PIONEER HEALTH

POLICY BRIEF

Prescription Drug Price Controls in the Inflation Reduction Act (IRA) and Trump's Most Favored Nation (MFN) Drug Pricing Proposal

By Robert Popovian & William Smith

The Importance of Rebates and Fees in the Prescription Drug Market

The pharmaceutical marketplace in the U.S. operates based on rebate contracting.[1] Drug makers pay rebates, fees, and other concessions to pharmacy benefit managers (PBMs).[2] The amount of rebates, fees, and concessions determines the type of coverage the medicine receives from the PBM.[3] PBMs are hired by health plans to construct a drug formulary, which is simply a list of prescription drugs the health plan makes available to its enrollees and any requirements the health plan may impose for patients to access individual medicines.[4] So, for example, a drug formulary may impose out-of-pocket (OOP) cost requirements on patients who must pay these costs at the pharmacy counter to access their prescription.[5] A drug formulary may also impose paperwork requirements on providers, such as "prior authorization," which are theoretically meant to ensure that the patients receive the appropriate drug for their condition.[6]

Contractual agreements between PBMs and drug makers often promise a drug maker that, in return for rebate payments, fees, and other concessions, the drug maker will secure a level of coverage for the drug maker's drug.[7] PBMs use higher OOP costs for patients and paperwork requirements imposed upon providers to steer patients toward, or away from, certain medications to allow the PBM to ensure the drug maker a certain level of access based on the contractual agreement.[8]

Generous rebate payments by drug makers may persuade PBMs to lift these conditions and ensure patients pay very little out-of-pocket for their prescription, or help reduce the administrative burden for providers.[9] In short, generous rebates, fees, or concessions make it significantly easier for patients to access certain prescription drugs.

However, this rebate system has a perverse incentive built into the model where PBMs sometimes favor more costly drugs on a health plan formulary.[10] This is the case because a higher-priced drug may offer more generous rebate payments than a lower-priced drug, since rebates are a percentage of a drug's list price. In addition, since fees are calculated based on the drug maker's list price, fees collected by PBMs are also significantly greater for the pricier medications.[11] Careful observers of drug markets have noted that biosimilar drugs, which are developed as cheaper substitutes for more expensive biologic drugs, were slower to gain market share in the U.S., likely due to the rebate system.[12]

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Furthermore, ample research shows that generics are now being placed at higher tiers, increasing OOP cost for patients, or brands are preferred outright in some cases instead of generic medicines.[13]

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Therefore, we can speculate that the lower prices imposed by the IRA may diminish rebate and fee revenue flowing to PBMs. For PBMs to recoup the profitability gained from rebates and fees, PBMs may impose higher OOP costs on patients.[14] In short, lower drug prices can sometimes make it more expensive for patients to access their medicine.

Let's take a hypothetical example from the first batch of drugs subject to the IRA's price controls. Four million Medicare patients take the blood-thinning drug Eliquis. In 2021, Eliquis had a list price of $520 for a 30-day supply. Under the IRA price control law, the federal government chose to push the cost for a 30-day supply of Eliquis down to $230.[15] Bristol Myers Squibb might be paying PBMs about $150 per prescription in rebate payments under the $520 price. We don't know the actual rebate amounts because they are confidential. Some academic studies have concluded that rebate levels are approaching half the list price. Hence, the $150 estimate may be low.

At a rebate level of $150, PBMs would obtain $600 million *per month* in rebate revenue. If the rebate payments dropped by about half, together with a 56 percent lower price, PBMs would stand to lose $300 million per month in rebate revenue. One way to compensate for the lost profitability is to raise patient OOP costs. While this is a hypothetical example and entails some speculation on rebate levels, we can say with some certainty that the scale of rebate payments for Eliquis runs billions of dollars each year. As such, the potential profit losses for PBMs may be in billions annually.

IRA Price Controls and What Patients Now Pay: Pioneer's Data on Out-of-Pocket Costs

Pioneer Institute recently released out-of-pocket (OOP) data on the first batch of drugs subject to the IRA's price controls.[16] In late November, the government will release prices on 15 more drugs subject to the price controls.[17] In results that may seem counterintuitive to some, Pioneer concluded that, for the first batch of drugs, the lower prices imposed by the IRA resulted in increased patient OOP burdens. For example, the IRA price controls pushed down the price of Merck's drug Januvia by 79 percent, but seniors paid more OOP for that medicine. The average price drop imposed by the law was more than 50 percent per drug.

These price reductions certainly portend a loss of rebate and fee revenue for PBMs. If one understands rebate contracting, this loss of rebate revenue could result in higher OOP costs for patients, precisely what Pioneer found. Pioneer studied 9 of the first 10 drugs subject to the IRA price controls (we left out the insulin product as the price of that product was set separately in the IRA law). The average OOP cost for the nine drugs studied by Pioneer rose by $23.91, from $71.51 to $98.42. The average OOP cost for the nine drugs studied rose by 32 percent.[18]

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Quite simply, for the drugs that had prices pushed down by the federal government's price controls, seniors were forced to pay ***more*** in OOP costs.

With an understanding of rebate contracting, we can conclude that the loss of rebate revenue, due to lower prices, caused PBMs to significantly raise patient OOP costs. When we examine the earlier example of the potential rebates paid for Eliquis, we see that PBM revenue losses due to lower prices are likely very significant, and, as for-profit entities, PBMs are probably making up for the losses by imposing additional costs on

patients. Our data found that the average OOP cost for Eliquis rose from $77.99 to $106.10 from Q1 of 2024 to Q1 of 2025, or a rise of $28.11 per prescription. With 4 million Medicare patients on Eliquis, this rise in patient OOP costs would secure over $122 million per month in revenue for PBMs.

Rebate Contracting and the Likely Outcome for President Trump's Most Favored Nation (MFN) Proposal for Drug Pricing

President Trump has promised to link U.S. drug prices to the lowest prices found in a market basket of developed countries.[19] The President has asserted that prices set using an MFN standard would be lower than those imposed under President Biden's IRA proposal.

If rebate contracting were to remain in place, lower prices set to MFN standards could result in significantly higher costs for patients receiving their drugs from a health plan that employs a PBM to construct the plan's formulary. Most importantly, this outcome would have adverse health consequences for patients who might skip their prescription to avoid higher OOP costs.[20] [21] Less significantly, however, this outcome would be politically perilous for President Trump, who would see rising OOP costs for millions of patients while promising lower drug prices.

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Granted, this outcome depends upon the survival of rebate contracting by PBMs, and President Trump did promise to "get rid of the middlemen," meaning PBMs. It is important to note that under the Health and Human Services (HHS) Secretary, Alex Azar, the Trump administration tried to make rebate contracting illegal in Medicare.[22] Due to pressure from the PBM lobby on administrators inside the executive branch, the entire effort was torpedoed. This time, it is unclear how easy it would be for President Trump to root out rebate contracting. Would it require revisiting the executive order or an act of Congress? Ultimately, it would come down to health plans and wealthy PBMs launching an aggressive antireform lobbying campaign against such a proposal. Even some major employers, who are increasingly dependent upon rebate revenue and mistakenly believe that the corrupt rebating model serves them well, might enter the lobbying fray to keep rebates in place.[23]

While policymakers will pay careful attention to the implementation of President Trump's MFN proposal, it might be more worthwhile to pay attention to reforming the rebate contracting system that is at the core of the U.S. pharmaceutical market. Without the prohibition of rebate contracting, it seems likely that IRA price controls and the President's MFN proposal will not succeed due to a lack of patient popularity due to higher OOP costs.

About the authors

Dr. Robert Popovian, Pharm.D., MS is the Founder of the strategic consulting firm Conquest Advisors. He also serves as Chief Science Policy Officer at the Global Healthy Living Foundation, Senior Healthy Policy Fellow at the Progressive Policy Institute, and Visiting Health Policy Fellow at the Pioneer Institute. He previously served as Vice President, U.S. Government Relations at Pfizer.

One of the country's foremost experts on every significant facet of biopharmaceuticals and the healthcare industry, he is a recognized authority on health economics, policy, government relations, medical affairs, and strategic planning.

Dr. Popovian has published extensively and referenced on the impact of biopharmaceuticals and health policies on costs and clinical outcomes in the most prominent medical sources and media publications, including the Wall Street Journal, Clinical Economics and Outcomes Research, The Oncologist, Journal of Vaccines and Vaccinations, Journal of American Pharmacists Association, Journal of Health Economics and Outcomes Research, USA Today, Washington Examiner, Managed Healthcare Executive, and The Hill. He is also a sought-after speaker and has been invited to provide detailed presentations, briefings, and expert reviews for the U.S. Congress and dozens of state legislatures, as well as at conferences andmedical symposiums throughout the country and worldwide.

Dr. Popovian is one of the select few researchers to study and publish clinical and policy-related economic analysis and empirical data regarding emerging payment models in the U.S. healthcare system and for biopharmaceutical reimbursement. His insight and analysis also led to one of the first inclusions of health outcomes data in a labeled indication of a biopharmaceutical.

Dr. Popovian is Chairman of the Board of Councilors at the University of Southern California School of Pharmacy, an Adjunct Clinical Assistant Professor at Rutgers School of Pharmacy, and an advisor to the Value of Life Sciences Innovation program at the Schaeffer Institute.

Dr. Popovian completed his Doctorate in Pharmacy and Master of Science in Pharmaceutical Economics and Policy degrees with honors at the University of Southern California. He has also completed a residency in Pharmacy Practice/Adult Internal Medicine and Infectious Diseases at the Los Angeles County-USC Hospital and a fellowship in Pharmaceutical Economics and Policy at USC.

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Endnotes

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