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Patient Affordability After the Inflation Reduction Act: Potential Impacts


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The Inflation Reduction Act (IRA) of 2022 contains a number of health care provisions, including those that will cut Medicare drug spending by an estimated $287 billion over 10 years, according to the congressional budget office (https://www.cbo.gov/publication/58290). Some of the most widely discussed changes ushered in by the IRA are several near-term changes to the Medicare Part D benefit. These changes are some of the most significant changes in Medicare regulation since the Medicare Modernization Act of 2003. However, as we analyze the bigger picture of true impacts of the IRA, we see that these short-term improvements may have deleterious impacts on access and affordability for everyone.

Beginning in 2023, the standard Part D deductible will not apply to insulin, and insulin out-of-pocket (OOP) cost will be limited to $35 per month. The IRA will also remove patient responsibility for the catastrophic phase starting in 2024 and institute an annual OOP cap of $2000 beginning in 2025 for all Part D beneficiaries, which includes the elimination of the illustrious “donut hole,” from the patient perspective. Also beginning in 2025, beneficiaries will be able to spread their OOP expenses over the course of the year. This would be implemented at any point in the year by dividing the amount of money the beneficiary owes the plan sponsor by the remaining months in the year. However, the pharmacy would still be paid in full by the plan sponsor at the time of sale. Last, the increases to premiums for Medicare Part D plans will be capped at 6% beginning in 2024 through 2029, at which time the premium calculations will revert to competitive bidding, which is the current method.

The upside of these changes is that there will improve access and adherence to medications, especially insulin. A cap on OOP expenses for high-cost specialty drugs will also help patients start and continue to access these medications, with an option to spread the OOP cost over the course of the year rather than front-loading it. However, these cost shifts heavily impact the margin of PDP and MAPD plans, with not much recourse because of the limits on premium increases beginning in 2026. Expect to see payers try to increase premiums as much as they can in 2024 and 2025 through the competitive bidding process, before the cap goes into effect in 2026. Also, because of the increases in costs associated with utilization and reformed cost sharing, plans are likely to look for other avenues to limit expenditures, such as increases to utilization management and a contraction in formulary product offerings. We can also expect payer rebate contracting strategies to shift to other categories to maintain rebate revenue and meet customer guarantees.

Biopharmaceutical manufacturers are examining how the changes in this law may affect the development of new drugs and market access. Of particular concern is the lack of acknowledgement of value in the IRA. Specifically, there is no recognition in the IRA that a drug that is cost-effective does not always equate to what is the cheapest. Instead of helping to drive the use of evidence-based, cost-effective drugs and biosimilars, the IRA takes aim at the

products based solely on those with the biggest spend as its targets for price control, ignoring products that are the most wasteful or the most inappropriately priced. This may disincentivize private companies from investing in new indications or pursuing new uses of a medicine proven safe and effective.

Additionally, consideration is lacking for how the drug delivery supply chain is connected to the price of drugs, with physicians, hospitals, pharmacies, and insurers often getting paid based on a percentage of the price of the drug (e.g., AWP, WAC, ASP). When drug prices are affected, practice patterns will change to the products with the highest reimbursement, not necessarily the least expensive. The IRA also increased the amount of risk assumed by insurers and biopharmaceutical companies for higher-cost patients in Medicare Part D. This is likely to put further pressure on smaller health insurers and biotech companies, resulting in further industry consolidation.

In conclusion, through a close review, the short-term patient affordability garnered from the IRA will not enhance value or help to pay for value in care delivery. Instead it is focused exclusively on the creation of government-decreed price controls. These types of government interventions on prices will not make it easier for biopharmaceutical companies developing low-cost generics and biosimilars to successfully compete with one another, as they enter a market with an artificially low-price bar.

Ready to understand the impact of IRA on your organization and create your strategy today?
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