cencora

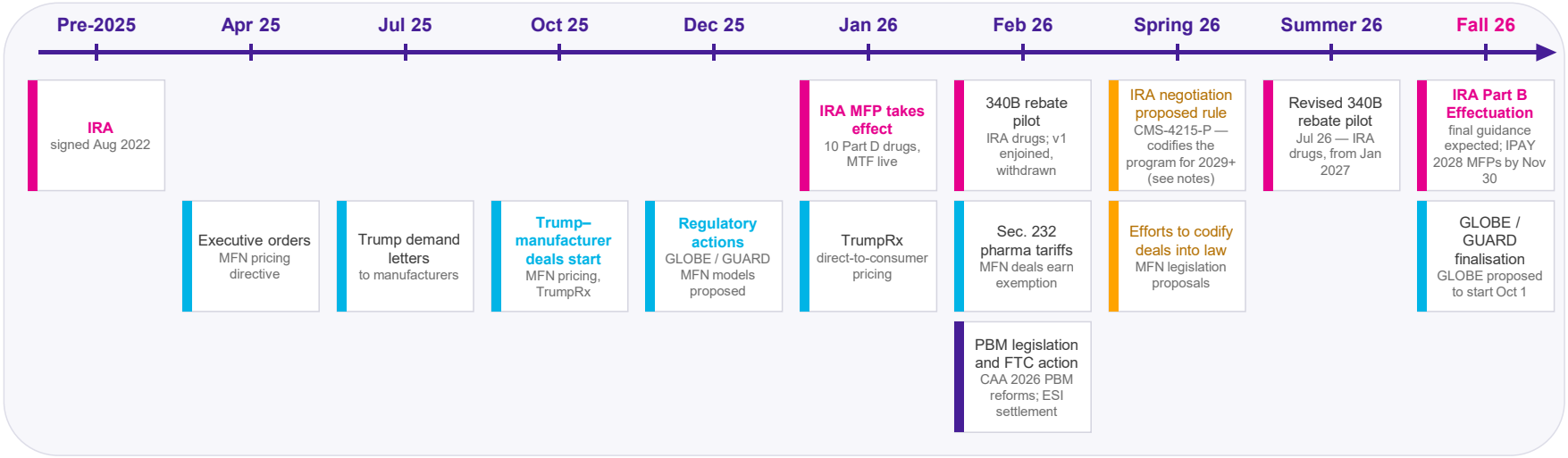
Vision Exchange
Policy Economics Update

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November 6 & 7, 2026

U.S. drug-pricing reforms expand in scope

Federal actions from the IRA (2022) through fall 2026. Pink marks IRA milestones that change what is paid; gold marks efforts to make reform permanent.



IRA implementation is underway, with the impact primarily on Part D products to date; Part B effectuation guidance is being finalised this fall for MFPs effective 1 January 2028.

Administration actions have expanded pricing reform beyond brands approaching LOE to launch pricing, most-favoured-nation models and manufacturer contracting.

Attention is increasingly shifting towards PBMs and supply-chain economics — PBM reforms enacted in February 2026 and FTC action.

Policymakers are moving to make pricing reform permanent — by regulation (CMS's June 2026 rule) and by legislation — beyond the current administration.

- CMS' June 2026 proposal primarily codifies the IRA negotiation program into formal regulation, increasing predictability and durability of the program. CMS continues to move toward an MFP-based reimbursement environment, but many operational questions remain open.

Sources: IRA (2022); CMS negotiation program milestones and proposed rule CMS-4215-P; CMS GLOBE / GUARD proposed rules (Dec 2025); Consolidated Appropriations Act, 2026 (PBM provisions); Section 232 proclamation (Apr 2026); HRSA revised 340B Rebate Model Pilot (Jul 2026). Illustrative; not legal, regulatory or financial advice.

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The IRA's Medicare drug-pricing provisions

Inflation Reduction Act of 2022, signed 16 August 2022. Negotiation is one of four Medicare drug-pricing pillars; Part B drugs enter negotiation with the 2028 cycle.

Four pillars · what the IRA changed for Medicare drugs

Drug price negotiation

CMS negotiates maximum fair prices (MFPs) for high-spend, single-source drugs. 10, then 15, then 15 drugs a year; up to 20 a year from 2029. Part D only in 2026–2027; Part B and/or D from 2028.

Inflation rebates

Manufacturers rebate Medicare when a Part B or Part D drug's price rises faster than inflation. In force since 2022–2023; Part B coinsurance is reduced on those drugs.

Part D benefit redesign

$35 monthly insulin cap; $0 adult vaccines; catastrophic coinsurance eliminated (2024); $2,000 out-of-pocket cap (2025, indexed); manufacturer discount program replaces the coverage gap.

What already reaches Part B

Inflation rebates and the $35 insulin cap already apply. Negotiation arrives with IPAY 2028: four of the 15 selected drugs are primarily Part B, and the payment limit becomes MFP + 6% instead of ASP + 6%.

Negotiation timeline · Part D first, Part B from 2028 — prices effective two years after selection

Cycle	IPAY 2026 first cycle	IPAY 2027 second cycle	IPAY 2028 third cycle — Part B enters	IPAY 2029 and later fourth cycle onward
Drugs selected	**10 — Part D**	**15 — Part D**	**15 — Part B and/or Part D**	**Up to 20 a year — Part B and/or D**
Selected drug list published	29 Aug 2023	17 Jan 2025	27 Jan 2026	1 Feb 2027, then each 1 Feb
MFPs published	15 Aug 2024	Nov 2025	By 30 Nov 2026	By 30 Nov of the selection year
Prices in effect	**1 Jan 2026**	**1 Jan 2027**	**1 Jan 2028**	**1 Jan 2029, then each 1 Jan**
Governed by	Program guidance	Program guidance	Guidance — Part B effectuation guidance in draft	Regulation — CMS-4215-P, final expected fall 2026

Effectuation — how the MFP actually reaches the pharmacy or provider — is set separately from negotiation. For Part B, that guidance is the subject of this deck.

Sources: Inflation Reduction Act of 2022; CMS Medicare Drug Price Negotiation Program fact sheets (IPAY 2026, 2027, 2028); CMS proposed rule CMS-4215-P (June 2026). The $2,000 out-of-pocket cap is indexed ($2,100 in 2026). Illustrative; not legal, regulatory or financial advice.

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Forty drugs selected so far — Part D and Part B

Selected drug lists per CMS. Three cycles so far; the 2028 cohort is the first to include drugs paid under Part B.

Part D — 36 drugs · pharmacy-dispensed; MFPs effectuated through the MTF since January 2026

IPAY 2026 10 drugs

in effect since 1 Jan 2026

- **Eliquis**
- **Jardiance**
- **Xarelto** exits 1 Jan 2027
- **Januvia**
- **Farxiga**
- **Entresto** exits 1 Jan 2027
- **Enbrel**
- **Imbruvica**
- **Stelara** exits 1 Jan 2027
- **Fiasp / NovoLog**

IPAY 2027 15 drugs

in effect 1 Jan 2027

- **Ozempic / Rybelsus / Wegovy**
- **Trelegy Ellipta**
- **Xtandi**
- **Pomalyst**
- **Ibrance**
- **Ofev**
- **Linzess**
- **Calquence**
- **Austedo**
- **Breo Ellipta**
- **Tradjenta**
- **Xifaxan**
- **Vraylar**
- **Janumet**
- **Otezla**

IPAY 2028 10 drugs

in effect 1 Jan 2028

- **Trulicity**
- **Biktarvy**
- **Cosentyx**
- **Erleada**
- **Kisqali**
- **Verzenio**
- **Lenvima**
- **Rexulti**
- **Xeljanz**
- **Anoro Ellipta**

Part B — 5 drugs · IPAY 2028

Botox

chronic migraine · spasticity · OAB

Orencia

rheumatoid and psoriatic arthritis

Entyvio

Crohn's disease · ulcerative colitis

Cimzia

Crohn's · RA · psoriasis

Xolair

Asthma · Chronic Spontaneous Urticaria

IPAY 2029*

*** Product List to be announced in Feb 2027**

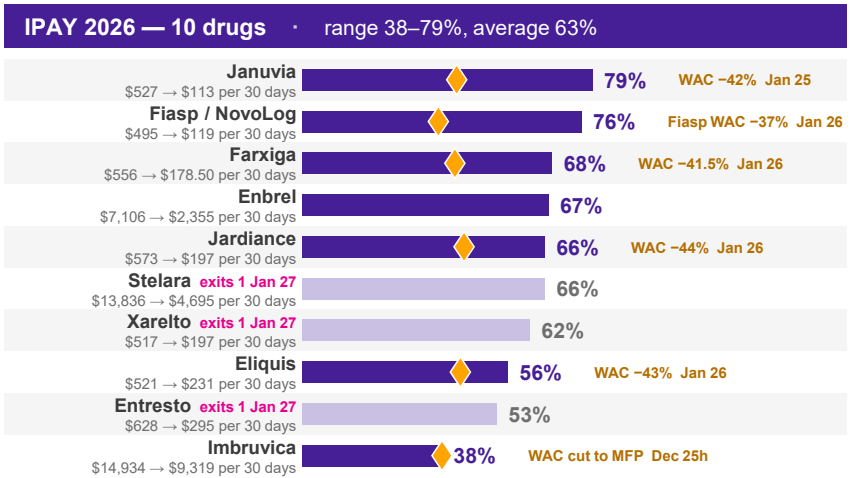
** Leaves the program on 1 January 2027 after generic or biosimilar entry. Tradjenta was also selected for renegotiation in the 2028 cycle.*

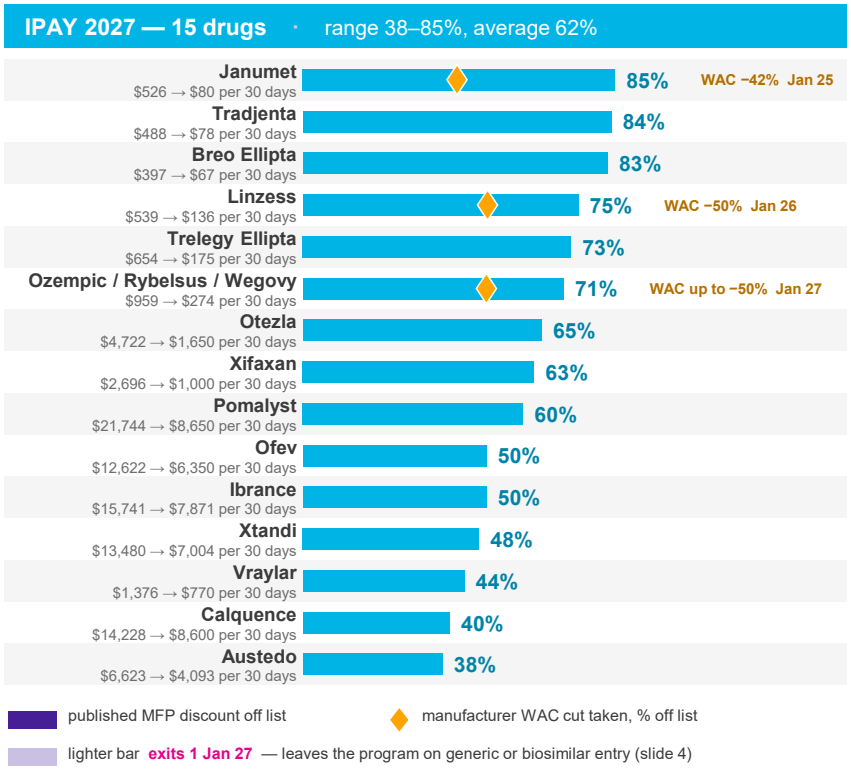
Sources: CMS selected drug list fact sheets for IPAY 2026, 2027 and 2028; CMS determination that Entresto, Stelara and Xarelto cease to be selected drugs from 1 January 2027. Part B spend and users per CMS for Nov 2024 – Oct 2025 (Part B and Part D combined). Illustrative; not legal, regulatory or financial advice.

Disclaimer: Brand names included herein are shown solely for educational purposes and should not be interpreted as an endorsement of any specific brand or product

How deep are the published MFP discounts off list?

CMS-published negotiated prices versus list price (WAC) for a 30-day supply, with the WAC cuts manufacturers have since taken. Part B MFPs due 30 Nov 2026.





Off list is not off net — and WAC is following the MFP down

Many of these brands already carried large Part D rebates: CMS puts the saving against Medicare's net price at 22% for the first cycle and about 44% for the second — the gap to the headline is the gross-to-net bubble.

Six of the ten first-cycle products have since cut WAC by 37–44% (Imbruvica all the way to its MFP), closing roughly half to two-thirds of the gap. None of the three exiting drugs did. In the 2027 cohort, Linzess (−50%), Janumet (−42%) and Novo's semaglutide franchise (up to −50% from January 2027) have moved ahead of their MFPs.

Sources: CMS, Negotiated Prices for IPAY 2026 (15 August 2024) and IPAY 2027 (November 2025), discounts against CY2023 and CY2024 list prices; WAC cuts per NCPA, 46brooklyn Box Score, Drug Channels and BGB/Hayden (2026); exits per CMS bona fide marketing determinations. Full citations in the speaker notes. Illustrative; not legal, regulatory or financial advice.

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Part D effectuation — how the MFP reaches the pharmacy

Retrospective effectuation: the pharmacy buys at its usual WAC-based price, is paid no more than the MFP, and the manufacturer refunds the difference via the MTF.

Six steps · about three weeks from dispense to refund — the manufacturer controls up to 14 days

1 Pharmacy buys

from its wholesaler at its contracted price — typically WAC less a few percent

Day 0

2 Dispenses and bills

the Part D plan pays no more than MFP plus a dispensing fee; patient cost-sharing is set on the MFP

Day 0

3 Plan sends the PDE

the Part D plan submits the prescription drug event to CMS

up to 7 days

4 MTF Data Module

passes the claim-level data to the manufacturer and starts the 14-day clock

—

5 Manufacturer refunds

the standard default refund amount — WAC − MFP per unit — and approves payment

up to 14 days

6 MTF Payment Module

optional service that pays the pharmacy by ACH with an 835 remittance

up to 5 business days

CMS reports refunds completing within about 21 days of the date of service on average — the 14-day manufacturer window sits between plan submission and banking.

Two ways a manufacturer can make the MFP available · most Part D manufacturers refund; a growing number simply cut WAC

	Retrospective — refund	Prospective — price
What the pharmacy pays	Its normal WAC-based price	A price at or below MFP — usually via a WAC reduction
Who makes the pharmacy whole	Manufacturer refund of WAC − MFP, via the MTF Payment Module or directly	No refund needed
Timing	14 days from receipt of claim data; ~21 days end to end	Immediate at purchase

Sources: CMS, MTF Overview for Dispensing Entities (April 2026); CMS final guidance on manufacturer effectuation of the MFP in 2026–2028. Standard default refund amount (SDRA) = WAC − MFP at NDC-11 level. Illustrative; not legal, regulatory or financial advice.

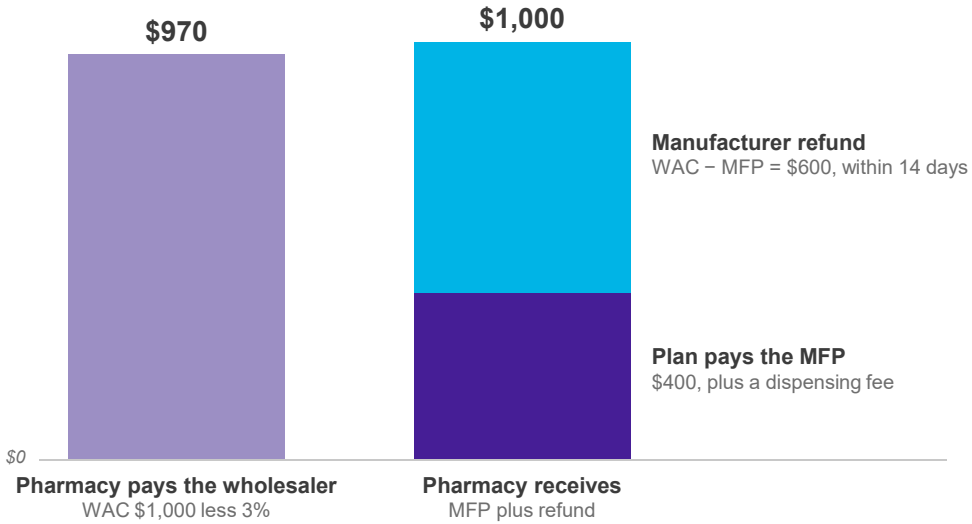
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Part D arithmetic — the pharmacy keeps its discount off WAC but some Effectuation plans differ

Illustrative; not legal, regulatory or financial advice.

Illustrative, per unit. WAC $1,000; MFP $400; the pharmacy buys at WAC − 3%. With a WAC-based refund, WAC and MFP cancel out of the pharmacy's position.

What the pharmacy pays and receives · per unit



+$30 per unit

= 3% of WAC — exactly the pharmacy's negotiated discount from its wholesaler.

The identity

Received: MFP + (WAC − MFP) = WAC
Paid: WAC − 3%
Margin: 3% of WAC
The MFP level does not enter the pharmacy's margin at all.

Before MFP, Part D reimbursement at AWP − X% was often below WAC. Under a WAC-based refund, the pharmacy keeps every dollar of its wholesaler discount — which is why many pharmacies gained on the first ten drugs.

The same logic drives the Part B question later in this deck: a WAC-based SDRA (Options 1a / 1b) preserves the provider's discount; an ASP-based SDRA (Options 2a / 2b) does not.

Standard default refund amount per CMS effectuation guidance = WAC − MFP at the NDC-11 level, regardless of the pharmacy's actual acquisition cost. Reimbursement comparison per Drug Channels (Dec 2025). Illustrative; not legal, regulatory or financial advice.

Disclaimer: not legal, regulatory or financial advice.

What Part D has taught us — five learnings

Nine months into MFP effectuation for the first ten drugs, drawing on CMS operational data, NCPA's February 2026 survey and Drug Channels' 2026 report.

1

WAC reductions are real and can reduce PBM reimbursement

List prices were cut on 6 of the 10 first-cycle products by April 2026 — AbbVie took Imbruvica's WAC all the way to the MFP — and on 3 products in the 2027 and 2028 cohorts before their MFPs even apply. When WAC falls, PBM reimbursement follows

2

Lower WAC means lower cash outlay

The pharmacy fronts less between purchase and refund, and the refund it waits for shrinks — cash-flow pressure eases in proportion to the cut.

3

Pharmacy reimbursement improved when WAC-based utilized but some Effectuation plans differ

With the default refund built on WAC, the pharmacy keeps its full discount off WAC. Under AWP − X% reimbursement, many were paid below WAC before MFP but some manufacturers depart from the SDRA;

4

Refunds take longer than 14 days & Reconciliation is hard

Manufacturers have 14 days from receipt of valid claim data, but plan submission and banking sit either side: 18–21 days on average. NCPA's February survey found 67% of pharmacies waiting 22+ days, 60% drawing on savings and 70% trimming high-cost inventory.

5

Other lessons

Authorized generics confuse. 340B nonduplication and the rebate pilot complicate contract pharmacy. Three drugs exit on 1 January 2027.

Sources: Drug Channels (Dec 2025, updated Apr 2026); 340B Insight (May 2026); NCPA letter to CMS, 26 Feb 2026 (survey of ~510 independent pharmacies); CMS MTF Overview for Dispensing Entities (Apr 2026); NCPA, 2 Dec 2025. Illustrative; not legal, regulatory or financial advice.

Disclaimer: not legal, regulatory or financial advice.

Outlook — what to expect next

Where Part D effectuation is heading, and what it implies for the Part B decision this fall.

More WAC cuts — about half of Part D selected products

Most likely where 340B discounts are high, or where a manufacturer would rather not stand up the operations to run MTF refunds. Each cut narrows the pharmacy's margin to its discount off a smaller WAC.

New entrants bring new delays

15 more Part D drugs take an MFP on 1 January 2027 and the first Part B drugs on 1 January 2028. Expect longer refund cycles while new manufacturers learn the MTF and their effectuation plans settle.

The read-across to Part B

A WAC-based **Standard Default Rebate Amount or SDRA** (Options 1a / 1b) reproduces the Part D logic — the provider keeps its discount off WAC. An ASP-based SDRA (2a / 2b) does not. That choice is what the rest of this deck models.

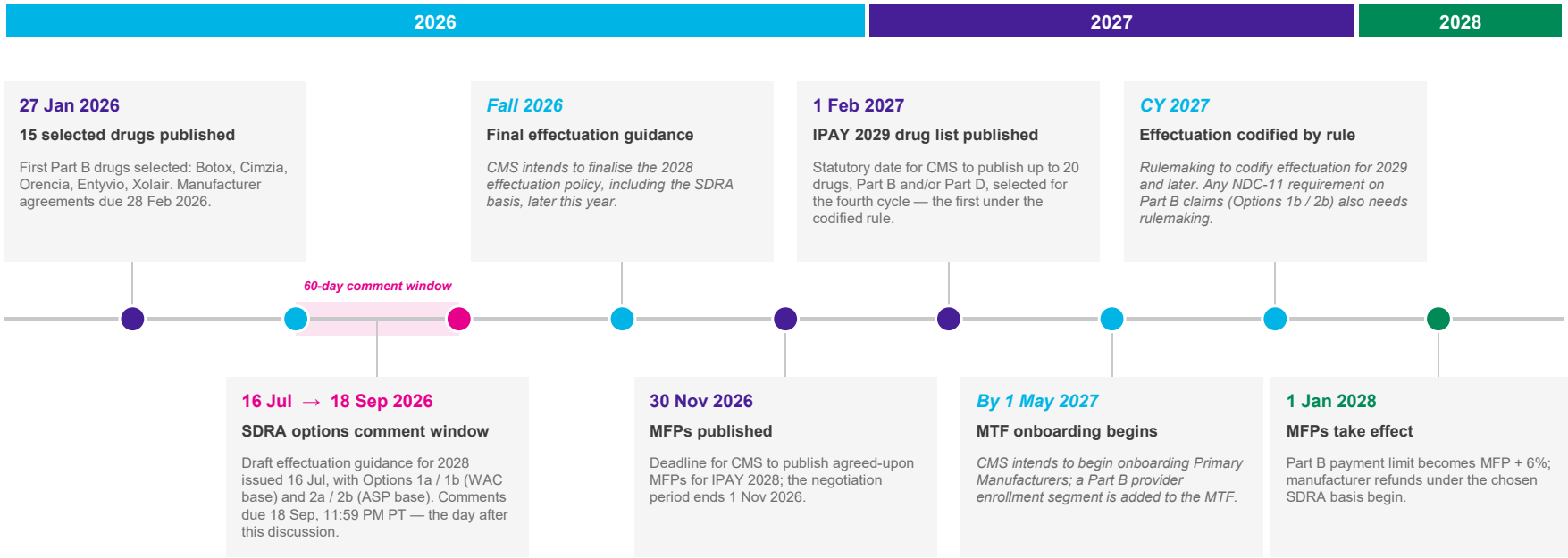
The SDRA basis CMS chooses this fall decides whether Part B providers inherit the Part D experience — a predictable, WAC-anchored refund — or an ASP-anchored one that shrinks as the MFP itself pulls ASP down.

Expectations are the working group's, informed by first-cycle experience (Drug Channels, NCPA, CMS MTF data). Illustrative; not legal, regulatory or financial advice.

Disclaimer: not legal, regulatory or financial advice.

Part B effectuation — key dates to go-live

The third negotiation cycle (IPAY 2028) is the first to include Part B drugs. Dates per CMS; items in italics are CMS's stated intentions rather than fixed deadlines.



From final effectuation guidance in the fall of 2026 to go-live on 1 January 2028 is roughly 14 months. If CMS lands on Option 1b or 2b, NDC-11 collection on Part B claims would also have to be proposed and finalised through rulemaking inside that window, so the SDRA decision and the claims-data decision travel together.

Sources: CMS fact sheets on the IPAY 2028 selected drug list (27 January 2026), the Negotiation Program proposed rule CMS-4215-P (June 2026) and the draft guidance on manufacturer effectuation of the MFP in 2028 (16 July 2026); 1 February 2027 is the statutory selected-drug publication date for IPAY 2029. CMS states it intends to issue final effectuation guidance later in 2026, begin MTF onboarding of Primary Manufacturers by 1 May 2027, and codify effectuation policy for 2029 and later years through rulemaking in calendar year 2027. Any NDC-11 requirement on Part B claims (Options 1b / 2b) would be proposed through separate rulemaking. Illustrative; not legal, regulatory or financial advice.

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The four SDRA options CMS is requesting input on

Per CMS's draft guidance on manufacturer effectuation of the MFP in 2028 (16 July 2026; comments due 18 September 2026). SDRA = standardized default refund amount.

What each option uses as the price reference · the SDRA is what the manufacturer refunds, so its base decides what the provider nets

	WAC base — Option 1 wholesale acquisition cost, the list price	**ASP base — Option 2** average sales price, the market's average net
a **Averaged across NDC-11s** HCPCS-level blend, weighted by ASP-reported volume. No change to Part B claims.	**Option 1a — blended WAC, weighted by ASP volume** Average of the WACs of all NDC-11s of the selected drug assigned to the HCPCS code, weighted by ASP-reported sales volume. **SDRA = blended WAC − MFP**	**Option 2a — blended ASP, weighted by ASP volume** Average of the reported ASPs of all NDC-11s of the selected drug assigned to the HCPCS code, weighted by ASP-reported sales volume. **SDRA = blended ASP − MFP**
b **Tied to the NDC-11 on the claim** Requires CMS to collect NDC-11 on Part B claims, via rulemaking.	**Option 1b — the NDC-11's own published WAC** WAC of the NDC-11 reported on the claim, as published in the pricing compendia as of the claim from-date. No weighting is performed. **SDRA = own WAC − MFP**	**Option 2b — blended ASP, weighted by Part B claims** The same reported ASPs, but weighted by the NDC-11 volume on Part B claims rather than by all-payer ASP volume. Still an HCPCS-level blend. **SDRA = Medicare-weighted ASP − MFP**

Definitions per CMS, Medicare Drug Price Negotiation Program: Draft Guidance for Manufacturer Effectuation of the Maximum Fair Price in 2028, section on the retrospective refund amount and SDRA for selected drugs payable under Part B. Under retrospective effectuation the provider buys at its contract price, bills Medicare, and the Primary Manufacturer refunds the SDRA within the 14-day prompt-payment window. ASP for a selected drug is reported to CMS but not published once the MFP applies. Modelled figures use WAC $10,000, MFP $6,000, contract WAC −4%, Medicare 40% of units, before sequestration. Illustrative; not legal, regulatory or financial advice.

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Part B effectuation — how the MFP would reach the provider

As drafted by CMS (16 July 2026). Grey text is settled; stacked boxes show the options CMS is still weighing. Payment falls to MFP + 6% while purchasing is unchanged.

Six steps · the same MTF machinery as Part D — but Part B claims carry HCPCS codes, not NDCs, and the refund basis is still open

1 Provider buys
Known
from its distributor or GPO at its contracted price — typically a discount off WAC
Day 0

2 Administers and bills
Known
MAC pays 106% of MFP less sequestration; the patient owes 20% of the MFP-based amount (MA coinsurance capped at MFP)
Day 0

3 Claim data to CMS
Open
Original Medicare: MAC adjudicates, claim posts to the IDR
Medicare Advantage: encounter data via EDS — shorter deadline under review
timing not yet set

4 MTF Data Module
Known
sends HCPCS-level claim data to the manufacturer and starts the 14-day clock
—

5 Manufacturer refunds
Open — the SDRA
1a blended WAC − MFP
1b own NDC-11 WAC − MFP
2a blended ASP − MFP (ASP-weighted)
2b blended ASP − MFP (claims-weighted)
up to 14 days

6 MTF Payment Module
Partly open
Optional ACH pass-through, as in Part D
Provider enrollment: encouraged today; PECOS sign-up and an MA-contract mandate under review
up to 5 business days

The 14-day manufacturer window carries over from Part D. What does not is a fixed clock for the front end — MAC adjudication and MA encounter data replace the 7-day PDE — so end-to-end timing is unknown until CMS finalises.

What differs from Part D · and why the refund basis matters more here

	Part D — live since Jan 2026	Part B — from Jan 2028, as drafted
Unit on the claim	NDC-11 — so the refund can reference the exact product's WAC	HCPCS code — NDC-11 only if CMS mandates it (Options 1b / 2b)
Refund basis	Settled: WAC − MFP at NDC-11 level	**Open: WAC-based (1a / 1b) or ASP-based (2a / 2b)**
Payer share and patient	Plan pays up to MFP + fee; patient cost-sharing on MFP	Medicare 80% of 106% × MFP less sequestration; patient 20%

Sources: CMS draft guidance on manufacturer effectuation of the MFP in 2028 and fact sheet (16 July 2026); CY2026 Physician Fee Schedule final rule; CMS MTF Overview for Dispensing Entities (April 2026). Full citations in the speaker notes. Illustrative; not legal, regulatory or financial advice.

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How the four SDRA options compare with Part B today

Illustrative; not legal, regulatory or financial advice.

Drawn from the definitions in CMS's draft effectuation guidance for 2028 (16 July 2026); the modelled consequences for the provider follow on the next slide.

Definitions and mechanics · what sets the payment limit, what the refund references, and what data each option needs

	Today — pre-MFP	WAC base — Option 1		ASP base — Option 2	
Property	**ASP + 6% no refund**	**1a blended WAC**	**1b own NDC WAC**	**2a ASP, ASP-weighted**	**2b ASP, claims-weighted**
Payment limit is built off	ASP + 6%	MFP + 6%	MFP + 6%	MFP + 6%	MFP + 6%
Refund reference (SDRA)	None — no refund	Blended WAC	NDC's own WAC	Blended reported ASP	Blended reported ASP
Weighting across NDC-11s	n/a	ASP-reported volume	None	ASP-reported volume	NDC volume on Part B claims
Requires NDC-11 on Part B claims	**No — HCPCS only**	**No**	**Yes**	**No**	**Yes**
Depends on ASP data	Yes — ASP sets the limit	Yes — for the weights	**No**	Yes — for the price	Yes — for the price
Reproducible by the provider	**Yes — published ASP file**	No — weights not published	**Yes — compendia WAC**	No — ASP not published	No — ASP not published

Options 1a and 2a keep the claim as it is today (HCPCS only) but rest on ASP data the provider cannot see; 1b is the only option the refund recipient can reproduce, at the cost of NDC-11 reporting on Part B claims. The modelled consequences follow on the next slide.

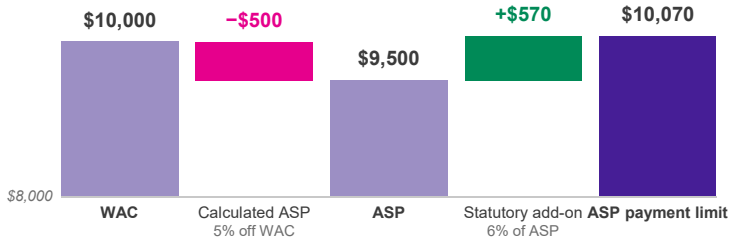
Today: payment limit = ASP + 6% = $10,070; no manufacturer refund; NCR = limit − contract price. Under MFP: payment limit = MFP + 6% = $6,360; refund = SDRA; net acquisition cost = contract price − SDRA; NCR = limit − net cost. Sequestration is 2% of Medicare's 80% share (limit $9,908.88 today, $6,258.24 under MFP). ASP-base refund path R(t) = $3,500 − 40% × average of R(t−2) through R(t−5), Medicare 40% of units. Definitions per CMS's draft guidance on manufacturer effectuation of the MFP in 2028 (16 July 2026). Illustrative; not legal, regulatory or financial advice.

The originator today (Pre-MFP), and Post MFP

Illustrative; not legal, regulatory or financial advice.

Illustrative, per dose. WAC $10,000 and ASP at WAC −5% held constant. MFP is a 40% reduction off WAC. Medicare is 40% of units.

Today — pre-MFP · the payment limit is built off ASP

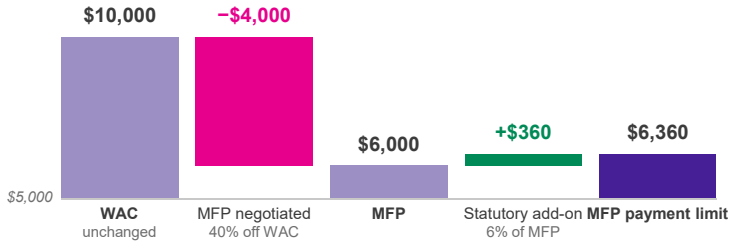


After sequestration the limit is $9,908.88 — the 6% becomes an effective 4.3%.

Contract price	Per dose	NCR $	NCR after seq.
WAC − 1%	$9,900	+$170	$8.88
WAC − 4%	$9,600	+$470	$308.88
WAC − 7%	$9,300	+$770	$608.88

The provider keeps the spread between a limit built on the market's average net and the price that account actually negotiated.

First through Sixth quarter of MFP · the payment limit is built off MFP — ASP no longer sets what Medicare pays



After sequestration the limit is $6,258.24 — the same effective 4.3%.

		WAC base 1a/1b		ASP base 2a/2b	
Contract price	Per dose	All quarters in MFP refund $4,000	WAC base after seq.	1 quarter into MFP refund $3,500	6 quarters into MFP refund $2,205
WAC − 1%	$9,900	+$460	+$358.24	−$40	−$1,335
WAC − 4%	$9,600	+$760	+$658.24	+$260	−$1,035
WAC − 7%	$9,300	+$1,060	+$958.24	+$560	−$735

Quarter 1 uses the ASP already in publication, which comes from pre-MFP sales — so the ASP-based refund is $3,500, not the $2,205 it reaches six quarters in as MFP units work their way into ASP; it settles at about $2,500 in a steady state, absent other price concessions or mix changes.

Six quarters is the modelled horizon throughout this deck: CMS publishes an MFP for a selected drug over a period of roughly 9 to 21 months. NCR = payment limit less the account's net acquisition cost, where net cost is the contract price less the refund. Sequestration is 2% of Medicare's 80% share. Illustrative; not legal, regulatory or financial advice.

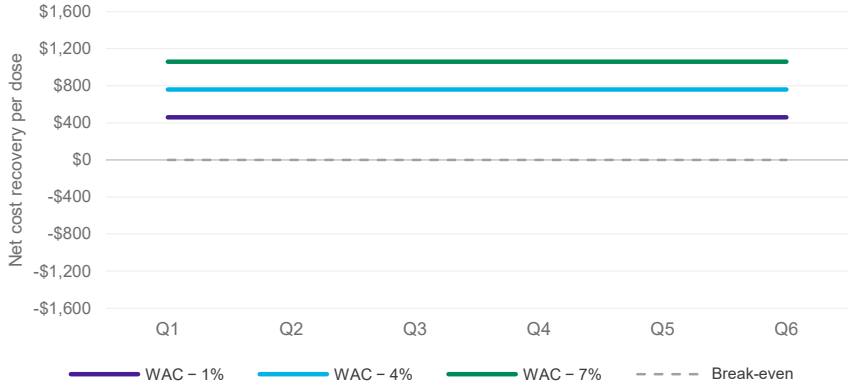
NCR reflects providers recovering 100% (80% from Medicare and 20% from the patient)

The same three accounts, six quarters, two effectuation bases

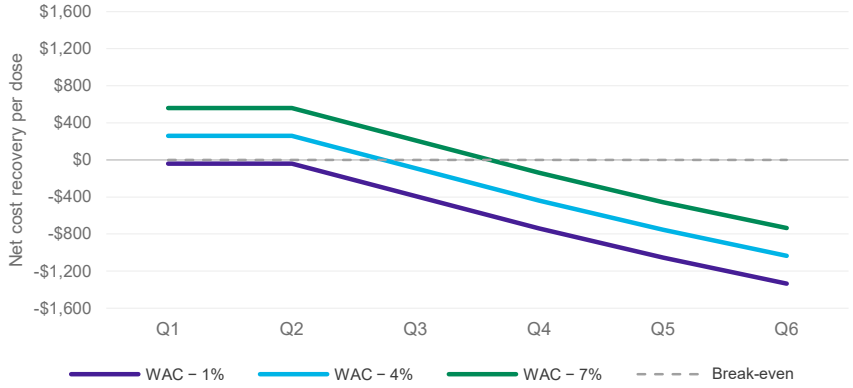
Illustrative; not legal, regulatory or financial advice.

Illustrative, per dose, originator only. Contract prices unchanged throughout. Both panels share an identical scale. Before sequestration.

WAC base — Options 1a / 1b



ASP base — Options 2a / 2b the rolling 12-month estimate



What each panel shows · both panels use the same three contract tiers and the same MFP

WAC-base is flat, and predictable

The WAC base does not move

Every tier earns its contract discount plus 6% of the MFP, in every quarter: $460 at WAC −1%, $760 at WAC −4%, $1,060 at WAC −7%..

ASP-base goes underwater

And worsens as MFP Units work their way into ASP

WAC −1% at Q1, WAC −4% at Q3, WAC −7% at Q4.

Six quarters is the modelled horizon. CMS publishes an MFP for a selected drug over roughly 9 to 21 months, so six quarters is the outer edge of the expected period. The ASP-based path continues to move after quarter 6.

WAC-base NCR = (WAC − contract price) + 6% of MFP. ASP-base NCR = 1.06 × MFP − contract price + refund, where the refund follows R(t) = $3,500 − 40% × (the average of R(t−2) through R(t−5)). Figures are before sequestration. Illustrative; not legal, regulatory or financial advice.

WAC-Base Options 1a and 1b compared — both reference WAC, only one is free of ASP

Illustrative; not legal, regulatory or financial advice.

Per CMS's draft guidance: 1a averages NDC-11 WACs weighted by ASP reported volume; 1b uses the NDC-11 WAC published in the compendia.

What each option requires as an input · per CMS's draft effectuation guidance

Input or property	Option 1a — HCPCS level	Option 1b — NDC-11 level
Price reference	Average of the WACs of all NDC-11s under the HCPCS code	Published WAC of the NDC-11 on the claim
Weighting input	ASP reported sales volume, by NDC	None — no weighting is performed
Requires ASP data	Yes, for the weights	No
Availability for a selected drug	ASP publication is suspended, so the weights are not published	Compendia WAC continues to publish throughout
Timing	Weights derive from a prior reporting period	WAC in effect on the date of service
Reproducible by the refund recipient	No — the weights are not visible	Yes — from a compendium subscription
Corresponds to a real transaction	No — a blend no purchaser pays	Yes — the NDC actually dispensed
Claims-data dependency	None — HCPCS is already on the claim	Requires NDC-11 collection on Part B claims

The first seven rows favour 1b and the eighth favours 1a. Both are drawn from the definitions, not from modelling.

Worked example — two NDC-11s under one HCPCS code · WAC $10,000 and $8,500, 50/50 ASP volume, each account contracted at WAC −4%, MFP $6,000

Option and NDC	Refund	Provider net cost	Net cost vs MFP	NCR	Spread X vs Y
1a NDC X — WAC $10,000	$3,250	$6,350	+$350	−$91.76	$1,440
1a NDC Y — WAC $8,500	$3,250	$4,910	−$1,090	+$1,348.24	
1b NDC X — WAC $10,000	$4,000	$5,600	−$400	+$658.24	$60
1b NDC Y — WAC $8,500	$2,500	$5,660	−$340	+$598.24	

Under 1a the two purchasers are $1,440 apart on identical contracting behaviour, and the buyer of the higher-WAC NDC nets $350 above MFP. Under 1b they are $60 apart and both net below MFP. The identities: 1a net = MFP + (contract − blended WAC), which exceeds MFP whenever the contract price is above the blend; 1b net = MFP − (own WAC − contract), which cannot exceed MFP because a contract price is never above its own WAC.

Definitions per CMS, Manufacturer Effectuation of MFP draft guidance for the 2028 cycle: 1a is the average of the WACs of all NDC-11s of a selected drug assigned to the HCPCS code, weighted by ASP reported volume; 1b is the NDC-11 WAC as published in the pricing compendia, and would require CMS to collect NDC-11 data on Part B claims. NDC reporting on Medicare Part B claims is not generally required except for dual-eligible beneficiaries, under the Deficit Reduction Act of 2005. The 50/50 volume split and the WAC −4% contract are illustrative. Illustrative; not legal, regulatory or financial advice.

Key takeaways — what to watch next

Illustrative; not legal, regulatory or financial advice.

Dates per CMS, HRSA, the White House and the Consolidated Appropriations Act, 2026. Items in italics are stated intentions or expectations rather than fixed dates.

Part D — what to watch

Fall 2026 — Negotiation program final rule

CMS-4215-P codifies the program in regulation for 2029+; effectuation to be codified by separate rulemaking in 2027.

30 Nov 2026 — IPAY 2028 MFPs published

Eleven Part D drugs plus the first four Part B drugs; prices effective 1 January 2028.

1 Jan 2027 — Second-cycle MFPs go live

Fifteen MFPs published in November 2025 take effect; Entresto, Stelara and Xarelto exit; the 340B rebate pilot on IRA drugs starts.

2026–27 — WAC reductions keep coming

Novo cuts Wegovy, Ozempic and Rybelsus WAC by up to 50% on 1 January 2027; expect roughly half of selected products to follow — watch pharmacy margins and MTF refund timing.

Jan 2028 — PBM delinking in Part D

CAA 2026 separates PBM pay from drug price and rebate volume in Part D; ERISA pass-through and reporting follow for plan years from August 2028.

Part B — what to watch

Fall 2026 — Effectuation guidance finalised

CMS picks the SDRA basis — WAC (1a / 1b) or ASP (2a / 2b). Comments closed 18 September; this deck's modelling is the case for WAC.

1 Oct 2026 — GLOBE Part B MFN model

Proposed start of the mandatory Part B model (about 55% of Part B drug spend); final rule still pending.

30 Nov 2026 — First Part B MFPs published

Botox, Cimzia, Orencia and Entyvio — the first read on how deep Part B discounts off WAC will be.

1 Feb 2027 — IPAY 2029 list: Keytruda, Opdivo?

Up to 20 drugs; both PD-1s become eligible in 2027 and CMS's fixed-combination proposal would sweep in their subcutaneous versions.

2027 — Build-out before go-live

MTF onboarding by 1 May; rulemaking to codify effectuation for 2029+; NDC-11 on Part B claims if 1b / 2b; renegotiate ASP-referenced commercial contracts before 1 January 2028.

Beyond the IRA

31 Aug 2026 — Nine more MFN deals

Alcon, Astellas, BeOne, BridgeBio, CSL, Kyowa Kirin, Sun, Teva and UCB bring the total to 26 companies; TrumpRx.gov live since February; efforts to codify the deals in law continue.

Pending — GLOBE / GUARD final rules

Mandatory MFN models for Part B (Oct 2026) and Part D (Jan 2027) as proposed; final rules not yet issued.

29 Sep 2026 — Section 232 pharma tariffs

100% tariff on patented drugs reaches remaining importers (Annex III companies from 31 July); MFN deal-makers exempt for three years; Commerce to advise by April 2027 on extending to generics.

Feb 2026 → — PBM reform in force

CAA 2026 signed 3 February; FTC–Express Scripts settlement; DOL fiduciary rules proposed; Part D delinking 2028, ERISA provisions 2028–29.

24 Sep 2026 — 340B rebate pilot approvals

HRSA approves manufacturer rebate plans for the revised pilot on IRA drugs; live 1 January 2027; watch contract-pharmacy carve-outs.

Sources: CMS (proposed rule CMS-4215-P and milestones; IPAY 2027 and 2028 fact sheets; Part B effectuation draft guidance); HRSA revised 340B Rebate Model Pilot; White House / CNBC on MFN deals (31 Aug 2026); Section 232 proclamation (2 Apr 2026); CAA 2026 PBM provisions. Full citations in the speaker notes. Illustrative; not legal, regulatory or financial advice.

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Appendix

In the ASP method, as Medicare exposure rises the losses worsen

Illustrative; not legal, regulatory or financial advice.

Illustrative, per dose, lagged treatment throughout, at the WAC −4% account ($9,600). Medicare share is the proportion of units refunded to MFP.

Steady state and trough, by Medicare share · the refund solves R = $3,500 − s × R, so R = $3,500 ÷ (1 + s)

Medicare share of units	Steady-state refund	NCR at steady state	Refund in quarter 6	NCR in quarter 6	Reported ASP at steady state
30%	$2,692.31	−$547.69	$2,509.06	−$730.94	$8,692.31
40%	$2,500	−$740	$2,205	−$1,035	$8,500
50%	$2,333.33	−$906.67	$1,914.06	−$1,325.94	$8,333.33
60%	$2,187.50	−$1,052.50	$1,636.25	−$1,603.75	$8,187.50
70%	$2,058.82	−$1,181.18	$1,371.56	−$1,868.44	$8,058.82

A larger Medicare share means each dollar of refund drags the blended ASP down harder, so the ASP settles lower and the refund settles smaller. Going from 30% to 70% costs the WAC −4% account $633.48 at steady state and $1,137.50 at the quarter-6 trough.

The same account, quarter by quarter · quarters 1 and 2 are identical at every share, because no refunded quarter has reached the window yet

Medicare share	Q1	Q2	Q3	Q4	Q5	Q6
30% Medicare	+$260	+$260	−$2.50	−$265	−$507.81	−$730.94
40% Medicare	+$260	+$260	−$90	−$440	−$755	−$1,035
50% Medicare	+$260	+$260	−$177.50	−$615	−$997.81	−$1,325.94
60% Medicare	+$260	+$260	−$265	−$790	−$1,236.25	−$1,603.75
70% Medicare	+$260	+$260	−$352.50	−$965	−$1,470.31	−$1,868.44

Drugs selected for MFP are selected by Medicare spend. That means the drugs an ASP base would govern tend to sit at the higher-exposure end of this table, where the refund settles smallest and the account's recovery settles lowest. The table is a sensitivity on one input; it is not a forecast of any particular drug.

Refund path R(t) = $3,500 − (Medicare share) × (the average of R(t−2) through R(t−5)), the rolling 12-month treatment of a lagged price concession under §414.804(a)(3). NCR = 1.06 × MFP − contract price + refund, before sequestration, at $9,600. Illustrative; not legal, regulatory or financial advice.

The 80/20 split — and what the payer mix does to it

Illustrative; not legal, regulatory or financial advice.

Illustrative, per dose, the WAC −4% account. The patient owes 20% either way; what differs is who pays it, whether the provider may bill it at all, and how much is recovered.

How the payment limit divides · and why the total collected does not fall by the same amount as the limit

Scenario	Payment limit	Patient owes 20%	Medicare's share before sequestration	Removed by sequestration	Total collected if both pay
Today — pre-MFP	$10,070	$2,014	$8,056	−$161.12	$9,908.88
MFP quarter 1	$6,360	$1,200	$5,160	−$103.20	$6,256.80
Change	−$3,710	−$814	−$2,896	−$57.92	−$3,652.08

The limit falls $3,710 but collections fall only $3,652.08 — sequestration takes 2% of Medicare's share alone, so a smaller limit means a smaller haircut, $161.12 down to $103.20. And note the starting point: breaking even today already needs 84.7% of the $2,014 owed.

NCR by source of supplemental coverage · weighted by the traditional-Medicare mix — Medicare Advantage is out of scope here

Coverage	Share of trad. MCR	Patient owes	Collected	NCR today	NCR WAC base	NCR ASP Q1	NCR ASP steady
Medigap or other secondary	43%	$1,200	$1,200	+$308.88	+$656.80	+$156.80	−$843.20
Employer or union retiree	29%	$1,200	$1,200	+$308.88	+$656.80	+$156.80	−$843.20
QMB — cost-sharing protected	14%	may not bill	$0	−$1,705.12	−$543.20	−$1,043.20	−$2,043.20
Other source	1%	$1,200	$1,200	+$308.88	+$656.80	+$156.80	−$843.20
No supplemental	13%	$1,200	$600	−$698.12	+$56.80	−$443.20	−$1,443.20
Blended across the mix	100%	$1,200	$954	−$103.99	+$410.80	−$89.20	−$1,089.20

No-supplemental shown at 50% collected; across the 40–60% band the blended WAC-base NCR runs +$395.20 to +$426.40 and the ASP-base quarter-one NCR −$104.80 to −$73.60.

Weighted across the mix, the basis determines the sign. Blended collection is $954 of the $1,200 owed — 79.5%. That leaves the WAC base at +$410.80 and the ASP base at −$89.20 in quarter one, widening to −$1,089.20 at steady state.

And the account is already slightly negative today. At $9,600 acquisition the provider needs 84.7% collection to break even pre-MFP and achieves roughly 80% on these assumptions, so the blended pre-MFP NCR is −$103.99. The MFP figures should be read against that starting point, not against zero.

Coverage shares are KFF's December 2025 analysis of the 2023 Medicare Current Beneficiary Survey, traditional Medicare only; Medicare Advantage enrollees, who are 54% of all Medicare and 68% of dual eligibles, are outside this analysis. Employer and union retiree coverage is assumed to cover Part B coinsurance in full, which not every retiree plan does. Pre-MFP coinsurance is 20% of the ASP-based payment amount; post-MFP, 20% of the MFP. Contract price $9,600; refunds of $4,000 under a WAC base and $3,500 in quarter 1 under an ASP base. Illustrative; not legal, regulatory or financial advice.

What each SDRA option nets the provider — against today

Illustrative; not legal, regulatory or financial advice.

Illustrative, per dose. WAC $10,000; ASP at WAC −5%; MFP $6,000; statutory add-on 6%. Before sequestration unless stated. Quarter 1 → quarter 6 shown where the value moves.

The WAC −4% account, step by step · the same cross-walk under each basis — payment limit, refund, net acquisition cost, NCR

	Today — pre-MFP	WAC base — Option 1		ASP base — Option 2	
Per dose, WAC −4% ($9,600)	**ASP + 6% no refund**	**1a blended WAC**	**1b own NDC WAC**	**2a ASP, ASP-weighted**	**2b ASP, claims-weighted**
Payment limit	$10,070	$6,360	$6,360	$6,360	$6,360
Manufacturer refund (SDRA)	—	$4,000	$4,000	$3,500 → $2,205	$3,500 → $2,205
Net acquisition cost	$9,600	$5,600	$5,600	$6,100 → $7,395	$6,100 → $7,395
NCR	+$470	+$760	+$760	+$260 → −$1,035	+$260 → −$1,035
NCR after sequestration	+$308.88	+$658.24	+$658.24	+$158.24 → −$1,136.76	+$158.24 → −$1,136.76

NCR by contract tier · the basis, not the discount, determines the sign — all three accounts move together

Contract price	**Today ASP + 6%**	**1a all quarters**	**1b all quarters**	**2a Q1 → Q6**	**2b Q1 → Q6**
WAC − 1% $9,900	+$170	+$460	+$460	−$40 → −$1,335	−$40 → −$1,335
WAC − 4% $9,600	+$470	+$760	+$760	+$260 → −$1,035	+$260 → −$1,035
WAC − 7% $9,300	+$770	+$1,060	+$1,060	+$560 → −$735	+$560 → −$735

Both WAC-base options lift every tier above today and hold it there: the NCR is the contract discount off WAC plus $360, in every quarter. Both ASP-base options start below today and turn negative for every tier by quarter 6 as the refund shrinks. The payment limit is identical across all four; the refund basis is the whole difference.

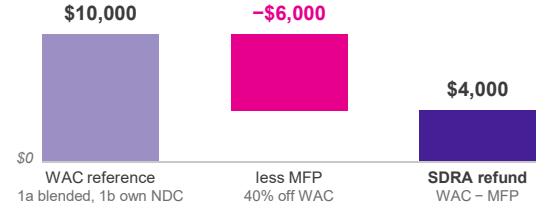
Today: payment limit = ASP + 6% = $10,070; no manufacturer refund; NCR = limit − contract price. Under MFP: payment limit = MFP + 6% = $6,360; refund = SDRA; net acquisition cost = contract price − SDRA; NCR = limit − net cost. Sequestration is 2% of Medicare's 80% share (limit $9,908.88 today, $6,258.24 under MFP). ASP-base refund path R(t) = $3,500 − 40% × average of R(t−2) through R(t−5), Medicare 40% of units; quarter-1 refund $3,500, quarter-6 refund $2,205. Illustrative; not legal, regulatory or financial advice.

How NCR is calculated under a WAC base — Options 1a / 1b

Illustrative; not legal, regulatory or financial advice.

Illustrative, per dose, the WAC −4% account ($9,600). WAC $10,000; MFP $6,000 (40% off WAC); statutory add-on 6% of MFP. Before sequestration.

Step 1 — the refund (SDRA) · the manufacturer refunds the gap between the WAC reference and the MFP, within 14 days of the claim

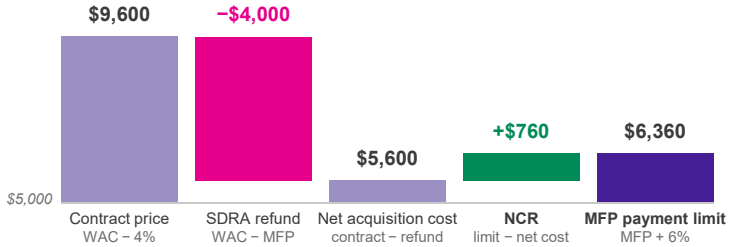


The refund does not move quarter to quarter: WAC is not affected by MFP sales.

Scenario and option	WAC reference	MFP	SDRA refund	Same for every buyer?
Single NDC-11 — 1a and 1b	$10,000	$6,000	$4,000	Yes
Two NDC-11s, 50/50 — 1a, either NDC	$9,250	$6,000	$3,250	Yes
Two NDC-11s — 1b, NDC X at $10,000	$10,000	$6,000	$4,000	No — by NDC
Two NDC-11s — 1b, NDC Y at $8,500	$8,500	$6,000	$2,500	No — by NDC

1a refunds one blended amount to every purchaser under the HCPCS code; 1b refunds the gap on the NDC actually dispensed. Both are fixed while WAC is unchanged.

Step 2 — the NCR · payment limit less the provider's net acquisition cost — the MFP payment limit is $6,360 in every quarter



After sequestration the limit is $6,258.24 and the NCR is +$658.24.

Contract price	Per dose	SDRA refund	Net acquisition cost	NCR all quarters	NCR after seq.
WAC − 1%	$9,900	−$4,000	$5,900	+$460	+$358.24
WAC − 4%	$9,600	−$4,000	$5,600	+$760	+$658.24
WAC − 7%	$9,300	−$4,000	$5,300	+$1,060	+$958.24

Every tier nets below the MFP — a contract price is never above WAC, so contract − (WAC − MFP) is never above MFP. The NCR is the contract discount plus $360: $100 + $360 at WAC −1%, $400 + $360 at WAC −4%, $700 + $360 at WAC −7%. It is flat across all six quarters because nothing in the chain references ASP.

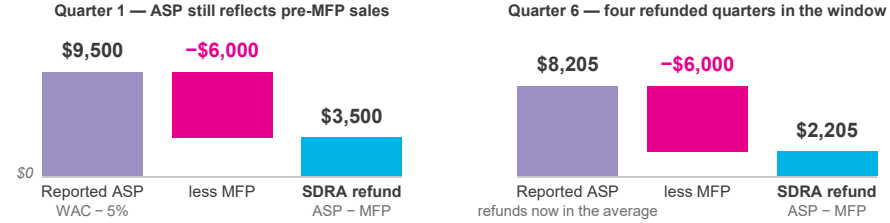
WAC-base identity: NCR = 1.06 × MFP − [contract price − (WAC − MFP)] = (WAC − contract price) + 6% × MFP. The MFP cancels out of the provider's net acquisition cost, so each account earns its contract discount off WAC plus the 6% add-on, in every quarter, for as long as WAC is unchanged. Under 1a the WAC reference is the ASP-volume-weighted average of all NDC-11s under the HCPCS code; under 1b it is the compendia WAC of the NDC-11 on the claim — with a single NDC-11 the two coincide. After sequestration the limit is $6,258.24 (2% of Medicare's 80% share). Illustrative; not legal, regulatory or financial advice.

How NCR is calculated under an ASP base — Options 2a / 2b

Illustrative; not legal, regulatory or financial advice.

Illustrative, per dose, the WAC −4% account ($9,600). MFP $6,000; reported ASP $9,500 in quarter 1 (pre-MFP sales), $8,205 by quarter 6. Before sequestration.

Step 1 — the refund (SDRA) · the reference is the reported ASP — which the refund itself pulls down, two quarters later

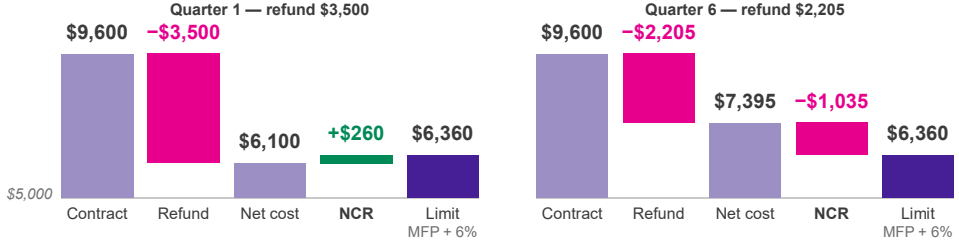


Quarter into MFP	Q1	Q2	Q3	Q4	Q5	Q6
Reported ASP	$9,500	$9,500	$9,150	$8,800	$8,485	$8,205
less MFP	−$6,000	−$6,000	−$6,000	−$6,000	−$6,000	−$6,000
SDRA refund	$3,500	$3,500	$3,150	$2,800	$2,485	$2,205

The refund is a price concession in the manufacturer's ASP report, so each refunded quarter lowers the ASP — and the next refund — two quarters later.

Quarters 1 and 2 use ASPs from pre-MFP sales, so the refund starts at $3,500. From quarter 3 the refunded quarters enter the rolling 12-month average and the refund steps down: $3,150, $2,800, $2,485, $2,205 — settling near $2,500 in a steady state. 2a and 2b differ only in how the NDC-11 ASPs are weighted; with a single NDC-11 they are identical.

Step 2 — the NCR · the same cross-walk as the WAC base, but the refund step shrinks each quarter — the MFP payment limit stays $6,360



Contract price	Per dose	Net cost Q1 refund $3,500	NCR Q1	Net cost Q6 refund $2,205	NCR Q6
WAC − 1%	$9,900	$6,400	−$40	$7,695	−$1,335
WAC − 4%	$9,600	$6,100	+$260	$7,395	−$1,035
WAC − 7%	$9,300	$5,800	+$560	$7,095	−$735

By quarter 6 the net acquisition cost is $1,035 above the payment limit — the NCR turns negative even before sequestration.

Break-even needs the account's discount to the reported ASP to cover the shortfall: NCR = $360 − (contract − ASP). In quarter 1 only WAC −1% is above ASP and it is already −$40; by quarter 6 the ASP has fallen to $8,205 and every tier is underwater. Compare the WAC base, where the same three accounts hold +$460, +$760 and +$1,060 throughout.

ASP-base identity: NCR = 1.06 × MFP − [contract price − (ASP − MFP)] = 6% × MFP − (contract price − reported ASP). The MFP again cancels out of the net cost; what remains is the account's position against the reported ASP, which the refunds pull down. Refund path R(t) = $3,500 − 40% × average of R(t−2) through R(t−5), the rolling 12-month treatment of a lagged price concession under 42 CFR 414.804(a)(3), at Medicare 40% of units. Under 2a the ASPs are weighted by ASP-reported volume; under 2b by NDC-11 volume on Part B claims — with a single NDC-11 the two coincide. Illustrative; not legal, regulatory or financial advice.