



# 2027 Medicare Advantage and Part D Advance Notice

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The Centers for Medicare and Medicaid Services (CMS) released the CY 2027 Medicare Advantage and Part D Advance Notice on January 26, 2026. The Advance Notice kicks off the annual bid cycle and lays out the methodological changes CMS is proposing for the next payment year. The bid season is already moving quickly, with that infamous first Monday in June already in sight! This article is a payer-oriented summary of proposed changes in Part D, covering what changed, why it matters and what to do.

## Part D Benefit Rules That Continue To Apply in CY 2027

### What Changed

Compared to the Part C rate discussion, the “new” Part D content in the CY 2027 Advance Notice is mostly (1) annual parameter updates and (2) CMS reiterating IRA-driven benefit rules that remain in force. Unless you’re into which parameters are adjusted by Annual Percentage Increase (API) vs. Consumer Price Index (CPI), the Part D Benefit Rules are far more impactful.

The Part D benefit parameters that are changing:

- The standard Part D deductible will increase from \$615 to \$700 (13.8% increase).
- The out-of-pocket threshold will increase from \$2,100 to \$2,400 (14.3% increase).

Key CY 2027 Part D items that CMS reiterates as continuing policy include:

- The revised standard benefit (coverage gap eliminated, \$0 beneficiary cost sharing in catastrophic, shifted plan/CMS/manufacturer liability throughout the benefit)
- Adult vaccines: ACIP-recommended adult vaccines continue to have \$0 cost sharing and are exempt from the deductible.
- Insulin: the “lesser of” insulin copay cap continues for a month’s supply: \$35, 25% of the insulin’s maximum fair price (MFP) (if applicable), or 25% of the negotiated price.
- TrOOP accounting (post-CY 2025 changes continue): TrOOP includes previously excluded supplemental benefits and excludes Manufacturer Discount Program payments.
- The Manufacturer Discount Program continues (and the Coverage Gap Discount Program has already sunset effective January 1, 2025).

Two items that do not get discussed explicitly in the Advance Notice but matter for CY 2027 planning:

- Medicare Prescription Payment Plan (M3P): required Part D program starting CY 2025; CY 2027 is the third contract year with the program in place.
- Medicare Drug Price Negotiation: the first negotiated Maximum Fair Prices (MFPs) for 10 Part D drugs are effective January 1, 2026, and CMS has also published negotiated prices for the second cycle (IPAY 2027), effective January 1, 2027, which includes an additional 5 Part D drugs, for a total of 15 negotiated Part D drugs.

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## What It Means

In the constantly-changing Part D world, these are no longer brand-new changes. However, they will still be impactful to bid strategy because they directly change member utilization behavior and plan liability. The practical difference for CY 2027 is that plans can start bids with more actual data around utilization responses under the new benefit design and reduced insulin and vaccine cost sharing, M3P uptake and receivables behavior, and MFP pricing effects.

## What To Do

Plans can now fully refresh their bid models with post-redesign experience rather than relying on trended-forward, pre-IRA assumptions. In practice, this means re-estimating underlying contingency tables, member cost-share sensitivity, and utilization response in areas where cost sharing materially changed.

Early uptake of the Medicare Prescription Payment Plan (M3P) has varied across plans, with many plans seeing reduced uptake, but awareness and participation will increase over time as beneficiaries and advocates become more familiar with the option. The program creates new operational tasks for plans: billing, delinquency handling, member communications, pharmacy/PBM coordination, and receivables and collections. Plans should work to close any gaps in those operations if they exist today.

Finally, benefit and formulary design will likely need to be a proactive part of CY 2027 bids, not a late-cycle patch. Given ongoing Part D trend pressure and the volatility many plans have experienced in the post-IRA world, benefit/package strategy work that aligns revenue needs, member value, and plan expansion vs. margin-retention goals may involve more dramatic benefit and formulary actions than is typical.

## Other CMS Drug-Pricing Initiatives That Will Matter for the CY 2027 Bid Cycle (not in Advance Notice)

### What Changed

Several significant CMS Part D pricing initiatives were announced in separate CMS press releases outside of the Advance Notice, but will intersect directly with CY 2027 bid pricing and formulary strategy. They are included here because of that intersection.

First, CMS published negotiated Maximum Fair Prices (MFPs) for 15 new high-spend Part D drugs that will take effect in 2027, expanding upon the first 10 MFPs that took effect at the start of the 2026 plan year. These drugs accounted for 15% of total Part D gross spend before negotiation, and CMS estimated that, if the negotiated prices had been in effect in 2024, they would have reduced net covered prescription drug costs by about \$8.5B (about 36% lower net aggregate spending for these drugs).

Second, CMS announced the 15 drugs selected for the third cycle of negotiations (prices effective January 1, 2028). This doesn't change 2027 benefit-year unit costs directly, but could impact current formulary strategy in anticipation for the 2028 pricing effects. This is also the first negotiation year that Part B drugs will be included in negotiation.

Third, CMS proposed two mandatory CMS Innovation Center drug pricing models that would tie certain Medicare drug costs to international pricing benchmarks: GLOBE (Part B) and GUARD (Part D). Both models are structured as manufacturer-rebate tests—i.e., CMS would require manufacturers to pay rebates when a drug's U.S. price (or inflation-related amount) exceeds an international benchmark derived from prices in "economically comparable" countries. CMS positions both models as mechanisms to reduce beneficiary out-of-pocket costs and generate Medicare savings. Both are currently framed as proposed rules with a public comment window through February 23, 2026.

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GLOBE (Part B) would run from October 1, 2026, through 2031 and operate in defined geographies representing about 25% of Medicare Part B beneficiaries. CMS's stated "solution" is that manufacturer rebates would be used when the drug price exceeds an international benchmark, with the intent of making the net cost to Medicare for those drugs more similar to what comparable countries pay. CMS also states the model would tie beneficiary out-of-pocket costs to the international benchmark.

The model targets single-source drugs and biologics on the Medicare Part B inflation rebate program drug list and uses filters, such as a spend threshold (\$100M in 2024) and limits based on product category and whether the drug already has a negotiated Maximum Fair Price (MFP). CMS also notes the international benchmark would be derived using either manufacturer-reported international pricing or other information available to CMS, and references GDP-per-capita / economy-size thresholds for the "comparable country" set.

GUARD (Part D) is the Part D analog and would modify the Part D inflation rebate calculation by using an international benchmark rather than the current domestic benchmark. GUARD would launch January 1, 2027 and run through December 31, 2031, and would apply to beneficiaries in randomly selected geographies representing about 25% of Part D enrollees. These rebates would continue to be paid by manufacturers to the Medicare Supplementary Medical Insurance Trust Fund.

The model would apply to certain Part D drugs in the Medicare Part D Drug Inflation Rebate Program, including sole-source drugs and sole-source biologics in a broad range of specified therapeutic categories.

Finally, CMS announced a Medicare GLP-1 payment demonstration beginning July 2026 as a bridge to the BALANCE (Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth) Model. CMS explicitly states that the GLP-1 demonstration will operate outside Part D coverage and payment flow, so that Part D sponsors will not assume risk for eligible GLP-1 products furnished under the demonstration. Under the initial payment demonstration and the full BALANCE program, Part D coverage would expand to historically non-covered weight management indications, eligible beneficiaries would pay \$50 per month for GLP-1s prescribed for weight management, and participating pharmacy manufacturers would be required to offer lifestyle management programs to beneficiaries participating in the program.

### What It Means

GLOBE and GUARD are still proposals, and for most plans, they currently raise more questions than they answer. Big questions include model geographies, how CMS's international price benchmarking methodology will function, and which products ultimately fall inside the model scope under CMS's inclusion criteria. A second set of questions is how these CMMI models interact with other drug-pricing mechanisms, such as 340B and Maximum Fair Prices (MFPs). If these models advance on CMS's currently stated rapid timeline, they would be live during the CY 2027 benefit year and, therefore, may need to be considered in current bid cycles.

For GLP-1s, CMS is signaling a clear answer to a policy question it has danced around in recent years: expanding access to historically excluded anti-obesity medications. The 2026 demonstration, which will operate outside of Part D plans, still raises practical issues for plans to address, including member communications, coordination with PBMs/pharmacies, care management integration, and potential shifts in utilization of non-GLP-1 classes. Plans also face a participation decision in early 2026 as CMS finalizes details for BALANCE participation in 2027.

### What To Do

The additional MFPs will again force formulary and benefit strategy decisions to address the loss of rebates and a potential shift in drug utilization. Where MFPs materially reduce point-of-sale costs to the beneficiary, plans should evaluate whether utilization increases enough to offset some of the unit-cost savings, and whether improved adherence plausibly creates downstream medical cost offsets for drugs that have historically been sensitive to cost-sharing barriers.

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The 2028 MFP selection list is already impacting 2026 manufacturer and PBM discussions around formulary coverage and rebates. Plans with multi-year PBM agreements should identify any performance or rebate guarantees that the current or expanded MFP list may impact.

With the other CMMI initiatives (GLOBE, GUARD, BALANCE, and the 2026 GLP-1 demonstration), there are still more open questions than answers, especially around model geographies, product scope, operational mechanics, and interactions with existing pricing programs such as 340B and the MFPs. Timelines could shift as CMS finalizes proposals, but if they do not, these initiatives will move forward quickly.



Lewis & Ellis and Axene Health Partners (LEAHP) are partnering to support Medicare Advantage organizations with concierge actuarial analytics and strategy needed to navigate the Medicare bid season and take the next leap forward in achieving their goals in the Medicare market. LEAHP provides bid development, risk and revenue optimization, risk model and coefficient impact studies, Part D formulary and pricing strategy under expanding MFPs and emerging CMMI models, and broader market-level bid strategy to respond to continued funding tightening.

If you'd like to discuss your CY 2027 priorities and where you see the greatest bid and execution risk, we'd welcome a working session to chart the course to a concrete plan of action so you can leap ahead of the competition and achieve your CY 2027 Medicare market goals.

