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Part D In 2024: Premium Increases, Shrinking Choices Signal Early Impact Of IRA Redesign

by Cathy Kelly

More impactful benefit changes coming in 2025; will destabilization among standalone plans follow?

The redesign of the Medicare Part D benefit established by the Inflation Reduction Act will not be fully implemented until 2025. But preliminary changes that went into effect 1 January already appear to be disrupting the market, driving unusually high premium increases and causing standalone plan options to decline to a historic low.

Premiums for the 2024 standalone plans rose an average of 21% compared to the year before, according to a recent analysis by the Kaiser Family Foundation. For the three leading plan sponsors, *Cigna Corp.*, *Humana Inc.* and *Aetna Inc.*, premiums have gone up between 33% and 57%.

A total of 709 standalone plans are being offered by 11 sponsors, representing the lowest number of independent plans and sponsors in the program since it began in 2006. The average Part D beneficiary will have 21 standalone plans vs. 36 MA-PDs to choose from in 2024, the analysis found.

The premium increase is driven by higher expected plan costs in 2024, resulting at least in part from a new cap on enrollees' out-of-pocket spending above the catastrophic threshold that eliminates the 5% coinsurance previously required.

Premium hikes were implemented by the major plans despite a provision in the IRA that attempted to head off such a response, which caps annual premium increases at 6%. However, the cap applies to growth in the Part D base beneficiary premium and not to individual plan premiums that enrollees pay, which has allowed increases that exceed 6%.

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The decrease in the number of standalone plans available likely reflects decisions by sponsors to discontinue plans that would not meet profit goals. At the same time, premiums remained stable in Medicare Advantage plans with a drug benefit in 2024 because MA-PD sponsors can use rebate dollars from Medicare payments to lower or eliminate Part D premiums in a way that is not available to PDPs.

The accelerating disparity between premiums in PDPs and MA-PDs is expected to contribute to a continuation of beneficiary migration from standalone plans to MA-PDs. (Also see "*Medicare Part D Comes Of Age: Most Beneficiaries Now In Fully Integrated Plans*" - Pink Sheet, 9 Feb, 2022.)

Since 2020, the number of PDPs available to the average beneficiary has decreased by 25% while the number of MA-PDs has increased by 57%, according to the Kaiser Family Foundation.

Some analysts are pointing to the shifts in the market as evidence the IRA redesign will destabilize the Part D market in ways that hurt beneficiaries. "There are a lot of plans that are finding it's not going to be profitable for them to do this," former Trump Administration advisor Joe Grogan told the *Pink Sheet*.

"Certain plans are increasing premiums of various designs by double-digits. And there are going to be issues for seniors on a fixed budget in an inflationary environment" that will influence "how much uptake [those plans] have. ... Some of them may drop the independent Part D coverage."

Grogan is "increasingly confident, the more payers I talk to, the more plans I talk to, and the more economists that really understand this, that the destabilization that was warned when [the IRA] it was passed is actually coming to fruition and there are a host of unintended consequences."

He believes that legislation to address some of those consequences could attract bipartisan support in Congress. (Also see "*Biopharma's Prospects Under A Second Trump Term: They Can't Get Much Worse*" - Pink Sheet, 3 Jan, 2024.) Grogan was previously director of the Domestic Policy Council in the White House and is now a principal in the Fire Arrow health care consulting firm.

> ***"If you think you've seen a shift from PDPs to Medicare Advantage, you ain't seen nothing yet. It's going to ramp up dramatically, especially with premium increases like this." – Drug Channels***

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Institute president Adam Fein

Drug Channels Institute president Adam Fein suggested the IRA redesign will lead to "the collapse of the standalone PDP market" during his "Outlook for 2024" webinar 15 December 2023.

"It's really going to hit in 2025" but "we're already seeing it in 2024," he observed. "If you think you've seen a shift from PDPs to Medicare Advantage, you ain't seen nothing yet. It's going to ramp up dramatically, especially with premium increases like this."

Vanderbilt health policy and cancer research professor Stacie Dusetzina, who is also a member of the Medicare Payment Advisory Commission, agreed that the changes in the market are concerning.

"I think there is a really important question here in looking at the data from the Kaiser Family Foundation that the number of choices that people have available in the standalone plans has dropped pretty substantially," she told the *Pink Sheet*. "We need to really carefully consider if we have enough competition or if there should be more competition introduced into the standalone market."

Maybe we should "think about revisiting a public option" in the marketplace, she suggested. Dusetzina noted that some stakeholders pushed for including of a provision in the Medicare Modernization Act allowing for a government-funded plan option in the Part D market to ensure robust competition. The policy was strongly opposed by pharma because it could encourage price controls. In the end, it was not included in the final version of the bill establishing the program.

She also pointed out the affordability challenges facing standalone Part D plans is part of an "overarching" issue related to Medicare Advantage, which can be much more affordable than traditional Medicare for beneficiaries (but require higher levels of government spending). "This has been going on for many years and it's now kind of reaching a point where we're really seeing those differences in premiums magnified when you compare … a standalone Part D plan and a Medicare Advantage Part D plan," she observed.

The Standalone Market 'Can't Go Away'

Nevertheless, "the standalone market can't really go away. It's the only option for you if you are in traditional Medicare and about half of people in Medicare pick traditional Medicare today," Dusetzina continued. "So that market needs to stay competitive and it needs to have good plan

options. ... We want people to have a real choice."

Manufacturers of Part B drugs might also be concerned about a wholesale shift to Medicare Advantage because those plans are able to apply utilization management tools such as prior authorization and step therapy for physician administered treatments and such tools are generally not used for such products in traditional Medicare, she noted. Part D coverage is more consistent between standalone and MA-PD plans.

Elimination of the 5% coinsurance requirement this year could encourage in a higher volume of scripts filled (and a boost in costs) because it effectively limits seniors' out-of-pocket spending at $3,333, which is the threshold for entering the catastrophic phase of the benefit in 2024, Dusetzina noted. The change also diminishes price sensitivity "because after people hit the cap, it doesn't matter if your drug is priced at $50,000 a year or $200,000 a year," she pointed out.

In most drug categories, pharmacy benefit managers will still be able to lower plan costs by pitting competing drugs against each other, including by threatening exclusion from formularies. (Also see "*Medicare Part D Redesign Could Expand Rebate-Driven Formulary Exclusions In Program*" - Pink Sheet, 26 Jan, 2023.)

But cancer drugs in particular present different challenges because they can be very high priced and must be covered as a Part D protected class. (Also see "*Medicare Part D Redesign Will Sharpen Policy Focus On Protected Classes*" - Pink Sheet, 13 Jun, 2023.)

"That's a really sticky problem because we have mandatory coverage and [seniors] are going to hit that [out-of-pocket] cap as soon as they bill their first drug of the year," Dusetzina said. "So, the lack of price sensitivity after that point is better for patients but also pretty concerning for spending."

The effect is likely to become more pronounced in 2025 and beyond, when out-of-pocket spending will be limited to $2,000 a year. But this year will be a test case of sorts, Dusetzina predicted. "When you further improve the benefit, I think there is a real question of how much more spending there will be. Plans would have seen how much behavioral response they get so this year, how many more people filled expensive drugs that they weren't filling before. So they'll have a better sense of that" for 2025.

Still, Dusetzina emphasized the importance of considering the premium increases "in the context of what that means for the average beneficiary."

The average increase in the KFF analysis is "fairly sizeable" for some seniors, she acknowledged. But "it's really hard to overstate" how important the cost sharing reductions in the redesign are for people with high-cost treatment needs, she maintained. "So if you have cancer you are

literally going from paying like $10,000 to under $3,500 this year and $2,000 next year so that … It's still a dramatic improvement in your financial protections for not that much money."