Impact of the Inflation Reduction Act on Part B Provider Payment and Patient Access to Care

Commissioned by Capitol Counsel on behalf of the Part B Access for Seniors and Providers Coalition

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Capitol Counsel, on behalf of the Part B Access for Seniors and Providers Coalition (ASP Coalition), engaged Milliman to quantify the potential impact of the Inflation Reduction Act (IRA) and its changes to Medicare Part B reimbursement on physician reimbursement and patient access to care. This report summarizes the findings from this study. This brief provides a summary of results; the full report can be found here.

We analyzed the financial impact of changes in Part B reimbursement resulting from the Medicare Drug Price Negotiation Program (MDPNP) enacted by the IRA as well as the impact of an alternative scenario in which the Protecting Patient Access to Cancer and Complex Therapies Act (PACTA) is passed. We modeled a 10-year window, beginning in 2028, which is the initial year Part B drugs are eligible for the MDPNP. We considered the impacts on the five key Part B stakeholders: providers, patients, government, plans, and pharmaceutical manufacturers.

Table 1 outlines the 10-year impact to each stakeholder. Impacts reflect the change in net costs for each stakeholder. A negative value reflects savings (or reduced costs) to the stakeholder while a positive value reflects additional cost to the stakeholder.

Table 1
Impact to Medicare Part B of IRA MDPNP and PACTA
10-Year Impact on Stakeholder Net Cost ($B)

Scenario	Provider	Patient	Gov't	Mfr
Impact of MDPNP	$56.3	-$93.3	-$68.1	$105.1
Impact of PACTA	-$55.6	$0.0	-$3.3	$58.9
Combined Impact	$0.6	-$93.3	-$71.3	$164.0

Under the IRA as written, provider reimbursement for Part B drugs will change from being tied to Average Sales Price (ASP) to being tied to what the act refers to as "Maximum Fair Prices" (MFPs) for selected drugs. This change is estimated to decrease provider reimbursement (or increase provider costs) by $56.3B over 10 years. PACTA would essentially be a technical fix to increase provider reimbursement back to pre-IRA levels, funded by rebate payments from manufacturers. The net impact of PACTA to providers is a cost increase (i.e., reduced reimbursement) of $0.6B over 10 years, driven by changes in the portion of costs subject to sequestration.

Changes to provider reimbursement vary significantly by provider specialty, given only certain drugs are subject to MFPs under the IRA. Table 2 outlines the IRA impact to provider reimbursement over the 10-year modeling period by provider specialty, absent any behavioral changes.

Table 2
Impact to Medicare Part B of IRA MDPNP and PACTA
Provider Net Cost Impact by Specialty ($M)

Specialty	10-Year Impact
Oncology	$26,927
Neurology / Psychiatry	$17,741
Rheumatology	$2,813
Allergy / Immunology	$2,694
Gastrointestinal	$2,690
Other	$1,815
Urology	$1,399
Ophthalmology	$184
Total	**$56,262**

Impacts to each specialty group are highly sensitive to the specific drugs chosen for negotiation. Please note, the list of drugs selected for negotiation in each year is difficult to predict, particularly in later years.

PACTA contains the following key provisions:[1]

- Reverts provider reimbursement to pre-IRA levels (i.e., ASP+6%) by converting negotiated MFP discounts to a retrospective government subsidy rather than a point-of-sale discount, which would reduce provider reimbursement to MFP+6%
- Holds patient cost sharing at a percentage of MFP+6% consistent with the IRA
- Excludes MFP from ASP calculation methodology

Patients are estimated to save up to $93.3B under the IRA, driven by both lower cost sharing and premiums, absent any changes to provider prescribing patterns or patient behavior. Total estimated patient savings does not change under PACTA, because cost sharing and premiums are expected to be the same as under the IRA.

The government is expected to see up to $3.3B in savings under PACTA, due to additional payments being subject to 2% sequestration (assuming current sequestration continues through 2037), plus an additional $68.1B in savings under the IRA due to reduced costs for negotiated drugs.

Manufacturer costs are expected to increase by $105.1B under the IRA attributable to MFP discounts for negotiated drugs. Under PACTA, manufacturer liability is expected to increase by an additional $58.9B to fund the increase to provider reimbursement back to pre-IRA levels.

[1] https://www.congress.gov/bill/118th-congress/house-bill/5391/text

Plan costs are neutral, as we expect changes to benefit costs to be offset by changes in benchmark payments and plan premiums.

Background

PROVIDER REIMBURSEMENT FOR MEDICARE PART B DRUGS

Pre-IRA Structure

Since the Medicare Modernization Act of 2003 (MMA), the Centers for Medicare & Medicaid Services (CMS) has used an average sales price methodology (ASP) for setting reimbursement rates for most medications covered under Medicare Part B. Historically, physician reimbursement for Part B medications includes a percentage-based add-on payment to the physician. The reimbursement rate is published quarterly by CMS in the ASP Drug Pricing Files and the payment limits provided within these files include a 6% add-on payment (which is ultimately reduced to 4.3% as a result of sequestration).[2] The add-on payment was designed to cover handling and administration costs associated with the drug.

The Part B MDPNP Provision of the Inflation Reduction Act (IRA)

Among other provisions, the IRA introduced the MDPNP. The MDPNP authorizes the HHS Secretary to negotiate prices for selected drugs.[3] For selected drugs, the HHS Secretary and the manufacturer will agree to a maximum fair price (MFP). The MFP varies by drug and is determined based on the time the drug has been on the market, current net prices, and CMS's discretion. In 2026, Part D MFPs for the 10 drugs selected by CMS for price negotiation ranged from 38% to 79% below list price.[4] Medications dispensed to Medicare beneficiaries cannot exceed the MFP. The MDPNP applies to Medicare Part D starting in 2026 and Medicare Part B starting in 2028.

As part of the implementation of the MDPNP, physician reimbursement for the selected Part B drugs will change from ASP+6% to MFP+6%[5] (prior to sequestration). We estimate this change will reduce physician reimbursement in the Medicare market by $56.3B. Since final guidance on the manufacturer cost under the IRA is not yet available for Part B drugs, we assume the manufacturer cost will be ASP less MFP, which is most analogous with existing guidance for Part D.

Protecting Patient Access to Cancer and Complex Therapies Act (PACTA)

PACTA was originally introduced by Senator John Barrasso and Congressman Michael Burgess in September 2023 to amend the IRA to keep physician reimbursement ASP-based by creating an additional rebate paid by manufacturers.[6,7] The rebate essentially reimburses the government for the difference between 6% of ASP and 6% of MFP, so that providers can in turn be paid the same revenue as pre-IRA. The proposed legislation sets patient coinsurance to be based on the MFP, consistent with how the IRA is written, such that patients still receive the benefit of the lower price.

Data, Methodology, and Assumptions

We used the Part A and B claims from the Centers for Medicare & Medicaid Services (CMS) Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC) for calendar year 2022, which we then trended to 2028 through 2037 and re-adjudicated claims in each year.

PART B TRENDS AND MFP ASSUMPTIONS

According to the IRA provisions, up to 15 drugs may be selected for negotiation in 2028, and up to 20 drugs in each year thereafter. The selected drugs must be among the top 50 negotiation-eligible drugs based on the highest total Medicare expenditure of a given historical cycle. We projected drug-level trends using a combination of recent ASP trends, industry reports, and Milliman research to identify high-expenditure drugs and assess their eligibility for potential negotiation in each projection year. We estimated MFPs using the ceiling price of the MFP calculation outlined in the IRA. Note, if final negotiated MFPs are lower than our estimated ceiling prices, the impacts to each stakeholder would grow.

OTHER MEDICAL CLAIMS

We trended medical cost and utilization in our analysis using trend assumptions from the 2024 Medicare Trustees report, which was the most recent available at the time of our analysis. The benefit designs assumed for each market segment and year are discussed in more detail below. We projected medical trends at the service level category based on Milliman research.

OTHER ASSUMPTIONS

We used the following assumptions in our analysis:

- **Physician Reimbursement:** We varied reimbursement for Part B selected drugs in each scenario as follows:
  - **Pre-IRA:** ASP+6%
  - **MDPNP:** MFP+6%
  - **PACTA:** ASP+6%
- **Application of coinsurance to Part B selected drugs:** We varied the coinsurance basis for selected drugs in each scenario as follows:
  - **Pre-IRA:** Percentage of ASP+6%
  - **MDPNP:** Percentage of MFP+6%
  - **PACTA:** Percentage of MFP+6%
- **Provider specialty grouping:** We assigned claims to a provider specialty grouping based on the provider taxonomy code listed on the claim. If the taxonomy code was unavailable, we used a clinician-developed mapping of drug (HCPCS code) to provider specialty based on the

[2] https://aspe.hhs.gov/sites/default/files/documents/fb7f647e32d57ce4672320b61a0a1443/aspe-medicare-part-b-drug-pricing.pdf
[3] https://edge.sitecorecloud.io/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2022-Articles/8-17-22_Weathering-the-Reform-Storm.pdf
[4] https://www.cms.gov/files/document/fact-sheet-negotiated-prices-initial-price-applicability-year-2026.pdf
[5] https://www.congress.gov/117/bills/hr5376/BILLS-117hr5376enr.pdf
[6] https://www.congress.gov/bill/118th-congress/house-bill/5391/text
[7] https://www.barrasso.senate.gov/newsroom-news-releases-barrasso-burgess-bill-protects-medicare-part-b-patients/

drug's most common indication and used that specialty for the entire claim. If the taxonomy code was unavailable for non-drug (HCPCS code) claims, we used the most common specialty code from claims on the same date.

Other assumptions are detailed in the full report.

Caveats, Limitations, and Qualifications

This report was developed to help Capitol Counsel on behalf of the ASP Coalition better understand the potential impact to providers, patients, and the government of changing provider reimbursement methodology for Part B drugs selected for negotiation. This information was created solely for Capitol Counsel. Capitol Counsel may share this information with outside entities with Milliman's permission. Milliman does not intend to benefit, and assumes no duty or liability to, other parties who receive this work product. Any other parties should obtain their own professional advice appropriate to their specific needs. Any release of this report should be in its entirety. Milliman does not endorse any public policy or advocacy position on matters discussed in this report.

Note, in preparing our estimates, we relied upon CMS Research Identifiable Files and other publicly available data. We accepted this information without audit, but we reviewed the information for general reasonableness. Our results and conclusions may not be appropriate if this information is not accurate. Actual results will certainly vary for specific health plans and patients due to differences in trends, reimbursement arrangements, formulary, utilization patterns, and rebate arrangements, among other factors.

Note, we did not attempt to evaluate every possible change in stakeholder behavior that could result from these program changes. Results could vary based on how patients and other stakeholders react to the changes if implemented, as well as the payment structure of the new design.

Michelle Robb and Katie Holcomb are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this information is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This report outlines the review and opinions of the authors of this report and not necessarily that of Milliman.

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