Insight

Medicare Part D: Understanding the 2024 Projected Financing

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Executive Summary

- Last week, the Medicare trustees released their 2024 report, which projected unexpected long-term reductions in drug spending for Medicare Part D, mostly as a result of the Inflation Reduction Act's (IRA) Medicare direct negotiations.
- Specifically, the trustees project that Medicare Part D will see a reduction in point-of-sale drug costs by 7 percent, aggregate drug prices by 19 percent, and plan benefits by 7 percent from 2024 to 2033.
- Policymakers should understand that the trustees' projections may be based on overly generous assumptions about the IRA's drug negotiation provisions – which are not yet in effect – that likely overstate Part D savings and may not reflect their negative impact of increasing seniors' premiums and out-of-pocket costs.

Introduction

Last week, the Medicare trustees released their 2024 report, which projected unexpected long-term reductions in drug spend for Medicare Part D.[i] The trustees assume that the Inflation Reduction Act (IRA) – through Medicare direct negotiations and inflationary rebates – will slow drug spending trends and reduce the overall cost of drugs. Of note, for 2023, Medicare Part D had a -2.6 percent change in total spending from 2022, with the program receiving $128.4 billion in funds and spending $130.5 billion in beneficiary payments.[ii] The trustees cite that one of the key factors for this deficit was an unexpected increase in drug net spending (the price after rebates).

The trustees project that Medicare Part D will see a reduction in point-of-sale drug costs by 7 percent, aggregate drug prices by 19 percent, and plan benefits by 7 percent from 2024 to 2033. Nevertheless, the trustee's projections about the impact of the IRA's drug price negotiation provisions are likely based on overly generous assumptions about the true impact of the law. It is more likely that the implementation of the IRA will increase the list price of new drugs.[iii] While the trustees predict that the aggregate net price of non-negotiated drugs will also decline, it is not yet known whether these manufacturers will match their competitors' maximum fair price to maintain or gain preferred formulary status. These two drug trend assumptions used by the trustees to calculate future savings to the Medicare Part D program are highly tenuous. What's more, policymakers should understand that the trustees' projections may not reflect the IRA's negative impact of increasing seniors' premiums and out-of-pocket costs in terms of Part D plan participation decisions.

Exploring the Trustees' Part D Projections

The trustees acknowledge that Part D benefit payments have "experienced an erratic growth pattern through the history of the program." The trustees highlight that drug costs have increased more than other categories of medical spending for two main reasons: 1) a "substantial increase in the proportion of prescriptions filled with

low-cost generic drugs that has helped constrain cost growth" and 2) a general increase in prescriptions for (and the prices of) specialty medications. The trustees also claim that direct and indirect remuneration (DIR) – which is best understood as post-sale rebates from both drug manufactures and pharmacies negotiated by a pharmacy benefit manager that are returned to Medicare Prescription Drug Plans (PDPs) and Medicare Advantage Prescription Drug Plans (MA-PDs) – slowed Part D spending growth and will be reduced over-time through recent regulatory changes and as more drugs are included in the Medicare direct negotiations.[iv]

For a deeper dive into DIR drug pricing provisions, see the American Action Forum's PRIMER: Prescription Drug Prices: Discounts, Fees, and Effects on Part D.

The trustees projected lower Part D expenditures under the assumption that the IRA's various drug pricing reforms (including Medicare direct negotiation, inflationary rebates in Medicare Parts B and D, and the broad redesign of the standard Part D benefit) will lower drug price growth through price direct negotiation and inflation rebates with more savings generated as additional drugs are negotiated. Of note, the trustees estimate that overall DIR will decrease by 46 percent following IRA implementation. Their other assumptions rely heavily on non-selected drugs' list or net prices decreasing in a meaningful way. If not, a decrease in DIR– with an increase in net drug spending *outside* of the selected drugs – would increase premium costs for seniors. Yet the trustees may be overstating the impact of the IRA in assuming that it will reduce overall net drug spending to such a degree.

Moreover, the trustees appear to ignore potential PDP and MA-PD incentives to reduce plan financial liability during the catastrophic phase for beneficiaries as a result of the IRA's Part D reforms, which could direct patients to take drugs with higher list or net prices depending on the rebate projected back to the plan. Moreover, PDPs and MA-PDs have limited mechanisms to limit costs as premiums are capped with a 6 percent increase until 2029. It is likely that plans will encourage beneficiaries to take drugs that have higher rebates if they save the PDP or MA-PD more money especially for classes *outside* negotiation and limited specialty drug formularies. In short, this will increase out-of-pocket costs for seniors, as they are more likely to pay for a drug based on the list price and not the net price.

The trustees believe that IRA implementation will meaningfully change drug manufacturer behavior to reduce the cost of drugs – either list or net – to generate meaningful savings for seniors or the federal government. Yet the IRA has created incentives for drug manufacturers to increase the launch price of a new drug to avoid future inflationary rebates. Thus, Part D plan spending for specialty medications will likely increase alongside an increase in generic dispensing, even as they tighten formularies to manage cost growth.

Conclusion

The trustees' projections on Medicare Part D spending rely heavily on the long-term successful implementation of the IRA. These projections assume that additional drugs that are negotiated will slowly reduce aggregate drug pricing and new drugs are likely be launched at higher and higher list prices to avoid the future inflationary penalties set in the IRA. The IRA transformed the Part D benefit, creating new PDP and MA-PD incentives that may not be fully accounted for in the actuarial analysis. Policymakers should consider if the trustees' assumptions on the IRA may reinforce erroneous policy beliefs and ignore potentially costly financial inducements that the regulatory overreach of the IRA may foster in the long-term.

[i] Medicare Part D cannot become insolvent given that U.S. Department of Treasury has the authority to transfer amounts to the Part D account on an as-needed basis as general revenue is available.

[ii] Dual-eligible beneficiaries receive a disproportionate amount of spending. MACPAC reported in January 2024 for 2019 data on 12.2 million dual-eligible Medicare beneficiaries that they account for 34 percent of spending and 19 percent of enrollees. In Medicaid, they account 30 percent of spending and 14 percent of enrollees. In 2019, combined Medicare and Medicaid spending on dual-eligible beneficiaries totaled $440.2 billion of which Medicaid accounted for $164.3 billion (37 percent)."

[iii] In February 2024, the Tax Foundation highlighted that "Now, based on the Congressional Budget Office (CBO) latest estimates, the IRA credits appear to cost approximately $786 billion over the new budget window (2024-2033), indicating the IRA legislation in total increases deficits by about $300 billion from 2024 to 2033, or $562 billion excluding the effects of IRS enforcement. Note this is a rough estimate, as it mixes two CBO baselines, but it shows the need for the CBO and the Joint Committee on Taxation to provide transparency and a new estimate of the IRA's budgetary impact."

[iv] The trustees highlight that Medicare Part D plans have increased their projected DIR even though actual DIR was lower during plan years 2018–2022. Pharmacy rebates that are collected after point-of-sale, commonly known as retrospective rebates or negative DIR, appeared to have increased from 2010–2022, with the Centers for Medicare and Medicaid Services (CMS) stating that "retroactive DIR fees increased by a staggering 107,400 percent." Retroactive DIR fees can be hard for a pharmacy to manage as they are paying back rebates to the Medicare PDP or MA-PD plan months after the prescription was filled. DIR rebate negotiations between a pharmacy benefit manager (PBM) and pharmacy are typically reflective of value-based contracting, meaning that amounts paid to the pharmacy, or amounts returned to the PBM from the pharmacy, are based on overall pharmacy performance. To mitigate the risk of negative retroactive DIR fees, CMS issued a final rule that prohibited retroactive DIR fees for plan year 2024. Instead, the negotiated price is based on the "lowest possible reimbursement" the pharmacy could receive from the Part D plan. One study projected that "two-thirds of beneficiaries would experience minimal change or a net increase (premium increases outweigh cost sharing savings) to their overall costs. The final rule did not change the way in which manufacturer rebates are calculated."