MILLIMAN WHITE PAPER

Medicare Part D risk and claim cost changes with the Inflation Reduction Act

How will risk and claim costs change for Part D plan sponsors?

What can plans do to manage these changes?

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The Medicare Part D program is on the verge of massive change due to the Inflation Reduction Act (IRA). In 2025, a new Part D benefit design will materially affect costs by stakeholder. This white paper examines these changes in costs and risk for Part D plan sponsors starting in 2025.

The Inflation Reduction Act will usher in arguably the largest changes to the Medicare Part D program since its inception in 2006. Specifically, the Medicare Part D benefit faces an overhaul in 2025, materially changing costs by stakeholder. We analyzed the impact of the 2025 Part D benefit redesign using Milliman's Part D Consolidated Database (PDCD) to assess the changes in plan liability and risk for plan sponsors. Under the new benefit design (starting in 2025), our analysis indicates that:

- 1% of members will account for nearly 30% of gross plan liability, compared to 15% of gross plan liability today
- 50% of gross plan liability will be concentrated in 4% of members, compared to 12% of members today
- Gross plan liability will increase by over 85% (before rebates), and will more than double for low-income (LI) members

This white paper explores risk and cost profile changes for various stakeholders, both in aggregate and specific to certain populations, and discusses possible risk mitigation strategies for plan sponsors after the Part D benefit redesign is fully implemented in 2025. The specifics of the Part D benefit redesign, along with other key healthcare-related components of the IRA, are detailed in this white paper.[1]

How will plan liability and risk change?

What impact will the IRA have on plan liability and risk for plan sponsors starting in 2025? One of the largest changes is an increase in plan sponsors' share of liability from 15% to 60% of gross cost for members with catastrophic spending. This increase in plan costs is driven by a decrease in Part D federal reinsurance from 80% of gross cost for all drugs to 20% for brand drugs and 40% for generic drugs. Federal reinsurance payments have increased materially over the past decade and, with the IRA, total reinsurance payments may revert to levels consistent with the early years of the Part D program.

These changes will materially increase overall plan expenses, particularly for high-cost members. The impact will differ for various member types (e.g., low-income vs. non-low-income) and for different therapeutic classes or condition states. We explore some of these changes in the figures and discussion below.

[1] Cline, M., Karcher, J., Klaisner, J.K., & Klein, M. (August 2022). Weathering the Reform Storm: The Inflation Reduction Act's Changes to Medicare and Other Healthcare Markets. Milliman Brief. Retrieved January 10, 2023, from https://www.milliman.com/en/insight/weathering-the-reform-storm.

AGGREGATE PLAN LIABILITY AND RISK CHANGES

Under the IRA, plan liability is increasingly concentrated in a smaller portion of the population. Figure 1 summarizes key statistics comparing gross plan liability (i.e., plan liability before rebates) pre-IRA and post-IRA to highlight this concentration of plan liability. Given these changes, plan sponsors may increase their emphasis on managing costs for the small subset of the population that accounts for most of the spending. We discuss potential strategies plan sponsors may implement to mitigate this increased plan liability for high-cost members later in this white paper.

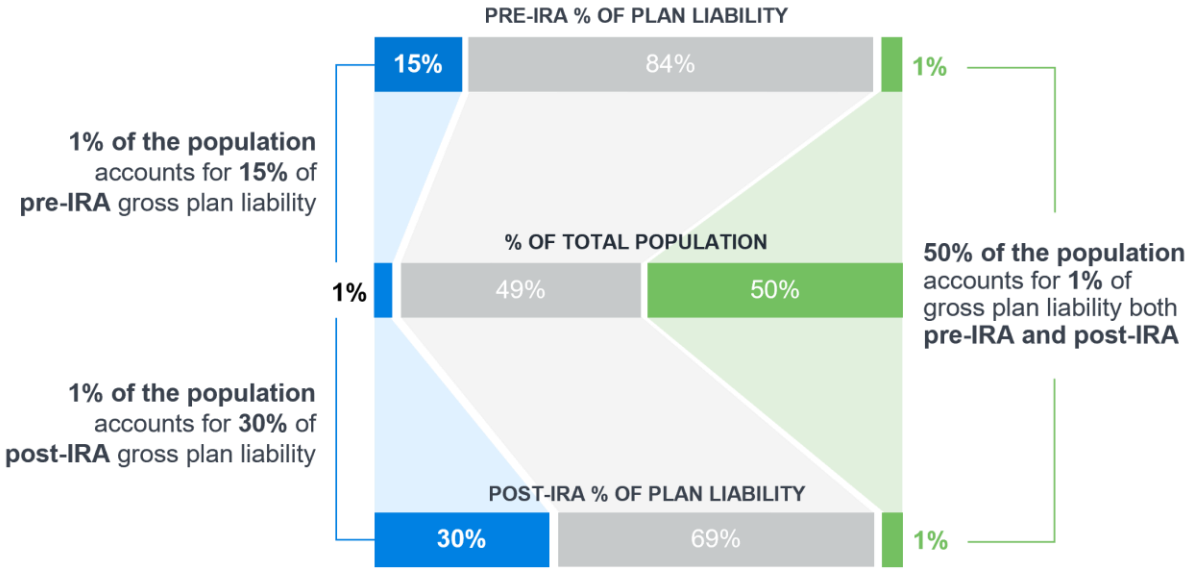
FIGURE 1: PART D GROSS PLAN LIABILITY COMPARISON PRE-IRA VS. POST-IRA

KEY STATISTIC	PRE-IRA	POST-IRA
50% of the population accounts for:	**1%** of gross plan liability	**1%** of gross plan liability
50% of gross plan liability is incurred by:	**12%** of the population	**4%** of the population
1% of the population accounts for:	**15%** of gross plan liability	**30%** of gross plan liability

Figure 2 visualizes the percentage of plan liability incurred by the top 1% of the population and bottom 50% of the population pre-IRA versus post-IRA (before rebates). The results presented in each figure reflect the same 2020 Part D claim data set, applying the 2023 defined standard benefit for the pre-IRA distribution and the 2025 benefit parameters and Part D maximum out-of-pocket (MOOP) for the post-IRA distribution. Additional detail on the distribution of plan liability is summarized in Appendix A.

We recognize rebates are impactful to the ultimate liability for a plan sponsor, but we did not consider them for the purpose of our analysis because (a) the risk score model of the Centers for Medicare and Medicaid Services (CMS) does not consider rebates, and (b) rebates are not directly impacted by these specific IRA plan design changes.

FIGURE 2: CONCENTRATION OF PART D GROSS PLAN LIABLITY AND POPULATION, PRE-IRA VS. POST-IRA



POPULATION-SPECIFIC PLAN LIABILITY AND RISK CHANGES

The Part D benefit design is also changing for different subsets of the population. In the current environment, LI members have a materially different benefit design than non-low-income (NLI) members. The two designs begin to converge in 2025, which will (a) materially decrease NLI member cost sharing, (b) increase plan liability associated with LI members, and (c) reduce low-income cost-sharing subsidies (LICS).

Figure 3 illustrates the change in average gross plan liability, separately for NLI and LI members. For NLI members, the average gross plan liability increases by almost 60% post-IRA. However, plan sponsors experience the largest change for LI members, with average gross plan liability more than doubling. On an overall population basis, we estimate the average gross plan liability will increase by 85%.

These variations by population also drive different plan liability relativities between NLI and LI members. Figure 3 displays the relativities pre-IRA and post-IRA for gross plan liability, along with average pre-IRA risk scores for each population. This figure illustrates that, while we modeled an increase for all plan liabilities relative to the average plan liability, NLI plan liabilities will decrease by 15% while LI plan liabilities will increase by 14%.

Given the changes in plan liability, CMS will need to recalibrate the prescription drug hierarchical condition category (RxHCC) risk score model with the new Part D benefit to align plan revenue with liability. The percentage change values in the table in Figure 3 could be representative of changes to NLI and LI risk scores levels due to the Part D redesign. CMS has not yet released its plans for when or how the Part D risk score model will change, but this figure may provide a sense of the potential magnitude of changes in average risk scores for each type of member in the years to come.

FIGURE 3: PART D RISK SCORE AND PRE-IRA VS. POST-IRA GROSS PLAN LIABILITY COMPARISON BY INCOME

	% INCREASE IN AVG. GROSS PLAN LIABILITY	PRE-IRA RISK SCORE	PLAN LIABILITY RELATIVITY*		
			PRE-IRA	POST-IRA	% CHANGE
Non-Low-Income	58%	0.85	0.78	0.66	-15%
Low-Income	111%	1.42	1.36	1.54	+14%
Total	85%	1.05	1.00	1.00	0%

*Plan liability relativities reflect the ratio of gross plan liability for the specific population relative to the population average.

CONDITION-SPECIFIC PLAN LIABILITY AND RISK CHANGES

We also analyzed differences in plan liability for members with specific conditions and diagnoses. Members with the same condition may have similar prescriptions and overall drug spend, leading to similar plan liabilities. Diagnoses, along with demographics, are used to determine member risk scores in the Part D market. Examining how plan liabilities change for members with specific diagnoses may indicate how risk scores could change post-IRA.

As an example of how the IRA can have a varying impact on members with different conditions, we analyzed members with psoriatic arthropathy and systemic sclerosis (PASS) and atrial arrhythmias (AA), as defined in the CMS RxHCC risk adjustment model. For these diagnoses, common treatments include different types of drugs (e.g., brand, specialty). Members with PASS commonly take autoimmune drugs (e.g., Humira, Enbrel), which are specialty products, and members with AA commonly take anticoagulants (e.g., Eliquis, Xarelto), which are traditional brand products. We selected these diagnoses because the drugs that are commonly used to treat these conditions reflect three out of the four top drugs based on gross Part D spend in 2020.

We projected significant increases in plan liability for both members with PASS and members with AA under the post-IRA design relative to the pre-IRA design. The increase for members with PASS is larger, with the post-IRA plan liability more than double the pre-IRA plan liability. Figure 4 shows the change in plan liability for members with PASS and AA. The large increase for PASS members relative to the average is driven by a high concentration of spending in the catastrophic phase, where federal reinsurance is decreasing under the IRA.

Figure 4 also illustrates the plan liability for members with PASS and members with AA relative to the total population. Comparing the conditions, members with AA have higher relative plan liabilities with the pre-IRA benefit design, while members with PASS have higher relative plan liabilities with the post-IRA benefit design. This could result in their risk scores changing positions post-IRA, with the PASS members being associated with higher risk scores and the AA members being associated with lower risk scores. This dynamic could occur for diagnoses similar to PASS, where specialty drugs are a common form of treatment, driving higher risk scores post-IRA.

FIGURE 4: PRE-IRA VS. POST-IRA PART D GROSS PLAN LIABILITY COMPARISON FOR SELECT DIAGNOSES

	% INCREASE IN AVG. GROSS PLAN LIABILITY	PLAN LIABILITY RELATIVITY*		
		PRE-IRA	POST-IRA	% CHANGE
Members with PASS	110%	1.58	1.79	+13%
Members with AA	63%	1.70	1.49	-12%

*Plan liability relativities reflect the ratio of gross plan liability for the specific population relative to the population average.

Although these results show the average plan liability for members with these conditions, there is significant variation in claim costs between beneficiaries, even with the same diagnoses, due to comorbidities, income status, drug utilization (e.g., generic vs. brand), and other factors. The plan liability relativities that plan sponsors observe in their populations may differ from these results as a result of underlying differences in the populations. To the extent that CMS recalibrates the CMS RxHCC risk adjustment model to the new post-IRA benefit design, the risk score and revenue for members with these diagnoses may follow a trajectory similar to the plan liability.

How might plan sponsors manage this increased plan liability and risk?

What risk management strategies could plan sponsors consider? An initial step is to assess plan liability and risk changes. Once plans have a detailed understanding of the potential impacts of the IRA, there are several strategies they might consider to prepare, mitigate, and optimize for these changes. We outline a few of these potential actions and strategies in this section.

PLAN LIABILITY AND RISK CHANGE ASSESSMENT

Each plan sponsor will see different liability impacts from the IRA based on their different member profiles. In addition, market-level changes will affect plan revenue and member premiums, due to changes in the direct subsidy and low-income premium subsidy amounts (LIPSAs). Here are a few key analyses plan sponsors might consider:

- **Drug or class-level impacts.** As illustrated in this white paper, the plan liability and risk changes can vary materially for particular condition states. Plan liability will increase significantly in the post-IRA environment, particularly for high-cost therapies where the member would exceed the MOOP. Plans could model how costs will change for different therapeutic classes and drugs to evaluate the potential for adverse selection and inform formulary and benefits strategy.
- **Plan-specific impacts.** Although the IRA includes a “premium stabilization” provision, it only applies to the national average member premium. There will be materially different premium impacts among plans. Plan sponsors should evaluate how these changes affect each plan and/or product type within their portfolios. In addition, plans may attempt to model the impact of the IRA on competitors’ plans or plan archetypes to inform future competitive positioning.
- **Aggregate market changes.** The direct subsidy and LIPSAs are market averages driven by the collective bids of all Part D plan sponsors. Plan sponsors should evaluate these aggregate market changes due to the IRA in preparation for bid submission starting in 2024. This analysis may also inform plan strategy considerations, due to changes in premiums and allocated Part C rebates, for Medicare Advantage prescription drug (MAPD) plans.

FORMULARY AND UTILIZATION MANAGEMENT STRATEGIES

Though plans will still be subject to the same formulary rules that exist today (e.g., they must cover at least two drugs per therapeutic class), there may be opportunities for plans to innovate with creative formulary and utilization management (UM) strategies. These strategies could affect plan selection for new members and help control costs for existing members. For example, plans might consider narrowing their formulary coverage to help mitigate some of the plan liability increases. In evaluating this strategy, plans should assess the impact of approved exceptions and transition fills on manufacturer rebates and the impact of potential member dissatisfaction from narrow formulary coverage on Medicare Star ratings.

Plans could also consider new UM solutions, such as additional step therapy edits or prior authorization controls. These UM edits may focus on high-cost medications where members exceed the MOOP, as there are limited incentives for members to select lower-cost drugs once a MOOP is reached. Step therapy may be particularly important once drugs are selected by the government for price negotiation, as these products will need to be covered on formulary and step edits might help steer members to lower-cost drugs.

In addition, the IRA changes rebate dynamics in the Part D market. The current Part D benefit design often leads to lower plan liability when plans favor products with high list prices and high rebates. Although a slight financial advantage may still exist, the value of rebates on plan premiums will be much closer to the value of list price discounts in the new environment. This dynamic may also change as drugs are selected for price negotiation by the government. Part D plan sponsors should have a strong understanding of the value of rebates post-IRA to assess which formulary strategies align with their overall goals.

CARE MANAGEMENT PROGRAMS

The increases in Part D plan sponsor liabilities may place greater emphases on population health and certain care management programs. As highlighted in Figure 1 above, on average approximately 4% of members will account for over 50% of Part D gross plan liability post-IRA. This concentration of plan liability in a relatively small population creates an opportunity to provide targeted care management programs focused on specific members. An effective program could provide plan sponsors a meaningful return on investment (ROI).

For MAPD plans, optimally designed programs will consider the total cost of care for members, including both medical and drug spending. The new Part D benefit design has the potential to drive greater adherence, which may increase pharmacy costs and potentially reduce medical costs. Programs considered by Medicare Advantage organizations (MAOs) should address the full patient experience, not just the drug component. Effective programs would include monitoring and tracking of key performance indicators (KPIs) specific to the particular population or condition (e.g., medication adherence, emergency room visits, preventive treatments).

RISK SCORE INITIATIVES

Part D risk scores will become more important post-IRA. For context, CMS makes direct subsidy payments to plan sponsors to subsidize premiums for Part D members. These payments are risk-adjusted. Plans with higher risk scores receive more revenue and plans with lower risk scores receive less revenue. In 2023, the Part D direct subsidy is approximately $2 per member per month (PMPM) and has been decreasing steadily for more than a decade. With plan liability increasing and federal reinsurance decreasing due to the IRA, we expect the direct subsidy will increase materially. With this change, direct subsidy payments will be more sensitive to Part D risk score changes, materially affecting plan revenue and profitability. MAPD plans, which can exert influence over the diagnosis capture process, may consider placing more of an emphasis on Part D initiatives focused on accurately capturing member diagnoses in the future.

Additional timing considerations may exist for risk scores. It is unclear when or how CMS will change the RxHCC Part D risk score model. Any timing differences between the risk score model update and the Part D benefit design changes could drive a misalignment between revenue and claim liability for plan sponsors. Plans will need to monitor timing closely to better understand implications of the new model once it is released.

What are areas for further exploration?

The analysis presented in this white paper only begins to explore the new dynamics in the Part D market. There are several areas for further exploration into the changes in plan liability and risk, including, but not limited to:

- **Evaluating plan economics holistically.** For the purpose of this analysis, we focused on gross plan liability before rebates. This approach aligns with how CMS calculates risk scores, but it ignores the impact of manufacturer rebates. Plans should explore how their cost distributions change with manufacturer rebates. The distribution of plan liability net of rebates might be even more concentrated in a small portion of the population, as many high-cost specialty drugs offer low or no rebates today.
- **Manufacturer discount program phase-in.** The manufacturer discount program is phased in over several years for "specified" and "specified small" manufacturers, with variation between LI and NLI members. Our analysis did not explicitly account for the phase-in of this discount program, which will materially affect plan liability for particular classes and condition states and will further affect the plan liability and risk score changes over time.
- **Targeted population review.** The concentration of liability in a small portion of the population warrants further exploration. Plans may find value in identifying which drug classes, member types (NLI vs. LI), and markets (MAPD vs. prescription drug plan [PDP]) drive this spending, and how the concentration varies among these categories. As part of bid development, plans sponsors may decide to review plan liability more closely for the top 1% of the population and apply more granular trends or projection factors to align with the anticipated cost changes for those members.

Methodology

We relied on Milliman's Part D Consolidated Database (PDCD) in calendar year (CY) 2020 to estimate the impact of the new Part D benefit design on different stakeholders. This proprietary data source includes claims experience from both Medicare Advantage and PDPs for over 6 million members. The costs by stakeholder were calculated using this data under two scenarios, without any projection factors or trends applied:

- 2023 CMS defined standard benefits
- 2025 benefit proposed with the IRA, with the following benefit parameters (see Appendix B for more details):
  - $505 deductible
  - $2,000 MOOP
  - 75% plan liability for generic drugs, 65% plan liability for brand drugs above the deductible and below the MOOP
  - 60% plan liability for all drugs after the MOOP

Note that our analysis focused on the benefit redesign only. We did not model the impact of the drug negotiation or inflation rebate payment provisions from the IRA. We also did not explore the impact of the manufacturer discount program phase-in for specified and specified small manufacturers, which would affect the distribution of plan costs. There is also the potential for increased demand for prescription drugs, given the introduction of a MOOP. Increased demand would affect members taking high-cost therapies, in particular, and was not modeled for the purpose of this analysis.

Conditions were assigned to members based on their prior year (CY 2019) diagnoses, consistent with the 2020 CMS RxHCC risk score model. Members new to Medicare were not assigned condition categories. For the purpose of this analysis, we focused on the following diagnoses:

- Psoriatic Arthropathy and Systemic Sclerosis (RxHCCs 82, 83, 84, or 316)
- Atrial Arrhythmias (RxHCC 193)

Caveats and Limitations

The results presented herein are estimates based on carefully constructed actuarial models. Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual amounts will differ from projected amounts to the extent that actual experience deviates from expected experience.

Models used in the preparation of our analysis were applied consistently with their intended use. We have reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOPs). The models, including all input, calculations, and output, may not be appropriate for any other purpose. Where we relied on models developed by others, we have made a reasonable effort to understand the intended purpose, general operation, dependencies, and sensitivities of those models. We relied on input, review, and validation by other experts in the development of our models.

In performing the analyses and forming the conclusion presented in this report, we relied on information from CMS, the Inflation Reduction Act, other publicly available information, along with a large sample of Part D claims. We have not audited or verified this data and other information but reviewed it for general reasonableness. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete.

Conclusion

The IRA is expected to have a material impact on the Medicare Part D market over the next several years. Plan sponsors will see a large increase in their Part D liabilities for high-spend members. How this will affect member premiums and plan profitability will depend on how (and when) CMS updates the Part D risk score model. Plan sponsors need to better understand how their liabilities will change and to evaluate potential strategies to achieve their goals in the new environment. This white paper begins to explore these new dynamics, but much more analysis is needed to understand, react, and optimize for the future.

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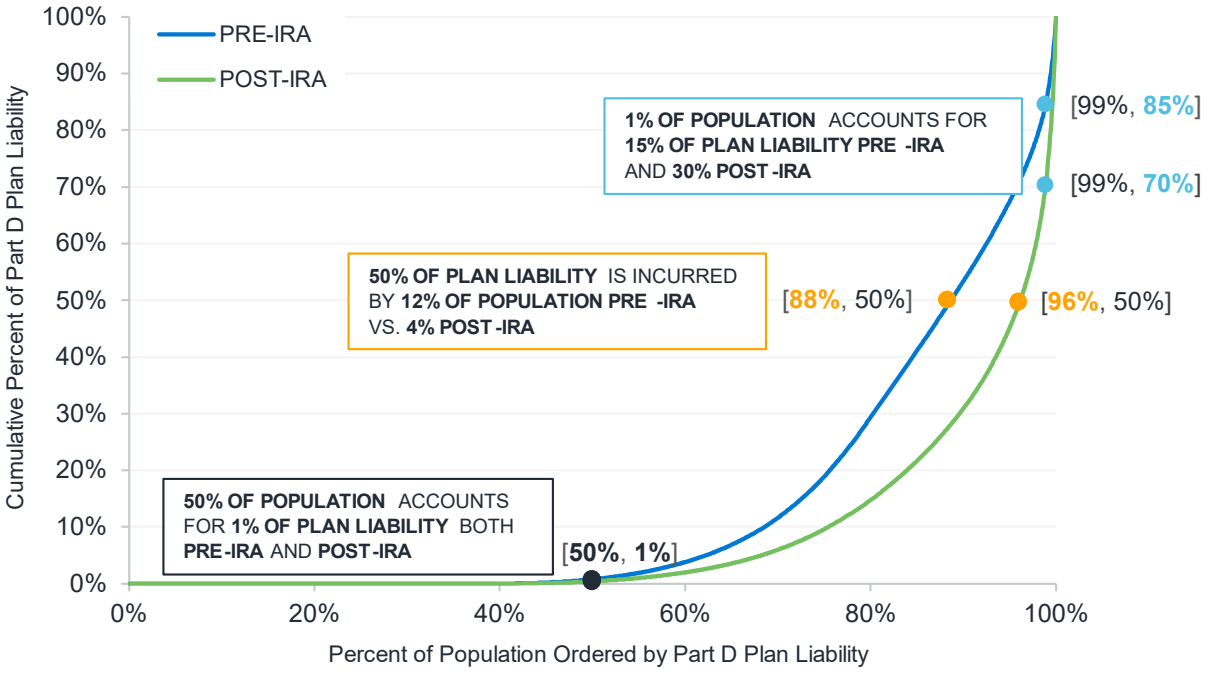
APPENDIX A: CUMULATIVE DISTRIBUTION OF PART D GROSS PLAN LIABILITY BY % OF POPULATION, PRE-IRA VS. POST-IRA



APPENDIX B: POST-IRA MEDICARE PART D BENEFIT REDESIGN – ASSUMING FULLY PHASED-IN MANUFACTURER LIABILITIES