TRIANGLE INSIGHTS GROUP by Valerís

Inflation Reduction Act in 2026:
Strategic Considerations for Pharma

Authors:
Matt Haynes, PhD
Meghna Shankar

Part 2 of 6 of "The Policy-Driven PMA Pivot Series"

March 2026

Copyright © 2026 Triangle Insights Group

Introduction

Since its enactment in 2022 under the prior administration, key drug pricing provisions of the Inflation Reduction Act (IRA) have been fully implemented, including Part D Redesign in 2025 and the first 10 CMS-negotiated maximum fair prices (MFPs) for drugs in initial price applicability year (IPAY) 2026. CMS has also negotiated an additional 15 Part D drugs for IPAY 2027, with an additional 15 drugs, including Part B therapies, selected for negotiation for IPAY 2028. While the practical implications of each of these policies (Part D Redesign, CMS Price Negotiations) by themselves have been discussed by Triangle Insights previously, the interplay between these policies is increasingly important for manufacturers to consider, given new policies implemented by the current administration in recent months. **Since the IRA became fully implemented, Triangle Insights has seen a dichotomy of incentives emerge between the two IRA policies (a signpost for other policies to come later in this series) that serve to place pressure on manufacturers as they determine their pricing and contracting strategies ahead of launch into the Medicare markets and as they competitively contract within the market.**

CMS Price Negotiations – Dichotomy of Incentives with Provider Demand for IPAY 2028

One of the key practical outcomes of IRA was to eliminate the gross-to-net (GTN) differential for the highest-spend pharmaceuticals in Medicare (CMS Price Negotiations), helping CMS reduce reinsurance for specialty drugs, and patients reduce their OOP cost sharing for retail and specialty-lite drugs. This lower-price, lower-rebate contracting approach accomplished that objective in 2026, with the average absolute reduction in price coming in at ~13% below estimated Part D rebates.1 However, since manufacturers are not obligated to share in statutory Part D Redesign costs (i.e., Manufacturer Discount Program cost-sharing obligations) once negotiated, the impact on their margins is expected to be less than the reported discount for retail and specialty-lite drugs and may even be minimal for specialty drugs – benefiting the bottom line for the negotiated drugs along with patients and CMS.

Competitor manufacturers, however, may require higher rebates to compete with CMS-negotiated drugs as well as higher patient assistance program (PAP) spend to drive conversion to paid scripts, since the CMS-negotiated drugs are guaranteed coverage in Medicare and carry a lower OOP cost for patients at the point of sale (potentially driving volume plays for drugs that previously faced coverage challenges). These risks have only increased in the most recent round of CMS negotiations (IPAY 2027), where the average absolute reduction in price is much higher than that observed in IPAY 2026.2

However, the real impact comes at the expense of institutional payers – certainly MCOs, who lose out on valuable rebate dollars, but also providers, who lose out on margin with MFP-based reimbursement in Part B. Importantly, 92% of providers in a recent survey suggest that they may may stop stocking Part B drugs subject to negotiation – underscoring the dichotomy of incentives that has emerged from IRA, with severe implications for Part B drugs selected for IPAY 2028.[8]

Part D Redesign – Dichotomy of Incentives with CMS Price Negotiations

Payer burden from CMS price negotiations compounds with the multitude of requirements from Part D Redesign – an annual cap on patient OOP spending at $2,000, fewer rebates from manufacturers overall, and a higher up-front cost-sharing obligation in catastrophic coverage. At the time, many in the industry anticipated that increased payer cost burden exposure would translate into heightened rebate demands across books of business.

Copyright © 2026 Triangle Insights Group

However, recent industry analysis shows that this has not broadly materialized. Rather than uniformly increasing rebates, many payers are pursuing alternative strategies to offset their higher cost exposure – such as by introducing or increasing coinsurance to shift more cost-sharing back to patients, or exiting the Part D market altogether, with the number of PDPs declining by 55% since the passage of the IRA[7]. These trends persist despite substantial increases in up-front direct subsidies from CMS that effectively counterbalance the losses in reinsurance payments to payers.[3] In essence, as Part D plans have seen increasing up-front costs and decreasing back-end support, the new Part D landscape has exceeded their risk tolerance.

Further, the Part D Redesign itself may not actually in practice incentivize the **lower-list, lower-rebate** contracting approaches motivating CMS Price Negotiations. As reported extensively by the team at Drug Channels, once changes in direct and indirect remuneration (DIR; i.e., the share of rebate dollars flowing to Part D plans vs CMS) are factored in, specialty drug manufacturers may be incentivized to implement **higher-list, higher-rebate** pricing strategies.[4] Thus, the dichotomy in incentives persists in the market – while many notable list price reductions for branded drugs have been publicized in the past few years,[5] an order of magnitude greater number have increased their WAC in just the first week of 2026.[6]

Implications of CMS Price Negotiations and Part D Redesign on Competitive Manufacturers

What Triangle Insights is seeing from the interplay between these two policies as they have been fully implemented (Part D Redesign, CMS Price Negotiations) is a signpost of broader challenges facing pharmaceutical manufacturers as they develop their pricing strategies. We routinely receive the following questions from our clients:

- "How do policies like IRA complicate the gross-to-net incentives in the market today?"
- "What interplay in incentives does IRA have with other policies (e.g., MFN, O3BA)?"
- "How should I price my products to be competitive in the context of these policy dynamics (high-list/high-rebate vs low-list/low-rebate)?"

As we continue this white paper series, we'll build upon the dichotomies from this discussion as we consider MFN and DTP/DTE emergence, ultimately building toward a framework for manufacturers to consider as they attempt to tackle these challenges.

Strategic Considerations

1. **MFPs Shaping Indication Price Corridor:** Manufacturers with drugs in therapeutic areas that will have MFPs implemented should be aware of possible reduced pricing potential for pipeline drugs and increased rebate demands for inline drugs

2. **Potential for Increased Patient Cost Burden:** As payers attempt to shift cost-sharing back to patients across channels to compensate for losses in Medicare, early-year abandonment rates may increase for Medicare patients, and additional Commercial copay support may be needed to ensure prescription fulfilment

3. **Deflation of the GTN Bubble:** As CMS Price Negotiations start to deflate the gross-to-net bubble, the bargaining power provided by rebates may be declining for certain drugs (e.g., retail, specialty-lite); manufacturers may need to consider low list/low net strategies, and adjust their copay spend (rather than rebates) in their forecasting to focus more on maximizing volume rather than price

Copyright © 2026 Triangle Insights Group

References

[1]*Health Affairs. "Interpreting the First Round of Maximum Fair Prices Negotiated by Medicare for Drugs." Accessed March 2026.*

[2]*Health Affairs. "Do Medicare's IPAY 2027 Negotiated Drug Prices Reflect Value For Money?" Accessed March 2026.*

[3]*CMS. "ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE AND FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUNDS" (2022-2025). Accessed March 2026.*

[4]*Drug Channels. "Surprise! Thanks to the IRA, Part D Plans Will Prefer High-List, High-Rebate Drugs." Accessed March 2026.*

[5]*Drug Channels. "U.S. Brand-Name Drug Prices Fell in 2025 as the Net Pricing Drug Channel Emerges." Accessed March 2026.*

[6]*46brooklyn. "This is the Way ... to Analyze Changes in Brand Drug List Prices." Accessed March 2026.*

[7]*Drug Channels. "Medicare Part D 2026: Preferred Networks Vanish as the PDP Market Collapses." Accessed March 2026*

[8]*Avalere Health. "Provider Survey on Part B Negotiation Impacts" Accessed March 2026*

Reach out to Triangle Insights Group today

https://triangleinsightsgroup.com/contact/

Durham
Raleigh-Durham Research Triangle
512 S. Mangum Street, #404
Durham, NC 27701
(919) 813 6100

San Francisco
San Francisco Financial District
650 California Street,
Suite 5-133
San Francisco, CA 94108
(628) 222 5288

New York
New York Midtown
27 E 28th St., Ste. 15-036
New York, NY 10016
(646) 974-39230

Copyright © 2026 Triangle Insights Group