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Modifying Monopoly: Negotiated Medicare Drug Price Reductions May Not Increase Access or Use for Most Patients Taking the Targeted Drugs

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ABSTRACT

This paper studies two major changes in the financing of Part D drugs for Medicare due to the Inflation Reduction Act (IRA). Effective 2025 it capped out of pocket (OOP) payments at $2000 per year, and effective 2026 it will pay lower prices (negotiated by Medicare) for 10 targeted costly and effective drugs. This paper uses a large representative claims sample to explore the combined effect of these two provisions on the marginal cost sharing that affects beneficiaries' access to these drugs. While many beneficiaries will be expected to see lower marginal OOP prices, we find that a majority of those using the targeted drugs will face either no change in their marginal OOP or, in a large fraction of cases, an increase in their dollar cost sharing per additional unit of use. This happens even when beneficiaries see reductions in their annual OOP cost because of the nonlinear nature of cost sharing in the Medicare Part D drug.

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Introduction

Patent protected prescription drugs have prices set higher than the competitive level, and higher than marginal cost. The reason why such prices are enabled and enforced by the power of government is to provide incentives to develop the intellectual property embodied in innovations. Welfare economics says that, in a tradeoff against innovation, there are two potentially adverse effects of monopoly power (relative to competition, once a discovery has been made): there will be inefficient underuse of the product, and there will be a transfer of welfare and wealth from those paying for the product to those supplying the product.

In the case of use of branded drugs by the Medicare population, the bulk of payments for those drugs comes from publicly subsidized Part D insurance. To reduce payments financed by public funds, the same government that enforces patent protection has through the Inflation Reduction Act implemented a policy of negotiation for lower prices for Medicare Part D beneficiaries using a subset of patented drugs: lower prices for 10 patent protected high cost drugs have already been negotiated and are due to take effect in 2026. A similar process for additional drugs is to ensue for several years.

In this paper we provide evidence on the extent to which lower negotiated price are or are not translated into incentives to beneficiaries to use larger quantities—which is the source of welfare improvement from lowering prices from the monopoly level. There has been some discussion of the proposition that the bulk of the redistribution of benefits from lower prices will go to the Medicare insurance plan (and those who fund it) rather than to the users of the drugs targeted for negotiation [1]. In this paper we show that lower negotiated prices will have zero or negative effects on use by most of these beneficiaries. Using data on the distribution of annual claims costs for users of these drugs, we find that, for a majority of such users, there will not be a reduction in marginal cost sharing, and that for a sometimes sizeable subset of such users, expected marginal cost sharing will actually increase (compared to no lower price negotiation), even as expected average out of pocket payments fall for these beneficiaries. This apparent paradox occurs because of the nonlinear nature of cost sharing as a function of total claims cost built into the design of Part D coverage.

The Policy Problem

An important provision of the Inflation Reduction Act (IRA) allows the Centers for Medicare and Medicaid Services (CMS), for the first time, to negotiate prices directly with makers of a selected but growing list of expensive drugs. Driven by the reality that a small number of drugs account for a significant share of Medicare Part D spending [2], the new Drug Price Negotiation Program enables the government to negotiate “Maximum Fair Prices” for select high-expenditure, single-source drugs covered by Medicare Part D, starting in 2026, and Part B, starting in 2028. Price negotiations can ensue after seven years of patent protection has passed for small-molecule drugs or eleven years for biologics [3].

CMS claims that this program will benefit current beneficiaries in an important way. "Medicare's new ability to negotiate prices for covered drugs will improve drug affordability for people with Medicare and lower costs for the Medicare program, improving access to innovative, life-saving treatments for people who need them." [4] A similar claim is made by Trish and Blalock (2025) that "because the prices set by CMS are notably lower than the drug's list price, beneficiary cost sharing will decline," [5] projecting that the negotiated lower prices for the first 10 selected drugs in 2026 will save beneficiaries enrolled in the Part D standard benefit design approximately $1.5 billion in out of pocket payments (OOP). These lower payments, it is usually assumed, will increase access and potential use of treatments. This insurance-stimulated increase in use may move the quantity used closer to the welfare optimum rate for already-invented drugs, though, of course, lower prices may reduce innovation incentives. But whether or not use will actually increase depends on how lower negotiated price affects marginal cost sharing for patients expecting to use these drugs.

Some commentators (Cogan, Heil, and Mulligan, 2025) claim that reductions in out of pocket payment may be limited if drug manufacturers respond by adjusting their launch or reference prices, and if cost sharing does not follow the standard model used in the CMS analysis. [6] They argue that the overall effect of price negotiations will eventually be of small benefit to people covered by Medicare, with cost savings both small and almost entirely captured by the Medicare Part D program's finances, not by beneficiaries. Cline, Holcomb, and Robb's (2024) estimates suggest that only 1.2 million beneficiaries will experience savings, while 2.2 million will see no change in cost, and 3.5 million will face cost increases because of drug price negotiations. Their report considers the impacts of differing Part D benefit designs, finding that non-LIS beneficiaries with copay benefits on Tier 3 selected drugs, where the majority of 2026 selected drugs are covered, will see a net increase in costs from price negotiations. [7]

In this paper we assume no changes in list or net price for negotiated drugs in order to focus on a different but important overlooked influence, the potential effect of lower prices on expected marginal cost sharing. We use a large sample of claims data to show that most users of the targeted drugs will see no change or even an increase in expected marginal cost sharing as drug list prices are reduced.

In addition to the Drug Price Negotiation Program, the second significant change from the IRA to standard coverage offered by Part D plans is the implementation of an annual out of pocket cap of $2000 per year. This OOP cap restructures the standard model of Part D coverage into three segments or phases: an initial deductible, a range of additional spending with 25% coinsurance (based on the list price) until total out of pocket (OOP) including the deductible amounts to $2000, and then zero OOP for additional spending beyond this level. The key result is that the marginal out of pocket price falls as spending increases from one phase or tier to the next. In effect, the combination of a lower OOP cap and lower negotiated prices, we will argue, will lead to conflicting and probably unintended effects on the marginal OOP price that will incentivize access.

That is, Medicare Part D's non-linear structure, coupled with reductions in total spending resulting from price negotiations, could have complex implications for beneficiaries' affordability and access. The two provisions in combination may lead a portion of beneficiaries using drugs selected for negotiation to see a reduction in overall OOP, but higher marginal OOP prices than before price reductions.

In examining how price negotiations will impact beneficiaries, we focus on two key aspects: 1) the marginal out of pocket (OOP) cost of any drug—specifically, the change in total OOP spending if the beneficiary were to obtain one more or fewer units of treatment, and 2) the total OOP over all drugs.

In economics, marginal cost or user price represents a major financial incentive that can affect patients' desired usage and adherence to the prescribed drug, as well as physician prescribing behavior. In the context of non-linear health insurance plans, studies have shown that consumers modify their spending based on their immediate OOP costs. [8,9,10] Notably, one study found that even among the sickest individuals with near certainty of exceeding their deductible, there is evidence that they reduce their incremental spending while in the deductible phase, reverting to normal spending levels once they enter the coinsurance phase. [11] However, the drugs for which prices have been negotiated are drugs used to treat chronic conditions, so patients should be able to forecast their annual total spending and its impact on the marginal cost sharing they could expect to save or spend if they reduced or increased their use.

Along with this direct incentive associated with a particular negotiated drug, beneficiaries may also experience a change in OOP costs for drugs not subject to price negotiation; specifically, if lower negotiated drug prices move a beneficiary into the deductible from the coinsurance phase (or into the coinsurance phase from the free phase), then their OOP costs for other drugs will increase as well. Hence the counterintuitive increase in user price from lower negotiated prices can spread to all other drugs.

Changes in user prices can matter, even though many of these drugs are supposed to be given on a fixed dosing schedule. Evidence shows that around one-fifth of adults aged 65 and older experience medication nonadherence. [12] This possible behavioral response to higher cost sharing is particularly relevant when considering that beneficiaries using one of the 10 drugs selected for negotiation typically allocate a significant portion of their total spending to that drug. In our sample, for seven of the ten drugs selected for negotiation, average spending on the target drug constitutes over 50% of total annual spending, reaching as high as 93% for Imbruvica.

These dynamics warrant a closer look at the interacting effects of the two IRA provisions on beneficiaries' spending.

Literature Review

To our knowledge, all other estimates of the effect of Medicare price negotiation on OOP payments have concentrated solely on impacts of average OOP payments, not marginal

payments. This is surely true of the various ASPE simulation models of the distributional impacts of the IRA. [13] It is also true of earlier estimates of the impact of price reductions for a hypothetical set of high-priced drugs. [14,15] Subsequent studies based on assumptions about the level of cost sharing (and in some cases list prices) that would have prevailed but for the IRA changes likewise estimate the distribution of average OOP. [16,17] These studies come to different conclusions about likely increases or decreases in average OOP payments, largely dependent on assumptions about average cost sharing in various Part D plan designs and possible pricing responses by drug firms, but none of them deal with possible impacts on marginal out of pocket prices.

Since negotiated Part D prices do not come into effect until 2026, there is as yet no data on how drug utilization will respond to increasing marginal prices. However, given the large number of beneficiaries that may be moved among the varying phases of cost sharing, we summarize the existing literature on how marginal (spot) prices affect prescription drug spending and health care utilization more broadly.

Beneficiaries with foresight (especially the beneficiaries with chronic illnesses who are users of the target drugs) should respond to the expected end-of-year marginal out-of-pocket price when they choose which prescriptions to fill at any time during the year; Dalton, Gowrisankaran, and Town [18] refer to this as the neoclassical benchmark. Abaluck, Gruber, Swanson [19] and Dalton, Gowrisankaran, and Town show that some Part D beneficiaries exhibit myopia with regard to the full mix of drugs they take. These authors find that patients respond to changes in the "spot" or current marginal price of prescription drugs used to treat unpredictable illnesses even when their end-of-year price does not change much. Einav, Finkelstein, and Schrimpf [20] demonstrate bunching of purchase timing at the Part D donut hole kink before it was closed, which is also consistent with responses to spot marginal prices. Aron-Dine et al. [21], Brot-Goldberg et al, [22] and Johansson et al. [23] study the effect of spot prices for health care utilization more broadly. Both current period and annual expected marginal prices matter. There is also evidence that current period and annual expected income effects of cost sharing matter. The drugs targeted for lower negotiated prices we explore are primarily drugs for people with chronic illnesses who would be expected to anticipate a given level of spending throughout the year. This means that expected marginal cost sharing should influence use, although some of the incentive effects may be mitigated by myopia.

Methods

In this paper, we use Part D claims distribution data to explore in detail the effects of the price reductions negotiated for the first 10 drugs in the program. We focus on beneficiaries that do not receive the low-income subsidy and take at least one of the 10 drugs selected for the first round of negotiations.

Our benchmark analysis is framed by several key assumptions: We assume that drug manufacturers of selected drugs maintain their initial list prices, and that beneficiaries are

covered by plans with standard cost sharing (a deductible followed by proportional coinsurance) up to the $2000 cap on out-of-pocket payments. This benchmark plan is used to determine beneficiaries True Out-of-Pocket Costs (TrOOP), which determine when they reach the annual $2,000 cap on Out-of-Pocket spending [24].

In the diagrammatic example in Figure 1, we focus on the anti-coagulation drug "Eliquis," widely used to treat deep vein thrombosis, atrial fibrillation, and clot prevention after joint surgery. (It is the negotiated drug with the largest total claims cost.) In the diagram we assume that this is the only drug being taken by the representative consumers we are describing. We assume that all these consumers choose as coverage a "standard" Part D plan (as described by Part D legislation), with a deductible, followed by a range of 25% coinsurance based on list price, up to an OOP maximum of $2000. Claims in excess of that amount have zero OOP cost.

We describe the pattern of OOP as a function of the volume of Eliquis purchased in a standardized Part D policy in 2022. We assume that there is a deductible of $480 (as there was in 2022), the drug is sold at a unit price of $1 and that this person only uses Part D benefits to cover Eliquis. (In our view, the assumption of a $1 unit price is a convenient, but innocuous assumption. The alternative would be to use the list price that coinsurance payments are based on. This would rescale the x-axis, but qualitatively change nothing.) The upper solid line shows that there are three phases of coverage: a deductible (D) for purchases up to $480, with a marginal OOP price of unity, a range of coinsurance (C), with 25% cost sharing for purchases up to $6,560. At this point OOP spending is 480 + (.25(6,560-480)) = 2,000; the line shows a slope of 0.25. Beyond this level of spending and use of Eliquis there is a range of free care (F) where the marginal price is zero.

CMS negotiated a 56% discount from the initial Eliquis list price. The dashed line shows OOP payments after negotiation as a function of the volume of Eliquis purchased. The deductible of $480 is now satisfied by purchasing 1,091 units, and the slope of the dashed line, the marginal price, over that range is $0.44. After the deductible is covered it will take purchase of up to 14,909 units to cover the OOP coinsurance of (0.25) (0.44) per unit. Then the buyer will enter the range of free care.

This results in five ranges after the price is lowered through negotiation:

1. DD: Includes beneficiaries that remain in the deductible phase both before and after the price reductions. These individuals continue to pay the deductible for the same units as before at a marginal price of $0.44, compared to a price of $1 before negotiation.
2. CD: Includes beneficiaries that have moved from the coinsurance phase to the deductible phase because of price negotiation. These individuals had been paying $0.25 per unit and now pay a higher marginal price of $0.44.
3. CC: Includes beneficiaries that remain in the coinsurance phase before and after negotiation. These individuals continue to pay coinsurance, which has fallen from $0.25 to $0.11.

4. FC: Includes beneficiaries for whom the lower price of Eliquis results in a transition from the free care range, with a marginal price zero, to the coinsurance range, with a marginal price $0.11.
5. FF: Includes beneficiaries who remain in the free care phase before and after negotiations. The marginal price is unchanged at zero.

In this simple example one can see that negotiating a lower list price for Eliquis had varying impacts on marginal OOP and financial access: sometimes it lowered OOP, sometimes OOP was unchanged, and (most strikingly) sometimes marginal OOP increased even as price (and average OOP) fell

Adding other drugs

What if the person bought other drugs whose prices were not reduced by CMS negotiated discounts? What happens to their marginal OOP prices? Assume the unit price is $1. The answer depends as before on the range in which total spending falls. If the beneficiary is in the DD range, the marginal price of other drugs remains at $1 after Eliquis is discounted. If the beneficiary is in the CD range, the marginal price for other drugs rises from the $0.25 coinsurance to $1. In the CC range, the marginal price stays at $0.25, but in the FC range it increases from zero to $0.25. Thus, price negotiation has the potential to increase marginal prices and reduce access for other drugs as well as for the target drug.

Data Analysis

Using a 5% sample of Part D data for all non-poor (low income subsidy) enrollees from 2022 [25], we explore how the pattern described by the diagrammatic illustration may impact marginal OOP and total OOP spending for those taking any of the first ten drugs selected for price negotiation. This study was granted an exemption from Institutional Review Board review because it involved the use of existing data and posed minimal risk to participants. We use the FDA National Drug Code Directory [26] to filter our sample for beneficiaries who filled prescriptions for at least one of the ten selected drugs.

For each beneficiary, we determine annual spending on the selected drugs, total annual drug spending, and the percentage of annual spending attributable to the selected drugs. Following the approach outlined in our diagrammatic illustration, we categorize beneficiaries into one of three initial insurance phases – deductible (D), coinsurance (C), and free care (F)–based on their annual spending on all drugs.

We use the same policy parameters as in the example. Assuming a unit price of $1 and a coinsurance rate of 0.25, we estimated total OOP spending using the following marginal prices by phase: $1 in the deductible phase, $0.25 in the coinsurance phase, and $0 in the free care phase. Average OOP spending on the selected drugs is calculated as total OOP * the percentage of annual spending accounted for by that drug. These values represent spending *before* price negotiation has taken place.

We then simulate price negotiation by applying CMS discounts defined in the "Factsheet: Negotiated Prices for Initial Price Applicability Year 2026" [27] to spending on each price negotiated drug and on all spending, assuming that spending on other drugs remains constant. For beneficiaries with spending on more than one drug selected for price negotiation, each drug's discount is applied individually before calculating the new total drug spending. Based on the new total drug spending (reduced annual spending on the selected drug plus unchanged spending on all other drugs, we reclassify each beneficiary into one of the following insurance phases: DD, CD, CC, FC, FF, indicating their insurance phase before and after simulated price negotiations. Once again, we calculate OOP spending for both all drugs and the selected drug, using the beneficiary's new total drug spending and insurance phase. As described through the diagrammatic illustration, marginal prices for price-negotiated drugs are adjusted in each insurance phase based on their negotiated discount: The new marginal prices for price-negotiated drugs are defined as follows: Deductible phase (D): $1 * (1 - discount); Coinsurance phase (C): $0.25 * (1- discount); and Free Care phase (F): $0. The marginal prices for other drugs remain unchanged conditional on benefit phase. Through this analysis, we can estimate the number and proportion of beneficiaries whose insurance phase may shift following price negotiations, namely in the CD and FC groups, corresponding to an increase in marginal OOP prices.

Results

Table 1a reports the number and proportion of beneficiaries within each insurance range by drug, for the sample of beneficiaries that use only one of the drugs selected for price negotiation; this sample parallels the illustrative analysis in Figure 1. The columns in Table 1 split our sample into mutually exclusive and exhaustive partition, and we label each set in this partition by two letters DD, CD, CC, FC, and FF, which we described in our methods section, e.g., CD corresponds to beneficiaries who are in the coinsurance phase *without* negotiated prices, but in the deductible phase *with* price negotiations.

The data in Table 1a show that, for seven of the ten negotiated drugs, there is a distribution of beneficiaries across all five of the cost sharing ranges. Because these are expensive drugs to treat serious illnesses, the proportion under the deductible is quite small. Nearly half are in the coinsurance range before and after the price change, and these persons will have lower marginal cost sharing (greater access) because of the lower negotiated prices. Most striking, however, is the percentage of users who experience either no change in cost sharing (remaining at zero in FF) or who see an increase in their marginal cost sharing (primarily in range FC). As shown in the rightmost column of this table, the percentage who see no reduction in user price ranges from 48 to 60 percent. For the three drugs with very high unit prices (Enbrel, Imbruvica, and Stelara), almost all users reach the free care range and pay the maximum $2000 deductible before and after drug price negotiations.

Table 1b repeats these calculations for the somewhat larger sample which includes persons taking more than one drug with negotiated prices. The qualitative pattern is very similar, but for

some of the drugs the existence of multiple negotiated drug use means that a larger share move from the FF to the FC range. Since using more than one drug with a reduced price reduces the level of OOP payment, the fraction with the same or higher marginal cost sharing rises to a range of 52 to 68 percent. Most users thus would not see lower marginal cost sharing after price negotiations under the standard benefit.

Table 2 describes the marginal OOP price for the price-negotiated drug, other drugs, and average OOP for all drugs, before and after price negotiation. The columns in Table 2 correspond to the same groups as in Table 1b; we use the full sample of beneficiaries that use any of the drugs targeted for price negotiations (instead of restricting to beneficiaries who use exactly one of the targeted drugs).

For Eliquis, marginal cost sharing decreases for beneficiaries in DD, and CC, it *increases* for beneficiaries in CD and FC, and it is unchanged for beneficiaries in FF. At the same time, average annual OOP costs decrease for all groups except FF. To calculate the average annual OOP change, we take beneficiaries who use Eliquis and are in the CD group (for example), and we calculate their annual OOP after price negotiations, and then subtract their annual OOP before price negotiations. The negative sign implies that these beneficiaries have lower annual OOP after price negotiations, and for the CD group in particular, they save on average $170.16 over the course of the year.

Across all drugs, Table 2 shows that marginal OOP decreases for beneficiaries in DD, and CC, it *increases* for beneficiaries in CD and FC, and it is unchanged for beneficiaries in FF. At the same time annual average OOP always decreases (except for group FF) with monotone savings across groups, i.e., the savings are smallest in DD and largest in FC.

Other changes relevant to drug coverage and use have been occurring at the same time as the price reductions are phased in that are not reflected in Table 2. Other drug prices have been increasing (at a rate of about 2% per year) and both enhanced benefit PDP plans and MA-PD plans have been switching from copayments to coinsurance, with about 84% of all PDP plans and 27% of MA-PD plans now using coinsurance above any deductible. These changes are small enough that the pattern described in Table 2 will still prevail.

We therefore find that, given data on the pattern of spending for each of the ten target drugs, lower negotiated prices will lead most beneficiaries in a standard or benchmark plan to face zero or increased marginal out of pocket payments; only a minority will see increased access in the form of lower coinsurance payments. What about people with coverage that differs from the basic plan (typically in the form of lower deductibles and copayments rather than coinsurance)—either in the form of enhanced benefits in a PDP or more generous benefits in a MA-PD plan? Because the triggers for changes in coverage as the deductible is covered and as cost sharing accumulates are by law calculated based on the same "true out of pocket payments" (TROOP) as in the basic plan, one can conclude that there will be exactly the same pattern of shifts across

phases of coverage as in that plan. The pattern of changes in marginal OOP will be the same as that shown in the tables.

That is, assuming the same distribution of spending, the majority of people in these other types of plans will also experience either no change or an increase in marginal cost sharing—and the proportion facing higher cost sharing for some of the drugs will be the same. However, one difference for these other populations is that they will not experience lower coinsurance payments because of lower negotiated prices but instead will be paying the same copayments as when list prices were higher. Hence there will be even less stimulus to increased use for the many beneficiaries who had chosen different and more generous plans.

Discussion

Because of the structure of the standard Medicare Part D drug coverage plan, the effect on marginal patient out of pocket payments from lower negotiated target drug prices is not uniform. Some enrollees will see lower cost sharing for additional use of target drugs, but others will see no change, and still others will see increased marginal prices. In the claims data we investigated, most users of each of the ten target drugs with lower prices would not see lower marginal prices compared to the situation in which list prices had not changed. In addition, many enrollees will also see higher marginal prices for other drugs not subject to price negotiation.

Part D insurance plans will likely see lower total claims costs from lower negotiated prices, but the effects on use by enrollees are ambiguous, even though they will generally experience lower average OOP payments (unless list prices change). Empirical evidence on use will not be available for several years, and speculation on likely impacts on access and use is ambiguous, since higher marginal cost sharing will discourage access for most beneficiaries, while lower OOP payments that offers more resources for greater use of drugs (and all other items of consumption) will increase income after cost sharing (and after potentially lower premiums) for all beneficiaries. Note that these changes also vary depending on where the individual is in the range of spending, so that spot and expected marginal prices and income effects can vary, as discussed in the survey of the literature. The magnitude of these substitution and income effects will also vary across specific drugs and across individuals depending on their other drug spending, and the timing of both kinds of spending. Current estimates of price and income responsiveness of use are too imprecise to permit reliable quantitative predictions.

There are other limitations to our analysis. Drug prices other than those in the negotiated set, have been increasing at a modest annual average rate of about 2% per year, but at different rates for different drugs. We did not adjust our spending distribution for other price changes because we do not know the pattern of increases—but any effects should on average be small. We have already commented on the possibility that, in addition to the other uncertainties about how patients respond to changes in expected marginal user price, they may also respond differently over the year as realized expenses accumulate and “spot” cost sharing changes. If this does occur it would not affect the predictions of our model of changes in expected marginal cost

sharing but might affect how people respond to those changes, yet the directional effects inferred from the measured cost sharing changes should still be probable. Finally, we do not know how CMS subsidies to Part D coverage or Part D firm plan design features like selection of preferred branded drugs might change in the future as a result of lower prices for the target drugs.

Since the drugs subject to price negotiations are among the most expensive but most effective available to Medicare enrollees, cost sharing changes may substantially impact health outcomes (Chandra, 2024). [28] If a beneficiary experiences a reduction in OOP burden from price negotiations but observes that the reduction can now be made even larger by reducing use of a drug at the margin, behavior is hard to predict. Variation in the marginal health benefits across drugs will make both income and substitution effects vary in currently unknown ways.

These observations suggest that careful monitoring of changes in use of both target drugs and other drugs as the IRA discounting policies are phased in may be helpful. Since enrollees do not all have the standard Part D coverage, the baseline values of cost sharing may vary more than those included in our study, and, of course, there may be other changes in drug firm pricing and plan benefits tiering as a result of the changes in list and acquisition prices by plans—as well as the IRA's shift in plan liability for catastrophic coverage.

Conclusion

In this paper, we show that lower negotiated prices under the IRA will have ambiguous on the *marginal price* that Part D beneficiaries pay out of pocket for prescription drugs with commensurate ambiguous effects on beneficiary access. Lower negotiated prices lead to savings for both beneficiaries and Medicare, but they are accompanied by an increase in marginal cost sharing that will discourage access—both to the drugs whose prices were cut and to all other drugs the beneficiary is using. (Changes to reinsurance and to the calculation of True Out of Pocket Costs are likely to result in higher costs for Part D sponsors.) The welfare implications of these changes for those covered by insurance and for those taxpayers subsidizing their Medicare drug coverage are thus unclear and deserve attention. This study highlights opportunities for further research into how beneficiaries may adjust their utilization in response to these conflicting incentives.

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Figures

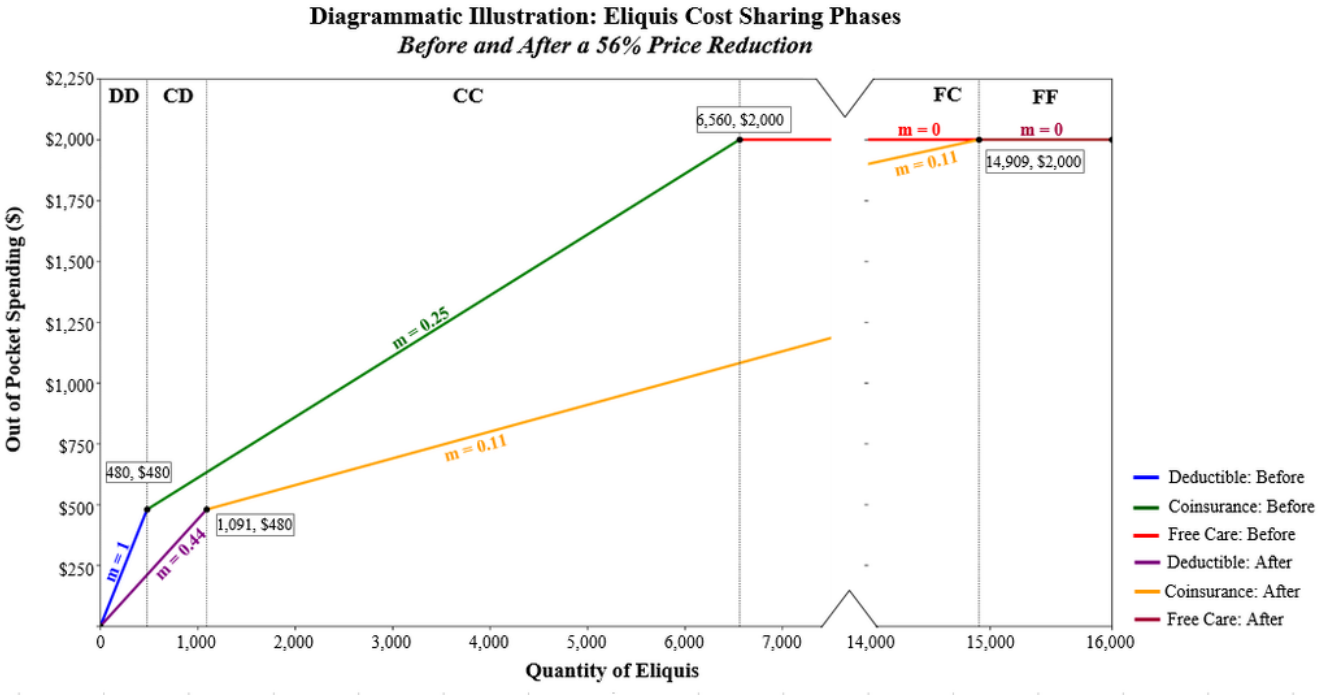


Figure 1. Diagrammatic Illustration: Eliquis Cost Sharing Phases Before and After a 56% Price Reduction. The diagram illustrates changes in cost sharing phases under the standard Medicare Part D benefit design following a hypothetical 56% price reduction in Eliquis, as projected under the Medicare Drug Price Negotiation Program (MDPNP). Cost sharing transitions are labeled using abbreviations for phase-to-phase changes. **Abbreviations:** DD: Deductible to Deductible, CD: Coinsurance to Deductible, CC: Coinsurance to Coinsurance, FC: Free Care to Coinsurance, FF: Free Care to Free Care.
Figure created by the author.

Tables

Table 1a
Projected Changes in Beneficiaries' Insurance Phases
Following Price Negotiations for Selected Drugs
Excluding Beneficiaries with Claims for More than One Selected Drug

	DD	CD	CC	FC	FF	Total	Without Marginal OOP Reduction
Eliquis							
Headcount	701	2,326	57,427	34,201	16,937	111,592	53,464
Proportion (%)	0.63	2.08	51.46	30.65	15.18		47.91
Jardiance							
Headcount	42	452	11,938	5,476	8,777	26,685	14,705
Proportion (%)	0.16	1.69	44.74	20.52	32.89		55.11
Xarelto							
Headcount	432	1,145	20,577	13,590	5,382	41,126	20,117
Proportion (%)	1.05	2.78	50.03	33.04	13.09		48.92
Januvia							
Headcount	26	510	7,167	5,391	2,923	16,017	8,824
Proportion (%)	0.16	3.18	44.75	33.66	18.25		55.09
Farxiga							
Headcount	14	222	5,184	2,036	3,910	11,366	6,168
Proportion (%)	0.12	1.95	45.61	17.91	34.40		54.27
Entresto							
Headcount	36	118	3,389	1,988	1,365	6,896	3,471
Proportion (%)	0.52	1.71	49.14	28.83	19.79		50.33
Enbrel							
Headcount					903	965	965
Proportion (%)					93.58		100.00
Imbruvica							
Headcount					640	640	640
Proportion (%)					100.00		100.00
Stelara							
Headcount					405	405	405
Proportion (%)					100.00		100.00
Fiasp/Novolog							
Headcount	46	211	4,884	2,265	4,811	12,217	7,287
Proportion (%)	0.38	1.73	39.98	18.54	39.38		59.65

Notes:
DD: Deductible to Deductible, CD: Coinsurance to Deductible, CC: Coinsurance to Coinsurance, FC: Free Care to Coinsurance, FF: Free Care to Free Care

Table 1b
Projected Changes in Beneficiaries' Insurance Phases Following Price Negotiations for Selected Drugs
Including Beneficiaries with Claims for More than One Selected Drug

	DD	CD	CC	FC	FF	Total	Without Marginal OOP Reduction
Eliquis							
Headcount	708	2,353	61,163	39,807	24,222	128,253	66,382
Proportion (%)	0.55	1.83	47.69	31.04	18.89		51.76
Jardiance							
Headcount	45	464	14,183	9,937	14,592	39,221	24,993
Proportion (%)	0.11	1.18	36.16	25.34	37.20		63.72
Xarelto							
Headcount	434	1,165	22,752	16,250	8,072	48,673	25,487
Proportion (%)	0.89	2.39	46.74	33.39	16.58		52.36
Januvia							
Headcount	26	519	8,347	8,974	5,801	23,667	15,294
Proportion (%)	0.11	2.19	35.27	37.92	24.51		64.62
Farxiga							
Headcount	14	230	6,434	4,429	7,307	18,414	11,966
Proportion (%)	0.08	1.25	34.94	24.05	39.68		64.98
Entresto							
Headcount	40	125	5,256	5,112	5,642	16,175	10,879
Proportion (%)	0.25	0.77	32.49	31.60	34.88		67.26
Enbrel							
Headcount					903	965	965
Proportion (%)					93.58		100.00
Imbruvica							
Headcount					640	640	640
Proportion (%)					100.00		100.00
Stelara							
Headcount					405	405	405
Proportion (%)					100.00		100.00
Fiasp/Novolog							
Headcount	48	218	5,582	3,488	8,172	17,508	11,878
Proportion (%)	0.27	1.25	31.88	19.92	46.68		67.84

Notes:

DD: Deductible to Deductible, CD: Coinsurance to Deductible, CC: Coinsurance to Coinsurance, FC: Free Care to Coinsurance, FF: Free Care to Free Care

Table 2
Change in Marginal and Average Out of Pocket Spending Following Drug Price Negotiations for Selected Drugs

	DD	CD	CC	FC	FF
Eliquis					
Marginal OOP Change: Selected Drugs ($)	-0.56	0.19	-0.14	0.11	0.00
Average OOP Change: All Drugs ($)	-111.09	-170.16	-461.82	-585.14	0.00
Average OOP Change: All Drugs (%)	-35.42	-32.35	-33.23	-29.26	0.00
Jardiance					
Marginal OOP Change: Selected Drugs ($)	-0.66	0.09	-0.17	0.09	0.00
Average OOP Change: All Drugs ($)	-106.44	-206.22	-466.63	-567.27	0.00
Average OOP Change: All Drugs (%)	-34.93	-37.06	-34.22	-28.36	0.00
Xarelto					
Marginal OOP Change: Selected Drugs ($)	-0.62	0.13	-0.16	0.10	0.00
Average OOP Change: All Drugs ($)	-136.53	-212.84	-586.15	-743.11	0.00
Average OOP Change: All Drugs (%)	-41.79	-38.39	-41.14	-37.16	0.00
Januvia					
Marginal OOP Change: Selected Drugs ($)	-0.79	-0.04	-0.20	0.05	0.00
Average OOP Change: All Drugs ($)	-95.93	-320.52	-663.69	-728.81	0.00
Average OOP Change: All Drugs (%)	-36.70	-48.69	-45.16	-36.44	0.00
Farxiga					
Marginal OOP Change: Selected Drugs ($)	-0.68	0.07	-0.17	0.08	0.00
Average OOP Change: All Drugs ($)	-65.17	-221.66	-468.95	-563.48	0.00
Average OOP Change: All Drugs (%)	-23.58	-39.77	-34.21	-28.17	0.00
Entresto					
Marginal OOP Change: Selected Drugs ($)	-0.53	0.22	-0.13	0.12	0.00
Average OOP Change: All Drugs ($)	-89.63	-155.92	-427.58	-452.61	0.00
Average OOP Change: All Drugs (%)	-28.96	-28.86	-31.35	-22.63	0.00
Enbrel					
Marginal OOP Change: Selected Drugs ($)				0.08	0.00
Average OOP Change: All Drugs ($)				-541.09	0.00
Average OOP Change: All Drugs (%)				-27.05	0.00
Imbruvica					
Marginal OOP Change: Selected Drugs ($)					0.00
Average OOP Change: All Drugs ($)					0.00
Average OOP Change: All Drugs (%)					0.00
Stelara					
Marginal OOP Change: Selected Drugs ($)					0.00
Average OOP Change: All Drugs ($)					0.00
Average OOP Change: All Drugs (%)					0.00
Fiasp/Novolog					
Marginal OOP Change: Selected Drugs ($)	-0.76	-0.01	-0.19	0.06	0.00
Average OOP Change: All Drugs ($)	-151.41	-242.45	-367.24	-447.94	0.00
Average OOP Change: All Drugs (%)	-46.21	-41.40	-26.66	-22.40	0.00

Notes:

DD: Deductible to Deductible, CD: Coinsurance to Deductible, CC: Coinsurance to Coinsurance, FC: Free Care to Coinsurance, FF: Free Care to Free Care