Weekly Checkup

Bending Beneficiary Data

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Earlier this week, the Department of Health and Human Services (HHS) released two big policy announcements on the health care impacts of the Inflation Reduction Act (IRA). First, it declared that the Centers for Medicare and Medicaid Services (CMS) provided counteroffers to all drug manufacturers participating in Medicare direct price negotiations as required by the IRA for the "most expensive" medicines. Second, it boasted that the IRA – in particular its direct price negotiation provisions – will especially benefit Medicare-enrolled women. **Let's explore these claims, the data used to support them, and whether they are accurate.**

Statement One: CMS Administrator Chiquita Brooks-LaSure said "CMS is proud to be negotiating in good faith with drug manufacturers to lower the prices of some of the most expensive drugs for people with Medicare." **Is this true – that CMS is helping to bring down the prices of, as Brooks-LaSure put it, the "most expensive" medications? Not quite.** While the first 10 drugs selected for direct price negotiation under the IRA are the *most-utilized* drugs in Medicare, they are not the most expensive per dose or course of treatment. According to data reported in the Medicare Part D Drug Dashboard for 2022, the most expensive treatment, with an average spending per beneficiary of $1,595,176, was Eteplirsen, a medication used to treat Duchenne muscular dystrophy, which was provided to 16 beneficiaries. In contrast, the top drug by total gross Medicare spending was Eliquis, a medication used to treat blood clots, with average spending per beneficiary of $4,342, which was provided to over 3.5 million beneficiaries. In other words, **the drugs on which CMS is focusing are not so expensive for the average beneficiary – they simply have so many users that the total spending on these drugs is high *in the aggregate*.** At best, CMS' claim is imprecise, and this is increasingly troubling as Medicare drug costs are framed based on *total gross* government spending, rather than other spending methodologies. It's important to note, however, that even if CMS *did* focus on the most expensive drugs, to put price caps on treatments like Eteplirsen would instantly disincentivize the development and investment into specialty medications that can only benefit a very small population.

Statement Two: **HHS Secretary Xavier Becerra stated that the "Inflation Reduction Act is making prescription drugs more affordable for women with Medicare." What did Becerra mean by this?** Perhaps that statement could be considered true, as more women than men remain enrolled in Medicare: Women live longer than men, and if some of the IRA's Part D redesign changes reduce out-of-pocket costs for some beneficiaries, it could be argued that women are more likely to benefit by default. But it's not exactly compelling. To lend much-needed support to Becerra's statement, an Assistant Secretary for Planning and Evaluation Office of Health Policy publication attempted to demonstrate that the IRA's direct price negotiation provision directly helps Medicare-enrolled women, noting that "the IRA's Medicare drug-related provisions are projected to improve the affordability of medications for women in Medicare." Again, another misleading statement: Of the top 10 drugs selected for negotiation, five (Eliquis, Januvia, Enbrel, Stelara and Novolog/Fiasp) are prescribed more to women and five (Jardiance, Xarelto, Farxiga, Entresto and Imbruvica) are prescribed more to men. **It's a stretch to conclude that the selection of these particular drugs – which seem to be prescribed to the sexes almost equally – will confer some special benefit to women.**

These statements seem erroneous on both accounts. **HHS and CMS are embarking on new price controls in Medicare Part D that neither target the most expensive drugs nor appear to benefit women more than men based on the drugs selected. The missteps aren't likely to stop there, however.** The Biden Administration continues to call for further expansion of the IRA to include additional drugs – without any data to demonstrate these drug price negotiations will increase savings for Medicare beneficiaries without increasing their premiums or reducing patient access. **Congress and the administration may need to take another look at the data, but perhaps it's simply easier to argue that the IRA is the panacea to all health care reimbursement ills.**