COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

The 'Inflation Reduction Act'
Raising Costs on Seniors

Higher Premiums, Less Access, Fewer Choices

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Executive Summary

President Biden and Congressional Democrats promised lower drug costs for Medicare beneficiaries. Did they deliver?

- The Medicare prescription drug program – Part D – is loved by beneficiaries for consistently delivering low premiums, robust choices, and broad access to drugs.

- The Inflation Reduction Act (IRA) radically rewrote Part D, imposing price controls on drugs while redesigning drug coverage in a way that is increasing premiums, reducing competition and choice, and raising out-of-pocket costs. Similar trends are happening in Medicare Advantage (MA), where more than half of Medicare beneficiaries receive comprehensive coordinated benefits.

- The IRA supposedly created a "cap" on premiums of 6 percent, however, that cap only applies to "base plans," not to premiums paid by beneficiaries for all plans. In 2024, average premiums for Part D plans (PDPs) increased 21 percent.[1]

- Heading into 2025, most beneficiaries will face significant disruption and cuts to their Medicare coverage, including premium increases between 50 and 100 percent or more for Part D, higher out-of-pocket costs, more utilization review, and reduced Medicare Advantage benefits.

- Beneficiaries will learn about higher premiums and reduced benefits and plan choices in late September and early October 2024, when they receive letters from their health plans (required by law) of coverage changes. On October 1, plan shopping starts for benefits that begin in January 2025. Beneficiaries will enroll for plans between October 15 and December 7.

- Long-term, beneficiaries will pay more for less access to plans and drugs. CMS may attempt to take steps to mitigate these problems, but their reach is limited by timing (plans have already submitted their bids to provide coverage and premiums for 2025), and the law. Ultimately, Congress will need to step in to fix the biggest flaws in the IRA.

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[1] Kaiser Family Foundation. (2023, November 8). *Medicare Part D in 2024: A first look at prescription drug plan availability, premiums, and cost-sharing.* https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2024-a-first-look-at-prescription-drug-plan-availability-premiums-and-cost-sharing/

The IRA Is Already Raising Premiums

The 2024 Impact

During the Inflation Reduction Act debate, the law's proponents promised premiums would grow no more than 6 percent per year because the law included a provision to cap increases. However, the cap does not apply to the total premium paid by enrollees. In 2024, average premiums for stand-alone Part D plans (PDPs) increased by 21.5 percent on average nationwide. This is the largest increase ever in PDP premiums.[2]

These increases are primarily driven by eliminating the 5 percent beneficiary cost sharing above the catastrophic level (high-cost threshold) and placing that risk onto the plans (both standalone PDPs and Medicare Advantage). Other factors that lead to increased premiums include adding a $35 monthly cap on insulin and requirements for PDPs to add pharmacy price concessions into the negotiated price.

- In 2024 Part D bids more than doubled for stand-alone plans and increased by 63 percent for Medicare Advantage prescription drug plans.[3]

- According to Avalere Health, 45 percent of PDP enrollees faced premium increases of more than 25 percent if they did not switch plans during open enrollment.[4]

- Part D premiums have historically stayed the same or decreased over time, but in recent years, the percentage of enrollees in plans with a premium increase of more than 25 percent has more than tripled.[4]

- Despite the increase in MA plan bids, MA-PD premiums remained stable in comparison, largely because MA plans can buy down premium increases with the supplemental rebates they receive and their ability to shift risk across the benefit. Avalere estimates only 8 percent of enrollees in an MA-PD plan faced total premium increases of more than 25 percent during the 2024 plan year.

Premium increases vary depending on where seniors are shopping. According to a HealthView Services analysis of plans offered by three of the largest insurers, the premiums available in the five states with the greatest over-age 65 population were significantly higher, with premiums increasing between 42 and 57 percent in those markets.[5]

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[2] Kaiser Family Foundation. (2023, November 8). *With Medicare open enrollment underway, beneficiaries typically will have a choice of 43 Medicare Advantage plans for 2024, consistent with 2023 but more than double the number from 2018.* https://www.kff.org/medicare/press-release/with-medicare-open-enrollment-underway-beneficiaries-typically-will-have-a-choice-of-43-medicare-advantage-plans-for-2024-consistent-with-2023-but-more-than-double-the-number-from-2018/

[3]CAHC's analysis of 2023 to 2024 trends in Iowa, Ohio, Oklahoma, and Montana indicate that, generally, premiums have both increased and decreased. Where premiums have decreased, cost sharing has increased, often to the maximum coinsurance amount. Kaiser Family Foundation also confirms this finding.

[4] Avalere Health. (2023, October 11). *Part D premium increases, market disruption expected in 2024.* https://avalere.com/insights/part-d-premium-increases-market-disruption-expected-in-2024#:~:text=Additionally%2C%2045%25%20of%20PDP%20enrollees,25%25%20(Figure%201).

[5] HVS Financial. (2023, November). *2024 Medicare Part D premiums interim data report.* HealthView Services. 2024 Medicare Part D Premiums: Interim Data Report (November 2023). https://hvsfinancial.com/wp-content/uploads/2023/11/2024-Medicare-Part-D-Premiums-Interim-Data-Report-November-2023.pdf

On a state-by-state basis, HealthView estimates average Part D premiums rose by 30 percent in Texas and 53 percent in New York, with a range of growth in plan prices across five states (CA, FL, NY, PA, and TX) between 21 percent and 77 percent.[5]

2025 Looks Worse

The Council for Affordable Health Coverage (CAHC) estimates average national market premiums to double in 2025. CAHC's estimate is based on two primary factors: 1) limiting beneficiary out-of-pocket costs to no more than $2,000 annually, and 2) a requirement for insurers to pay a higher percent of the costs above the $2,000 limit.

Percentage Increase in Average Monthly Part D Premium

In 2025, insurers will pay 60 percent of the costs on all prescription drug claims above $2,000, up from 20 percent today. Taxpayers and manufacturers will pick up the other 40 percent. Plan liability and costs will increase in 2025, with some therapeutic areas nearly doubling. This shift of costs from taxpayers to plans and drug manufacturers means plans are assuming much greater risk – three times the previous level – on much more costs (the difference between $8,000 and $2,000). Higher premiums reflect both the increased costs and the additional risk to insurers in covering them.

Americans Have The Fewest Part D Plan Choices Ever Under The IRA

Considering enhanced risks and costs, Part D plans are reassessing their participation in Part D. In 2024, the fewest number of plans participate in the Part D market since Medicare Part D's 2006 launch.[1]

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[5] HVS Financial. (2023, November). *2024 Medicare Part D premiums interim data report.* HealthView Services. 2024 Medicare Part D Premiums: Interim Data Report (November 2023). https://hvsfinancial.com/wp-content/uploads/2023/11/2024-Medicare-Part-D-Premiums-Interim-Data-Report-November-2023.pdf

[1] Kaiser Family Foundation. (2023, November 8). *Medicare Part D in 2024.*

- Even so, while the average beneficiary has a choice of 21 stand-alone plans and 35 MA-PD plans, since 2020, the number of PDPs available has decreased by 25 percent. This reflects a general consolidation of insurance plans in the market.[1]

- Mutual of Omaha and Blue Cross and Blue Shield of Kansas City, the largest non-profit plan in Missouri, announced they will be leaving the Part D and Medicare Advantage markets, respectively in 2025.[6]

- More plans are expected to leave markets nationwide, leaving millions of seniors and people with disabilities facing fewer choices in 2025.

Low-Income Americans' Access to Care Is Worse Now Than Last Year, With The Least Number of Options Ever

Medicare Part D provides significant additional help to about 13 million low-income subsidy (LIS) eligible beneficiaries, whose resources are limited and whose incomes fall below a percentage of the Federal Poverty Level.[1, 7] This includes no deductibles, no premiums for PDP plans, and limited out-of-pocket costs for drugs. To receive coverage without a premium, LIS beneficiaries must enroll in a "benchmark" plan.

- In 2024, LIS beneficiaries have access to only three benchmark stand-alone prescription drug plans, the least amount since the start of Part D.

- Overall, there was a 34 percent reduction in premium-free Part D stand-alone drug plans for low-income subsidy-eligible individuals. Only 20 percent of plans are now premium-free. [8]

- According to the Kaiser Family Foundation, an estimated 2.4 million LIS enrollees – half of all LIS enrollees in PDPs – needed to shop for and switch plans in 2024 if they want to retain premium-free coverage. [1]

Most Enrollees are Facing Much Higher Cost Sharing For Brand-Name Drugs in 2024

Plans that are taking on more risk are also increasing cost-sharing as a strategy to mitigate the additional risk. According to the Kaiser Family Foundation[1] cost-sharing is changing in the following ways:

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[1] Kaiser Family Foundation. (2023, November 8). *Medicare Part D in 2024.*
[6] Blue Cross and Blue Shield of Kansas City. (2024, May 30). *Blue KC to exit Medicare Advantage market in 2025.* https://www.bluekc.com/press-release/blue-kc-to-exit-medicare-advantage-market-in-2025/
[1] 8.3 million (62%) LIS are in MA Prescription Drug Plans and 5.2 million (38%) are in stand-alone Part D plans; KFF, Medicare Part D in 2024
[7] National Council on Aging. (2024, March 22). *Understanding Medicare Part D low-income subsidy (LIS/Extra Help).* https://www.ncoa.org/article/understanding-medicare-part-d-low-income-subsidy-extra-help
[8] Kaiser Family Foundation. (2023, October 17). *An overview of the Medicare Part D prescription drug benefit.* https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/

- **Preferred brands:** a copayment of $47 or coinsurance of 21 percent for preferred brands (up from $44/17 percent in 2023)

- **Non-preferred drugs**: 46 percent coinsurance for non-preferred drugs, which can include both brands and generics (an increase from 45 percent in 2023; the maximum allowed is 50 percent). Almost half of all national stand-alone plans charge the maximum 50 percent coinsurance for non-preferred drugs.

- **Specialty drugs:** Coinsurance for specialty tier drugs ranges from 25 percent to 33 percent, with half of the national stand-alone plans charging 25 percent and two charging 33 percent (the same as 2023).

Government Price Setting in Part D is Problematic

One of the most problematic and disruptive changes to Part D made under the IRA is the creation of a new government authority to set the prices for certain medicines in Medicare, starting with Part D drugs in 2026 and 2027 and expanding to include Part D and Part B beginning in 2028. Government price-setting has already harmed research, development, and introduction of new treatments for cancer, autoimmune diseases, and viral infections.[9]

The long-term ripple effects of the IRA on Part D will be profound and disruptive because it also will affect price negotiations, formulary placement, and utilization management policy - not only for the selected drugs - but for competing medicines as well.

- The IRA requires plans to cover Maximum Fair Price (MFP) price-set medicines but does not stipulate whether those drugs receive preferential formulary placement. As a result, some Medicare beneficiaries may pay less for a non-MFP drug than for a price-controlled drug.

- MFP price-setting will significantly impact market competition across drugs within the same category or class as some drugs are price-controlled and others are not. Industry experts believe this will encourage plans to favor high list price, high rebate specialty drugs because a greater share of manufacturer rebates will be allocated to plan obligations.[10]

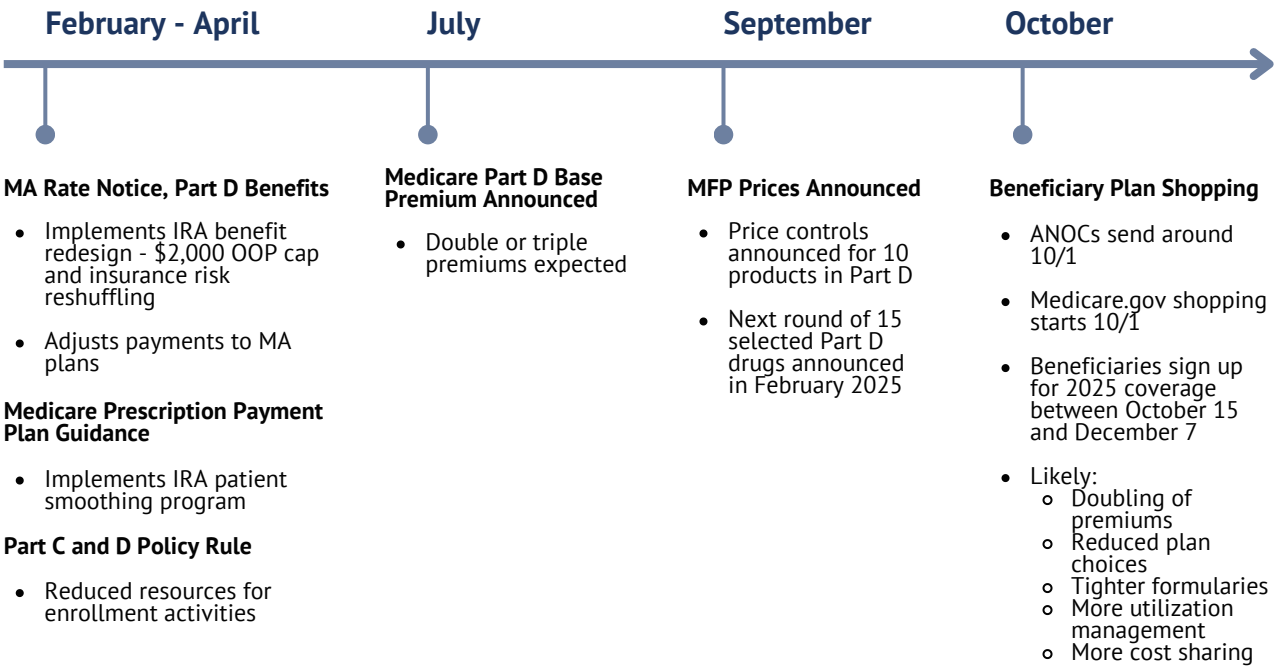
[9] Incubate. (2024, June). *Life Sciences Investment Tracker*. https://lifesciencetracker.com/
[10] Drug Channels. (2024, February 21). Surprise! Thanks to IRAs, Part D Plans Will Prefer High-List, High-Rebate Drugs. https://www.drugchannels.net/2024/02/surprise-thanks-to-ira-part-d-plans.html

- Changes in plan utilization management strategies and formulary tiers post-IRA may mean some patients get lower-cost drugs but will face more aggressive, non-financial barriers to treatment. One strategy is to move medicines, including MFP medicines, to higher-cost specialty tiers.[11]

- A February 2024 survey supported concerns related to future access among drugs selected for negotiation as plans are likely to implement more utilization management strategies, such as prior authorization and step therapy, as a result of the increased costs they will face under the IRA.[12]

Timing

As the IRA's changes ripple through the market, plans, enrollment experts, Medicare beneficiaries and CMS are getting ready for annual open enrollment when consumers start shopping for plans on October 1 and start signing up for benefits on October 15.



CMS has already adopted the regulatory parameters implementing the IRA's benefit redesign. In late July or early August, it will announce the Base Beneficiary Premium. On September 1, there will be much fanfare around the IRA leading to lower drug prices as the final rates- set by the government- are released for the first 10 drugs in the IRA's "negotiation program."

[11] Hayden Consulting Group. (2024, January). IRA: Revisiting price negotiation paper. https://haydencg.com/wp-content/uploads/2024/01/IRA-Revisiting-Price-Negotiation-Paper.pdf
[12] Patterson JA, Wagner TD, O'Brien JM, Campbell JD. Medicare Part D Coverage of Drugs Selected for the Drug Price Negotiation Program. JAMA Health Forum.

We believe the celebration will be short-lived, as millions of Medicare beneficiaries will receive a letter (Advance Notice of Change) from their Part D or MA plan at the end of September and find out their plan may cost much more or no longer be available. Starting on October 1, Medicare enrollees will see their new premiums for 2025 on Medicare.gov. During the annual Open Enrollment Period (AEP) that begins October 15 and ends December 7, 2024, beneficiaries can stay in their current plan, disenroll, or switch Medicare plans.

On January 1, 2025, Medicare beneficiaries will begin receiving benefits – and paying premiums – in their new plans.

Conclusion

For many voters, including many Medicare beneficiaries, awareness of the IRA and its potential impacts on their healthcare remains low. Although the Biden Administration and Democrats are likely to continue touting provisions that cut drug prices in Medicare, it may not be enough to sway voters as they begin to experience the real-world consequences of the law. Primary among these impacts will be:

- Higher Part D premiums, as the actual premiums charged by plans grow considerably more than the 6 percent cap promised on "standard" benefits;
- Fewer plan choices, as insurers struggle to recoup costs in the stand-alone PDP market; and
- More delays and denials of care as health plans seek to manage the risk placed on them and that will eventually be passed through to beneficiaries.

Unintended or not, the real-world impact of the IRA in Medicare will be the opposite of what was promised – higher drug plan premiums, less access, and shrinking choices for patients and consumers. Ultimately, Congress must step in to address the deeply flawed drug pricing provisions of the IRA and take steps to mitigate premium increase and plan exits. In the meantime, the Administration should reaffirm its commitment to America's seniors by doing all it can administratively to mitigate the loss of patient access and Part D market disruption being caused by the IRA.

Background

The Inflation Reduction Act

Since the creation of the Medicare Part D drug benefit in 2003, Congress has modified the program several times, most recently, and most significantly, through the Inflation Reduction Act (IRA). The IRA made changes in two major areas that impact Part D:

- Price controls, or the so-called Medicare Drug Price Negotiation Program, took negotiating power away from private plan experts and vested it with government actors to set prices on the highest total cost drugs in Medicare. This change is a watershed departure from market pricing and will result in fewer products, less access and innovation, and a dangerous insertion of politicians and bureaucrats between patients, their choice of health plan, and their doctors.

- Benefit redesign is intended to make the Part D standard benefit more generous by limiting out-of-pocket costs annually, access to zero-cost sharing vaccines, a $35 monthly cap on insulin, and a provision to allow some patients to spread out-of-pocket costs for drugs over the year. The IRA caps total out-of-pocket costs at $2,000 annually, helping about 1.5 million beneficiaries.[13] These are positive changes for some patients but could have been done in a way that would have limited the shift in costs onto premium payers – about 66 million beneficiaries.

The Unintended Consequences of Government Interference in a Successful Program Grounded in Market Competition

Part D Benefit Reform

Medicare Part D is a voluntary outpatient prescription drug benefit for people with Medicare provided through private plans that contract with the federal government. Beneficiaries can choose to enroll in either a stand-alone prescription drug plan (PDP) to supplement traditional Medicare or a Medicare Advantage Prescription Drug Plan (MA-PD) that provides all Medicare-covered benefits, including hospital and physician care, prescription drugs, and sometimes extra benefits and reduced cost sharing. As of 2023, of the 66 million people with Medicare, 50.5 million enrolled in Part D (22.2 million in a PDP and 28.3 million enrolled in an MA-PD).

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[13] Kaiser Family Foundation. (2024, February 8). Millions of people with Medicare will benefit from the new out-of-pocket drug spending cap over time. https://www.kff.org/medicare/issue-brief/millions-of-people-with-medicare-will-benefit-from-the-new-out-of-pocket-drug-spending-cap-over-time/

Part D plans are required to offer at least a standard benefit, but plans may, and typically do, offer more generous coverage and vary premiums based on the actuarial value of that coverage. Just 2 percent of enrollees choose a standard benefit plan.

The Inflation Reduction Act creates a newly defined standard Part D benefit consisting of three phases: an annual deductible, initial coverage, and catastrophic coverage.

- *Annual Deductible*: Amount paid by beneficiaries before benefits begin. For example, in 2024, the standard benefit annual deductible is $545 annually.

- *Initial Coverage*: Cost sharing is split between enrollees and plans. Beneficiaries pay 25 percent of total drug costs and plans pay 75 percent, up to total drug costs of $4,660 in 2023. Most plans charge fixed-dollar copayments or percentage-based coinsurance for drugs in this phase.

- *Coverage Gap Phase*: Plans, beneficiaries, and manufacturers pay a portion of costs up to an out-of-pocket threshold. In 2024, enrollees pay 25 percent of total drug costs for both brand-name and generic drugs. Plans pay the remaining 75 percent of generic drug costs and 5 percent of brand drug costs, while manufacturers provide a 70 percent price discount on brand names.

- *Catastrophic Coverage*: Above a limit defined by out-of-pocket costs, beneficiaries no longer spend any money out-of-pocket. Before 2024, beneficiaries were responsible for 5 percent of the costs above the limit. The IRA eliminates this 5 percent requirement and places it on plans so that once beneficiaries pay $3,300 in brand drug costs (total of beneficiary spending out-of-pocket + value of the manufacturer price discount on brands), their out-of-pocket costs are zero. Total spending by plans, manufacturers, and beneficiaries totals $8,000.

The IRA establishes a lower annual out-of-pocket threshold of $2,000 in 2025, down from about $3,300 in 2024, and changes the liability of taxpayers, beneficiaries, plans, and manufacturers over time.

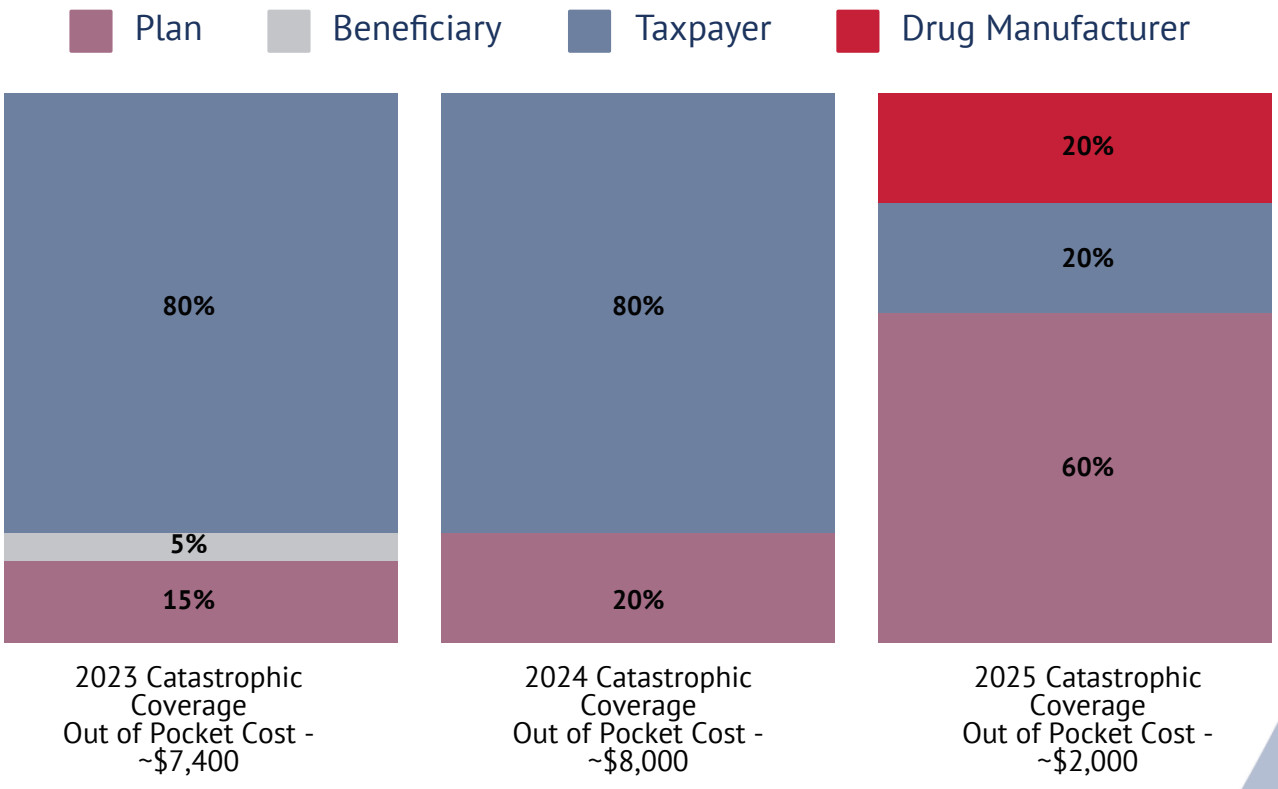
- Annual Deductible: The standard benefit annual deductible is increased to $590 annually.

- Initial Coverage: Cost sharing is split between enrollees and plans. Beneficiaries will pay 25 percent of drug costs. Plans will pay 75 percent for generics, and 65 percent for brand name drugs. Drug manufacturers will provide a 10 percent discount on brand-name drugs, which replaces the 70 percent price discount in the coverage gap phase.

- Coverage Gap Phase: In 2025, this phase is eliminated.

- Catastrophic Coverage: Part D plan liability for costs more than the $2,000 out-of-pocket threshold will increase from 20 percent to 60 percent. Taxpayer responsibility for costs above the out-of-pocket limit go from 80 percent in 2024 to 20 percent in 2025 for brand-name drugs, and 40 percent for generic drugs.[14]

IQVIA estimates that just 1 percent of all patients reach annual out-of-pocket costs above $2,000 compared to 3 percent in Medicare. In 2023, 1.3 million Medicare enrollees reached prescription out-of-pocket costs of over $2,000. If trends remain the same, this new cap will be an immense help to these patients saving them $2.4 billion in aggregate or $1,924 per patient on average, according to IQVIA.[15]



[14] The IRA Manufacturer Discount is phased-in for certain drugs of qualifying drug manufacturers during the initial coverage phase from 2025 through 2028 and in the catastrophic phase from 2025 through 2030. For drugs subject to the phase-in, plans will be responsible for the additional cost that would have otherwise been covered by the manufacturer discount.
[15] IQVIA Institute for Human Data Science. (2024, April). The use of medicines in the US 2024: Usage and spending trends and outlook to 2028. https://www.iqvia.com/-/media/iqvia/pdfs/institute-reports/the-use-of-medicines-in-the-us-2024/the-use-of-medicines-in-the-us-2024-usage-and-spending-trends-and-outlook-to-2028.pdf

The IRA also provided additional changes that impact beneficiaries, including:

- Beginning in 2024, beneficiaries who have incomes up to 150 percent of the poverty line and resources at or below the limits for partial low-income subsidy benefits will be eligible for full benefits under the Part D Low-Income Subsidy (LIS) Program. The law eliminates the partial LIS benefit currently in place for individuals with incomes between 135 percent and 150 percent of poverty. This extra help includes zero-dollar deductibles, no premiums, and reduced out-of-pocket cost-sharing for prescriptions.

- Also in 2024, the law implemented a $35 monthly cost-sharing cap for insulin products and zero-dollar cost-sharing for the Advisory Committee on Immunization Practices recommended vaccines.

- Starting in 2025, Part D enrollees have the option of spreading out their out-of-pocket costs over the year.

All told, about 6 million beneficiaries will be helped by these provisions, with more over time.[16]

These changes also have significant implications for Medicare beneficiaries' ability to afford drug coverage. Because redesign will have a different level of impact depending on the type of Part D plan, costs, and premiums are likely to vary. Even so, bids and average premiums are significantly greater in 2024 than historical trends.

The IRA's authors knew premiums would spike and designed a new premium subsidy to cap expected premium increases to 6 percent annually from 2024 to 2029.[17] The 6 percent limit is placed on the base beneficiary premium, which reflects an average of plan bids for standard benefits weighted by enrollment.[18] Actual plan benefits may be more generous, and premiums reflect those costs. This subsidy applies only to a portion of the premium (the standard benefit), not what Medicare beneficiaries actually pay in the market. As a result, beneficiaries' actual premium increases were, in many instances, much more than the 6 percent cap that was highlighted by the Biden Administration and the IRA's authors.

[16] About 1.5 million have costs above $2,000 annually. Another 1.7 million with insulin costs above $35 month, and 3 to 4 million access vaccines. Less than 0.5 million people will benefit from the low income subsidy provision.
[17] Under the program, CMS subsidizes the increase in base beneficiary premium beyond the 6 percent growth, and applies the subsidy equally across all plans to limit the BBP to 6 percent.
[18] More specifically, the base beneficiary premium is equal to the product of the beneficiary premium percentage and the national average monthly bid amount. The beneficiary premium percentage ("applicable percentage") is a fraction, with a numerator of 25.5 percent and a denominator equal to 100 percent minus a percentage equal to (i) the total reinsurance payments that CMS estimates will be paid for the coverage year, divided by (ii) that amount plus the total payments that CMS estimates will be paid to Part D plans based on the standardized bid amount during the year, taking into account amounts paid by both CMS and plan enrollees.

About The Council for Affordable Coverage

The Council for Affordable Health Coverage (CAHC) is the leading organization fighting to lower consumer premiums and out-of-pocket costs through market-based reforms. Since 2001, CAHC has been bringing market leaders together to develop solutions, advocate for reforms, and inform the public. Our members include employers, medical providers, patient groups, insurers, agents and brokers, technology companies, pharmaceutical manufacturers, and pharmacy benefit managers.

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