As I wrote recently in the New York Times, the Inflation Reduction Act “is the single biggest political loss the drug industry has sustained,” and in that sense it is a “statement about what’s politically possible in reforming the health system.”

Among the various measures included in this law recently signed by President Biden, is a provision that would give the federal government authority for the first time to negotiate the prices of some drugs in Medicare. The government’s leverage would come from a new tax on drug companies that walk away from the negotiating table.

Starting next year, drugmakers will also have to pay penalties to Medicare if they increase prices faster than inflation, and monthly insulin co-pays will be capped at $35 for those enrolled in the Medicare Part D drug benefit. The legislation that created this benefit in 2003 was a pathbreaking expansion in coverage for seniors and people with disabilities, but the pharmaceutical industry used its legendary political clout to include language specifying that the government “may not interfere with the negotiations between drug manufacturers and pharmacies and PDP [prescription drug plan] sponsors.”

Unsuccessful efforts to use the government’s leverage to restrain drug prices go back decades, at least to President Bill Clinton’s failed Health Security Act proposed in 1993. That plan would have added a drug benefit to Medicare, with the government negotiating the prices of medications with pharmaceutical manufacturers. The Clinton health plan went down in the face of a blizzard of opposition from many segments of the health care industry. In addition to guaranteeing universal health coverage, the plan also sought to control health care costs through restraints on insurance premiums, hospital and physician fees, and drug prices.

The lesson health reform advocates took from the failure of the Clinton health plan is that unified opposition from powerful health care interest groups cannot easily be overcome, thus a plan that tries to control costs is much harder to achieve than one that focuses instead primarily on expanding coverage. In other words, health reform that produces more paying health care customers without constraining prices is going to be much more attractive to the health care industry.

As a product of that lesson, the Affordable Care Act (ACA) succeeded legislatively where the Clinton plan failed. The ACA focused more on expanding health coverage than controlling underlying costs, although it did trim the rate of growth in Medicare payments to hospitals and included new taxes on individuals with higher incomes and on insurers and drug companies to help fund the coverage expansion. Without significant threats to their prices or profits—and with significant expansions in coverage that brought in new revenue—major health care industry groups did not fight against the ACA as they did with the Clinton reform plan, helping to pave the way for its passage.

The Inflation Reduction Act is politically significant in that it passed despite strong opposition and lobbying by the powerful pharmaceutical industry. These drug pricing restraints represent the biggest health reform step since the ACA was enacted in 2010.

Yet, as momentous as this legislation is, it goes only so far. Negotiation of drug prices in Medicare will apply initially to a limited number of drugs: 10 in 2026, another 15 in each of 2027 and 2028, and an additional 20 in each year after that. Plus, negotiation does not take effect until well after a drug receives approval from the US Food and Drug Administration (9 years for small-molecule...
drugs and 13 years for biological products). Also, unlike the sweeping changes originally envisioned, negotiated drug prices will not apply to private insurance plans outside Medicare.

The drug pricing provisions in the Inflation Reduction Act represent a rare Medicare policy change that saves money for both the federal government and beneficiaries, who will experience lower costs due to negotiated prices, slower growth in prices, and a cap on out-of-pocket costs. Some of the cost relief will kick in relatively quickly, although price negotiation will take more time, in part because the US Department of Health and Human Services has minimal expertise in drug pricing and will have to build that infrastructure.

In addition, although providing relief from drug costs has been a high priority for the public, other parts of the health care system contribute much more to overall health spending. For example, although retail prescription drug prices represent about 8% of total health spending in the US, hospital care makes up 31%.

The drug pricing reforms in the Inflation Reduction Act represent a foot in the door for health care cost containment that has seemed politically unattainable up until now. Whether this is just the beginning of a stronger and broader push to address health care costs remains to be seen.

ARTICLE INFORMATION
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