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From ASP to MFP: The looming disruption of the medical benefit

The Inflation Reduction Act of 2022 is transforming how the US government manages pharmaceutical costs, primarily through the Medicare Drug Price Negotiation Program (MDPNP). This article explores the expansion of the program to now include Part B drugs, highlighting the significance of the upcoming 2026 selection cycle for 2028 implementation.

Key recent developments in the program include:

- The first two years of the MDPNP only covered retail-dispensed therapies but starting in this selection year physician-administered therapies are now included.
- Fifteen high-cost drugs have been selected for negotiation in 2026, six of which are at least partially on the medical benefit.
- The expanded scope aims to further reduce medication costs for Medicare but a variety of issues including physician incentives and commercial reimbursement linked to ASP may cause significant disruption to medications on the medical benefit.

Expanding Medicare negotiations: Part D and Part B drugs

The Inflation Reduction Act (IRA) of 2022 is a landmark federal law which had multiple objectives, one of which was to reduce the cost of pharmaceutical products to the US government. A primary mechanism to achieve this goal is the MDPNP. We have explored this topic in a previous ***Insight***, but in summary, the Center for Medicare and Medicaid Services (CMS) selects a specified number of high-cost drugs each year and enters into a structured negotiation to reduce the cost of those medications to the Medicare system.

In its initial years the drugs selected were mandated to be covered under Medicare Part D (i.e., retail-dispensed oral and self-administered therapies). However, beginning with the 2026 selection cycle (for implementation in 2028), CMS has expanded the scope to include drugs typically reimbursed under Medicare Part B, such as physician-administered injections and infused therapies.

15 Drugs to be negotiated in 2026 for 2028 implementation		
Pharmacy benefit	**Both pharmacy and medical benefit**	**Medical benefit**
• Trulicity (Diabetes) • Biktarvy (HIV) • Erleada (Prostate Cancer) • Kisqali (Breast Cancer) • Verzenio (Breast Cancer) • Lenvima (Various Cancers) • Rexulti (Mental Health) • Xeljanz (Immunology) • Anoro Ellipta (COPD)	• Orencia (Immunology) • Cosentyx (Immunology) • Entyvio (Immunology) • Xolair (Asthma) • Cimzia (Immunology)	• Botox (Migraine and others)

Pharmacy benefit drugs are typically dispensed by a pharmacy, pursuant to a prescription from a healthcare provider, and reimbursed through a distinct, pharmacy-based payment pathway. Pharmacy reimbursement is typically based on a small dispensing fee plus some type of negotiated discounts to benchmark prices, most commonly Average Wholesale Price (AWP), though some contracts utilize Wholesale Acquisition Cost (WAC) or National Average Drug Acquisition Cost (NADAC). In contrast, medical benefit drugs are generally administered by the prescribing provider, who often purchases the product and is reimbursed under a "buy-and-bill" model. When multiple products offer comparable clinical profiles, these differences in reimbursement mechanics can meaningfully influence product selection.

In the Medicare setting, reimbursement for physician-administered drugs is standardized at Average Sales Price (ASP) plus 6%, effectively reduced to ASP+4.3% after sequestration. In the commercial market, however, reimbursement approaches are more heterogeneous, often tied to either WAC or ASP with an added margin. Notably, when ASP-based reimbursement is used, the associated markup is frequently higher than that observed in Medicare, further amplifying financial considerations in product choice.

As a result of the IRA negotiations through the MDPNP, CMS is only expected to publish the Most Favored Price (MFP) for medical benefit products and will cease publishing an ASP. This creates a variety of potential issues for manufacturers, payers, and physicians.

Incentive issues

When only a subset of products in a therapeutic class are negotiated, provider incentives could push providers towards products that have not yet undergone negotiation. Without a specific push by payers / CMS to use negotiated products, physicians may be more likely to use higher priced products.

In this illustrative hypothetical example, consider a class of products that all cost $1,000 to acquire and have an ASP that is equal to their WAC. We'll consider Medicare reimbursement levels of ASP + 4.3% and that CMS is able to negotiate a 50% reduction as part of the MDPNP to $500.

	Prior to negotiation OR non–Negotiated products	Negotiated products
Wholesale Acquisition Cost	$1,000	$1,000
Manufacturer Payment to implement MFP (50% Discount)	N/A	$500
Reimbursement (ASP + 4.3%)	$1,043	N/A
Reimbursement (MFP + 4.3%)	N/A	$522
Net cost recovery (Reimbursement – (Acquisition cost – MFP Payments))	**$43**	**$22**

As observed from this simple example, if the clinical outcomes of the non-negotiated products are the same as the negotiated products, a provider would be better off prescribing the non-negotiated product at a higher cost to the system. If a system of utilization management is not carefully implemented by both CMS and payers, they are likely to end up not realizing the benefits of the negotiation.

Commercial reimbursement issues

For the portion of commercial payers that utilize ASP as a reimbursement metric, this key benchmark will stop being reported once an MFP price is established. CMS will still require manufacturers to report ASP on a quarterly basis, but so far has signaled that they will only be regularly publishing MFP or payment limits that are based off of MFP. As a result, it is unclear how commercial payers that use ASP as a reference price are planning to reimburse providers once this change is implemented.

Further, in the commercial market, providers will not receive an MFP price, so potential adoption of MFP as a reimbursement standard will likely imply significantly negative net cost recovery levels unless the markup on MFP is substantial. Importantly, one of the historical implications of ASP as a reference price is that it dynamically reflects market concessions across a broad set of transactions. By contrast, the MFP is administratively set and expected to remain relatively static over time, limiting its ability to capture evolving market dynamics. As a result, its utility as a commercial benchmarking mechanism may be inherently less attractive than ASP.

Even if ASP is still published, CMS has clarified that units sold at the MFP must be included in the calculation of ASP. While the IRA's MFP effectuation mechanism may involve prospective discounts or retrospective refunds to providers, these payments function as either lower initial prices or price concessions respectively and are therefore reflected in ASP as part of the net realized price. As a result, ASP will increasingly incorporate MFP-level pricing over time, even though it will no longer serve as the operative reimbursement benchmark for selected drugs.

CRA has conducted research with a wide cross-section of national and regional managed care payers. While this potential challenge of losing a key reimbursement benchmark is generally recognized, most payers have not yet begun to actively address it. Doing so will likely require the renegotiation of provider contracts, a process that is expected to be both operationally complex and resource-intensive.

Without careful attention to this issue, it is possible that providers will be "underwater," that is they will pay more than they are reimbursed for these drugs, within the commercial channel. This will even more strongly encourage them to not use these negotiated products over clinically equivalent options.

Conclusion

The expansion of the MDPNP into Medicare Part B drugs has the potential to fundamentally disrupt the economics of provider-administered therapies, including but not limited to traditional buy-and-bill models. By replacing an adaptive market-based benchmark (ASP) with an administratively set price (MFP), the IRA risks creating misaligned incentives, operational uncertainty, and unintended consequences across Medicare and commercial markets alike. Without proactive intervention from CMS, payers and manufacturers, the program may struggle to deliver savings and could instead drive behavior that increases system costs.

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