Weekly Checkup

Gross Price Controls and Net Effects

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On Tuesday morning, the Biden Administration released the list of the first 10 Part D drugs subject to "negotiation" by the Centers for Medicare and Medicaid Services (CMS). This is a big deal, so let's talk about it.

A bit of background: The Inflation Reduction Act (IRA), passed in 2022, instituted a price-control scheme (described as "negotiation" in the law) for Medicare. The scheme starts with a "maximum fair price" (MFP) – i.e., as high as Medicare is willing to go – for drugs that are among the 50 single-source drugs (excluding existing brand competition or impending generic competition) with the highest total expenditures. Depending on how long the drug has been on the market, the MFP can be anywhere between 40 and 75 percent of the non-federal average manufacturer price (AMP), with bigger discounts applied to drugs that have been around longer. **Manufacturers can counteroffer, but ultimately, if they don't play ball, they will be hit with a 95-percent excise tax or be forced to pull their drug from Medicare coverage.**

CMS chose Eliquis, Jardiance, Zarelto, Januvia, Farxiga, Entresto, Enbrel, Imbruvica, Stelara, and several variations of an injectable insulin as its 10 drugs subject to negotiation. **Eliquis, a stroke prevention medication, comes in as the "most expensive" by a large margin, apparently costing CMS almost $16.5 billion for use by about 3.7 million Part D enrollees. Except Eliquis didn't actually cost Medicare that much.** CMS decided to use total Part D *gross* covered prescription drug costs from June 2022–May 2023. **It's important to note that *gross* costs are the costs to Medicare *before* the standard rebates are applied, meaning the *net* cost was likely much lower.** Doing some extremely rough back-of-the-envelope math using Bristol-Meyers Squib's (BMS, the maker of Eliquis) 10K forms, with Medicare's Eliquis spending representing 23.7 percent of BMS' total gross sales and BMS' total Medicare and Medicaid rebates at $11.3 billion – and assuming Medicare's percentage of BMS' rebate is roughly equal to Medicare's percentage of its gross sales – this author estimates BMS gave Medicare a rebate of at least $2.9 billion for Eliquis in 2022. For context, I estimate that BMS netted a profit from Eliquis of only $1.85 billion from Medicare. **Considering the number of Part D users, that's an estimated $500 in profit per patient for stroke prevention. In contrast, a stroke costs a combined average total of $44,929 for Medicare and the beneficiary.**

The exact number isn't the point; it's simply that a focus on gross expenditures is a flawed metric. It doesn't capture Medicare's actual spending on a drug and it doesn't capture the value of that spending. CMS knows what its net spend is after it factors in all rebates and other clawbacks, and Congress should obtain those numbers to get a better picture of what these drugs actually cost. **One is tempted to think that CMS considered gross spend in its calculations for purely political purposes. Bigger numbers, after all, always generate bigger headlines.**

Ultimately, whether CMS uses gross or net spend is of little consequence compared to the IRA's overall cost to the physical and fiscal health of the country. **Price controls in Medicare will mean cost increases in the private market as drug manufacturers try to recoup losses, potentially through lower rebates.** Additionally, the inflation penalty in the IRA means higher list prices at launch, meaning consumers may see higher premiums *and* higher out-of-pocket costs at the pharmacy counter. **Even worse, evidence-based research out of the University of Chicago predicts the impact of the price-control scheme equates to somewhere in the range of $663 billion less in research and development spending, resulting in 135 fewer**

new drugs and a loss of 331.5 million life years in the United States through 2039. Gross, indeed.