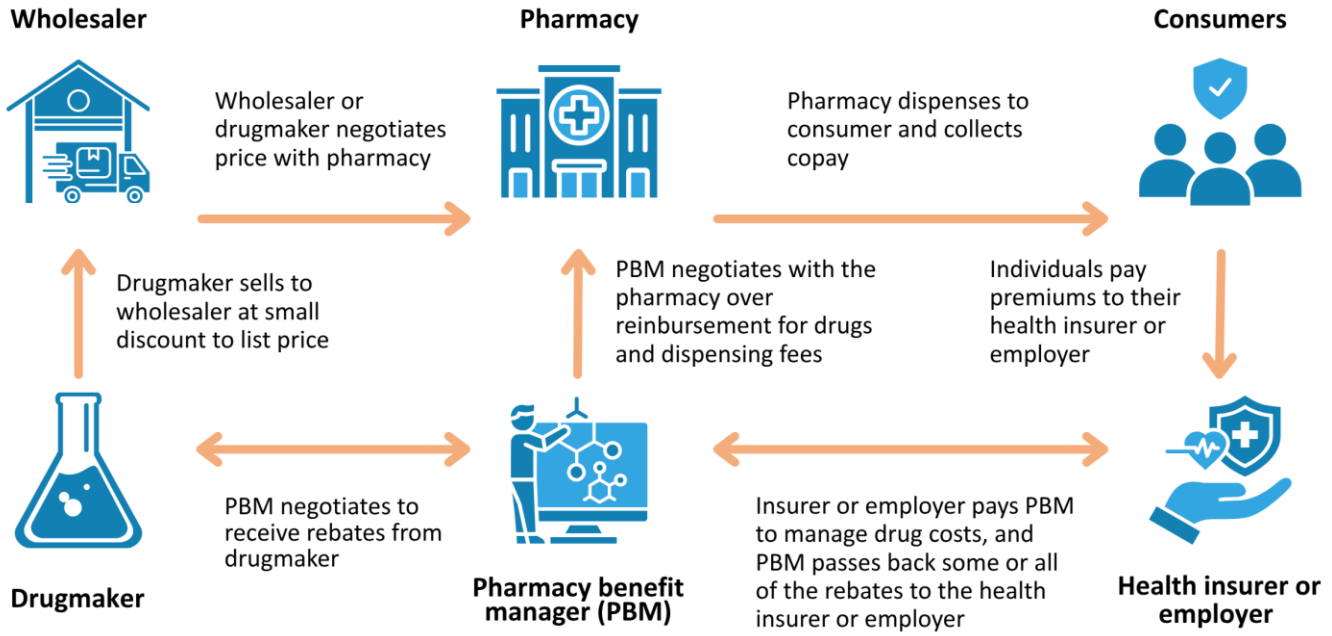

Figure 4.1. How PBMs operate within the U.S. prescription-drug payment system. PBMs administer prescription-drug benefits for health plans and employers, including negotiating manufacturer rebates and pharmacy reimbursement. Major PBMs include CVS Caremark, Express Scripts (Cigna), and Optum Rx (UnitedHealth Group).

Recent proposals target:

- Rebate pass-through requirements (directing rebates to plan sponsors or patients rather than PBMs)
- Spread pricing restrictions (limiting the difference between what PBMs charge plans and pay pharmacies)
- Enhanced reporting and transparency requirements

However, available evidence suggests that focusing on a single PBM revenue mechanism in isolation may not reduce overall spending if contracting incentives remain unchanged. For example, analysis of Medicare Part D generic drugs indicates that prohibiting spread pricing alone may not lower total spending if PBMs shift revenues to other mechanisms (e.g., administrative fees).[82]

4.2.3 Alternative Purchasing Pathways

Another area of activity involves purchasing pathways outside traditional rebate-based systems. HHS has issued guidance clarifying how manufacturers may offer lower-cost direct-to-consumer purchasing options under anti-kickback safeguards, provided that drugs are not billed to federal programs and that other conditions are met.[77] These arrangements are typically structured as cash-pay transactions and do not change Medicare or Medicaid reimbursement rules.

In parallel, Medicaid-focused models such as GENEROUS rely on supplemental rebates and voluntary state participation rather than statutory federal price controls. The GENEROUS framework aims to reduce net Medicaid drug costs through enhanced supplemental rebate arrangements.[78] Collectively, these approaches expand purchasing options but remain distinct from Medicare negotiation.

Key developments are summarized in **Table 4.1**.[32,72-78]

Table 4.1. Major Federal Drug Pricing Policy Developments Since 2022.

Policy Area	Key Idea	Status Since 2022	Relevance
IRA Medicare Drug Price Negotiation	Establishing Medicare authority to negotiate MFPs for selected high-expenditure drugs	Implementation underway following IRA enactment; litigation ongoing	First direct federal drug price negotiation within Medicare
Medicare Part D Benefit Redesign	Structural redesign of Part D, including a $2,000 annual out-of-pocket cap and realignment of plan and manufacturer liability	Phased implementation in progress	Restructures Medicare Part D benefit incentives
Medicare Inflation Rebates	Manufacturer penalties when price increases exceed inflation	Active implementation	Constrains launch and post-launch price growth
Federal MFN Reference Pricing Proposals	Linking U.S. drug payment levels to selected foreign benchmarks	Policy proposals and model exploration ongoing	Signals potential movement toward global price benchmarking
PBM Reform	Increased federal and state regulation of PBM business practices	Federal and state proposals under consideration	Targets supply-chain incentives and transparency
Direct-to-Consumer Drug Purchasing Models	Manufacturer-sponsored cash-pay purchasing programs	Federal guidance issued; programs emerging	Expands alternative purchasing channels outside traditional insurance
Medicaid MFN Supplemental Rebate Models	International reference–based supplemental rebate arrangements in Medicaid	CMS Innovation Center model in development	Enables state-level experimentation with international price alignment

Chapter 5. Policy Impact Across the Ecosystem

The IRA represents a structural shift in U.S. pharmaceutical policy, particularly within Medicare Parts B and D. Historically, the federal government influenced drug prices through Medicaid rebates, the Veterans Affairs purchasing framework, and the 340B program (which requires manufacturers to provide discounts on drugs to eligible safety-net providers). Medicare, by contrast, relied primarily on private plan negotiations for Part D and formula-based reimbursement for Part B.[14] In Part B, most clinician-administered drugs have traditionally been reimbursed under a statutory formula tied to ASP plus an add-on, rather than through direct price negotiation.[10]

The IRA changes this structure by introducing direct federal involvement in price formation for selected drugs through a time-triggered, statute-bound MFP. Although negotiation applies to a subset of high-spending products, its effects extend beyond those drugs because policy shocks ripple unevenly through the ecosystem, first in financial markets, then in corporate strategy, and ultimately in how drugs are paid for and used.[83] The main channels through which these effects propagate are summarized in **Table 5.1**.

Table 5.1. Channels of IRA Impact on the Pharmaceutical Ecosystem.

Stakeholder	Primary Mechanism	Observed or Anticipated Response
Investors	Revenue exposure and changes in net present value	Asset-specific repricing; focus on Medicare intensity
Manufacturers	Lifecycle and portfolio strategy	Indication sequencing, pipeline planning, diversification
Patients	Out-of-pocket reductions	Improved affordability and adherence
Providers	Prescribing incentives	Financial relationships influence utilization
Plan sponsors	Liability redesign	Stronger formulary and cost-management incentives

5.1 Implications for Investors

For capital markets, the IRA matters to the extent that it changes expected future cash flows. Drug development is capital-intensive, and company valuations often depend disproportionately on a small number of successful products. As a result, even targeted pricing reforms attract investor scrutiny.

Available analyses suggest that aggregate revenue exposure to negotiation may be smaller than early rhetoric implied, but exposure can be substantial for specific products and manufacturers with high Medicare concentration.[83] Many top-selling drugs are either too new to qualify, face competition, or generate significant revenue outside Medicare. Eligibility thresholds (7 years for small molecules and 11 years for biologics) also skew selection toward more mature products, often past the earliest high-growth phase.[84] Even among eligible products, Medicare frequently represents a minority share of global revenue, which further limits aggregate exposure.

Investor behavior, therefore, tends to reflect product-level repricing rather than broad sector pessimism. Market commentary emphasizes three variables: Medicare revenue intensity, remaining exclusivity, and timing of negotiation eligibility. Investors also distinguish between small molecules and biologics because the negotiation timelines differ, resulting in heterogeneous perceived risk across portfolios. Some analysts explicitly incorporate eligibility timing into discounted cash flow models and adjust discount rates or terminal values accordingly.[85]

Model-based analyses suggest that valuation sensitivity depends on how negotiated prices affect the marginal net present value.[86] If discounts reduce lifetime revenues only modestly relative to development costs and probability of success, many projects remain commercially viable. In several scenarios, the revenue impact resembles risks markets already model, especially loss-of-exclusivity (LOE) events. Historically, LOE ("patent cliff") revenue drops are steep, predictable, and heavily priced into valuations well in advance. From this perspective, IRA negotiation becomes one additional policy variable alongside existing lifecycle and reimbursement risks, rather than a singular determinant of investment decisions.[87,88]

While much of the immediate market response has been observed in publicly traded firms, the implications for early-stage biotechnology investment may differ. Venture capital (VC) investors typically focus on long development timelines, high technical uncertainty, and exit opportunities through acquisition or public listing, rather than near-term revenue streams.[89] Because eligibility for IRA negotiation is triggered several years after market entry, early-stage assets may appear less directly exposed at the time of initial investment. However, the policy may still influence VC behavior indirectly by altering expected downstream pricing environments and exit valuations, even if early aggregate evidence on VC funding effects remains mixed.[90]

For example, if anticipated price constraints reduce the projected peak revenue of late-stage assets, this may compress acquisition multiples or public market valuations, thereby affecting the expected returns to early investors—a mechanism consistent with investor-reported changes in deal value, exit expectations, and investment strategy.[85] In turn, VC firms may adjust portfolio strategies by prioritizing therapeutic areas with lower Medicare exposure, greater differentiation, or clearer value propositions under constrained pricing conditions.[91] These effects are likely to be more diffuse and mediated through capital market expectations rather than immediate repricing, but they suggest that IRA-related policy signals may propagate upstream into early-stage financing decisions.

5.2 Implications for Manufacturers

Because R&D decisions depend on expected returns, pricing policy can influence corporate decision-making beyond pricing itself, including lifecycle management, pipeline planning, and indication strategy.[92] Negotiation eligibility is tied to time since approval and Medicare spending, which increases the strategic value of revenue timing across a product's lifecycle. The key question for manufacturers is not only "how much" a product earns, but "when" it earns revenue relative to eligibility thresholds.[86]

Although the IRA has raised concerns that manufacturers may respond by increasing launch prices, several features of the statute—including delayed negotiation eligibility, inflation-based rebate penalties, and ongoing payer constraints—limit the scope for widespread launch-price escalation. To date, evidence does not indicate

a clear IRA-driven shift in launch pricing behavior, suggesting that manufacturers are more likely to adapt through lifecycle management and portfolio strategy than through across-the-board increases in initial prices.

Most modeling suggests that the IRA modestly reduces expected returns for a subset of products—particularly those with high Medicare exposure and marginal commercial prospects. Products with strong differentiation, large global markets, or multiple payer segments remain attractive. Consistent with this, policy models and Congressional Budget Office projections suggest relatively small aggregate effects on innovation, with impacts accumulating gradually over time.[93,94] Because implementation is recent, evidence on realized R&D shifts remains limited, and many conclusions still rely on simulation-based methods.

Revenue-exposure studies also underscore heterogeneity: for diversified manufacturers, negotiated drugs may represent a modest share of total portfolio value, allowing pressure to be offset by other products, geographies, or therapeutic areas.[70,95] Smaller firms may be more sensitive to single-asset exposure, but risk is often shared through licensing, partnerships, and external financing.[96]

Strategic adaptation may therefore dominate outright retreat. Likely responses include:

- Portfolio rebalancing toward areas with lower Medicare intensity or broader commercial demand.
- Launch and indication sequencing designed to maximize pre-negotiation revenue windows (e.g., accelerating development or prioritizing indications with faster uptake).
- Lifecycle planning that anticipates negotiation as a new, modelable milestone—similar to LOE planning.

These shifts mirror how firms have historically responded to reimbursement and regulatory incentives by reallocating effort toward more favorable projects rather than reducing research activity uniformly. Clear empirical confirmation, however, will require longer observation windows.[97,98]

5.3 Implications for Other Stakeholders

5.3.1 Patients

For patients, the IRA's most immediate impact comes from changes in affordability and benefit design, rather than from price negotiation alone. The IRA phases in an annual Part D out-of-pocket cap and limits cost-sharing in key products such as insulin, reducing financial burden for beneficiaries with diabetes and making annual expenses more predictable.

Available analyses suggest that savings are concentrated among beneficiaries with very high out-of-pocket costs—a relatively small share of enrollees who account for a disproportionate share of spending.[6] Early evidence suggests that lower cost-sharing (e.g., for insulin) can translate to increased fills and potentially improved adherence.[99] By reducing volatility and the risk of catastrophic spending, the IRA may also mitigate cost-related nonadherence among patients with chronic disease.

5.3.2 Providers

Prescribing is driven primarily by clinical evidence and patient needs, but it is also influenced by financial and informational environments. Evidence predating the IRA shows that industry payments to physicians are

associated with higher prescribing of promoted drugs, even after adjusting for observable characteristics, and that even small transfers (e.g., sponsored meals) can correlate with measurable prescribing differences.[100] While these relationships are not created by the IRA, IRA-driven shifts in relative prices and plan incentives may indirectly influence utilization patterns by changing formulary placement, patient cost sharing, and the relative attractiveness of therapeutic alternatives.

Comparisons between Medicare Advantage and original Medicare also suggest that providers respond to payer incentives and benefit design. Plans that emphasize efficiency tend to encourage the use of lower-cost options when clinically appropriate. In practice, financial signals embedded in coverage design can influence prescribing patterns without overtly restricting clinical autonomy.[101]

5.3.3 Plan sponsors

Medicare Part D drug coverage is delivered through private plan sponsors under CMS rules. CMS sets payment policies and now negotiates MFPs for selected drugs, while Part D plan sponsors (e.g., stand-alone PDPs and Medicare Advantage plans with integrated drug coverage) design formularies and manage utilization management.[102]

For plan sponsors, the IRA changes both prices and risk.[103] Part D redesign redistributes liability across plans and manufacturers, strengthening incentives for cost management. Even where certain liabilities decline in the catastrophic phase, plans face greater responsibility earlier in the benefit structure and remain exposed through premium-setting dynamics and related stabilization mechanisms. These features amplify incentives to manage high-cost drugs through formulary design, tier placement, cost sharing, and utilization controls.

Early indicators suggest that plans are actively adapting—adjusting deductibles and cost-sharing structures and refining utilization management to manage exposure under the redesigned benefit. This highlights an important point: negotiation is not a standalone intervention. It operates within—and interacts with—a broader set of payer incentives.

As illustrated in **Figure 5.1**, the IRA introduces new constraints and incentives without fully displacing underlying market dynamics. Its effects propagate through expectations, contracts, and behavioral responses rather than uniform price control across the market. The drug price negotiation program is therefore likely to generate substantial early savings by repricing a concentrated set of mature, high-expenditure drugs. Over time, however, its marginal impact on overall Medicare drug spending growth may diminish, as the pool of eligible high-spend legacy drugs shrinks and spending growth increasingly shifts toward newer therapies that remain outside the program for extended periods.

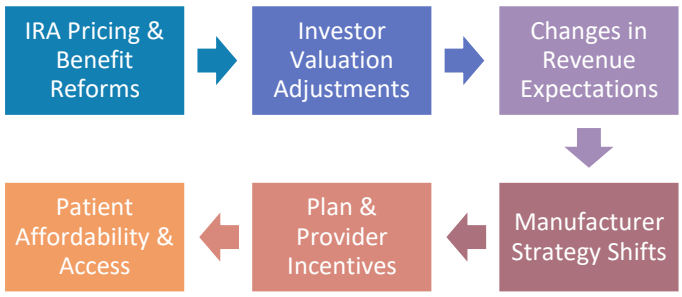

Figure 5.1. Conceptual Pathways of IRA Policy

The long-run implications for innovation, spending, and access will depend on how stakeholders continue to adapt within the evolving policy environment.

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