MILLIMAN REPORT

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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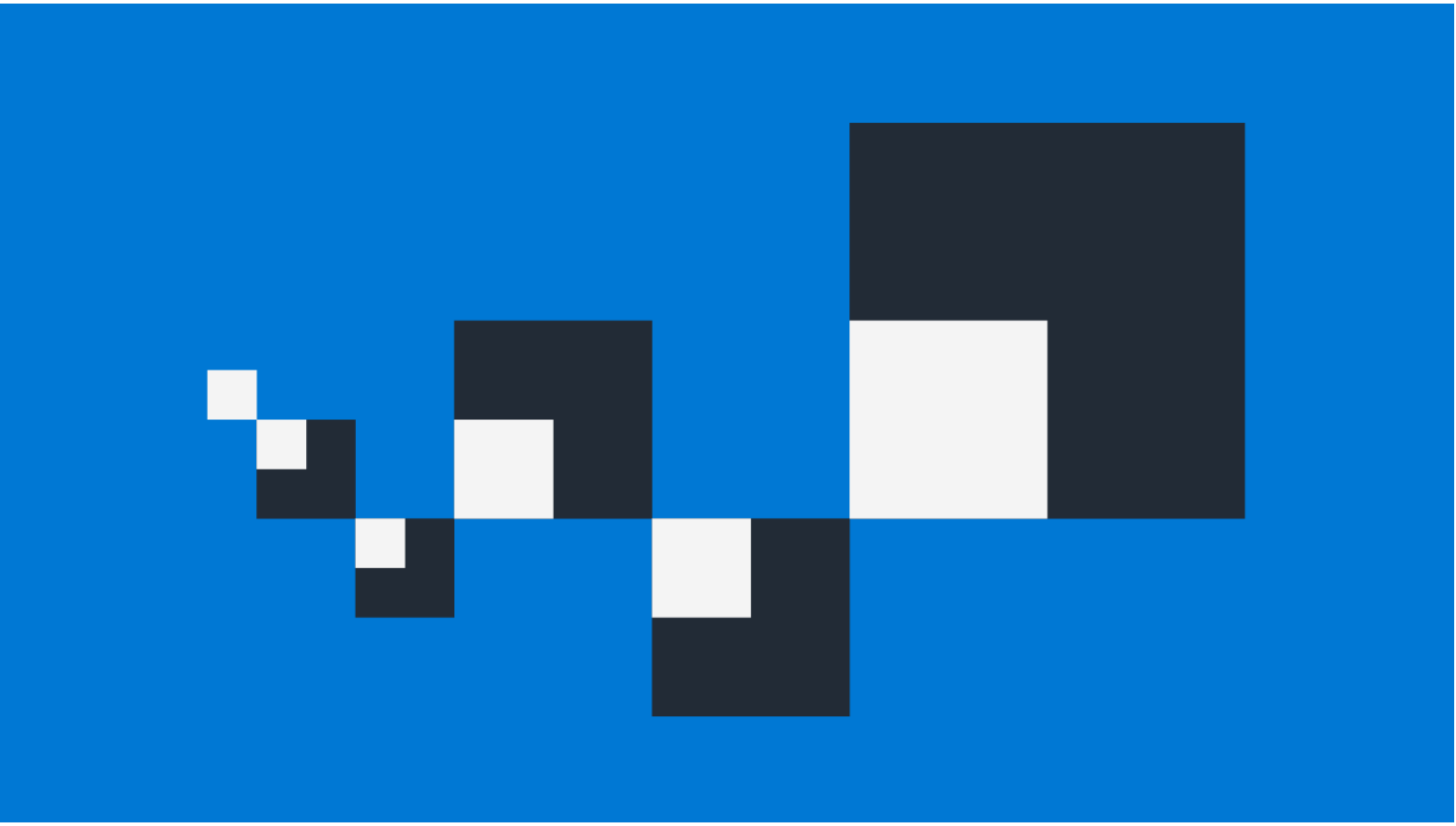

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I. EXECUTIVE SUMMARY

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.

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 under each scenario. 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	Government	Plan	Manufacturer	Total
Impact of MDPNP	$56.3	-$93.3	-$68.1	$0.0	$105.1	$0.0
Impact of PACTA	-$55.6	$0.0	-$3.3	$0.0	$58.9	$0.0
Combined Impact	$0.6	-$93.3	-$71.3	$0.0	$164.0	$0.0

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 below 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
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%

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

- 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.

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

II. BACKGROUND

Capitol Counsel, on behalf of the Part B Access for Seniors and Providers Coalition (ASP Coalition), is exploring a change to provider reimbursement intended to mitigate changes to physician reimbursement for Part B drugs subject to the Medicare Drug Price Negotiation Program (MDPNP). One strategy that has been proposed to achieve this objective is to keep provider reimbursement at ASP+6% for selected drugs through the Protecting Patient Access to Cancer and Complex Therapies Act (PACTA). Capitol Counsel, on behalf of the ASP Coalition, engaged Milliman to estimate the impact of this proposal on five key Part B stakeholders: providers, patients, government, plans, and pharmaceutical manufacturers.

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.

Table 3 below summarizes the key aspects of these payment structures.

Table 3
Key Aspects of Payment Structures for Selected Part B Drugs

Scenario	Provider Reimbursement	Patient Cost Sharing	Manufacturer Cost
Pre-IRA	ASP+6%	% of ASP+6%	N/A
IRA MDPNP	MFP+6%	% of MFP+6%	ASP less MFP
PACTA	ASP+6%	% of MFP+6%	ASP+6% less MFP+6%

[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/

Note, the IRA does not explicitly state whether MFPs will be included or excluded from ASP calculations. For purposes of this analysis, we assumed that Medicare Advantage contracts are tied directly to Medicare fee-for-service (FFS) rates, such that MA reimbursement for selected drugs would be based on MFP. To the extent some MA contracts are instead based on a percentage of ASP, results could differ from our analysis. Further, if MFP impacts ASP, reimbursement is likely to decrease in the commercial market, as many commercial contracts are based on a percentage of ASP. PACTA, on the other hand, includes a provision to exclude MFP discounts from the calculation of ASP.

Cash Flow Illustration

In Figure 1 below, we show the cash flows under each regulation. In this illustrative example, we assume the ASP is $100 and the MFP is $60. The illustration reflects a patient enrolled in FFS. For simplification, we do not reflect the impact of sequestration.

In the pre-IRA example in Figure 1:

- The provider pays $100 to the manufacturer to acquire the drug.
- The provider then receives $106, or ASP+6%, made up of 20% coinsurance from the patient ($21.20) and 80% coinsurance from the government ($84.80).
- The provider receives $6 in margin prior to sequestration (i.e., $106 in reimbursement less the $100 purchase price).
- Ultimately, after sequestration, the $6 provider margin is reduced to $4.30 to reflect $1.70 (2% of $84.80) in sequestration withholding.

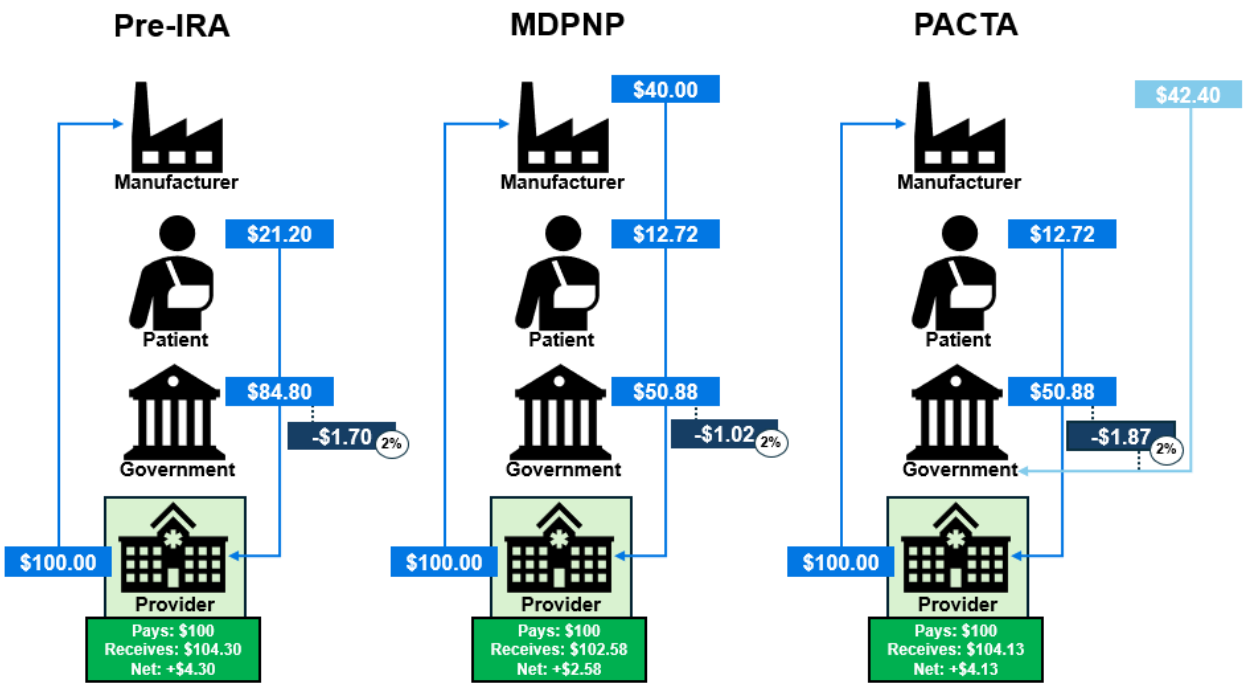
In the MDPNP example:

- The provider pays $100 to the manufacturer to acquire the drug.
- The provider receives $63.60, or MFP+6%, made up of 20% coinsurance from the patient ($12.72) and 80% coinsurance from the government ($50.88).
- The provider then also receives an MFP refund of $40, or ASP minus MFP, from the manufacturer shortly after prescribing the drug.
- The provider receives $3.60 in margin (i.e., $63.60 in reimbursement plus the $40 MFP refund less the $100 purchase price) prior to sequestration – a decrease of $2.40 from the pre-IRA example .
- Ultimately, after sequestration, the $3.60 provider margin is reduced to $2.58 to reflect $1.02 (2% of $50.88) in sequestration withholding.

In the PACTA example:

- The provider pays $100 to the manufacturer to acquire the drug.
- The provider receives $106, or ASP+6%. The patient coinsurance is 20% of MFP+6% ($12.72), and the government pays the remaining balance ($93.28).
- The manufacturer pays a rebate of $42.40 to the government of ASP+6% less MFP+6%. This is equivalent to the $40 MFP discount plus the decrease in physician reimbursement from the IRA example. This allows government costs to remain neutral relative to IRA.
- The provider receives $6 in margin (i.e., $63.60 in reimbursement plus the $42.40 rebate less the $100 purchase price) prior to sequestration – consistent with the pre-IRA example.
- However, after sequestration, the $6 provider margin is ultimately reduced to $4.13, which is slightly lower than the pre-IRA example. This reflects a sequestration withholding of $1.87 (2% of $93.28). Sequestration is higher under PACTA than pre-IRA, since the portion paid by the government at the time of the claim is higher. The government is later reimbursed by the manufacturer via a rebate.

Figure 1: Illustrative Cash Flow Example



MEDICARE BENEFIT STRUCTURE

Medicare Fee For Service (FFS)

Medicare FFS is the traditional Part A and B medical coverage offered through the federal government. Under the FFS benefit, the beneficiary must fulfill a Part B deductible ($257 in 2025), followed by 20% coinsurance on most future Part B costs. The beneficiary does not have a maximum out-of-pocket (MOOP) limit, and therefore, there is no cap to beneficiary spend. There are about 34 million beneficiaries with traditional FFS benefits in 2025, though the majority of these beneficiaries receive supplemental coverage from Medigap, employers, or Medicaid (around 90% of Medicare beneficiaries have some form of supplemental coverage[8]). Note in our modeling, we account for Medigap coverage, but we do not reduce cost sharing for Medicaid or employer coverage, which can vary.

Medigap

Medigap policies, also known as Medicare Supplement, are sold by private companies and provide coverage to supplement beneficiary cost sharing beyond traditional Medicare FFS coverage. About 13 million FFS beneficiaries are enrolled in a Medigap plan in 2025.[9] There are several standard Medigap benefit designs, which generally cover nearly all FFS cost sharing. We average results across all Medigap designs, using current enrollment by plan, for all patients in the analysis.

Medicare Advantage (MA)

MA plans are offered through a Medicare Advantage Organization (MAO) as an alternative to traditional FFS. MA plans currently cover about 40 million enrollees, and are growing each year as a percentage of the Medicare-eligible population. MA Part C provides combined Part A and B coverage, and most plans also include Part D coverage of prescription drugs as well. MA plans typically offer enhanced benefits above and beyond traditional FFS through decreased cost sharing and supplemental benefits not covered under FFS. MA plans are also required to include a MOOP – this limit cannot exceed $9,350 in 2025. While MA plans typically offer several cost sharing reductions relative to the traditional FFS benefit, few plans offer cost sharing reductions on the Part B drug benefit, as it may cause

[8] MedPAC. https://www.medpac.gov/wp-content/uploads/2021/10/July2021_MedPAC_DataBook_Sec3_SEC.pdf
[9] https://www.medpac.gov/wp-content/uploads/2024/07/July2024_MedPAC_DataBook_Sec3_SEC.pdf

anti-selection for the plan. Among plans that do provide reduced Part B drug cost sharing, it typically applies to a small subset of Part B drugs.

SEQUESTRATION

Sequestration refers to "automatic spending cuts that occur through the withdrawal of funding for certain government programs.."[10] For Medicare payments, the current sequestration percentage is generally 2%. For purposes of this analysis, we assume this sequestration level continues through 2037. Sequestration reductions are applied to the portion of the payment paid to providers by Medicare and are determined after accounting for patient cost sharing.[11]

Specific to Part B drugs, under current legislation, sequestration reduces provider reimbursement from 6% to 4.3% based on the following calculation:

$$ASP \times (1+6\%) \times (80\% \times (1 - 2\%) + 20\%) = ASP+4.3\%$$

In this calculation, the 80% refers to the government share of the claim (i.e., the patient pays 20%). Under PACTA, the government share increases, because patients pay 20% of MFP+6% but providers receive the full ASP+6%. As such, the provider reimbursement net of sequestration is reduced below 4.3%, varying depending on the magnitude of MFP discount.

STAKEHOLDER CASH FLOWS

In this analysis, we model changes to each stakeholder's net costs (cash inflows less cash outflows). These cash flows are described in Table 4.

Table 4
Stakeholder Cash Flows

Providers	Cash Inflows	Claim reimbursement (allowed cost) reduced for sequestration
	Cash Outflows	Drug acquisition cost, cost of providing medical service
Patients	Cash Inflows	None
	Cash Outflows	Cost sharing, plan premium, Part B premium (net of any MA plan buydown)
Government	Cash Inflows	Part B premium
	Cash Outflows	Benefit cost (if FFS), benchmark and rebate payments (if MA)
Manufacturer	Cash Inflows	Average sales price paid by providers
	Cash Outflows	Rebates, MFP discount, additional rebate under PACTA scenario
Plans*	Cash Inflows	Plan premium, benchmark and rebate payments (if MA)
	Cash Outflows	Benefit cost (net of rebates)

**Results not shown since inflows and outflows net to zero.*

[10] https://www.cbo.gov/topics/budget/sequestration
[11] https://crsreports.congress.gov/product/pdf/R/R45106

III. ANALYSIS

We used the Part A and B claims data from the Centers for Medicare & Medicaid Services (CMS) Chronic Conditions Warehouse (CCW) Virtual Research Data Center (VRDC) for calendar year 2022. We then trended claims to 2028 through 2037 and re-adjudicated claims in each year. Results reflect our best estimate of selected drugs and MFP ceiling prices in each year. Note, results are highly dependent on which drugs are selected, as well as MFP levels. If final negotiated MFPs are lower than our estimated ceiling prices, the impacts to each stakeholder would grow.

We applied the following benefits[12] to each beneficiary's total Part A and B claims:

- **FFS:** We applied the FFS benefit design, which contains a $1,600 Part A deductible and a $226 Part B deductible, followed by coinsurance (typically 20%) on Part B drugs in 2022. The 2025 Part B premium is $185 per member per month (PMPM). The Part A deductible, Part B deductible, and Part B premium are projected through 2037 using the 2024 Medicare Trustees Report. We assume the government will adjust Part B premiums to align with projected changes in Part B costs under each scenario. We did not model any commercial supplemental coverage for these beneficiaries.

- **Medigap:** We applied each Medigap plan design, weighted using historical enrollment by plan. We adjusted this assumed mix of standardized Medigap plans for those that are no longer sold to new beneficiaries and historical changes in market share. Medigap benefit designs provide full or close to full coverage of FFS Part A and Part B cost sharing. We estimate Medigap beneficiary premium based on our underlying claims experience and assumed average benefit design.

- **Medicare Advantage:** We applied the actual 2025 benefit design for each claim based on associated 2022 plan ID. We applied crosswalks for 2022 plans that were terminated by 2025. For years 2028 through 2037, we trended the beneficiary's deductible and MOOP assuming consistent trends projected by CMS in the 2024 Trustees Report.

  We assumed an MA beneficiary premium of around $18, in addition to the Part B premium of $181 reduced for average Part B givebacks of $4, for a total of approximately $199 PMPM. Each scenario's beneficiary premium is assumed to change in line with the estimated plan liability change relative to the baseline scenario. We assume CMS will adjust the Part B premium and MA payment rates to account for changes in provider reimbursement.

Note, across all markets, some "beneficiary cost sharing" may be covered by employers and, therefore, is not entirely beneficiary out-of-pocket costs. Beneficiary cost sharing has been adjusted to reflect subsidies for dual-eligible beneficiaries.

Table 5 outlines the range of impacts by stakeholder by year of each scenario.

Table 5
Impact to Medicare Part B of IRA MDPNP and PACTA
Impact on Stakeholder Net Cost by Year ($B)

	Year										
Stakeholder	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
Impact of MDPNP											
Provider	$3.0	$3.4	$1.9	$2.8	$5.3	$6.8	$7.8	$8.1	$8.4	$8.8	$56.3
Patient	-$4.8	-$5.5	-$3.8	-$5.0	-$9.1	-$11.4	-$12.8	-$13.2	-$13.6	-$14.2	-$93.3
Government	-$3.8	-$4.3	-$2.5	-$3.9	-$6.4	-$8.0	-$9.2	-$9.6	-$10.0	-$10.5	-$68.1
Plan	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Manufacturer	$5.6	$6.4	$4.4	$6.1	$10.2	$12.6	$14.1	$14.7	$15.2	$15.9	$105.1
Total	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**
Impact of PACTA (Relative to MDPNP)											
Provider	-$2.9	-$3.4	-$1.8	-$2.7	-$5.2	-$6.7	-$7.7	-$8.0	-$8.3	-$8.7	-$55.6
Patient	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Government	-$0.2	-$0.2	-$0.1	-$0.2	-$0.3	-$0.4	-$0.4	-$0.5	-$0.5	-$0.5	-$3.3
Plan	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Manufacturer	$3.1	$3.6	$2.0	$2.9	$5.5	$7.1	$8.2	$8.5	$8.8	$9.2	$58.9
Total	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**

[12] Note, the 2019 Medicare Trustees Report was the latest available data at the time of this analysis.

PROVIDERS

Table 6 outlines the impact on provider costs in each scenario by Medicare market. We include reimbursement for drugs administered in both outpatient and professional settings.

Table 6
Impact to Medicare Part B of IRA MDPNP and PACTA
Impact on Provider Net Cost by Year ($B)

	Year										
Market	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
Impact of MDPNP											
MA	$1.5	$1.8	$0.9	$1.5	$2.8	$3.6	$4.1	$4.3	$4.5	$4.8	$29.8
Medigap	$0.6	$0.7	$0.4	$0.5	$1.0	$1.3	$1.4	$1.5	$1.5	$1.6	$10.4
FFS	$0.9	$1.0	$0.6	$0.8	$1.5	$2.0	$2.2	$2.3	$2.3	$2.4	$16.1
Total	**$3.0**	**$3.4**	**$1.9**	**$2.8**	**$5.3**	**$6.8**	**$7.8**	**$8.1**	**$8.4**	**$8.8**	**$56.3**
Impact of PACTA (Relative to MDPNP)											
MA	-$1.5	-$1.8	-$0.9	-$1.5	-$2.7	-$3.5	-$4.1	-$4.3	-$4.5	-$4.7	-$29.5
Medigap	-$0.6	-$0.7	-$0.4	-$0.5	-$1.0	-$1.3	-$1.4	-$1.5	-$1.5	-$1.5	-$10.3
FFS	-$0.9	-$1.0	-$0.6	-$0.8	-$1.5	-$2.0	-$2.2	-$2.3	-$2.3	-$2.4	-$15.9
Total	**-$2.9**	**-$3.4**	**-$1.8**	**-$2.7**	**-$5.2**	**-$6.7**	**-$7.7**	**-$8.0**	**-$8.3**	**-$8.7**	**-$55.6**

Under the IRA as written, we estimate provider reimbursement will decrease by $56.3B due to reduced reimbursement on selected drugs. Under PACTA, we estimate provider reimbursement will correspondingly increase by $55.6B relative to the IRA Part B MDPNP scenario. The manufacturer rebate paid under PACTA is intended to bring provider reimbursement in line with pre-IRA reimbursement, though it is calculated prior to the impact of sequestration. The impact of sequestration causes providers to not quite be made whole. This is because under PACTA, patients pay a smaller share of costs (tied to MFP), so the government sequesters a greater share of costs, resulting in final net revenue less than the 4.3% of ASP collected today.

340B hospitals, which generally must treat a minimum percentage of low-income Medicare and Medicaid patients,[13] are expected to see significant decreases in provider reimbursement under the IRA. 340B hospitals represent less than half of claims for drugs projected to be selected in our study period, but contribute to more than half of the overall provider reimbursement impact since they have a greater cost increase than non-340B providers.

Results by Provider Specialty

Changes to provider reimbursement vary significantly by provider specialty, given only certain drugs are subject to MFPs under IRA. Table 7 below outlines the IRA impact on provider reimbursement over the ten year modeling period by provider specialty, absent any behavioral changes.

Table 7
Impact to Medicare Part B of IRA MDPNP and PACTA
Provider Net Cost Impact of MDPNP by Year and Specialty ($M)

	Year										
Specialty	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
Oncology	$2,283	$2,519	$930	$1,442	$1,858	$2,812	$3,490	$3,670	$3,860	$4,063	$26,927
Neurology / Psychiatry	$216	$239	$163	$430	$2,226	$2,633	$2,863	$2,925	$2,988	$3,057	$17,741
Rheumatology	$208	$211	$215	$218	$314	$324	$327	$329	$332	$335	$2,813
Allergy / Immunology	$195	$203	$209	$214	$299	$304	$309	$315	$320	$326	$2,694
Gastrointestinal	$3	$196	$227	$275	$288	$301	$320	$339	$360	$382	$2,690
Other	$67	$77	$96	$112	$175	$213	$253	$263	$273	$285	$1,815
Urology	$0	$0	$26	$92	$124	$202	$211	$221	$234	$289	$1,399
Ophthalmology	$0	$0	$0	$0	$0	$33	$35	$36	$38	$40	$184
Total	**$2,972**	**$3,446**	**$1,864**	**$2,783**	**$5,285**	**$6,821**	**$7,808**	**$8,099**	**$8,406**	**$8,777**	**$56,262**

Impacts to each specialty group are highly sensitive to the specific drugs chosen for negotiation. Since many drugs anticipated to be selected for negotiation are oncology drugs, we expect the largest reduction in provider reimbursement to come from oncology providers.

[13] https://www.gao.gov/products/gao-23-106095#:~:text=Fast%20Facts,to%20the%20COVID%2D19%20pandemic

We note, the list of drugs selected for negotiation in each year is very difficult to predict and the margin of error is large, particularly in later years which may be impacted by drugs that are not on the market today.

PATIENTS

Table 8 outlines the impact on patient net cost by Medicare market by year in each scenario. Patient net costs include cost sharing and premium.

Table 8
Impact to Medicare Part B of IRA MDPNP and PACTA
Impact on Patient Net Cost by Year ($B)

	Year										
Market	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
Impact of MDPNP											
MA	-$1.5	-$1.7	-$1.2	-$1.6	-$2.9	-$3.7	-$4.3	-$4.5	-$4.7	-$5.0	-$31.0
Medigap	-$2.2	-$2.5	-$1.7	-$2.2	-$4.0	-$5.0	-$5.6	-$5.7	-$5.9	-$6.0	-$40.9
FFS	-$1.2	-$1.3	-$0.9	-$1.2	-$2.1	-$2.6	-$2.9	-$3.0	-$3.1	-$3.2	-$21.4
Total	**-$4.8**	**-$5.5**	**-$3.8**	**-$5.0**	**-$9.1**	**-$11.4**	**-$12.8**	**-$13.2**	**-$13.6**	**-$14.2**	**-$93.3**
Impact of PACTA (Relative to MDPNP)											
MA	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Medigap	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
FFS	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Total	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**	**$0.0**

Patients are expected to have consistent cost sharing in both reimbursement scenarios. Under both the MDPNP and PACTA scenarios, cost sharing is based on MFP+6% (compared to ASP+6% pre-IRA).

Patient impacts vary by market segment. Patients are impacted in the following way for each segment under the IRA Part B MDPNP scenario:

- **FFS:** The patient is responsible for a Part B deductible, followed by 20% coinsurance on Part B drugs. Under both the MDPNP and PACTA, patients will pay less in cost sharing since they will pay 20% of a lower drug cost (MFP) compared to the historical cost (ASP). Note, a majority of this reduction may be absorbed by supplemental coverage for patients enrolled in Medicaid or employer coverage. The shift to lower cost drugs resulting from the MDPNP will reduce overall Part B claim spending, which results in lower Part B premiums for patients as well. We assumed Part B premiums are approximately 2.14% of Part B costs based on historical trends.

- **Medigap:** Because Medigap plans already buy down Part B drug costs to $0 or close to $0 for patients, patients are assumed to have a minimal reduction in cost sharing. However, patients are expected to have premium savings under IRA because the Medigap premium is impacted by the estimated reduction in the plan's liability as drug prices decrease.

- **Medicare Advantage:** The patient is responsible for 20% coinsurance on Part B medications until reaching their plan's MOOP, at which point they are responsible for no cost. Similar to FFS beneficiaries, some of these patients will see reduced cost sharing due to coinsurance based off the MFP, though changes for many patients will be dampened as they will continue to reach the MOOP. We assumed any plan liability savings would be reflected through reduced payment rates from the government to MAOs and also reduced MA premiums.

Under the PACTA scenario, patients maintain the same cost sharing and premiums as under the IRA Part B MDPNP scenario.

GOVERNMENT

Table 9 outlines the impact on government net costs by Medicare market by year in each scenario. Government net costs include changes to FFS costs, Part B premiums, Medicare Advantage benchmark payments, and sequestration.

Table 9
Impact to Medicare Part B of IRA MDPNP and PACTA
Impact on Government Net Cost by Year ($B)

	Year										
Market	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
Impact of MDPNP											
MA	-$2.7	-$3.1	-$1.7	-$2.8	-$4.5	-$5.7	-$6.6	-$6.9	-$7.2	-$7.6	-$48.8
Medigap	$0.5	$0.5	$0.4	$0.5	$0.9	$1.1	$1.2	$1.2	$1.3	$1.3	$8.9
FFS	-$1.5	-$1.7	-$1.2	-$1.5	-$2.8	-$3.5	-$3.8	-$3.9	-$4.0	-$4.2	-$28.1
Total	**-$3.8**	**-$4.3**	**-$2.5**	**-$3.9**	**-$6.4**	**-$8.0**	**-$9.2**	**-$9.6**	**-$10.0**	**-$10.5**	**-$68.1**
Impact of PACTA (Relative to MDPNP)											
MA	$0.2	$0.2	$0.1	$0.1	$0.2	$0.3	$0.4	$0.4	$0.4	$0.5	$2.7
Medigap	-$0.1	-$0.1	-$0.1	-$0.1	-$0.1	-$0.1	-$0.2	-$0.2	-$0.2	-$0.2	-$1.2
FFS	$0.1	$0.1	$0.1	$0.1	$0.1	$0.2	$0.2	$0.2	$0.3	$0.3	$1.8
Total	**$0.2**	**$0.3**	**$0.1**	**$0.2**	**$0.2**	**$0.4**	**$0.5**	**$0.5**	**$0.5**	**$0.5**	**$3.3**

The government is impacted in the following way for each segment under the IRA Part B MDPNP scenario:

- **FFS:** The government is responsible for 80% of drug costs after the deductible is met. In the IRA Part B MDPNP scenario, the government is responsible for less cost since the drug cost is reduced to MFP+6% (compared to ASP+6%).
- **Medigap:** The government impact is similar for Medigap as for FFS, as the Medigap plan covers FFS cost sharing, and government claim payments are the same as for FFS.
- **Medicare Advantage:** The government does not pay any portion of MA claim costs but instead pays a subsidy to the plan that is estimated to cover the FFS costs for the enrolled population. We assume the benchmark rate paid to the plan decreases to reflect the reduced medication costs.

Under the PACTA scenario, we expect $3.3B in savings relative to the IRA Part B MDPNP scenario due to increased sequestration. As noted above, this is because a greater percentage of claims are subject to sequestration, as beneficiary cost sharing, which is not sequestered, decreases relative to pre-IRA.

Manufacturers

Table 10 outlines the impact on manufacturer net costs by Medicare market by year in each scenario. The impact to manufacturers is made up of MFP discounts and the additional rebate under PACTA.

Table 10
Impact to Medicare Part B of IRA MDPNP and PACTA
Impact on Manufacturer Net Cost by Year ($B)

	Year										
Market	**2028**	**2029**	**2030**	**2031**	**2032**	**2033**	**2034**	**2035**	**2036**	**2037**	**Total**
Impact of MDPNP											
MA	$2.7	$3.1	$2.0	$2.9	$4.6	$5.8	$6.7	$7.0	$7.4	$7.8	$50.0
Medigap	$1.2	$1.3	$1.0	$1.2	$2.2	$2.6	$2.9	$3.0	$3.1	$3.2	$21.6
FFS	$1.8	$2.0	$1.5	$1.9	$3.4	$4.1	$4.5	$4.6	$4.8	$4.9	$33.5
Total	**$5.6**	**$6.4**	**$4.4**	**$6.1**	**$10.2**	**$12.6**	**$14.1**	**$14.7**	**$15.2**	**$15.9**	**$105.1**
Impact of PACTA (Relative to MDPNP)											
MA	$1.6	$1.8	$1.0	$1.6	$2.9	$3.7	$4.3	$4.5	$4.7	$5.0	$31.1
Medigap	$0.6	$0.7	$0.4	$0.5	$1.0	$1.3	$1.5	$1.6	$1.6	$1.6	$10.9
FFS	$0.9	$1.1	$0.6	$0.8	$1.6	$2.1	$2.3	$2.4	$2.5	$2.5	$16.9
Total	**$3.1**	**$3.6**	**$2.0**	**$2.9**	**$5.5**	**$7.1**	**$8.2**	**$8.5**	**$8.8**	**$9.2**	**$58.9**

Under the IRA, we expect manufacturer liability to increase to reflect the MFP discount for negotiated drugs. Under PACTA, we estimate manufacturer costs will increase by an additional $58.9B due to additional rebate payments meant to increase provider reimbursement to pre-IRA levels.

Discussion

We did not model any behavioral changes that any stakeholders may have as a result of changes to provider reimbursement resulting from the MDPNP or PACTA. These reactions are difficult to predict and may materially impact results. Examples may include changes in manufacturer pricing strategy or provider behavior.

We did not model any explicit impact to account for cash flow timing, though we note there is likely some interest rate impact or potential cash flow strain under both the MDPNP and PACTA scenarios. There is likely some impact to CMS under PACTA as manufacturers have until six months following the end of the calendar quarter of the claim to furnish the rebate to CMS.

Additionally, we assume CMS will prospectively adjust benchmark payments to Medicare Advantage plans to reflect the reduction in costs due to the MDPNP. If CMS were to not adjust payments, there would be a period of time when plans would be effectively overpaid for Part B costs until the point at which MFPs are reflected in the historical experience used to set benchmark payments. In the past, CMS has prospectively adjusted benchmark payments when material cost savings were expected to occur, such as the permissibility of ESRD beneficiaries to enroll in Medicare Advantage in 2021.[14]

As of the 2026 Medicare Rate Announcement, CMS has incorporated negotiated prices into the Part D (RxHCC) risk adjustment model. We expect CMS would similarly incorporate negotiated prices into the Part C (CMS-HCC) risk adjustment model beginning in 2028. Making this change to the risk adjustment models better aligns risk-adjusted payments to plans with their expected costs.

[14] https://www.cbo.gov/budget-options/60900

IV. 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 selected drugs in each scenario as follows:
  - **Pre-IRA:** We assumed provider reimbursement to be ASP+6%.
  - **MDPNP:** We assumed provider reimbursement to be MFP+6%.
  - **PACTA:** We assumed provider reimbursement to be 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:** We assumed coinsurance to be a percentage of ASP+6%.
  - **MDPNP:** We assumed coinsurance to be a percentage of MFP+6%.
  - **PACTA:** We assumed coinsurance to be a percentage of MFP+6%.

  We took the minimum of the assumed coinsurance (generally 20%) and the plan specific coinsurance (i.e., if the Medigap coinsurance was lower than the assumed coinsurance, we used the Medigap coinsurance for Medigap patient spend).
- **Premiums / Government Payments:** We assume the following by Medicare segment:
  - **Part B Premium:** We used the expected Part B premiums through 2033 from the 2024 Medicare Trustees Report. We assumed later years would trend at the same rate as 2031 through 2033 Part B premiums. Under the IRA and PACTA scenarios, we assumed Part B premiums would maintain the same percentage of Part B costs as seen historically (approximately 25.7%). Note, this premium applies to all beneficiaries.
  - **Medigap:** We assumed Medigap plan premiums will reflect the change in plan liability resulting from provider reimbursement in each scenario.
  - **Medicare Advantage:** We estimated the average MA premium for each projection year using 2025 and historical public premium information. We included an average Part B buy-down offered by some MA plans as an offset to MA premium.
  - **Government Payments:** We assumed the government MA payment rates to MA plans will be adjusted accordingly to account for changes in provider reimbursement through a program adjustment.

- **Benefit design:**
  - **FFS**: We applied the average FFS cost sharing with parameters trended as in the 2024 Medicare Trustees report. We assumed no cost sharing for home health and hospice services and 20% coinsurance on all remaining Part B services.
  - **Medigap:** There are a variety of standardized Medigap plans, with each plan type covering different aspects of the standard FFS cost sharing. We used historical enrollment data from Kaiser Family Foundation,[15] to develop average cost sharing for Medigap beneficiaries. We used all FFS claims as the experience basis for Medigap projections, since we are unable to tell which FFS beneficiaries are also enrolled in Medigap.
  - **Medicare Advantage:** We analyzed publicly available plan designs for 2025 by service category. We applied actual 2025 benefit designs to the 2022 claims (using crosswalks where needed), then trended deductibles and maximum out-of-pocket (MOOP) trends from the 2024 Medicare Trustees report.
    - We assumed no trend in flat copays as these copays do not generally increase steadily from year to year.
    - The prescription drug portion of the benefit (i.e., Part D) was not analyzed as the impact studied is limited to the Part B benefit.

  Note, across all markets, some "beneficiary cost sharing" may be covered by employers and, therefore, is not entirely beneficiary out-of-pocket costs. Beneficiary cost sharing has been adjusted to reflect subsidies for dual-eligible beneficiaries.

- **Manufacturer Rebates:** We assume manufacturer rebates for Part B drugs are used to help lower premiums for MA plans. Manufacturer rebate amounts are considered highly confidential, and there is little public information available regarding the magnitude of Part B rebates. Because manufacturer rebates for Part B drugs are typically concentrated among just a few specific types of products, we assume Part B drugs selected for negotiation are not eligible for rebates.

- **Enrollment:** We used the total Medicare enrollment projections and MA enrollment projections from the 2024 Medicare Trustees report. We assumed beneficiaries have 12 months of Medicare enrollment. We determined the portion of Medigap beneficiaries using the historical distribution and trend information from Kaiser Family Foundation.

- **No change to administrative charges or profits:** We assumed a flat dollar amount for administrative fees and profit, such that plan sponsor net revenue would not change as a result of IRA or PACTA.

- **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 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.

- **340B hospitals:** We used a combination of Medicare IDs and National Provider Identifier (NPI) numbers to identify hospitals participating in the 340B program. In order to be flagged as a 340B hospital, a hospital had to participate in the 340B program on calendar year 2022.
  - For drugs administered at 340B hospitals, we assumed an acquisition discount of 35% − the midpoint of a reported average discount range of 20% to 50%.[16]

[15] https://www.kff.org/medicare/issue-brief/key-facts-about-medigap-enrollment-and-premiums-for-medicare-beneficiaries/
[16] https://healthpolicy.usc.edu/research/the-340b-drug-pricing-program-background-ongoing-challenges-and-recent-developments/

V. 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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