Inflation Reduction Act

Impact on Retiree Healthcare Plans

Alisa Bennett, FSA, EA, MAAA
alisab@cavmacconsulting.com

President Joe Biden signed the Inflation Reduction Act of 2022 into law on August 16, 2022. The Inflation Reduction Act (IRA) aimed to make historic investments in the nation's social safety net. The new bill contains provisions to combat climate change, to lower the cost of prescription drugs and to raise taxes on corporations. Of particular interest to public sector retiree healthcare plans and retirement systems are the changes to Medicare Part D and a three-year extension of the enhanced subsidies for plans purchased on the Affordable Care Act (ACA) exchanges. The enhanced ACA subsidies were originally provided as part of the American Rescue Plan Act, a COVID-19 relief bill, and were set to expire at the end of 2022.

Changes to Medicare Part D Impacting Retiree Healthcare Plans and Employer Group Waiver Plans (EGWPs)

The major provisions of the IRA that are of interest to public sector retiree healthcare plans and retirement systems concern the changes to Medicare Part D and drug pricing. Drug pricing has been an ongoing concern of the Democratic party and was a priority of the Biden administration. The reason the provisions in the law only apply to Medicare and not to all prescription drug costs is because the bill could only pass through budget reconciliation since Democrats only had 50 votes (with Vice President Harris as the tie breaker) and no Republicans would vote for it.

The provisions applicable to Medicare Part D plans are:

- Beginning in 2023, the copay for insulin is capped at $35 per month for people with diabetes enrolled in Medicare.
- The Secretary of Health and Human Services will be able to negotiate the prices of certain Medicare drugs each year. The negotiations will take effect in 2026 for 10 drugs covered by Medicare, increasing to 20 drugs in 2029.
- Drug companies will have to pay rebates for drugs used by Medicare beneficiaries if prices rise faster than inflation.
- The 5% coinsurance for catastrophic coverage in Medicare Part D is eliminated in 2024, there will be a $2,000 cap on Part D out-of-pocket spending in 2025, and annual increases in Part D premiums will be limited for 2024-2030.
- Eligibility for Medicare Part D Low-Income Subsidy full benefits will be expanded.
- Cost sharing for adult vaccines covered under Medicare Part D will be eliminated and access to adult vaccines under Medicaid and CHIP expanded.
- Implementation of the Trump Administration's drug rebate rule is further delayed.

The specifics and cost implications of many of the provisions are still unclear. The fact remains that prescription drugs are expensive and are only becoming more expensive with biologics and other specialty drugs being approved. These drugs are a positive outcome for preservation and quality of life of the users, but can be surprisingly expensive, and someone has to pay for them. When it comes to Medicare in particular, costs are shared between various entities:

- the Federal Government,
- the Health Plan (Part D plan or EGWP) – which is either subsidized by the employer in the case of an employer sponsored plan or is paid for entirely by the participants in the form of premiums,
- the participant in the form of premiums and/or out of pocket costs such as deductibles, coinsurance and copays,
- and the drug manufacturers in the form of price concessions (if any) and rebates.

Any amount of cost shifting due to the Inflation Reduction Act shifts costs from one payer to another and it is unclear how this will all fall out. Items to consider and potential implications are as follows:

Price negotiation of certain Medicare drugs and the requirement of drug companies to pay rebates if prices rise faster than inflation for drugs used by Medicare beneficiaries.

The bill removes Medicare's prohibition to negotiate prices directly with prescription drug manufacturers for a specified set of drugs. The negotiations will take effect in 2026 for 10 drugs covered by Medicare, increasing to 20 drugs in 2029. The bill also requires drug companies to pay rebates if prices rise faster than inflation for drugs used by Medicare beneficiaries.
The most obvious potential implication of these provisions is that the drug companies will attempt to make up any lost revenue on Medicare beneficiaries by increasing costs for everyone else. This would impact the active employee population as well as pre-Medicare retirees.

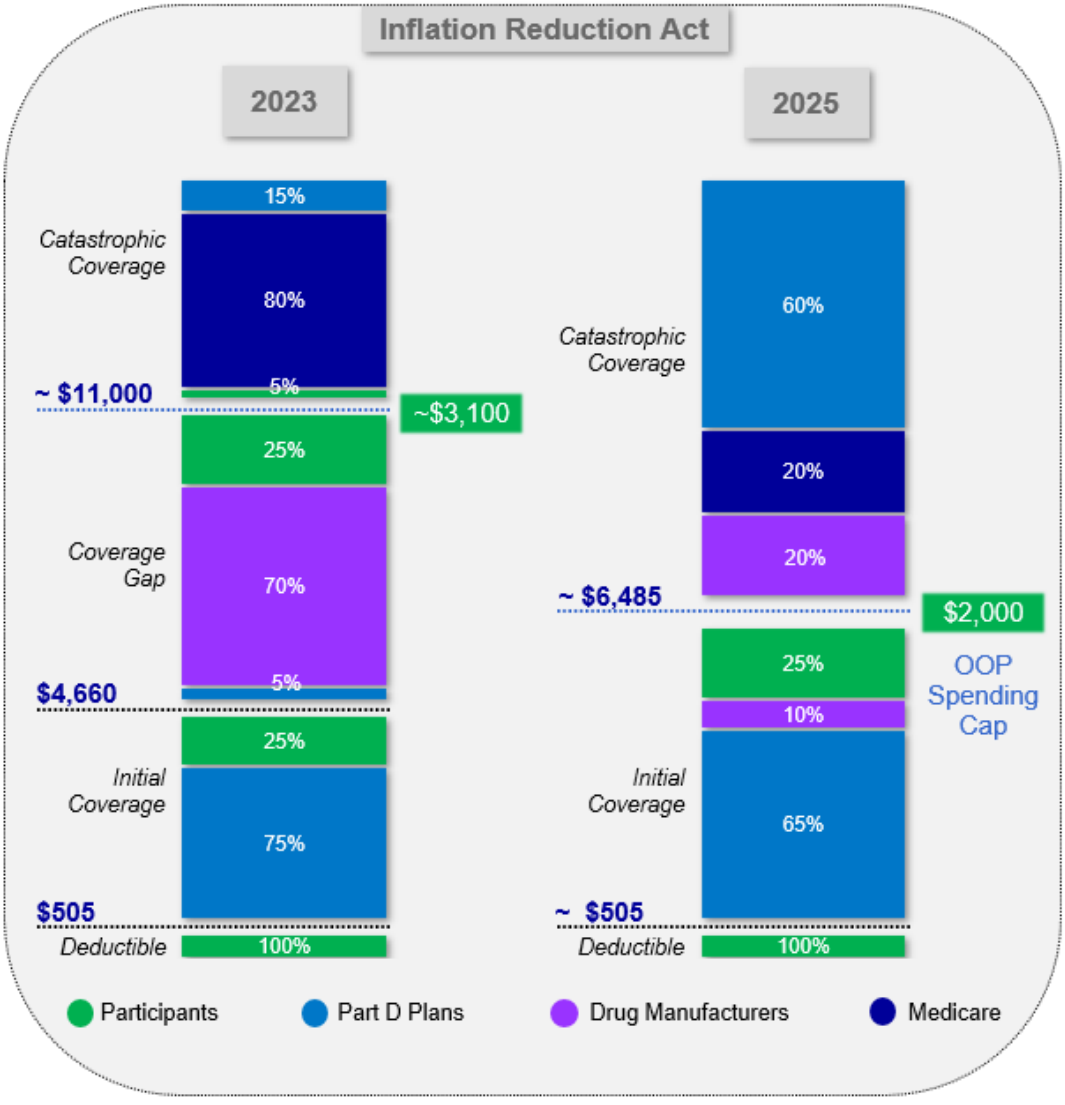
The limits on price increases to that of general inflation could impact launch prices, meaning that the drug manufacturers could increase the initial price of a new drug that enters the market to protect against restrictions on their ability to increase prices later.

Drug negotiations do have the potential to pave the way for additional lower cost biosimilars. The law, while it will allow the government to negotiate some drug prices, limits biologics eligible for Medicare negotiation to those which have been on the market for 11 years and which do not have a biosimilar version in the pipeline. This may alter incentives for brand-name biologic companies and drive more low-cost biosimilars. There are currently few biosimilar drugs (similar to the specialty drug's composition, but not identical) that can be used in place of specialty medications—the FDA only approved four in all of 2021. The exemption in the law only requires the biosimilar to be available, but it doesn't have to be interchangeable, meaning that it can be automatically switched with the reference biological product, similar to how generic

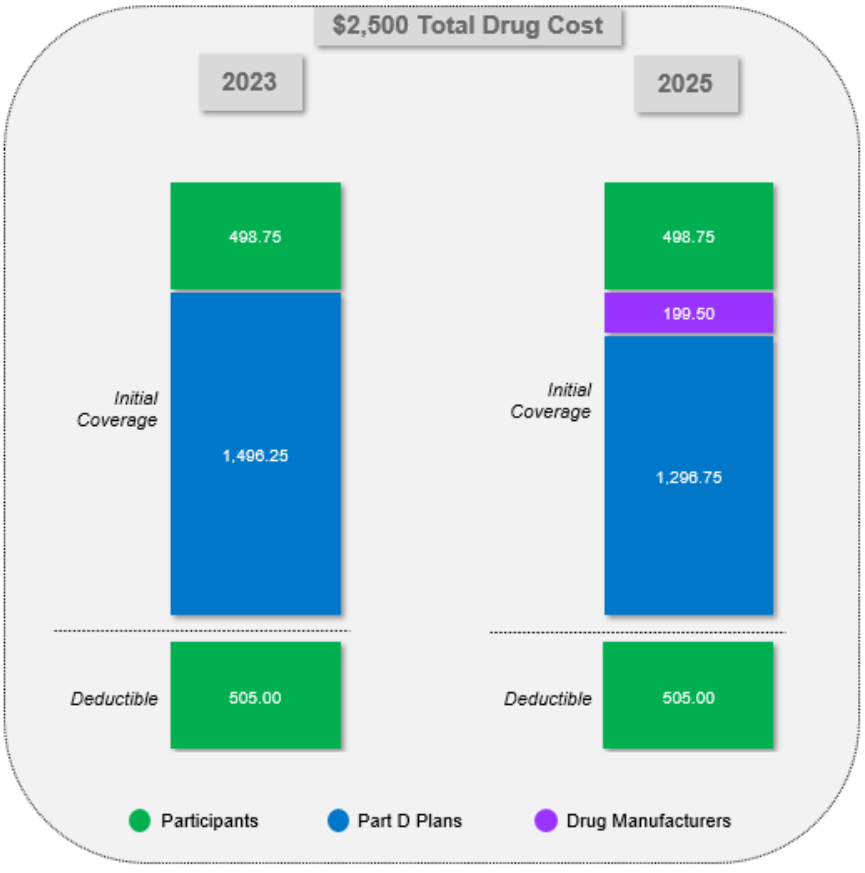
drugs are routinely substituted for brand name pills. So, drug manufacturers may opt to produce more biosimilars rather than allow their biologics to be open to price negotiation.

Elimination of 5% coinsurance for catastrophic coverage in Medicare Part D in 2024, addition of a $2,000 cap on Part D out-of-pocket spending in 2025

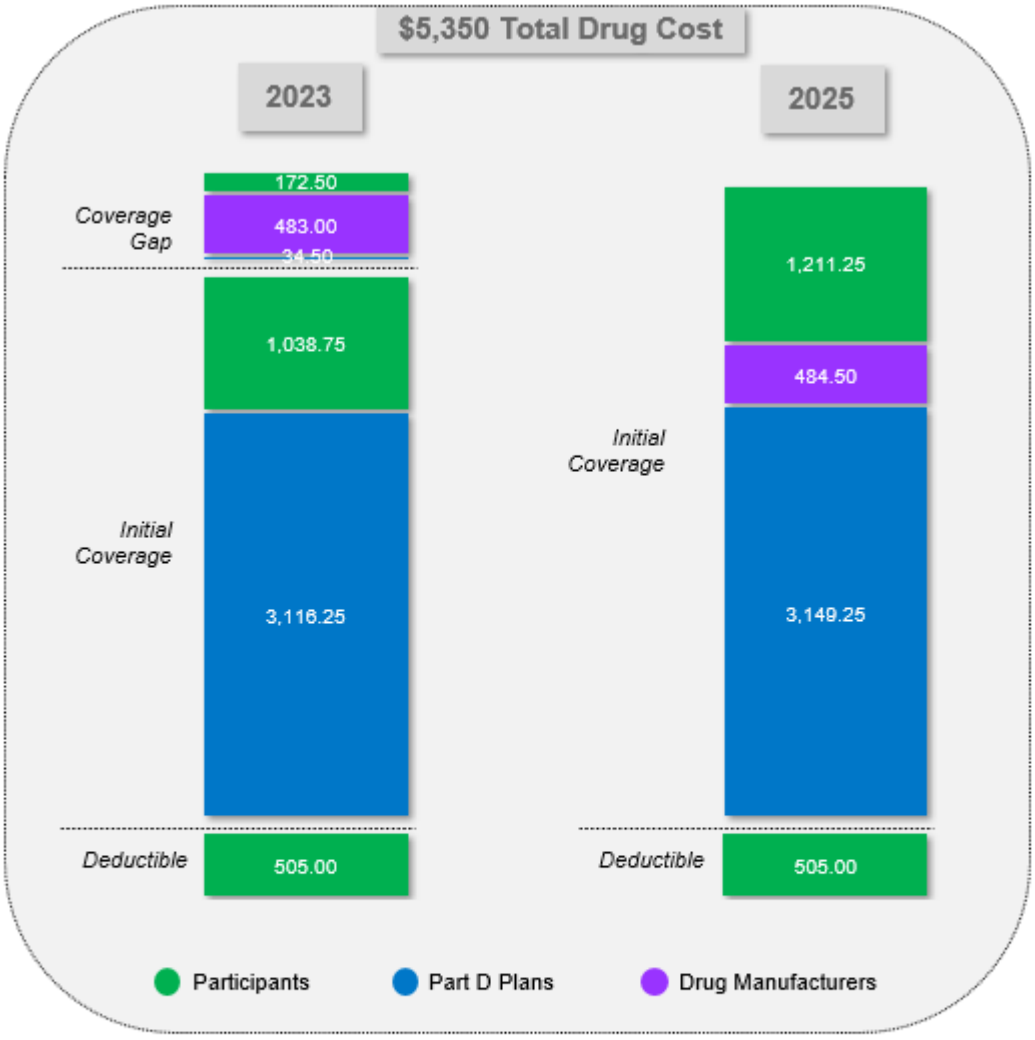
By 2025, the Medicare Part D plan design will cap participant out of pocket spending at $2,000 and alter the cost sharing between the Participant, the Part D Plan, the Drug Manufacturers and Medicare at all total applicable drug cost levels beyond the deductible. The chart below shows how this will work.



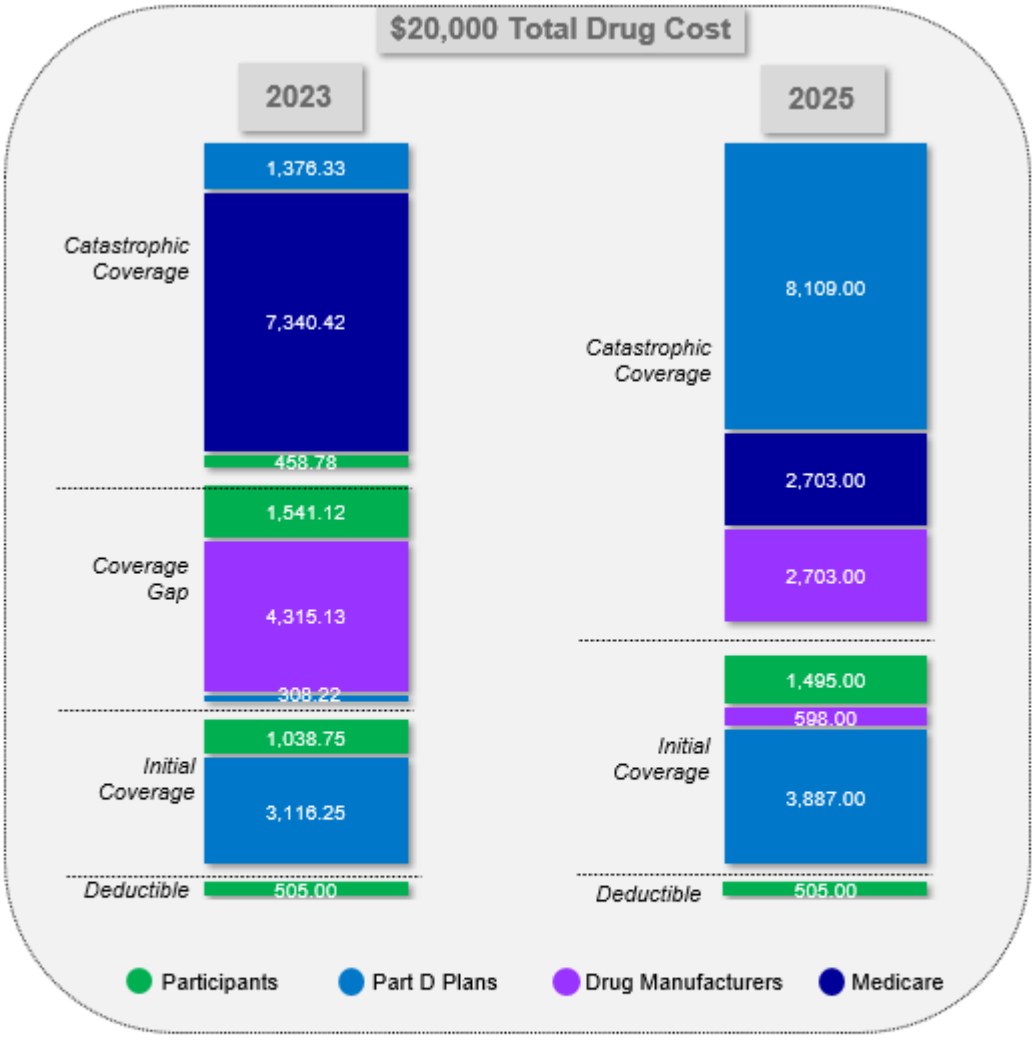
It should be noted that for very expensive drugs, the participant's 5% share in the catastrophic phase can be significant. As examples, using the 2023 deductible and parameters, and assuming all brand drugs for purposes of the drug manufacturers cost, the following charts illustrate the change in cost share for the 2023 Part D design versus the 2025 design at various total drug cost levels. Under the 2025 plan design, Part D plans spend less and drug manufacturers spend more at lower total drug cost levels, with the break-even point for the Part D plan in 2023 versus 2025 being around $5,350. At higher total drug cost levels, the Part D plan cost is significantly higher with the 2025 design, leading to speculation that the Federal Direct Subsidy will increase starting in 2025.



	2023	2025
Participants	$ 1,003.75	$ 1,003.75
Part D Plans	1,496.25	1,296.75
Drug Manufacturer	0.00	199.50
Medicare	0.00	0.00
Total Cost	$ 2,500.00	$ 2,500.00



	2023	2025
Participants	$ 1,716.25	$ 1,716.25
Part D Plans	3,150.75	3,149.25
Drug Manufacturer	483.00	484.50
Medicare	0.00	0.00
Total Cost	$ 5,350.00	$ 5,350.00



	2023	2025
Participants	$ 3,543.65	$ 2,000.00
Part D Plans	4,800.80	11,996.00
Drug Manufacturer	4,315.13	3,301.00
Medicare	7,340.42	2,703.00
Total Cost	$ 20,000.00	$ 20,000.00

There are a lot of questions about how costs will be impacted by the new Part D structure starting in 2025.

First of all, for Employer Group Waiver Plans (EGWPs), which frequently have a different plan structure such as flat dollar copays that vary by drug tier (such as generic, preferred brand, non-preferred brand and specialty) with no deductible, it appears that the portion of the cost that would be paid by the participant under standard Part D coverage but that is paid by the Plan

under the EGWP ***will*** count toward the $2,000 out of pocket maximum. This will get the participant through the initial coverage period faster and to the catastrophic phase where the Federal government starts to pay reinsurance and the drug manufacturers pay more. However, the specific language guaranteeing this is unclear. Even if this is the case, the Plan will pay more after the $2,000 participant out of pocket maximum is reached than they do under the current plan. Using the 2023 deductible of $505, this threshold is reached at $6,485 of total applicable drug spend. For purposes of this discussion, we will assume the 2023 deductible amount stays level until 2025. So before $6,485 in total applicable drug costs, the Plan pays slightly less (65%) starting in 2025 than the current 75%, with the drug manufacturers picking up the additional 10%. However, after the $2,000 participant OOP is reached, the Plan pays 60% which is significantly more than the 15% the Plan pays in the current catastrophic phase. Of course, the break points are also different, but as illustrated above, the crossover point where the 2025 plan design costs the plan more than the 2023 design is $5,350 in total drug cost. In 2020, the average gross drug cost for Medicare Part D members was $4,190 and the average Plan cost was $2,759. However, unlike a commercial Medicare Part D plan, an EGWP receives no allowances or adjustments to mitigate the impact of covering high-cost prescription drug users. The EGWP covers their own retirees, for better or for worse.

One feature whose magnitude remains to be seen is the direct subsidy provided by the Federal government to Part D plans. The direct subsidy is based on the national average bid amount and the Part D base beneficiary premium. This amount has been steadily dropping in recent years, but in 2025 when the plan design changes, the national average bid amount is expected to rise and the direct subsidy to increase. This will increase the direct subsidy amount for EGWPs.

In addition, since the drug manufacturers are on the hook for 20% of applicable drug costs after the $2,000 participant out of pocket maximum is reached, instead of 70% in the coverage gap and $0 in catastrophic coverage, one theory is that they will be more sensitive to extremely

high drug prices for Medicare members. Once again, this has the potential to shift those costs from the Medicare population to the pre-Medicare population (actives and pre-Medicare retirees.)

So what does this mean for Employer Sponsored Health Plans?

The changes to drug price negotiation, Medicare Part D design and the extension of the enhanced subsidies on the ACA exchanges have the potential to affect retiree health plans and possibly active employee health plans. The extension of the enhanced subsidies on the ACA exchanges make more pre-65 retirees eligible for the government subsidies and could make an employer wrap-around HRA a viable plan option. For Medicare eligible retirees, one could argue that since standard Medicare Part D will be more valuable to the participant with the coverage gap (donut hole) closed and a $2,000 out of pocket maximum, accessing the individual market with a flat dollar HRA or similar arrangement may be beneficial. On the other hand, EGWPs appear to be protected with assumed higher direct subsidies and allowing costs paid by the EWGP that would have been participant under standard Part D to count toward the $2,000 out of pocket maximum, ensuring that the EGWP can continue to provide a superior plan for an affordable cost. Many details of the IRA are yet to be determined, as are the cost implications and the subsequent behavior of the drug manufacturers and their reaction to the price negotiations for Medicare recipients and Medicare Part D cost sharing. The potential impact to both the commercial market affecting active employees and pre-65 retirees as well as Medicare eligible retirees will be watched closely as the various pieces of the law start to take effect.