White Paper: Impact of the Inflation Reduction Act on Medicare Beneficiary Affordability and Mortality

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INTRODUCTION

The Inflation Reduction Act (IRA) introduced multiple reforms to Medicare prescription drug payments, including a redesign of the Part D prescription drug benefit, rebates for drugs with price increases beyond inflation, the ability for Medicare to negotiate the price of certain drugs, and an option to have a predictable monthly payment plan for some beneficiaries. These changes are intended to improve the affordability of prescription drugs for Medicare beneficiaries.

High out-of-pocket (OOP) drug costs are a well-documented barrier to medication adherence in the United States. Cost-related non-adherence (CRNA) is common in the United States and is associated with adverse health outcomes, including mortality. This issue is of particular concern for those with chronic conditions, who may rely on expensive medications long-term. By reducing OOP costs, the IRA has the potential not only to generate financial savings, but also to improve medication adherence and health outcomes.

While prior studies have examined the effect of some IRA provisions, particularly the Medicare negotiation provision, on federal expenditures and beneficiary affordability, none at the time of writing had analyzed how these provisions may impact medication adherence and health outcomes, such as mortality. In addition, no study has examined potential beneficiary savings across individual IRA provisions.

This report addresses these gaps by exploring the impacts on beneficiary affordability of four IRA provisions and, where possible, downstream health outcomes:

1. **Cost-sharing reductions:** The IRA redesigned Medicare Part D to reduce cost-sharing for some beneficiaries, including (1) capping cost-sharing for covered insulins to $35/month, (2) eliminating cost-sharing for ACIP-recommended adult vaccines, and (3) capping beneficiary cost sharing to $2,000 per year. This report estimates the impact of this Part D redesign on CRNA and mortality from chronic conditions.
2. **Medicare negotiation:** The IRA allows Medicare to negotiate prices for certain high-cost drugs, which lowers the prices used to calculate beneficiary cost-sharing. This report estimates the impact of Medicare negotiation on the amount of beneficiary savings for drugs not used to treat chronic conditions.
3. **Inflation rebates:** The IRA requires manufacturers to provide rebates when drug prices increase faster than inflation, which can lower beneficiary cost-sharing for affected drugs. This report estimates the amount of beneficiary savings from these inflation rebates for drugs not used to treat chronic conditions.
4. **Predictable monthly OOP payments:** The IRA introduced the Medicare Prescription Payment Plan (MPPP), which allows some beneficiaries to spread out-of-pocket costs over the course of the year rather than paying them at the point of sale. This report estimates how much beneficiaries' out-of-pocket costs could have been smoothed into predictable monthly payments under this program if it had been implemented earlier.

METHODS

1. IMPACT OF PART D REDESIGN ON CRNA AND MORTALITY FROM CHRONIC CONDITIONS

Cost-related non-adherence (CRNA) is common in the United States and is associated with adverse health outcomes, including mortality. This issue is of particular concern for those with chronic conditions, many of whom rely on expensive medications long-term. Reducing OOP costs may increase medication adherence, thus potentially improving health outcomes and reducing mortality risk from those conditions.

In 2020, the Council for Informed Drug Spending Analysis (CIDSA) commissioned Xcenda to estimate the effects of reducing beneficiary out-of-pocket costs on CRNA and mortality. This study examined policy changes proposed in H.R.3, which contained early versions of several provisions ultimately included in the IRA.

Model parameters in the CIDSA-commissioned report were used to estimate baseline adherence and mortality and the effects of the described OOP reductions on these measures. (Table 1) The model considered five chronic conditions common among Medicare beneficiaries, including atrial fibrillation, chronic kidney disease, chronic obstructive pulmonary disease, diabetes mellitus, and ischemic heart disease. The parameters for this analysis were based on the report's pooled estimates of adherence and mortality associated with each disease across the Medicare population.

TABLE 1. MODEL PARAMETERS ADAPTED FROM CIDSA REPORT

	POINT ESTIMATE (MODELED RANGE)	SOURCE
BASELINE ASSUMPTIONS		
Medicare population with ≥1 chronic disease	75.56% (68.87%, 82.24%)	Assumption described in model report
Adherence	85.31% (76.78%, 93.84%)	Lester, 2016
Mortality	4.45% (4.45%, 4.47%)	Krumholz, 2015
PRICE ELASTICITIES AND OFFSET EFFECTS		
Price elasticity of demand (adherence)	−0.123% (−0.135%, −0.111%)	Assumption described in model report [a]
Mortality offset effect	−0.7% (−0.72%, −0.59%)	Assumption described in model report

[a] Values for Medicare represent the median of 5 chronic disease states included in the model

Like the model used in the CIDSA report, estimates were for Medicare beneficiaries who do not qualify for the low-income subsidy (LIS), who are most exposed to high OOP costs. Unlike the model, estimates were generated for a single year. Baseline estimates of CRNA-associated mortality from this model were projected to 2025, assuming that the policies predating the IRA remained in effect.

The effects of individual provisions of the IRA on beneficiary out-of-pocket (OOP) costs were estimated using projections by the Office of the Assistant Secretary for Planning and Evaluation (ASPE).

These provisions included the following changes to the Part D benefit:

- Capping cost-sharing for covered insulins to $35/month
- Eliminating cost-sharing for ACIP-recommended adult vaccines
- Capping beneficiary cost sharing to $2,000 per year

In addition, it was assumed that negotiation for 7 of the first 10 selected drugs (with negotiated prices going into effect in 2026) contributed to beneficiary OOP savings, as these drugs are indicated to treat the chronic conditions considered in the previously commissioned study.

2. BENEFICIARY SAVINGS FROM MEDICARE NEGOTIATION OF SPECIALTY DRUGS

Three drugs are not captured in the above model of chronic conditions. Stelara, Enbrel, and Imbruvica are specialty drugs used to treat autoimmune conditions and cancers. These products are commonly subject to coinsurance rather than fixed copays. Negotiated prices replace gross prices for purposes of calculating beneficiary cost-sharing, resulting in lower OOP payments when these drugs are subject to coinsurance.

To estimate the reductions, claims with coinsurance-based payments for these three drugs were identified in 2023 Medicare Part D Event data. Claims with beneficiary cost-sharing below $500 per claim and that ended in .00, .35, and .99 were considered to be copayments based on their observed frequency in the data and excluded from the analysis. The remaining claims were adjusted to reflect the maximum fair price (MFP) to calculate the difference between coinsurance based on WAC versus negotiated prices. These claims were used to calculate the number of beneficiaries who would have benefited from lower coinsurance due to negotiated prices, as well as average and total beneficiary savings.

3. BENEFICIARY SAVINGS FROM INFLATION REBATES

In addition to Part D redesign and Medicare negotiation, the IRA also introduced a requirement that manufacturers pay Medicare rebates for drugs with price increases in excess of inflation. As of April 1, 2023, beneficiary coinsurance for such drugs are also reduced by the excess increase.

To estimate beneficiary savings from these reductions, we identified Part B claims for drugs on the rebate list and calculated what beneficiary coinsurance amounts would have been with and without the reductions in place for the 2023 calendar year.

4. SPENDING FLEXIBILITY FROM MPPP

In addition to the newly introduced $2,000 OOP cap in Part D, beneficiaries can also enroll in a program to roll over OOP amounts in excess of $167 per month, allowing them to smooth payment over time. Although this program may not lead to savings beyond the $2,000 cap, it may encourage adherence to drugs with cost-sharing that beneficiaries could not afford as a one-time payment.

Two measures were used to calculate the potential effect of this program on OOP payments. One was the total amount of OOP that individual beneficiaries could have carried over from month to month in Part D claims, up to the annual $2,000 maximum per beneficiary. The other was the number of months in which beneficiaries' OOP spending in Part D claims exceeded $167, to identify how often they might have benefited from this program.

LIMITATIONS

MORTALITY

Part D redesign included aspects of affordability that are not specific to the chronic conditions estimated in the model. The effect of these dynamics on adherence and mortality estimates is unclear. Reducing OOP for non-chronic disease treatments increase beneficiaries' budgets to treat chronic conditions. At the same time, OOP reductions for drugs used to treat other conditions likely also increase adherence and reduce mortality from those conditions. This makes it difficult to isolate mortality based on cause. However, the substantial projected reduction in mortality from the model is in line with the disproportionate share of mortality attributable to chronic disease.

In addition, the present estimates only capture one year. A dynamic model would account for deaths in this cohort that would occur in future years.

The shift from non-LIS to LIS is not captured in these estimates. It is reasonable to assume that people who gain full LIS through the IRA will benefit at least as much as estimated by the model, but likely more due to additional benefits such as greater reductions in cost-sharing than otherwise provided by the IRA to non-LIS beneficiaries.

EFFECT OF NEGOTIATED PRICES ON COINSURANCE PAYMENTS FOR SPECIALTY DRUGS

Because Part D event data do not identify whether patient cost-sharing is attributable to copayments versus coinsurance, we developed an algorithm to identify likely instances of coinsurance. In particular, we considered only claims with payments above $500 to avoid counting claims during the deductible phase, and further limited the analysis to only claims for which beneficiary OOP was not clustered on a specific number. As a result, our estimates of savings from negotiated prices are likely to be conservative. In addition, they are likely to undercount the number of individuals with LIS who have coinsurance, due to the requirement that payments be at least $500.

PART B INFLATION REBATES

Many FFS beneficiaries have supplemental insurance that reduces their cost-sharing under Part B. As a result, the financial benefits of the Part B inflation rebate may accrue more to the sponsors of these supplemental benefits than to beneficiaries.

MPPP

Capping monthly out-of-pocket costs has an effect by acting on monthly budget constraints, which are important for individuals on a fixed income. However, MPPP does not in and of itself reduce the amount beneficiaries will pay in cost-sharing, as deferred amounts are due in later months.

FULL ANALYSIS

The estimates for individual provisions are not additive, as they interact with one another. For example, negotiated prices will exert downward pressure on patient coinsurance. However, beneficiary cost-sharing is now capped at $2,000. As a result, beneficiaries will experience the reduced coinsurance as a less direct financial benefit. Instead, they will pay less per claim and fill more prescriptions before hitting the cap.

RESULTS

1. IMPACT OF PART D REDESIGN ON CRNA AND MORTALITY FROM CHRONIC CONDITIONS

ASPE estimates that LIS and non-LIS beneficiaries will save 84% and 26.8% on OOP spending, respectively. However, the absolute magnitude of the spending reduction is disproportionately concentrated among non-LIS beneficiaries, who both outnumber and spend more at baseline than their LIS counterparts. (Table 2)

TABLE 2. 2025 ASPE ENROLLMENT PROJECTIONS AND ESTIMATES OF OOP COSTS; XCENDA PROJECTIONS FOR BENEFICIARIES WITH ≥1 CHRONIC CONDITION

	2025 PROJECTIONS WITHOUT IRA	2025 PROJECTIONS WITH IRA	DIFFERENCE
BENEFICIARIES ENROLLED IN PART D	51,627,730	51,627,730	
LIS	14,368,070	14,368,070	
Non-LIS	37,259,660	37,259,660	
2025 AVERAGE ANNUAL OOP / BENEFICIARY	$486	$342	-$144 (-29.6%)
LIS	$86	$13	-$73 (-84.3%)
Non-LIS	$640	$468	-$172 (-26.8%)
2025 TOTAL ANNUAL OOP	$25,081,836,420	$17,624,305,790	$7,457,530,630 (-29.7%)
LIS	$1,235,654,020	$186,784,910	$1,048,869,110 (-84.9%)
Non-LIS	$23,846,182,400	$17,437,520,880	$6,408,661,520 (-26.9%)
PART D BENEFICIARIES WITH ≥1 CHRONIC CONDITION	39,009,912	39,009,912	
2025 TOTAL ANNUAL OOP FOR BENEFICIARIES WITH ≥1 CHRONIC CONDITION	$18,951,835,599	$13,316,925,455	-$5,634,910,144 (-29.7%)
LIS	$933,660,178	$141,134,678	-$792,525,500 (-84.9%)
Non-LIS	$18,018,175,421	$13,175,790,777	-$4,842,384,645 (-26.9%)

For non-LIS beneficiaries with ≥1 chronic condition, Part D redesign reduces OOP by 26.9%. These reductions increase the number of beneficiaries who adhere to their medications by 3.2 percentage points, from 85.3% to 88.5%. As a result, the mortality rate declines from 4.45% to 4.35%, or 38,554 fewer deaths in 2025.

TABLE 3. ESTIMATES OF CHANGES TO ADHERENCE AND MORTALITY BASED ON XCENDA MODEL

PARAMETER	ANNUAL ESTIMATE (MODELED RANGE)	NUMBER OF NON-LIS BENEFICIARIES ADHERENT (MODELED RANGE)
ADHERENCE		
Without IRA	85.3% (76.8%, 93.8%)	33,279,356 (29,951,811 – 36,606,902)
With IRA	88.5% (88.2%, 88.8%)	34,517,063 (34,396,311 – 34,637,815)
Change		1,237,706 (1,116,954 – 1,358,458)
MORTALITY		
Without IRA	4.45% (4.45%, 4.47%)	1,735,941 (1,735,941 – 1,743,743)
With IRA	4.35% (4.35%, 4.37%)	1,697,386 (1,696,285 – 1,703,445)
Change		-38,554 (-39,656 to -32,496)

2. IMPACT OF MEDICARE NEGOTIATION ON SPECIALTY DRUGS

In 2023, 22,930, 47,838, and 17,100 Medicare beneficiaries received at least one prescription of Stelara, Enbrel, or Imbruvica, respectively. Among these, 36%, 24%, and 69% were identified as having paid coinsurance during any phase of the Part D benefit. Applying negotiated prices to these filled prescriptions in 2023 would have reduced their coinsurance payments by $98 million in total. (Table 4) On average, non-LIS beneficiaries taking these three drugs could have saved between $2,269 and $4,874 per person.

TABLE 4. ESTIMATED EFFECT OF LOWERING COINSURANCE FOR NEGOTIATED DRUGS NOT USED TO TREAT CHRONIC CONDITIONS

DRUG	NUMBER OF BENEFICIARIES WITH CLAIMS	NUMBER OF BENEFICIARIES WITH AT LEAST ONE COINSURANCE PAYMENT	TOTAL ANNUAL COINSURANCE PAYMENT PRE-IRA	TOTAL REDUCTION IN COINSURANCE PAYMENTS	AVERAGE REDUCTION PER YEAR PER PATIENT WITH COINSURANCE
ALL BENEFICIARIES					
Stelara	22,930	8,258	$60,444,164	$39,893,148	$4,831
Enbrel	47,838	11,361	$37,830,648	$25,346,534	$2,231
Imbruvica	17,100	11,822	$86,972,801	$33,049,664	$2,796
NON-LIS BENEFICIARIES					
Stelara	11,947	8,144	$60,141,339	$39,693,284	$4,874
Enbrel	21,353	11,076	$37,501,528	$25,126,024	$2,269
Imbruvica	13,323	11,345	$86,343,781	$32,810,637	$2,892

LIS BENEFICIARIES					
Stelara	10,983	114	$302,824	$199,864	$1,753
Enbrel	26,485	285	$329,120	$220,511	$774
Imbruvica	3,777	477	$629,021	$239,028	$501

3. BENEFICIARY SAVINGS FROM INFLATION REBATES

197,000 beneficiaries were administered drugs under Part B that had reduced coinsurance amounts between April 1 and December 31 in 2023. On average, coinsurance declined by $13.73 per beneficiary, and, in total, coinsurance payments decreased by $2.7 million. Assuming the same level of utilization, extending these changes for the full calendar year would have resulted in a $3.6 million reduction in coinsurance payments. (Table 5)

TABLE 5. ESTIMATED EFFECT OF INFLATION REBATES ON COINSURANCE IN PART B

NUMBER OF BENEFICIARIES THAT WOULD HAVE BENEFITED FROM REDUCED COINSURANCE RATE	TOTAL SAVINGS FROM SELECTED INFLATION-ADJUSTED PART B DRUGS	AVERAGE DIFFERENCE IN COINSURANCE PER BENEFICIARY
197,000	$2,704,877	-$13.73

4. SPENDING FLEXIBILITY INTRODUCED BY MONTHLY OOP SMOOTHING

In total, 8.2 million beneficiaries had spending in excess of $167 in at least one month of 2023 before attaining the annual $2,000 cap. The majority—6.5 million—had spending that did not exceed the cap and experienced an average of 2.1 months during which spending exceeded $167. (Table 6) These beneficiaries would have been able to carry $81 in OOP across months under the MPPP. Although there were fewer beneficiaries with spending above the $2,000 cap, they experienced an average of 3.7 months of payments in excess of $167 before meeting the threshold. On average, the MPPP would have allowed these beneficiaries to carry $665 in OOP across months before they hit the cap, which would have affected $1.1 billion in OOP spending.

TABLE 6. ESTIMATED EFFECT OF COPAY SMOOTHING ON BENEFICIARY COST-SHARING BEFORE ANNUAL $2,000 MAXIMUM OUT-OF-POCKET SPENDING

TYPE OF BENEFICIARIES	NUMBER OF BENEFICIARIES	AVERAGE NUMBER OF MONTHS WITH PAYMENTS ≥ $167	AVERAGE OF PAYMENTS THAT COULD HAVE BEEN SMOOTHED	TOTAL PAYMENTS THAT COULD HAVE BEEN SMOOTHED
ALL BENEFICIARIES				
$2k+ OOP	1,690,786	3.7	$665.16	$1,124,640,845
<$2k OOP	6,497,143	2.1	$81.10	$526,904,842
All beneficiaries	8,187,924	2.4	$201.71	$1,651,545,687

NON-LIS BENEFICIARIES				
$2k+ OOP	1,683,943	3.7	$664.45	$1,118,891,645
<$2k OOP	6,383,897	2.1	$81.98	$523,336,572
All beneficiaries	8,067,840	2.4	$203.55	$1,642,228,217
LIS BENEFICIARIES				
$2k+ OOP	6,838	3.2	$840.77	$5,749,200
<$2k OOP	113,246	1.9	$31.51	$3,568,270
All beneficiaries	120,084	2.0	$77.59	$9,317,470

CONCLUSION

Our estimates suggest that the IRA's drug affordability measures are poised to deliver meaningful benefits to Medicare beneficiaries. We project that the cost-sharing caps could prevent nearly 39,000 deaths annually by reducing cost-related non-adherence among beneficiaries with chronic conditions. In addition, negotiated prices that went into effect in 2026 may reduce annual coinsurance payments for patients using three high-cost specialty drugs by between $2,269 and $4,874. If patient spending followed similar patterns to those in 2023, beneficiaries may be able to pay $1.6 billion in out-of-pocket costs as manageable monthly installments. Meanwhile, Part B inflation rebates reduced coinsurance payments by $2.7 million within the first nine months of implementation.

Our projections align with emerging data showing that OOP reductions from the IRA measurably impact utilization and adherence.[1] As in our analysis, the effect appears to be particularly significant for those who do not qualify for the low-income subsidy.[2] Utilization increases in this group have exceeded expectations,[3] suggesting that poor affordability affects those with higher incomes more than previously understood. Policymakers weighing further reforms should carefully weigh the financial and health consequences of policies that may affect affordability.

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[1] Myerson, R., Qato, D. M., Goldman, D. P., & Romley, J. A. (2023). Insulin fills by Medicare enrollees and out-of-pocket caps under the Inflation Reduction Act. JAMA, 330(7), 660–662. https://doi.org/10.1001/jama.2023.12951; Medicare Payment Advisory Commission. (2025, March). The Medicare prescription drug program (Part D): Status report. In Report to the Congress: Medicare payment policy (Chap. 12).

[2] Marinacci, L. X., Oseran, A. S., Narasimmaraj, P., Engel-Rebitzer, E., & Wadhera, R. K. (2026). Medication adherence among Medicare beneficiaries with cardiovascular conditions after the 2024 Inflation Reduction Act provisions. Journal of the American College of Cardiology. Advance online publication. https://doi.org/10.1016/j.jacc.2025.12.083; Feller, M., Madden, R., & Holcomb, K. (2025, April 15). Part D trend insights: 2024 trend analysis reveals sharp increase in specialty drug utilization among non-low income beneficiaries. Milliman. https://www.milliman.com/en/insight/part-d-trend-insights-analysis-specialty-drug-utilization; Feller, M., Madden, R., & Holcomb, K. (2025, September 8). Milliman MedIntel Part D trend insights: Utilization trends for non-low income Part D members show no signs of slowing in the first half of 2025. Milliman. https://www.milliman.com/en/insight/medicare-medintel-part-d-trend-insights-halfyear-2025

[3] Congressional Budget Office. (2025, November 21). A call for new research in the area of spending on Medicare Part D. https://www.cbo.gov/publication/61824

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