Inflation Reduction Act – Insights and Impact on Different Therapeutic Areas from the US Commercial Payer Perspective

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Introduction

The US Inflation Reduction Act (IRA) was signed into law by President Biden on August 16, 2022. The IRA brings about several sweeping reforms with the ultimate aim to lower prescription drug costs for people with Medicare and reduce drug spending by the federal government. Provisions within the IRA that are considered to have a major impact on the current system include the requirement for the federal government to negotiate prices for select Medicare Part B and D drugs with the highest total spend, implementation of out-of-pocket (OOP) caps for Medicare Part D enrollees, and limitations or elimination of cost-sharing for insulin and vaccines. These provisions will clearly affect Medicare beneficiaries, but the impact on commercial insurers, including Medicare Advantage (MA), employer-sponsored, and self-insured plans is less clear. Since commercial insurers often eventually follow the policies that the Centers for Medicare & Medicaid Services (CMS) implement, it is important to gain a better understanding of the broader implications of the healthcare cost containment policies in the United States on commercial plans.

Objective

To consider how the US Inflation Reduction Act (IRA) might impact US commercial payer management of drugs within several disease areas and therapy types including oncology, diabetes, cardiovascular disease (CVD), neurology, immunology, vaccines, generics, biosimilars, orphan drugs, and cell and gene therapies (CGTs), and to understand how costs, payer management, and contracting might evolve with the implementation of certain IRA provisions.

Methods

Details regarding IRA provisions related to specific disease areas and therapeutic types were obtained from a review of white papers, press releases, and public domain sources. Five 30-minute interviews were conducted over teleconference with US payers representing National and Regional Managed Care Organizations (MCOs), Integrated Delivery Networks (IDNs), and Pharmacy Benefit Managers (PBMs). The objectives of the interviews were to gain feedback from the advisors on current and anticipated impact of the IRA on commercial plans and to understand if any disease areas or therapy types will be particularly impacted by the IRA in terms of costs, utilization management (UM), and contracting from a commercial plan point of view.

Results

Patient and Plan Costs

Payers acknowledged that patient and plan costs will shift as a result of the IRA with a greater cost burden on health insurance plans, specifically MA plans. The primary driver of this shift in costs is due to the reduced patient OOP cap from $3,100 in 2023 to $2,000 by 2025. Though there is a reduced cost burden on plans in the initial coverage phase (from 75% currently to 65% in 2025), once patients hit the $2,000 OOP spending cap and reach the catastrophic coverage phase, plans will be responsible for 60% of costs compared with only 15% currently. As a result of the decreased OOP cap, Medicare patients may initiate more expensive treatments that they otherwise would not have taken due to high OOP costs. Patients may also remain on these costly treatments for a longer time since their OOP burden is capped.

To offset the reduced patient OOP cap, plans are anticipated to increase premiums for MA beneficiaries, though increases will likely be gradual and are limited to annual maximums. Standalone Medicare Part D prescription drug plans (PDPs) are considered to take the biggest hit as a result of the $2,000 OOP cap and many may be forced to exit the market altogether, as they lack medical benefit coverage for MA enrollees, which advisors believe will offset PDP-only losses. As a result, payers hypothesized that more Medicare beneficiaries will migrate towards MA plans. Premiums for employer-sponsored plans may not be impacted, but commercial plan offerings will be more incentivized to enact greater levels of UM and contracting to keep overall plan costs down, which may lead to commercially-insured patient OOP increases.

In terms of plan costs, neurology, orphan disease, and oncology products were considered to be impacted significantly with 4, 4, and 3 out of 5 respondents anticipating increases in plan costs, respectively. One advisor noted that for most branded oncology products, the health plan will immediately be responsible for a large sum of the costs. Additionally, several advisors noted that they believe newly launched products in these areas will likely launch with higher prices in order to counterbalance the potential downstream IRA price negotiations.

Utilization Management

The shift in costs from MA patients to MA health plans will result in commercial insurers offsetting these losses through increased UM for other privately (employer-sponsored and self-pay) insured individuals. Interviews confirmed that this will inevitably result in more control on formularies to limit product choice and drive utilization toward more cost-effective treatments, greater implementation of step-edits, and increased use of electronic prior authorizations (PAs). Three out of five respondents anticipated a greater level of UM to occur as a result of the IRA in the disease areas of diabetes, CVD, neurology, and immunology as well as with CGTs. UM is unlikely to change for oncology products given their status as a protected class.

Contracting

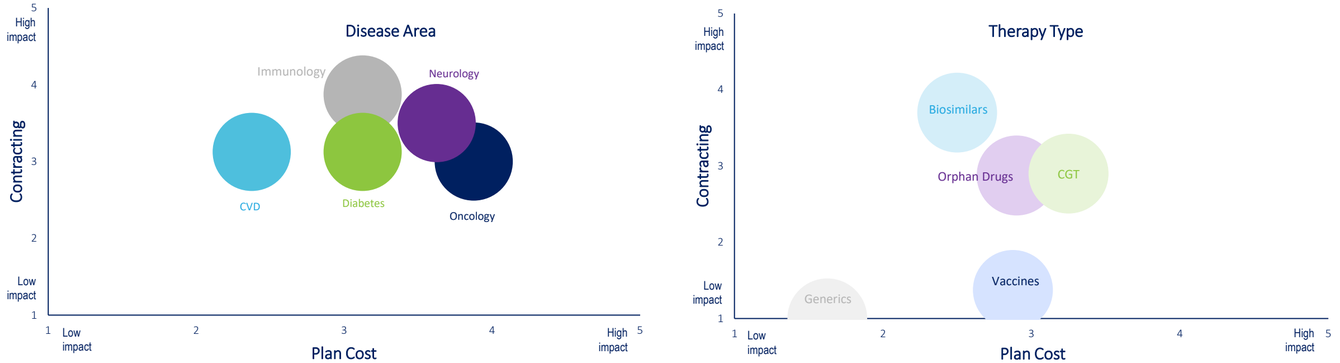
Commercial payers may benefit from IRA price negotiations in terms of financial contracting. In the current system, payers use any public price point as leverage in financial negotiations. If payers identify the rebate levels used within IRA negotiations, they will attempt to use those as leverage to obtain greater discounts for all their available plans. Payers believed that large health plans would be able to better negotiate a similar rebate to Medicare, but smaller health plans would have significant difficulty in getting the same level of discounts. There is also concern that manufacturers with treatments subject to IRA price negotiations will look to reduce rebates with commercial insurance plans to offset manufacturers' reduced profits from Medicare plans. Most payers view diabetes, CVD, and neurology as the disease areas which will see the greatest increase in contracting for preferred products. Several payers noted that they would consider covering only one product within a treatment class for disease areas like diabetes and neurology where there are already several covered products within the same treatment class e.g., SGLT2s in diabetes. They also agreed that the possibility of innovative contracting such as value-based agreements would be more likely, particularly with CGTs, though this is due less to the IRA and more to the anticipated presence of new options in diseases with larger patient populations like sickle cell anemia. Payers noted that contracting in immunology will be impacted due to the impending launches of biosimilars in the space for products such as Humira, but this is not particularly due to the IRA.

Other Considerations

Beyond the pre-selected disease areas included in our research, US payers believed that treatments for respiratory disease would also see a large impact as a result of the IRA. In particular, therapies for diseases such as asthma and chronic obstructive pulmonary disease (COPD) would likely see the biggest impact in terms of patient and plan costs, UM, and contracting.

Though there are specific provisions in the IRA that eliminate cost-sharing for adult vaccines covered under Part D, payers do not consider the IRA to have a major impact since most commercial plans already cover adult vaccines with minimal or no OOP costs for the majority of their members.

Figure 1. Impact of the IRA on Plan Cost vs. Contracting Across Different Disease Areas and Therapy Types *(where impact was assessed as 1 = no/ low impact and 5 = high impact)*



Conclusions

- Most US payers indicated that patient costs will decline due to the upcoming $2,000 OOP cap and agree that neurology products would be the most likely to be impacted in terms of reduced patient costs
- Regarding plan costs, oncology products and orphan drugs are most likely to result in increased costs due to the IRA; plan costs for CGTs will also increase, but this is more due to increased number of treatments launching in the near term
- With higher plan costs, increased UM is inevitable, and diabetes, CVD, neurology, immunology, and CGT products are those most likely to experience restrictions, steps, and even significant product choice limitations
- Payers agreed that financial contracting for preferred products will increase, and plans may consider covering only one product within a treatment class for diabetes and neurology specifically
- The IRA will clearly impact MA plans, but the impact on other commercial segments such as employer-sponsored plans is less clear at this point; further research is needed to fully understand the long-term impact on these plans

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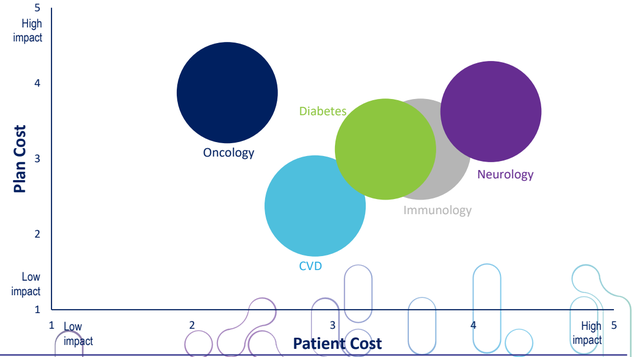
Figure 2. Impact of the IRA on Patient vs. Plan Cost Across Different Disease Areas *(where impact was assessed as 1 = no/ low impact and 5 = high impact)*



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