

Addendum: Second-Quarter 2026 Update

Pioneer Institute has updated its analysis to include Medicare prescription data through the second quarter of 2026. The update utilizes the same methodology as the original report. Weighted average out-of-pocket (“OOP”) costs are calculated from prescriptions for which beneficiaries had patient liability greater than zero, referred to as “positive-OOP prescriptions,” while prescriptions with zero-dollar patient liability are analyzed separately. The analysis includes 24 non-insulin medicines selected during the first two cycles of the Medicare Drug Price Negotiation Program and prescriptions processed through CVS Caremark, Express Scripts, Humana, and OptumRx.

Updated Historical Data

IQVIA periodically updates its historical claims data as it incorporates additional information. As a result, the data extract used for this Q2 2026 update includes modest revisions to certain 2024 and 2025 prescription volumes and weighted average OOP amounts previously reported by Pioneer Institute. These revisions changed some dollar values and percentage estimates but did not alter the original analysis's principal finding: average OOP costs increased for 14 of the 24 medicines between 2024 and 2025 and decreased for 10.

The updated historical figures presented in this addendum should be treated as the most current values. The original report nevertheless remains an accurate representation of the patterns identified using the data available at the time of publication. The revisions did not change the direction of the 2024–2025 findings for any of the nine first-cycle medicines with Maximum Fair Prices (“MFPs”) effective in 2026.

Updated Historical OOP Estimates for First-Cycle Medicines

Weighted average OOP per prescription. Dollar amounts are rounded to the nearest dollar.

	2024 OOP Costs		2025 OOP Costs		% Change 2025 vs 2024	
Medicine	Original analysis	Updated analysis	Original analysis	Updated analysis	Original analysis	Updated analysis
Eliquis	\$77	\$76	\$78	\$80	+2%	+5.2%
Enbrel	\$733	\$733	\$968	\$979	+32%	+33.6%
Entresto	\$78	\$77	\$73	\$75	–6%	–2.7%
Farxiga	\$69	\$69	\$85	\$87	+23%	+26.2%

	2024 OOP Costs		2025 OOP Costs		% Change 2025 vs 2024	
Medicine	Original analysis	Updated analysis	Original analysis	Updated analysis	Original analysis	Updated analysis
Imbruvica	\$1,589	\$1,569	\$1,274	\$1,266	-20%	-19.3%
Januvia	\$53	\$53	\$47	\$48	-11%	-9.8%
Jardiance	\$66	\$65	\$68	\$70	+4%	+7.0%
Stelara	\$722	\$714	\$572	\$574	-21%	-19.6%
Xarelto	\$78	\$77	\$79	\$80	+1%	+4.5%

Q1 and Q2 2026 Findings

Across all 24 medicines selected during the first two negotiation cycles, the weighted average OOP was approximately \$89 per prescription in Q1 2026, compared with \$105 in Q1 2025 and \$76 in Q1 2024. Average OOP therefore decreased from the elevated Q1 2025 level but remained above Q1 2024. In Q2 2026, the weighted average OOP decreased to approximately \$52, compared with \$67 in Q2 2025 and \$66 in Q2 2024, placing the Q2 average below both corresponding historical levels.

Among the nine non-insulin first-cycle medicines with MFPs effective in 2026, eight had lower average OOP in Q2 2026 than in Q2 2025. Eight of the nine also had lower OOP in Q2 2026 than in Q2 2024; Imbruvica was the exception in both comparisons. The Q2 2026 results therefore indicate that OOP costs decreased for most first-cycle medicines relative to both the immediately preceding year and the earlier pre-MFP baseline.

We analyzed the 15 second-cycle medicines, for which MFPs do not become effective until 2027, separately as a pre-implementation contextual cohort. Seven had lower average OOP in Q2 2026 than in Q2 2024, while eight had higher OOP. Because their MFPs were not yet effective, we cannot attribute these changes to the Negotiation Program. Instead, the variation among these medicines illustrates how benefit design, formulary decisions, manufacturer pricing changes, generic and biosimilar competition, and other contemporaneous market developments can affect patient costs independently of an MFP.

The preliminary results also show that observed reductions in beneficiary OOP were not necessarily proportional to the published MFP reductions from the applicable CMS reference list-price benchmarks. For the first half of 2026 compared with the first half of 2025, none of the

nine first-cycle medicines had an OOP reduction equal to or greater than its published MFP reduction. Examples include:

- Farxiga’s average OOP decreased by approximately 44 percent, compared with a published MFP reduction of approximately 68 percent;
- Imbruvica’s average OOP decreased by approximately 3 percent, compared with a published MFP reduction of approximately 38 percent;
- Enbrel’s average OOP decreased by approximately 63 percent, compared with a published MFP reduction of approximately 67 percent;
- Jardiance’s average OOP decreased by approximately 35 percent, compared with a published MFP reduction of approximately 66 percent; and
- Stelara’s average OOP decreased by approximately 15 percent, compared with a published MFP reduction of approximately 66 percent.

These comparisons should not be interpreted as evidence that plans or pharmacy benefit managers (“PBMs”) retained a particular portion of MFP-related savings. The published difference between an MFP and the applicable CMS reference list-price benchmark is not necessarily equivalent to the change in a plan’s net drug cost after accounting for preexisting rebates, discounts, fees, and other concessions. Nevertheless, the divergence between published MFP reductions and observed changes in beneficiary OOP reinforces the need for CMS to measure whether, and to what extent, reductions in applicable negotiated or net prices are reflected in actual patient liability.

Important Limitations and Market Developments

These findings are preliminary and should not be interpreted as a definitive evaluation of MFP implementation. The first half of 2026 represents only the first six months during which MFPs were effective for the first-cycle medicines. Changes in deductibles, benefit phases, prescription timing, beneficiary progression toward the annual OOP threshold, and other elements of Part D benefit design may distribute patient costs differently over 2026 than in 2024 or 2025.

Q1-to-Q1 and Q2-to-Q2 comparisons may therefore not predict full-year beneficiary spending. Complete third- and fourth-quarter data—and ultimately full-calendar-year 2026 results—will be necessary to determine the magnitude, durability, and causes of the observed changes. The first-half results should be treated as directional evidence rather than as a final causal evaluation of the Negotiation Program.

Prescription-volume changes also demonstrate the need to separate MFP implementation from independent market developments. Across all 24 medicines, zero-dollar prescription volume

decreased by approximately 50 percent between Q2 2025 and Q2 2026, while total prescription volume decreased by approximately 12 percent. Much of the overall volume change was concentrated among products experiencing generic or biosimilar competition.

Branded Entresto prescription volume decreased by approximately 1.4 million prescriptions, or 98 percent, between Q2 2025 and Q2 2026 following generic entry. Branded Stelara prescription volume decreased by approximately 54 percent over the same period following biosimilar entry. These changes affect the composition of beneficiaries remaining on the reference brands and make brand-only OOP comparisons harder to interpret.

Entresto, in particular, should not be treated as a primary measure of the MFP's effect. Following substantial generic substitution, beneficiaries remaining on branded Entresto may include patients with dispense-as-written prescriptions, unusual benefit designs, delayed access to the generic, or other circumstances that distinguish them from the much larger population that shifted to generic sacubitril/valsartan. The average OOP observed among the remaining branded Entresto prescriptions is therefore more appropriately understood as a residual brand-market result following substantial generic substitution than as evidence of an MFP effect.

CMS should evaluate combined active ingredient utilization and OOP for branded Entresto and generic sacubitril/valsartan. CMS should similarly evaluate Stelara and its biosimilars, including combined active-ingredient utilization, patient OOP, market share, switching patterns, formulary placement, and access restrictions. Once generic or biosimilar competition produces substantial switching, brand-only OOP should no longer be treated as the primary measure of the Negotiation Program's affordability effect.

Implications for Biosimilar Competition

The differing utilization patterns for Entresto and Stelara also raise broader questions about competition effectiveness in the small-molecule and biologic markets. After generic entry, branded Entresto prescription volume fell by about 98 percent between Q2 2025 and Q2 2026, while branded Stelara volume fell by about 54 percent after biosimilar entry.

This disparity suggests that biosimilar competition may not yet produce the rapid, broad-based substitution commonly observed following small-molecule generic entry. The difference does not, by itself, establish why Stelara biosimilar uptake was slower or demonstrate that any particular plan or PBM impeded competition. Potential contributing factors include pharmacy-level substitution requirements, state law, prescribing practices, medical-versus-pharmacy benefit administration, specialty-pharmacy distribution, formulary management, contracting arrangements, and the timing and availability of biosimilar launches.

The disparity nevertheless supports closer examination of whether the current biosimilar market is producing broad-based competition comparable to the small-molecule generic

market. A more effective biosimilar market could increase competition, accelerate the use of lower-cost alternatives, and reduce reliance on government-administered pricing mechanisms to achieve savings.

This issue also warrants examination of how vertically integrated arrangements may influence biosimilar access. PBMs and their affiliated insurers, specialty pharmacies, group purchasing organizations, distributors, or other entities may participate in formulary selection, contracting, distribution, and utilization management. PBM private-label biosimilars could potentially decelerate adoption and lower costs.

The current Pioneer analyses do not establish that affiliation, private-label arrangements, rebate incentives, or other PBM practices caused the observed Stelara utilization pattern. However, they do support collecting the information needed to examine those possibilities. CMS should evaluate reference biologics and biosimilars at the active-ingredient, plan, and PBM levels and identify whether preferred products are affiliated with a PBM as a private-label biosimilar.

Such an evaluation would help determine whether private-label and affiliated-product arrangements expand meaningful competition and patient access or primarily change which entity controls the formulary and distribution channel. A competitive biosimilar market should favor products that deliver sustainable savings and meaningful patient benefits. CMS should therefore examine whether formulary and contracting arrangements reward lower net costs and improved affordability rather than financial returns generated elsewhere within a vertically integrated supply chain.

Conclusion

The preliminary Q1 and Q2 2026 findings reinforce the central conclusion of Pioneer Institute's original report: lower prices paid by Medicare or Part D sponsors do not automatically translate into proportional or durable reductions in beneficiary OOP costs. Eight of the nine first-cycle medicines had lower OOP in Q2 2026 than in Q2 2025; eight also had lower OOP than in Q2 2024. However, none of the nine first-cycle medicines had a first-half OOP reduction equal to or greater than its published MFP reduction.

These findings demonstrate why the Negotiation Program should be evaluated based on actual patient affordability and access, not solely on the size of the federally negotiated discount or the reduction in government and plan spending. CMS should determine whether applicable price reductions are transmitted to beneficiaries and whether savings on selected medicines are offset by higher OOP costs, premiums, formulary restrictions, or access barriers elsewhere in the Part D benefit.

The updated findings also reinforce the importance of separating MFP effects from generic and biosimilar competition, voluntary manufacturer price reductions, formulary and benefit-design

changes, and other market developments. Entresto demonstrates that conventional generic competition can rapidly and substantially shift utilization independently of an MFP. Stelara, by contrast, raises questions about whether the current biosimilar market provides comparably broad and effective competition and whether formulary, contracting, distribution, or vertically integrated arrangements influence the rate and direction of biosimilar adoption.

These comparisons do not establish that one policy, company, or market mechanism caused every observed change. They do show why CMS should not attribute all post-implementation savings to the IRA without accounting for naturally occurring competition and other contemporaneous developments. Generic and biosimilar competition, when functioning effectively, can generate substantial price and utilization changes independent of government-negotiated prices. As such, they ought to be measured separately when evaluating the effects of the Negotiation Program.

Complete calendar-year 2026 data will be necessary to determine whether the reductions observed during the first two quarters persist, whether full-year OOP for first-cycle medicines falls below comparable pre-MFP levels, and whether beneficiaries receive savings proportionate to reductions in applicable negotiated or net prices. Full-year data will also be necessary to determine whether savings on selected medicines are offset by higher costs or reduced access elsewhere in the Part D benefit.

The program's ultimate success should be measured by whether beneficiaries experience lower total financial liability and meaningful access, after accounting for market competition, benefit design, formulary changes, and other independent factors. CMS should establish that monitoring framework now and continue evaluating the results as additional quarterly and full-year data become available.