Insight

The Inflation Reduction Act and Prescription Drug Plans: Incentives and Potential Responses

DOUGLAS HOLTZ-EAKIN | MAY 8, 2023

Executive Summary

As a result of the Inflation Reduction Act (IRA) and its sweeping changes to Medicare Part D, stand-alone drug plans and Medicare Advantage prescription drug plans will face substantial new costs for both seniors' catastrophic drug expenses and the Low-Income-Subsidy population. The actions plans may take in response would likely have significant impacts on Medicare beneficiaries.

- This study estimates that in the absence of a behavioral response by plans to compensate for these costs, the IRA's provisions will increase the costs of Part D plans by roughly $48 billion per year; this is a dramatic increase as the combined profits of Part D plans are about $4.6 billion annually.
- In response to these new costs, plans are likely to adjust their annual bids and raise premiums and/or to negotiate more fiercely for lower drug acquisition costs, yet plans are typically loath to do the former and face practical limitations to the latter.
- Accordingly, beneficiaries may see changes in the number and types of plans they are offered, changes in the design of Part D plan formularies, and attempts to increase utilization management.

Introduction

The Inflation Reduction Act (IRA) introduced sweeping changes to the Medicare Part D drug benefit and the pharmaceutical market more generally. The reforms have been advertised as a way to insulate seniors from the cost of prescription drugs, although American Action Forum research suggests that only 10 percent of overall Medicare beneficiaries will directly benefit from the insulin copay caps, zero cost-sharing vaccinations, and a new out-of-pocket cap in Part D. The IRA's "negotiation" provisions are *de facto* price controls that may harm incentives to create and develop new therapies. These incentives have been the topic of great discussion and will be examined in future research.

Another impact of the IRA has been far less noted. As part of the redesign of the Part D benefit, prescription drug plans (including Medicare Advantage prescription drug plans, or MA-PDs) will face substantial new costs for both seniors' catastrophic drug expenses and the Low-Income-Subsidy (LIS) population. How will those plans react? Will they adjust their bids and raise premiums? Will they negotiate more fiercely to reduce the acquisition costs of their drugs? Will they attempt to more extensively manage seniors' drug spending through utilization management tools, new formularies, or even changes in the number of plans?

This paper reviews the IRA's key changes to Part D drug benefits and considers what plans may do in response. While this inquiry is inherently speculative, it is reasonable to conclude that plans will do *something* to

compensate for the IRA's new costs – and any of their available options is likely to erode seniors' access to affordable medication.

Key Provisions of the Inflation Reduction Act

The IRA redesign provisions change Medicare Part D drug plan liability in several ways. First, under the maximum out of pocket cap, plans will be responsible for ?65 percent of all beneficiary costs after the deductible in 2025, adjusted from current liability of 75 percent in the initial coverage phase for all beneficiaries and 5 percent in the coverage gap for non-LIS. Second, in the catastrophic phase, plan liability will grow from 15 percent in 2023 to 60 percent for all beneficiaries in 2025. Finally, plans will be responsible for?additional liability for LIS beneficiaries, as they previously had no liability for LIS during the coverage gap. Collectively, this study estimates that in the absence of a behavioral response or change in bidding, these provisions will increase the costs of plans by roughly $47.8 billion per year [1]. To put this in perspective, the combined annual profits of Part D plans average around $4.6 billion.

These estimates are necessarily imprecise. Nevertheless, the magnitude of these new costs dictates that plans alter their pricing and plan offerings.

Potential Responses to IRA Incentives

According to the Kaiser Family Foundation, the typical Medicare beneficiary could choose among 54 plans in 2022 – 23 stand-alone plans and 31 MA-PD plans. These plans are popular with seniors: According to polling from Medicare Today, 88 percent of beneficiaries said they were satisfied with their Part D plan and 86 percent said their plan provided good value. In short, the Part D program is functioning well for beneficiaries. Despite this, the IRA provisions require significant changes to those plans.

Premium Increases

One response to the IRA's higher liability for plans would be for plans to simply adjust their bids to account for their higher liability, resulting in an increase in federal subsidies but also an increase in premiums. The law provides that beginning January 1, 2024, the average premium increase must be limited to 6 percent over the previous year. Nevertheless, there will be upward pressure on premiums, but this study anticipates that plans will view premium increases only as a last resort. Plans need market share to bargain effectively with manufacturers and will be reluctant to endanger their book of business with a premium increase. Premium increases are also notoriously politically unpopular, and one can expect plans to be very reluctant to simply pass along higher costs.

Negotiation with Manufacturers

The original insight embedded in the Part D design was that plans would have an incentive to bargain with manufacturers for lower drug prices. The IRA provisions sharpen this incentive considerably. One can anticipate that collectively Part D plans will seek to reduce their acquisition costs considerably. Their ability to be successful is unclear. Notice, however, that if plans *are* successful in pushing these costs onto manufacturers, it would entail less disruption of the existing plan offerings. Unfortunately, it would also mean a bigger impact on manufacturers' drug development.

New Plan Offerings

MA has seen a dramatic rise as a popular platform for delivering medical services to seniors, with a majority of beneficiaries likely to be covered by MA in the next few years. As a result, the number of stand-alone Part D plans declined from 1,198 in 2012 (one-third of plans) to 1,006 in 2022 (under 20 percent of plans). At the margin, the IRA provisions may contribute to this trend. Because the profit margins are better in the MA setting than in the stand-alone plans, insurers may react to the cost pressures by focusing their offerings in the MA space.

Changes in Formularies

The next logical possibility is that plans – or new plan offerings – will rely on formularies that are adjusted to reduce likely drug spending. While plans do have some mandatory formulary coverage requirements in Part D, such as at least two drugs per class and all or substantially all drugs in the six protected classes, plan formularies today typically exceed the minimum requirement of two drugs per class. In an effort to minimize drug spending, plans could opt to reduce the number of medicines covered, resulting in more narrow formularies.

Utilization Management

A final avenue for plans to respond to the IRA is to control spending on unnecessary prescriptions or unnecessarily expensive prescriptions through tools such as prior authorization or step therapy. For perspective on this issue, consider the graphic (below). The left side of the figure shows the experience in Medicare prior to the IRA. It indicates that 40 percent of prescriptions are initially filled, and 20 percent are immediately abandoned. Of the remaining 40 percent, 6 percent are rejected as part of a regime of step therapy/prior authorization, 16 percent are rejected as not being part of the formulary, and 19 percent are not filled for some other reason. The second bar from the left indicates that over the ensuing 30 days, 24 percent of those prescriptions initially rejected are filled, for a total fill rate of 64 percent of prescribed medicines in Medicare Part D.

The two bars on the right side of the figure show the comparable experience in the commercial market. While the final fill rates are comparable after 30 days (58 percent versus 64 percent in Part D), the commercial market displays much more initial use of utilization management tools.

The main question is the extent to which insurers import their commercial market cost-control protocols into the management of their Part D book of business. It seems unlikely, for example, that Part D would transform to look like the commercial market as the minimum requirements for formularies and the potential for both political and regulatory pressure are much greater in Part D.

Nevertheless, the financial incentives for plans to increase their management of utilization are strong and clear; it is worth monitoring the response of plans over time.

Conclusion

The Inflation Reduction Act creates strong incentives for Medicare Part D prescription drug plans to change their bottom line by raising beneficiary premiums and negotiating cheaper drug purchases. It also provides incentives to alter the number and types of plans offered, the formulary coverage in those plans, and to further employ utilization controls. In each case, the changes will have direct implications for beneficiaries as well, with the obvious concern that the IRA will inflict unintended damage to Part D.