

Health care policy should get us closer to health equity. The Inflation Reduction Act fails to do so.

The Inflation Reduction Act (IRA) took important steps to lower costs for some patients by capping annual out-of-pocket costs and allowing beneficiaries to spread their costs over the course of the year in Medicare Part D.¹ Unfortunately, the IRA's price setting policies do more harm than good for many patients. In particular, the negative impacts are most likely to be felt by underserved communities, who disproportionately bear the burden of many illnesses.^{2,3,4}

This is a system-level miss by Congress that further cements health inequities in the United States. Here's how:

The IRA discourages research and development (R&D) for diseases that disproportionately impact historically underserved communities. The Black community is twice as likely to die from diabetes and more likely to die from certain cancers, as compared to white people.⁵ Some Latino communities are more likely to develop dementia as compared to white peers.⁶ Future treatments and cures have the potential to drastically reduce disparities in these diseases and others, yet research already shows a reduction in R&D for disease areas that disproportionately impact historically underserved populations.^{7,8}

IRA's impact on the medicine pipeline:

78%

of companies expect to **cancel early-stage pipeline projects**

82%

with pipeline projects in cardiovascular, mental health, neurology, infectious disease, cancers and rare diseases expect **"substantial impacts" on R&D decisions**

95%

said they expect to **develop fewer new uses for medicines**

*2022 survey of PhRMA member companies⁹

Congress should make it a priority to advance health equity.

Learn more at <https://phrma.org/en/Inflation-Reduction-Act> and <https://phrma.org/equity>

The IRA created a "pill penalty" that hinders improvements to medicine adherence. Improving medicine adherence is a key driver of improving health outcomes and reducing health care costs.^{10,11,12,13} Patients who get their prescription in pill or tablet form through the mail or local pharmacy can take the medicine at home, which can reduce such barriers to medicine like travel time to a physician's office or hospital. Delivery of medicines through the mail can also be an adherence game changer for patients living in pharmacy deserts or for caregivers trying to keep up with their loved ones' treatment plans.

Egregiously, the law targets medicines that come in pill or tablet form by subjecting them to earlier price setting than other types of medicines, which can discourage companies from researching and developing them at all. **Congress did not consider this blow to health equity when writing the "pill penalty" into the IRA.**

Underserved communities are less likely to adhere to their medicines due to factors like:

- **Pharmacy deserts in their communities**¹⁴
- **Disproportionate impact of insurance design schemes**¹⁵
- **Caregiver costs and lost wages**¹⁶

The IRA failed to address the root causes of health disparities, including social determinants of health.

It also let insurers and their pharmacy benefit managers off the hook, allowing them to pocket tens of billions in drug manufacturer rebates and discounts that should be going to patients at the pharmacy counter.

Worse, the IRA **exacerbates system-level barriers to health equity.** Its arbitrary barriers hinder researchers' ability to find new treatments and cures for diseases that disproportionately impact communities of color – innovations that can make it easier for patients to take their prescribed medicines and improve health outcomes.

Endnotes

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