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Early impacts of the IRA's Medicare Drug Price Negotiation Program: Pricing trends for Medicare Parts B and D

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Key Takeaways

With passage of the Inflation Reduction Act (IRA), Medicare gained authority to negotiate maximum fair prices (MFP) for select high-spend, single-source drugs in Parts B and D. This analysis evaluates how list prices (wholesale acquisition cost, WAC) for top-spend drugs have shifted using pre/post observation windows for each program. The findings focus on WAC price changes and the pace of list-price movement, rather than net cost, and are intended to inform executive budgeting, forecasting and contracting decisions.

Top 3 takeaways

- **Redistribution, not uniform reduction:** Post-policy list-price behavior reflects a redistribution of growth: many products accelerated, some held steady or slowed and a smaller subset decreased — signaling strategic adjustments rather than a uniform pullback.
- **Part B price durable acceleration:** Medicare Part B drug WAC pricing shows a clear and consistent pattern of acceleration in the post-policy period, with nearly all analyzed products increasing at a faster rate than before the IRA. The median annual growth rate doubled from 6.5% to 13.3%, signaling a broad-based upward shift.
- **Varied Part D moderate acceleration with dispersion:** In contrast to Part B, Medicare Part D drug pricing displays a more varied pattern, including accelerations, slowdowns and selective reductions. The negotiated-drug cohort (IPAY 2026) showed particularly diverse behavior, with some products slowing or cutting prices while others accelerated within modest bounds.

Summary of impact

Pricing behavior in the post-policy period suggests the market has entered a transition phase as manufacturers recalibrate list-price strategies. Rather than a uniform slowdown, we observe a rebalancing: many products are accelerating, some are holding steady and a smaller subset is taking proactive reductions ahead of the 2026 negotiations. Ongoing monitoring will be essential to distinguish policy-driven changes from routine price cycling and to support more responsive budgeting, forecasting and contracting decisions.

Background

The IRA, signed into law Aug. 16, 2022, reshapes aspects of drug pricing and insurance policy in the United States. Key provisions within the IRA aim to reduce out-of-pocket expenses and improve access to essential treatments, particularly for Medicare beneficiaries. These provisions include granting Medicare the authority to negotiate prices for certain costly drugs covered by Medicare, capping insulin costs at $35 per month among Medicare enrollees, reducing out-of-pocket costs under Medicare Part D and eliminating expenses for adult vaccines recommended by the Advisory Committee on Immunization Practices. The law also introduces inflation-based rebates that require manufacturers to pay Medicare when drug prices increase faster than inflation. As these changes are phased in — with most changes occurring from 2023 to 2029 — early observation of their effects on medication access and patient behavior can begin to be analyzed.

Among the most closely watched elements of the IRA is the Medicare Drug Price Negotiation Program (MDPNP), which began with the selection of 10 Part D drugs in 2023, with pricing and reimbursement-related changes set to take effect Jan. 1, 2026 [otherwise known as initial price applicability year (IPAY) 2026]. Public response has been mixed: Patient advocacy groups and policy experts applauded the legislation as a long-overdue shift toward affordability and transparency, while the pharmaceutical industry mounted legal challenges and voiced concerns about potential impacts on innovation. As implementation advances, manufacturers, providers and policymakers are closely monitoring changes in pricing dynamics, market behavior and the broader implications for healthcare sustainability.

How the IRA is shaping healthcare

Medicare Drug Price Negotiation Program (MDPNP)

Under the IRA, the U.S. Department of Health and Human Services secretary is required to negotiate prices for select single-source drugs under Medicare Part D (retail prescription drugs) starting in 2026 and Part B (physician-administered drugs) starting in 2028. These negotiations aim to lower prescription drug costs for Medicare beneficiaries and reduce overall program spending.

The negotiation process is structured and phased. It began in 2023 with the identification of the first 10 high-expenditure Part D drugs eligible for negotiation. To qualify, a drug must be among the top-spending, single-source brand products in Medicare, have been on the market for at least seven years (for small molecules) or 11 years (for biologics) and lack generic or biosimilar competition. The selected drugs for IPAY 2026 are:

- Apixaban (Eliquis)
- Dapagliflozin (Farxiga)
- Empagliflozin (Jardiance)
- Etanercept (Enbrel)
- Ibrutinib (Imbruvica)
- Insulin aspart (Fiasp/NovoLog)
- Rivaroxaban (Xarelto)
- Sacubitril/valsartan (Entresto)
- Sitagliptin (Januvia)
- Ustekinumab (Stelara)

Methodology

The top 100 Medicare Part B and Part D drugs by total spend were identified from the Centers for Medicare and Medicaid Services (CMS) Part B and Part D Drug Spending Dashboards (2023 final report). For each product, WAC data were obtained from the Medi-Span Price Rx database to capture all price changes within the study period. The pre-policy periods were defined as October 2020 through September 2022 for Part D and January 2021 through December 2022 for Part B, while the post-policy periods extended from October 2022 to September 2025 for Part D and January 2023 to September 2025 for Part B. Data were compiled in Microsoft Excel and included the following fields: drug name, national drug code (NDC) or Healthcare Common Procedure Coding System code, manufacturer, date of price change, WAC price, source and notes. The products exempt from the IRA and from this analysis include vaccines, plasma-derived products, medical supplies, diabetic testing supplies, viscosupplements and biosimilar products. Only products with complete pricing information during both the pre-policy and post-policy periods were included, and thus any products that received initial U.S. Food and Drug Administration approval during these periods were excluded.

For each NDC, the WAC prices were identified for both the pre- and post-policy periods to calculate percentage point changes over each timeframe. These NDC-level changes were then aggregated to the product level by taking the median price change across all NDCs associated with each product.

Two complementary analyses were conducted. First, products were grouped into four categories based on their pre-policy annual price growth [low (0–5%), medium (6–10%), mid-range (11–15%) and high (>15%)] to assess whether baseline inflation levels were associated with different post-policy pricing patterns. For each tier, the approximate change in percentage points was calculated as the median of product-level differences in annual price growth between the post- and pre-policy periods, rather than as the simple difference between the tier-level medians.

Second, to evaluate how individual products' pricing behavior shifted relative to their own historical norms, each product's pre-policy annual WAC growth rate served as a baseline for typical pricing behavior. Post-policy growth rates were compared against this baseline and categorized to demonstrate the rate of price changes and characterize the distribution of product-level changes in pricing behavior.

Four categories demonstrated the rate of price changes:

1. **Price decrease:** Prices declined during the post-policy period.
2. **Slower rate of price increase (deceleration):** Prices continued to rise, but at a slower pace than before.
3. **Same rate of price increase:** The pace of price growth remained stable, showing little to no change.
4. **Faster rate of price increase (acceleration):** Prices rose more quickly than in the pre-policy period.

This framework distinguishes true price decreases and slower — but still positive — price growth and identifies products that maintained or accelerated price increases, highlighting how pricing behavior redistributed across the market rather than shifting uniformly in one direction.

Impact on drug pricing analysis

Medicare Part B

The Medicare Part B dataset included 62 products encompassing 127 NDCs that represented a range of physician-administered drugs. All products analyzed are single-source, brand-name drugs, making them eligible for potential inclusion in the Medicare Part B negotiation program once that phase of the policy is implemented.

From the pre-policy window of January 2021 through December 2022 and the post-policy window of January 2023 to September 2025, the median annual WAC growth rose from 6.5% pre-policy to 13.3% post-policy period — roughly double the pre-policy pace (+6.3 percentage points).

Table 1 compares median pre- and post-policy annual WAC growth by baseline inflation tier. Most products (n=30) fell in the medium starting tier (6–10%) and exhibited the largest increase in growth, rising from 6.9% pre-policy to 14.1% post-policy (+6.5 percentage points). Products with the lowest baseline inflation (0–5%, n=12) also accelerated, increasing from 2.4% to 4.8% (+3.7 percentage points). Mid-range starters (11–15%, n=11) rose more modestly, from 10.3% to 15.3% (+3.9 percentage points), while products with the highest pre-policy growth (>15%, n=9) remained elevated, increasing from 15.5% to 21.2% (+5.9 percentage points). Across all tiers, median post-policy growth exceeded pre-policy levels, indicating broad-based price acceleration in Part B.

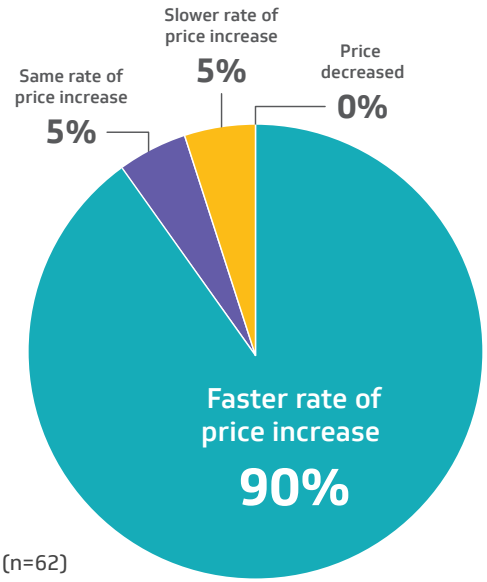
Table 1. Part B tiered pricing behavior by starting price growth

Pre-policy tier (rounded)	Products (count)	Median pre	Median post	Median change* (percentage points)
0–5%	12	2.4%	4.8%	+3.7
6–10%	30	6.9%	14.1%	+6.5
11–15%	11	10.3%	15.3%	+3.9
>15%	9	15.5%	21.2%	+5.9

* For each tier, the approximate change in percentage points was calculated as the median of product-level differences in annual price growth between the post- and pre-policy periods, rather than as the simple difference between the tier-level medians.

Figure 1 shows the distribution post-IRA rates of price changes for Medicare Part B products (n=62). The vast majority — about 90% — moved to a faster rate of price increase while only a small share held at the same rate (5%) or slowed (5%), and none demonstrated a price decrease. Taken together, these results indicate that following IRA implementation, Part B pricing accelerated in a clear, consistent pattern with the speed-up strongest among lower-growth starters but evident across every tier, signaling a market that has shifted toward faster price growth rather than price restraint.

Figure 1. Medicare Part B – Post-IRA rate of price change by product



(n=62)

Medicare Part D

The Medicare Part D dataset included 85 products encompassing 339 NDCs that represented a range of retail and specialty drugs reimbursed under Part D. From October 2020 through September 2022, the median pre-policy cohort annual WAC growth was 10.5%. In the post-policy period (October 2022 to September 2025), it rose to 12.0%, a +1.5 percentage point change.

Table 2 compares median pre- and post-policy annual WAC growth by baseline tier. Products with lower pre-policy growth posted the largest increases: low starters (0–5%, n=10) rose from 4.0% to 12.5% (+8.0 percentage points), and medium starters (6–10%, n=45) moved from 9.0% to 12.0% (+5.0 percentage points). Mid-range starters (11–15%, n=21) increased more modestly from 12.0% to 14.0%, +2.0 percentage points), while high starters (>15%, n=12) slowed on average from 17.0% to 10.5%, −6.0 pp). Taken together, the tiers show a compression pattern: lower-growth products accelerated the most, mid-tier products edged higher and the highest-growth group leveled off.

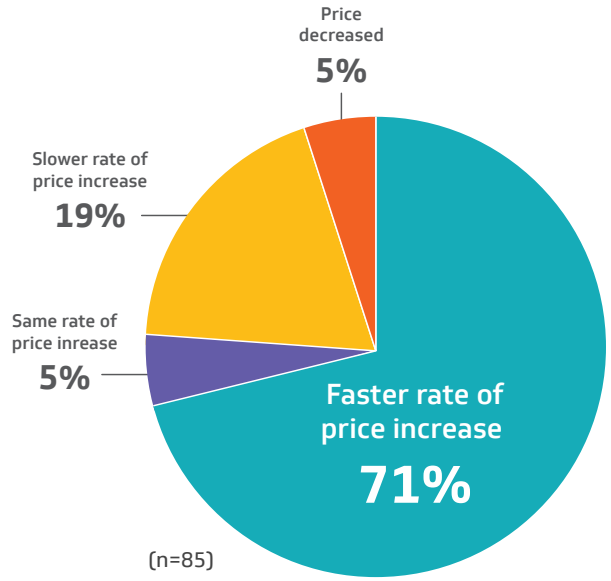
Table 2. Part D tiered pricing behavior by starting price growth

Pre-policy tier (rounded)	Products (count)	Median pre	Median post	Median change* (percentage points)
0–5%	10	4.0%	12.5%	+8.0
6–10%	45	9.0%	12.0%	+5.0
11–15%	21	12.0%	14.0%	+2.0
>15%	12	17.0%	10.5%	-6.0

* For each tier, the approximate change in percentage points was calculated as the median of product-level differences in annual price growth between the post- and pre-policy periods, rather than as the simple difference between the tier-level medians.

Following policy implementation, most Part D products continued to experience positive price growth, with 71% increasing at a faster rate than before the IRA (Figure 2). At the same time, 19% of products showed a slower rate of price increase, 5% of products demonstrated the same rate as the pre-policy time period and 5% showed a price decrease. These results indicate a more varied pattern of post-policy pricing behavior in Part D, reflecting a mix of accelerations, slowdowns and selective reductions — contrasting with the more uniform upward shift observed in Part B.

Figure 2. Medicare Part D – Post-IRA rate of price change by product



Pricing behavior among IRA-negotiated drugs

To assess whether negotiated status is associated with distinct pricing behavior, a separate analysis was conducted on the first 10 products selected for Medicare price negotiation, which prices take effect Jan. 1, 2026. The pre- and post-policy patterns were compared with the broader Part D market to evaluate any differences attributable to negotiation exposure.

Before policy implementation, annual WAC growth among the 10 negotiated drugs ranged from 6% to 18%. In the post-policy period, that range widened from 9% to 24%, showing greater variability in price movement. Six of the 10 products — apixaban (Eliquis), dapagliflozin (Farxiga), empagliflozin (Jardiance), etanercept (Enbrel), rivaroxaban (Xarelto) and ustekinumab (Stelara) — experienced overall price acceleration. In contrast, four products — ibrutinib (Imbruvica), insulin aspart (Fiasp/NovoLog), sacubitril/valsartan (Entresto) and sitagliptin (Januvia) — showed slower growth or outright price decreases (Table 3).

Table 3. Negotiated drug pricing behavior (product-level)

Generic (brand)	NDC (count)	Median pre %	Median post %	Change (percentage points)
Faster rate of price increase				
Etanercept **(Enbrel)**	6	18.0	24.0	+6.0
Rivaroxaban **(Xarelto)**	18	10.0	16.0	+6.0
Ustekinumab **(Stelara)**	4	10.0	14.0	+4.0
Apixaban **(Eliquis)**	5	12.0	15.0	+3.0
Dapagliflozin **(Farxiga)**	2	6.0	9.0	+3.0
Empagliflozin **(Jardiance)**	6	9.0	10.0	+1.0
Slower rate of price increase				
Ibrutinib **(Imbruvica)**	6	15.0	13.0	−2.0
Sacubitril/valsartan **(Entresto)**	6	17.0	11.0	−6.0
Price decrease				
Insulin aspart **(Fiasp/NovoLog)**	14	0	−75.0	−75.0
Sitagliptin **(Januvia)**	13	10.0	−37.0	−47.0

Insulin aspart: A unique outlier

Unlike other negotiated products, insulin aspart recorded no price growth during the pre-policy period, maintaining stable pricing across all presentations. On Jan. 1, 2024, all NDCs underwent a single, synchronized list-price decrease, ranging from −50% to −75%, marking it as the drug with the largest price reduction across the analysis.

Part D summary

Overall, Medicare Part D pricing between January 2023 and September 2025 reflects a redistribution of price behavior rather than a single, uniform trend. Using two complementary analyses — grouping products by pre-policy inflation tiers and comparing each product's post-policy growth rate to its own historical baseline — most products continued to raise prices, but at markedly different speeds. Products with low to moderate pre-policy inflation (0–10%) showed the largest increases in median price growth, while those with the highest baseline inflation (>15%) generally slowed, producing a compression effect across the market. At the same time, product-level analyses revealed that a substantial majority accelerated their rate of price increase, whereas a meaningful minority slowed, flattened or decreased prices altogether.

This blended pattern underscores a diversifying manufacturer response: Lower-growth products appear to have used available headroom to raise prices, mid-range brands moved up more modestly and high-growth products largely leveled off. The same continuum extends to drugs subject to a negotiated MFP, where mixed behavior suggests that IRA provisions are shaping strategy in different ways — some products accelerating within new bounds and others decelerating or implementing one-time price resets, such as the 2024 list-price reduction for insulin aspart. Together, these findings indicate that the IRA may have introduced greater variation and segmentation in pricing behavior across Part D, producing both moderation and acceleration depending on where products started and how they are affected by new policy constraints.

Conclusion

Findings across Medicare Parts B and D show that the IRA's early pricing effects differ meaningfully between the two segments of the market.

- **In Part B**, price acceleration was widespread and largely uniform. Most products increased at a faster rate than before the IRA, and the median annual growth rate doubled — from 6.5% to 13.3%. This acceleration was broad-based and most pronounced among slower-growing drugs with available headroom but visible across all starting inflation tiers. Notably, Part B drugs aren't subject to the MDPNP until IPAY 2028, meaning these early shifts occurred outside the context of formal negotiations.
- **In Part D**, pricing behavior was more varied, reflecting a broader continuum of outcomes. Tier-based analyses showed large increases among lower-inflation products and a slowdown among the highest-growth drugs, while product-level analyses revealed that most products accelerated but a meaningful minority slowed or decreased prices. The negotiated drug cohort (IPAY 2026) displayed especially heterogeneous behavior — ranging from slowdowns and price reductions (e.g., Januvia, insulin aspart) to moderate accelerations.

Overall, these patterns suggest a transitional market environment in which manufacturers are recalibrating pricing strategies in response to early IRA signals rather than uniformly slowing price growth. The initial impact of the IRA appears to involve greater segmentation and a compression of pricing behavior — some products accelerating, others leveling off and a few taking proactive price reductions in advance of formal negotiations. Continued monitoring will be essential to differentiate emerging policy effects from normal market dynamics as subsequent phases of IRA implementation take hold.

Limitations

Several limitations should be considered when interpreting these early findings.

First, the analysis captures WAC list prices rather than the net prices that reflect rebates, discounts or negotiated rates — meaning actual payer and provider price points may differ from the changes reported within the analysis. Second, because the post-policy window (2023–2025) overlaps with the phased implementation of multiple IRA provisions — inflation-based rebates, the upcoming Medicare negotiation program and other manufacturer or market factors — pricing behavior observed here can't be attributed solely to the drug price negotiation program. Broader dynamics such as supply chain costs, commercial launches of competitor medications and changes in therapeutic demand, among others, likely influenced manufacturer decisions, as well. Third, the data represents a limited timeframe following enactment, and longer-term effects may emerge once negotiated prices take effect in 2026 and subsequent years. Finally, while the analysis spans the top-spend drugs in Medicare Part B and Part D based on total spending in 2023, results may not generalize to lower-spend products or those excluded from rebate provisions (e.g., vaccines, plasma-derived products, biosimilars or orphan drugs with a single approved indication).

Together, these factors suggest that results should be viewed as early directional signals of post-policy period pricing behavior rather than definitive evidence of policy-driven change.

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