Hope for the Best, Prepare for the Worst: The Inflation Reduction Act's Unintended Consequences for Medicare Part D in 2025 and 2026

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

With almost 57 million beneficiaries enrolled, Medicare Part D has been largely a success story of government and commercial health plans coming together to bring prescription drug access to eligible older Americans and people with disabilities.[i] To date, beneficiaries have generally had access to a wide range of medications across therapeutic classes, abundant plan options for enrollment, and protections to ensure they receive needed medications. The successful balance of these features in Medicare Part D has been foundational to the program earning 90%+ satisfaction rates from beneficiaries.

Yet the program has not been without its challenges, including high out-of-pocket (OOP) costs. While the Affordable Care Act and Bipartisan Budget Act, through pharmaceutical manufacturer discounts, closed the coverage gap for branded drugs, access and affordability remain a problem. According to the Department of Health and Human Services, about 1.5 million enrollees reached the catastrophic phase of the benefit in 2023; on average, they paid about $3,093 in OOP costs for their Part D medications.[ii] And it is not the same patients who are impacted year over year; between 2012 and 2021, 5 million beneficiaries had OOP drug costs over $2,000 for at least one year.[iii]

Enacted in 2022, the Inflation Reduction Act (IRA) took steps to minimize costs for Medicare beneficiaries. IRA, for the first time, puts in place an OOP cap for beneficiaries in Medicare Part D. In 2024, the OOP cap is at $8,000, but because of brand manufacturer contributions to the coverage gap program, most beneficiaries will not pay more than about $3,300 for their Part D prescriptions.[iv] Starting in 2025 (when the manufacturer coverage gap discount program will sunset), the cap changes to a hard $2,000 OOP cap, which will adjust each year based on inflation. In addition, beneficiaries will be able to spread out their OOP prescription costs over the course of the year.

The MAPRx Coalition helped lead efforts to advocate for the OOP cap in Part D and a mechanism to smooth, or evenly spread, high OOP prescription drug costs throughout a given plan year and is excited to have these changes in place. **And yet, it is cautious optimism.** This is because IRA enacted the most significant changes to Part D since its inception, and these reforms have major implications for beneficiaries who rely on the program.

In this paper, the MAPRx Coalition examines the potential impact of three of IRA's major Part D provisions:

1. **Broad redesign of the program that includes creation of an OOP cap and "smoothing" mechanism and changes in how the program is financed through Part D premiums, manufacturer discounts, and government financial support;**
2. **New authority for the government to negotiate lower prices for certain drugs in Part D; and**
3. **Imposition of financial penalties if a drug's price rises faster than the rate of overall inflation. While some of these provisions—in particular, the OOP cap and smoothing mechanism—will improve affordability and deliver significant benefits to Medicare beneficiaries through lower OOP costs, the impact of other provisions is less clear and may include significant unintended consequences for beneficiaries.**

IRA shifts financial liability in Part D in ways that must be understood and prepared for and which could result in higher premiums and more restrictive formularies. In the longer term, IRA may impact patient access through changes that affect the development of new medications and others that challenge the viability of the standalone prescription drug plan (PDP) market. These long-term consequences are largely outside the scope of this paper.

Given the potential for Part D plans to restrict access to medications, and the fact that Part D plans already have signaled they are planning to make changes that could limit access,[v] never has the Centers for Medicare & Medicaid Services' (CMS) role in safeguarding beneficiary protections been more important. As such, this paper assesses IRA's potential unintended consequences, and it offers policy solutions for CMS and Congress to minimize adverse impacts on Part D beneficiaries and ensure they have access to needed medications for 2025 and beyond.

OVERVIEW OF IRA'S CHANGES TO MEDICARE PART D

As noted, IRA has several significant components impacting beneficiaries: a broad redesign of the Part D benefit, including to cap OOP costs and smooth cost-sharing on a monthly basis; a program authorizing CMS to negotiate the prices of certain medicines, starting in Part D in 2026 and expanding to Part B in 2028; and financial penalties if a drug's price rises faster than the rate of overall inflation (**Figure 1**).

Figure 1. Core healthcare components of IRA

Part D Benefit Redesign

IRA significantly redesigned the structure and benefits of the Part D program by:

- In 2024, eliminating catastrophic coverage for beneficiaries, which limits cost-sharing to approximately $3,300 for most beneficiaries
- Capping Part D beneficiary OOP costs at $2,000 starting in 2025
- In 2025, implementing the Medicare Prescription Payment Plan (MPPP), in which Part D beneficiaries may choose to smooth out the cost of their medications over the course of the year. Part D beneficiaries may enroll in this voluntary program during the annual election period or at any time during the plan year. There are no eligibility requirements to enroll in the MPPP, nor limit to the number of medications whose costs can be applied to the MPPP
- Extending the full benefit of the Low-Income Subsidy (LIS) to all beneficiaries at or below 150% of the Federal Poverty Level, which also helps to increase access to medications for those with modest resources and assets
- Capping monthly insulin OOP costs at $35
- Mandating $0 OOP costs for vaccines covered under Part D

Medicare Negotiation

IRA mandates pharmaceutical manufacturers of selected drugs to negotiate drug prices with Medicare or risk exclusion from participating in Medicare or Medicaid or face a significant excise tax that increases over time.

The number of drugs selected for negotiation increases over time, based on the schedule outlined below:

- 10 Part D drugs in 2026
- An additional 15 Part D drugs in 2027
- An additional 15 Part D and Part B drugs in 2028
- An additional 20 Part D and Part B drugs in 2029 and later years

Inflation Penalties

IRA requires drug manufacturers to pay a penalty for Medicare price increases exceeding the rate of inflation.

While some of these changes could have positive impacts on beneficiary OOP spending at the point of sale, the reality of market dynamics will likely result in unintended consequences that limit beneficiary access to medicines. Overall, these changes shift more of the costs from Part D beneficiaries and the federal government to Part D plans and pharmaceutical manufacturers, and their reactions must be understood, planned for, and, where possible, mitigated.

FOR EACH ACTION, THERE IS AN EQUAL AND OPPOSITE REACTION: UNINTENDED CONSEQUENCES

The Part D redesign puts much greater financial pressure on health plans to manage drug utilization prior to the catastrophic phase, and as a result, formulary exclusions and utilization management are likely to increase. This is in addition to Medicare negotiation, which also is expected to lead to more restrictive coverage in drug classes with one or more selected drugs.

To understand these dynamics, it is important to recognize that over time, and until IRA was enacted, Part D plans have paid less toward overall Medicare Part D spending. Increasing costs have occurred in the catastrophic phase of the benefit, which historically has been paid for by the government through reinsurance.

Over time, reinsurance has crept up to represent almost half of Medicare Part D spending.[vi] Medicare Payment Advisory Commission (MedPAC) analysis confirms this finding. Its March 2024 report showed that in 2022, Part D plans were responsible for only 25% of the insurance risk compared to the government, which was responsible for 62%. Beneficiaries were at risk for 13%.[vii]

What this means is that plans have had less incentive to manage the benefit and, given the payment structure, there is a strong plan preference for high-cost, high-rebate drugs that contribute to plan profit because the federal government—and not Part D plans—has borne most of the costs in the catastrophic phase. These high-cost, high-rebate drugs can create beneficiary affordability challenges. Beneficiary cost-sharing for high-cost drugs is typically calculated using coinsurance, and Part D plans do not lower the cost the patient faces at the point of sale by the amount of the rebate.

Throughout this paper, we refer to plans but should note that they work with pharmacy benefit managers (PBMs) to administer the prescription drug benefit with PBMs often responsible for drug negotiation, formulary development, and utilization management under direction from the plan. As discussed later in this paper, this will not entirely change with the implementation of IRA, but beneficiaries are now somewhat protected from the impact because of the Part D redesign.

The Part D benefit redesign radically changes the incentives for Part D plans, as they will now bear more of the financial burden compared to the previous benefit design (see **Figure 2**). The coverage gap had 5% plan liability and has grown into a larger initial coverage phase where plans are liable for 65% of the cost. Plan cost-sharing in the catastrophic phase grows from 20% to 60%.[viii]

Figure 2. Comparison of previous and future Part D benefit designs

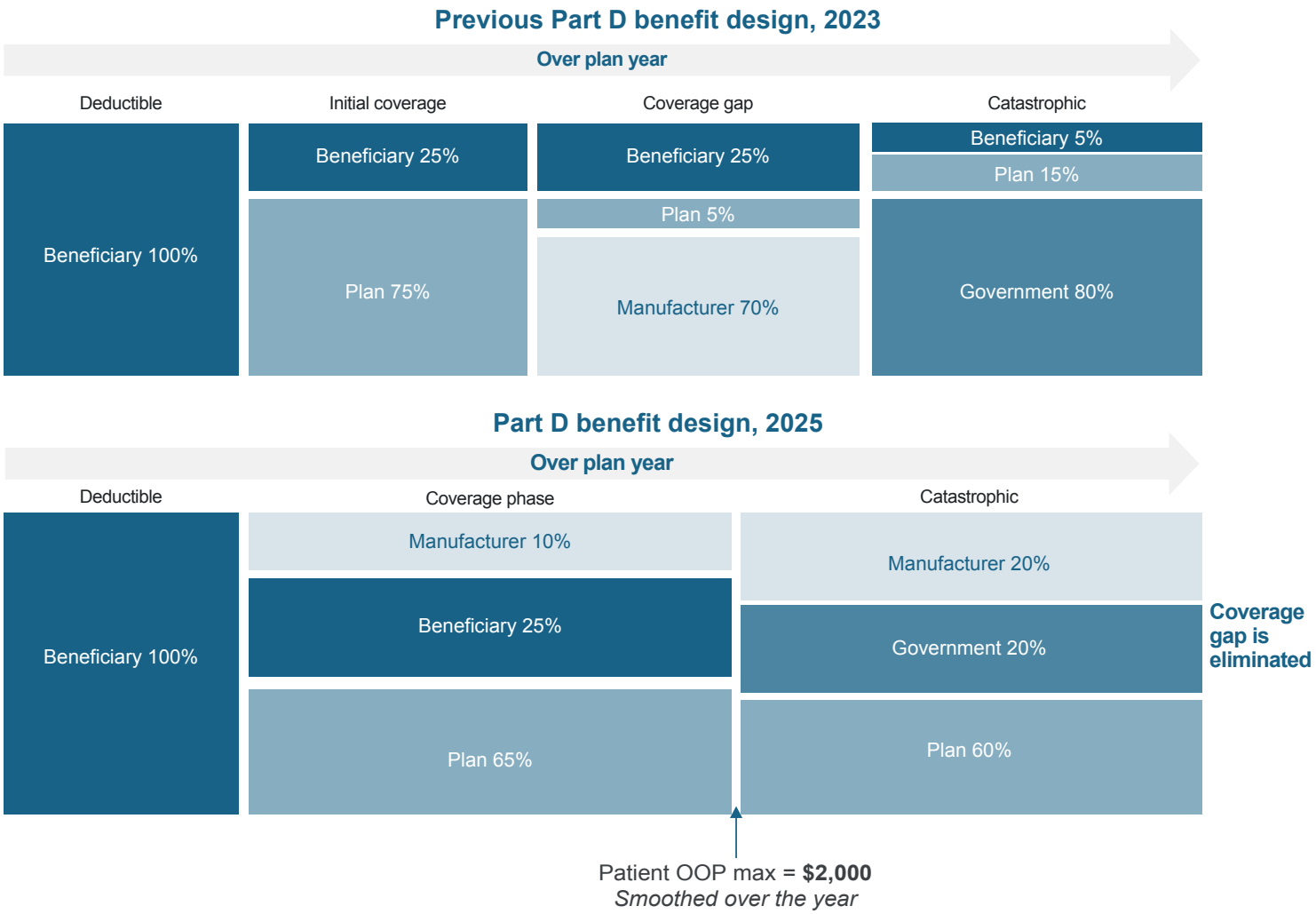


Table 1 shows examples of a $400 per month and a $12,000 per month drug before and after the IRA redesign.[ix] In the example of a $400 per month drug, plan spending goes down a little as it is buoyed by the 10% manufacturer contribution. However, if one looks at a $12,000 per month drug, plan spending goes up over $60,000 for the year where government spending decreases by almost $80,000. A shift like this will inevitably have a market reaction.

Table 1. Comparison of benefit redesign impact by stakeholder group, 2025

	Product A: $400/month		Product B: $12,000/month	
	Pre-IRA benefit design	IRA benefit design	Pre-IRA benefit design	IRA benefit design
Beneficiary	$1,616	$1,616	$9,990	$2,000
Part D plan	$3,184	$2,759	$23,575	$86,356
Manufacturer	–	$425	$4,720	$28,111
Government	–	–	$105,715	$27,533

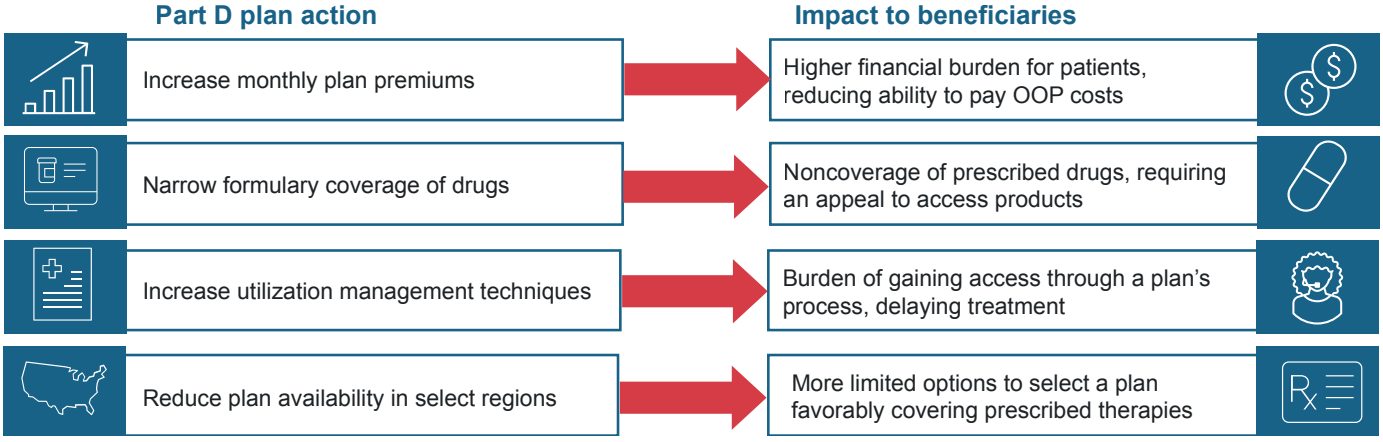
The Product A scenario results in minimal changes, while the Product B scenario significantly shifts costs for all stakeholders. Both beneficiaries and the federal government have much lower costs annually, as Part D plans and drug manufacturer costs significantly increase.

In addition, CMS's new authority to negotiate drug prices has further potential to create unintended access challenges in drug classes with one or more drugs that are subject to negotiation. While Part D plans must include negotiated drugs on formularies, those drugs may still be subject to utilization management restrictions, which can limit beneficiary access. In some instances, drugs not subject to negotiation will be at higher risk for coverage exclusion or utilization management because it is more financially advantageous for plans to prefer the negotiated drug. In other instances, a negotiated drug may be placed in a less favorable position on a formulary if a plan is able to negotiate greater price concessions for a non-negotiated drug.

The bottom line is that, because of the increased financial liabilities, Part D plan sponsors are likely to respond by ramping up existing strategies to manage their costs. Those strategies include:

- Narrowing formularies to limit the number and types of drugs covered
- Increasing utilization management, such as prior authorization and step therapy, which can delay or restrict access to prescribed medications
- Increasing monthly plan premiums[a]
- Reducing choice of plans in the standalone PDP market, including zero-premium "benchmark" plans for low-income beneficiaries

Figure 3. Comparison of benefit redesign impact by stakeholder group, 2025

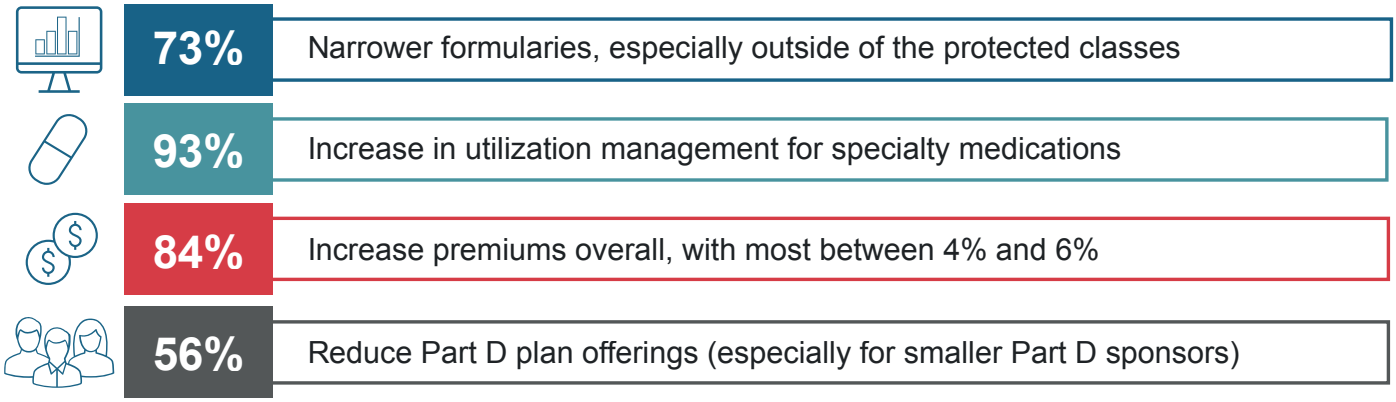


[a] The Part D base beneficiary premium is capped at 6% growth annually. However, this is only one of several components in the calculation of a plan's premium. The premium stabilization only lasts through 2029.

[b] Under this policy, Part D plans must cover all or substantially all drugs in the following classes: antineoplastics, antipsychotics, antidepressants, antiretrovirals, anticonvulsants, and immunosuppressants for organ transplants.

According to a 2024 survey of Part D plan sponsors, nearly half (49%) expect the Part D redesign to have an adverse financial impact on their Part D plans.[x] Over 70% of Part D plans project narrowing formulary coverage through drug exclusions, but nearly all plans are looking to increase utilization management across the board (even for drugs mandated for coverage under the six protected classes policy[b]) (**Figure 4**).[xi]

Figure 4. Part D plan cost management strategies for the Part D benefit redesign in 2025, based on survey results of Part D plans[v]



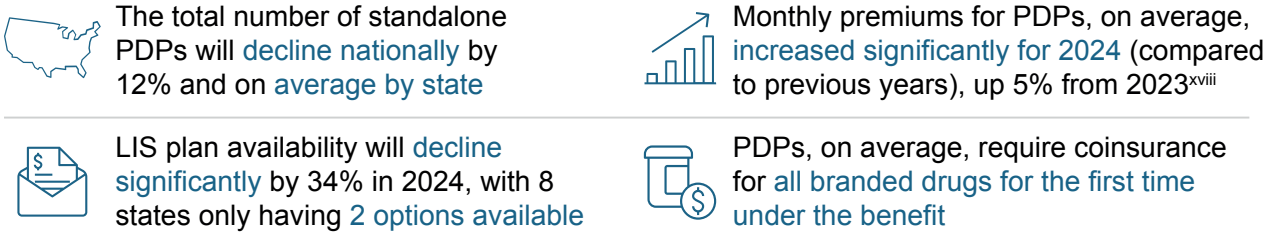
While survey data from Part D plan sponsors is helpful in predicting unintended consequences in 2025, current and past plan behavior is an even greater indicator of future behavior. Already, Part D plans have implemented significant changes in 2024, potentially foreshadowing even more profound changes in 2025 and beyond.

Premium Increases

The average Part D premium, both for base benefits as well as supplemental, has been incredibly stable for several years. That is until the effects of IRA started to be felt.

In 2024, the base beneficiary premium would have gone up by 20% had a 6% cap not been established by IRA.[xii] As seen in **Figure 5,**[xiii] the average premium per standalone PDP plan increased by roughly 5% from 2023 to 2024, which represents a sizable increase in the generally stable Part D market. In 2025, the base beneficiary premium will increase by the highest percentage of 6%, likely portending a higher average premium overall for beneficiaries.[xiv]

Figure 5. Part D market trends in 2024[xvi]



Premium increases are a trade-off that many patient advocates understood as inevitable but were willing to accept in exchange for more robust benefits and patient protections such as the OOP cap and smoothing mechanism. Currently, Part D plans offer lower premiums to attract beneficiaries. However, those who are sicker and utilize the benefit subsidize low premiums through utilization management and high cost-sharing that may restrict their access to care. By establishing an OOP cap, beneficiaries who have higher Part D utilization can have their costs lowered and access improved, while all beneficiaries pay slightly more in premiums.

Plan Availability

One potential consequence of the IRA is the erosion, or even the eventual disappearance, of the standalone prescription drug market. Currently, beneficiaries have two options for accessing Medicare Part D. They can sign up for a standalone PDP, which only offers prescription drug coverage (with beneficiaries generally receiving medical coverage through Original Medicare), or they can sign up for a Medicare Advantage plan with Part D coverage. Medicare Advantage plans with Part D cover inpatient hospital care (Medicare Part A), in-office and outpatient care (Part B), and prescription drugs (Part D).

Over the past 10 years, Medicare Advantage enrollment has grown from 38% of the Part D market to 58%.[xv] The draw of Medicare Advantage over standalone PDPs is easy to see; premiums are often lower. Using government payments, Medicare Advantage plans can buy down the Part D premium so that some beneficiaries face $0 premiums for Part D if they sign up for the Medicare Advantage plan.

As enrollment in Medicare Advantage has grown, standalone PDP availability has declined. In 2024, the number of PDPs declined nationally by 12%, reducing beneficiary choice and options in the Part D marketplace.[xiv] Moreover, while non-LIS beneficiaries may still have an adequate number of standalone plan options, the subset of PDPs offering a $0 premium for LIS enrollees declined by 34%, with 8 states having two or fewer options available.[xvii] This reduced choice, which is expected to accelerate with IRA, makes it more difficult for beneficiaries to find plans that meet their medication and affordability needs. For example, LIS enrollees in these states have limited recourse if one or two of the plans do not cover their prescribed medications.

The long-term viability of the PDP market is concerning. Without the ability to offset premium increases with the level of rebates available to Medicare Advantage plans, PDPs may find that their premiums increase sharply, which will push more beneficiaries to Medicare Advantage. This could create a downward spiral of increasing premiums and fewer plan choices that each year chip away at the number of PDPs available. There may be a time in the future where beneficiaries have few plans per area to select from and may not have plan options that provide adequate coverage of the prescription drugs they need. When the Part D benefit was passed in 2003, there was an open question of whether plans would offer these PDPs. Policymakers should monitor these trends, as there may be a need to revisit a provision from the Medicare Modernization Act of 2003 that required Medicare to stand up two fallback options for beneficiaries to choose from.[xviii]

Formulary Exclusions

As Part D plans look for ways to manage their costs, they are likely to restrict access to medications through increased formulary exclusions.

This is a growing trend already seen in the Part D program. According to a Health Affairs study, Part D plans excluded 20.4% of brand and generic drugs in 2011 compared to 30.4% in 2020.[xix] The study further found that plans excluded 44.7% of branded medications in 2020.[xx]

Recent analysis by Cencora found an overall decline in the coverage of branded medicines with the average number of branded medications covered by a Part D plan formularies declining by 6% from 713 in 2020 to 667 in 2024.[xxi] While some of this can be explained by drugs losing patent status and market exclusivity, it is not the whole story, especially given record approvals of new drugs in recent years.

In addition to the overall narrowing of formularies, plans have begun limiting coverage for specific classes of drugs. For example, a Milliman analysis of branded medicines treating multiple sclerosis found that coverage for these medications generally declined from 2020 to 2023.[xxii] While this analysis acknowledges that generic competition may be the cause for some of the declining coverage, it also notes other financial pressures likely contributed to the trend.[xxiii]

Even if plans cover a drug and include it on their formularies, they may require beneficiaries pay high OOP costs by placing the drug on a formulary tier with increased cost-sharing requirements. Over time, Part D plans have consistently placed more of the cost-sharing burden onto patients through higher coinsurance rates and copayment amounts, especially for expensive therapies.

The trend of shifting costs to beneficiaries when plans had limited financial liability is especially concerning knowing the increased financial pressures on plans due to the changes under IRA. Moreover, these trends in plan behavior with formularies in recent years, combined with survey data, indicate that formularies may become more restrictive and more costly for beneficiaries after IRA is fully implemented, further exacerbating beneficiary access challenges. It is important to note that although there is an exceptions process for beneficiaries to gain access to a nonformulary drug, it is cumbersome, and plan sponsors have broad flexibility in determining the cost-sharing for a nonformulary drug approved under the exceptions process.[xxiv]

Utilization Management

It is widely expected that plans will increase their use of utilization management—particularly prior authorization and step therapy. Prior authorization requires beneficiaries to get pre-approval before a prescription is filled. Step therapy requires patients to take one or more alternative medications before they can access the medicine prescribed by their provider. Like formulary exclusions, use of utilization management has increased over recent years. The percentage of generic and brand Part D drugs subject to utilization management increased from 31.9% in 2011 to 44.4% in 2020, according to a study analyzing utilization management trends.[xxv] "When you're talking about branded products, almost seven out of 10 have either some restriction or they're excluded. That's pretty high," says Geoffrey Joyce, one of the primary authors of the study.

This trend has continued especially for branded medications. Part D plans, on average, required prior authorization for 43% of branded medications in 2024, compared to 38% in 2020, representing a 13% increase.[xxvi]

Specific classes of drugs, such as those used to treat autoimmune diseases and multiple sclerosis, are subject to "some degree" of utilization management, with step therapy often required.[xxvii] Many states have legislation for the commercial market that allows beneficiaries who have already tried and failed a drug to not repeat that drug as part of the step therapy requirement; there no such requirement within Medicare.

As a result of utilization management, beneficiaries may abandon medications at the pharmacy counter or (along with their physicians) undergo a burdensome process to gain access to a product. These barriers could have serious consequences for beneficiaries by delaying the start of or reducing adherence to a prescribed therapy, in turn resulting in poorer outcomes and quality of life.

In some ways, growth in utilization management is more concerning than that of formulary exclusions. Beneficiaries often choose their plans based on premiums and whether their drugs are on formulary, but not necessarily knowing about any required utilization management. The Medicare Plan Finder, which helps beneficiaries find a plan in their area, indicates whether a drug is on formulary and what it will cost but does not indicate whether there are utilization management requirements. Like formulary exclusions, use of utilization management has grown and is likely to continue to grow considering IRA changes.

With both formulary exclusions and utilization management, patients will rely on CMS oversight of formularies to provide adequate access. Over the years, this has not been a transparent review process.

Continued Pressure on Formulary Coverage and Utilization Management

The higher liability facing Part D plans due to the benefit redesign and even the provision requiring formulary coverage of drugs selected for the Medicare negotiation program are likely to result in plans deploying the cost-management strategies (eg, narrower formularies, greater utilization management) discussed throughout this white paper.

While IRA mandates coverage of Medicare-negotiated drugs, it does not guarantee access to these medications. The $2,000 OOP cap and the ability for beneficiaries to spread their OOP cost over the course of the year will lessen the financial burden for some beneficiaries; however, increased beneficiary cost-sharing and utilization management of these negotiated drugs will still impact beneficiaries and limit access to medications.

In fact, aside from the OOP cap, which applies to all Part D drugs, the law does not provide CMS with the authority to ensure those in Part D who are prescribed a negotiated drug will directly benefit from any reduction in the price of the drug. CMS has said that it will use its formulary review process to assess if negotiated products are at least at parity in coverage with nonselected drugs in the same class.[xxviii] This means that negotiated drugs still may be placed on formulary tiers with high cost-sharing and may be subject to restrictions such as prior authorization and step therapy. In short, IRA mandates these drugs are covered; it does not mandate beneficiaries have access to them.

In recent years, Part D plans also have placed high-cost, branded biologics and insulins with high rebates on preferred formulary tiers, as opposed to preferring low-cost products with lower rebates. While the rebate technically means that the drugs are less expensive, this does not necessarily result in lower OOP costs for beneficiaries. For nearly all branded medications, Part D plans require beneficiaries pay coinsurance (or percentage of the cost of the drug) rather than a fixed copayment (eg, $35). Part D plans do not apply rebates to the actual price beneficiaries face at the point of sale, so they do not realize the benefit of a lower price and OOP cost. As a result, beneficiaries may pay thousands of dollars in OOP costs for drugs and biologics used to treat cancer, multiple sclerosis, rheumatoid arthritis, lupus, and other conditions.

The thought was that with the Part D redesign, plans might prefer drugs with lower list prices to keep beneficiaries out of the catastrophic phase, thus reducing overall plan spending. However, given the way that plans are paid and the lower prices for Medicare-negotiated drugs, the preference for rebates over a lower list price might not go away. Plans do have more financial liability, but the reinsurance phase is also larger, so they would prefer to keep any of the rebate they can collect. This could be troublesome for Medicare-negotiated products because they may end up more costly to the Part D plan than comparable products offering discounts.[xxix]

Long-Term Impacts

The Medicare Drug Price Negotiation Program (MDPNP) could also impact drug development into the future. The program requires Medicare to negotiate prices for drugs that are highly utilized and incur the most costs for the Medicare program, among other important criteria for selection. For example, orphan drugs are excluded from the negotiated program provided they have one orphan designation tied to a single FDA-approved orphan indication (or indications tied to the same orphan designation). If the manufacturer adds a second orphan designation, or the drug is approved to treat a second disease, the drug is eligible for negotiation; therefore, this dynamic could discourage research into other orphan diseases and result in more limited treatment options for patients with rare diseases.

Moreover, other provisions may also affect drug development in the future. The provision allowing CMS to select all drugs with multiple uses and different formulations for negotiation may potentially discourage research into new formulations for existing drugs or for new drugs with the possibility of multiple uses. Also, the different timelines for selecting drugs for small molecule (7 years after approval) and large molecule (11 years after approval) could shift the research focus for manufacturers to only certain types of products.

Given these potential dynamics, many patient advocates are concerned about the long-term impact on research. A study from the University of Chicago finds the MDPNP will dramatically reduce the number of drugs coming to market by 135 (through 2039)[xxx]; the Congressional Budget Office projects a much more muted impact of just 1 fewer drug through 2032 and 5 fewer drugs from 2033 to 2042.[xxxi]

While not in the scope of this white paper, the unintended consequence of discouraged investment in research must be continually monitored and potentially addressed in the future.

WORKING TOGETHER TO GET AHEAD OF THE CONSEQUENCES

Medicare Part D has a long history of success and a positive impact on the lives of millions of Medicare beneficiaries. CMS has played an integral role in safeguarding beneficiary protections throughout the course of the benefit. As CMS works to implement the provisions of IRA, it can extend and expand upon its record by promulgating policies that strengthen access and minimize the law's unintended consequences.

To that end, MAPRx recommends the following policy solutions to minimize the effect of unintended consequences and maximize beneficiary protections.

Patient access

- Offer transparency and more rigor into the formulary review process to ensure access to a wide range of drugs and classes
- Allow beneficiaries to appeal for a lower OOP for drugs on specialty tiers
- Minimize inappropriate access barriers and ensure plans do not create new barriers to negotiated drugs required to be covered on Part D plan formularies or to other medicines in those drug classes
- Enhance the Medicare Plan Finder tool to enable beneficiaries to identify whether utilization management requirements (prior authorization and step therapy) apply to drugs on formularies
- Explore approaches to evaluate and strengthen the appeals process for beneficiaries
- Clarify through Congressional action that the number of orphan drug designations obtained by a product has no effect on its eligibility for Medicare drug price negotiation and that the "clock" for Medicare negotiation selection starts with FDA approval of the second orphan indication
- Provide updates to Congress and stakeholders on the implementation of IRA to ensure the regulatory activity is consistent with the intent of policymakers

Patient feedback

- Establish a structured process to enhance patient engagement and obtain meaningful input from beneficiaries to inform Medicare negotiation
- Create a formalized process for CMS to obtain beneficiary input on the Part D experience, including formulary design, utilization management, and appeals, to better understand the impact of reduced access to drugs and greater access barriers
- Conduct regular focus groups with Part D beneficiaries to ensure program and educational outreach are meeting their assigned objectives

Plan choice

- Explore approaches to ensure LIS beneficiaries have more than one to two PDPs available to them in a given PDP region
- Monitor the PDP program to ensure adequate choice for all beneficiaries

Medicare Prescription Payment Plan (MPPP)

- Enhance the agency's education and outreach on MPPP (beyond existing proposed plans), including strengthening plan requirements around beneficiary outreach
- Enhance options to enroll into the program (eg, enrollment option via the Medicare Plan Finder) and to re-enroll every new plan year
- Offer a point-of-sale enrollment option for MPPP, and specifically conduct targeted outreach via pharmacies at the point-of-sale
- Release publicly available data on beneficiary participation within the MPPP on an annual basis

The MAPRx Coalition[c] has consistently been a strong proponent of enacting an OOP cap and accompanying program that smooths or evenly distributes beneficiary OOP costs throughout the plan year in Part D.

As discussed throughout this paper, the ongoing potential for greater plan cost management threatens to further erode beneficiary protections. Past Part D plan behavior and their cost-management strategies for 2025 suggest that beneficiaries will face continued access barriers to medications, ongoing affordability challenges, and limited plan availability.

No legislation is perfect; IRA is not unique in that way. Each reveals itself and its flaws over time. It will be critical for CMS to ensure it maintains many current beneficiary protections and builds on others in the future. For example, the MPPP program is new and the rollout may introduce unforeseen challenges that need to be addressed quickly. All stakeholders will need to work with CMS to communicate these challenges and steer toward appropriate solutions. And, where changes are beyond the scope of CMS authority, Congress will need to pass legislation that makes the appropriate adjustments.

MAPRx is committed to partnering with CMS and other stakeholders to minimize any negative impacts of the unintended consequences of IRA. The challenge in appropriately balancing beneficiary protections and plan flexibility in managing costs is formidable. We urge CMS to use its vast set of tools and partnerships with stakeholders focused on patient access to make necessary changes and conduct oversight to ensure a robust and successful Part D program in the future.

[c] MAPRx is a national coalition of more than 60 beneficiary, caregiver, and healthcare professional organizations committed to improving access to prescription medications and safeguarding the well-being of Medicare beneficiaries with chronic diseases and disabilities. The coalition has championed policies in Part D that improve the affordability of medications and beneficiary access to those medications.

Cencora and Jennifer Snow at Apteka contributed to the research and writing of this white paper.

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