The Daily Dish

Drugs and the IRA – Perverse Outcomes Update

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I was feeling a little upbeat, so I thought I'd fix that by revisiting the drug provisions of the Inflation Reduction Act (IRA). Recall that the misbegotten "negotiation" process begins with the selection of the first 10 drugs, which are to be selected from the 50 with the greatest Medicare Part D spending by September 1 of this year. "Negotiations" proceed from October 2023 to August 2024, the "maximum fair price" (MFP) is published in September 2024, and the price goes into effect January 1, 2026.

So I dialed up the Centers for Medicare and Medicaid Services' (CMS) Part D Drug Dashboard and took a look. For 2021, the top 10 for Part D spending were:

Drug	2021 Part D Spending ($B)
Eliquis	$12.6
Revlimid	$5.9
Xarelto	$5.2
Trulicity	$4.7
Januvia	$4.1
Jardiance	$3.7
Imbruvica	$3.1
Humira Pen	$2.9
Lantus Solostar	$2.8
Ozempic	$2.6

Leading the list is Eliquis, an anticoagulant that treats blood clots. What was even more interesting is that coming in at number three is another blood thinner, Xarelto. (Further down is a third, Pradaxa.) Both of these look like sure-fire bets to enter the "negotiation" regime, which seems a little weird. Neither is a particularly expensive drug when measured by cost per dose ($8.50 and $16.40), cost per claim ($739 and $809), or cost per beneficiary ($4,023 and $4,153). The league-leaders in those categories came in at $42,825, $304,487, and $1.6 million.

These aren't the high-priced poster children of drug negotiation. These are simply widely prescribed modern therapies. They also compete head-to-head for market share among seniors, not just by price but also by paying rebates for preferred placement on drug plans' formularies, i.e., a tier having little or no cost-sharing for the beneficiaries.

What happens when CMS starts price-fixing? Suppose that the MFP gets set at the old "net price" – the price after paying rebates. If so, the plans get this low price automatically, but have no particular incentive for formulary placement. Moreover, the IRA implementation rules say only that the plan must keep the drug on the formulary, with no mention of what tier the drug must be. In this scenario, it could easily be the case that the

manufacturers are unscathed, the plans are better off, and the only loser is the beneficiaries who now have greater out-of-pocket costs and less access to the therapies. Does that sound like a good idea?

Of course, the MFP might be even lower, so the manufacturers of modestly priced, widely used, highly successful drugs will be punished, as was the irrational goal of the IRA all along. But seniors will still face threats related to cost and access.

The administration continues to tout the IRA as the greatest thing for seniors, even though relatively few will be directly helped, and for them, only modestly. But if the indirect impact is to reduce access, raise out-of-pocket costs, and stifle innovation, perhaps it might be time to call the whole thing off.