PRI CENTER FOR MEDICAL ECONOMICS AND INNOVATION

ISSUE BRIEF

Maximum Fair Price Folly

States that adopt Medicare drug price controls will increase the policy's adverse consequences

Wayne Winegarden

FEBRUARY 2025

A Pacific Research Institute Publication

Maximum Fair Price Folly
States that adopt Medicare drug price controls will increase the policy's adverse consequences
Wayne Winegarden

February 2025

Pacific Research Institute
PO Box 60485
Pasadena, CA 91116
Tel: 415-989-0833
www.pacificresearch.org

Nothing contained in this report is to be construed as necessarily reflecting the views of the Pacific Research Institute or as an attempt to thwart or aid the passage of any legislation.

©2025 Pacific Research Institute. All rights reserved. No part of this publication may be reproduced, stored in a retrieval system, or transmitted in any form or by any means, electronic, mechanical, photocopy, recording, or otherwise, without prior written consent of the publisher.

Executive Summary

The Inflation Reduction Act, signed into law in August 2022, empowered the Secretary of the U.S. Department of Health and Human (HHS) to set a Maximum Fair Price (MFP) on selected drugs. The MFP is established in negotiations between the federal Centers for Medicare & Medicaid Services (CMS) and pharmaceutical manufacturers.

Initially, 10 drugs under Medicare Part D will be subject to the MFP negotiations, effective in January 2026, increasing to 15 new drugs each year in 2027 and 2028, and 20 new drugs annually starting in 2029. Medicare Part B drugs will be eligible for the negotiation process starting in January 2028.

The terms of the MFP negotiations are skewed in the government's favor, consequently the MFP process empowers the CMS to effectively impose price controls on the Medicare market.

The Nevada legislature passed legislation (Assembly Bill 250 in 2023) that would have applied the MFP to state residents. Such a policy would have expanded the harm caused by the MFP without meaningfully reducing out-of-pocket costs for patients. Gov. Joe Lombardo vetoed the legislation. Despite the veto, lawmakers are considering similar legislation this year..

The ultimate purpose for imposing price controls is to reduce costs on patients. Adopting the MFP in Nevada would not achieve this goal because these costs are determined by patients' insurance designs. The MFP cannot and does not alter patients' fixed dollar copays. Patients' coinsurance obligations are set by payers as a percentage of drug list prices. The MFP neither changes these percentages nor lowers drug list prices.

By adopting the MFP, Nevada will also put statewide healthcare facilities at risk of losing money because their drug costs are based on national prices, but their reimbursements would be capped at the lower MFP. This risk of losing money will reduce patient access to the price-controlled drugs. And reduced access will decrease health outcomes for Nevadans while increasing overall healthcare spending as opportunities to avoid costlier surgeries and reduced hospital stays would be lost.

Enforcing and administering the MFP in Nevada, or in any state, also creates administrative costs. If legislation similar to AB 250 were enacted in the future, Nevada could be required to spend $2.3 million annually and would also need to invest in new technology to administer the MFP, which could cost the state millions.

Broadly speaking, price controls discourage future drug innovations, harming patients living with untreated diseases. Opportunities to improve health outcomes and reduce overall U.S. healthcare spending by avoiding costlier hospital stays and surgeries are lost. From an economic perspective, a key driver of the U.S. economy – pharmaceutical innovation – are diminished, hindering income and employment growth overall.

Due to the policy's inability to drive down patient costs while worsening health outcomes and triggering higher net spending, it is ill advised for Nevada or any other state to enact MFP legislation.

Introduction

The Inflation Reduction Act (IRA) empowered the Secretary of the U.S. Department of Health and Human Services (HHS) to establish a Maximum Fair Price (MFP) for a pre-selected number of drugs on behalf of the federal Medicare program. The MFP for ten drugs under Medicare Part D were set in 2024 for introduction in January 2026. By statute, the Secretary is authorized to select an additional 15 drugs under Medicare Part D, starting in 2027. Fifteen more drugs will be added in 2028 for drugs under Parts D and B, and up to 20 more drugs will be added each year after that, starting in 2029.

Calling this price setting process a negotiation is a misnomer. Instead, the IRA stacks the process in Washington's favor because the government can levy crippling excise taxes and civil monetary penalties on any manufacturer that fails to comply with the negotiation. Consequently, the MFP process is essentially a means for imposing price controls on innovative medicines. Drug price controls disincentivize continued innovation and ultimately impose large costs on patients, the healthcare system, and the macroeconomy.

> "Drug price controls disincentivize continued innovation and ultimately impose large costs on patients, the healthcare system, and the macroeconomy.

Making matters worse, the Nevada legislature passed Assembly Bill 250 in 2023 that would have applied the MFP to drug purchases in the state. Gov. Joe Lombardo vetoed the legislation. In spite of the veto, legislation to apply the MFP in Nevada is being considered once again.. Enacting an MFP would impose excessively high costs on Nevadans, create significant implementation costs for the state, and ultimately would harm patients.

State Adoption of the MFP Increases the Policy's Harm

Should all states adopt the federal MFP, then the equivalent of a national price control policy would be imposed on virtually all U.S. patients for those drugs selected for negotiation by CMS.

Under such a scenario, the large economic costs from the MFP negotiation process that are discussed in the next section would be significantly increased. Innovation would stagnate, opportunities to improve patient outcomes would be squandered, and the ability to reduce overall healthcare spending by avoiding higher cost surgeries and hospital stays would be lost. Even if only one state, such as Nevada, were to adopt the nationally-set MFP, there would be adverse consequences including new expenses required for administering the price controls and broader adverse impacts on healthcare costs and quality.

State Adoption of MFP Increases Government Administration Costs

At the national level, the federal government hired 91 people to implement the drug pricing negotiation scheme created by the Inflation Reduction Act.[1] Implementing the Medicare drug price negotiation provisions will cost taxpayers $3 billion – an average of $300 million annually – over the first decade of the program.[2] Applying the national MFP to all patients within Nevada or any state would incur additional state-level administrative costs.

Nevada's state costs would be smaller than CMS' costs because the state will not have to negotiate with manufacturers. Adopting the MFP would require the state to spend money administering and enforcing the price controls just like the state allocates resources to enforce other regulations.

In determining what this could cost, consider that in the 2024 state budget, Nevada allocates $2.5 million toward the Office of Labor Commissioner, which has a staff of 22 full-time equivalent jobs, to enforce state wage laws. Approximately $800,000 of this budget is devoted toward resolving wage disputes and ensuring compliance with the minimum wage and other labor laws.[3]

Another benchmark is the rates and rulemaking activity of the Department of Business and Industry, Insurance Division, which ensures that companies submit complete rate requests that are are consistent with state law. Approximately 17 percent of the Department of Business and Industry budget is allocated toward reviewing rates and rulemaking. Assuming consistency with the budget, approximately 15 full-time equivalent jobs (out of a total of 88 full-time equivalent jobs in the Insurance Division) are devoted toward this function.

> "Even if only one state, such as Nevada, were to adopt the nationally-set MFP, there would be adverse consequences including new expenses required for administering the price controls and broader adverse impacts on healthcare costs and quality.

Just like with labor laws, rate review and rulemaking, enforcing the MFP would require Nevada to invest in a regulatory structure to ensure that,

- All healthcare and pharmacy facilities comply with the statute,
- All impacted organizations have access to the up-to-date pricing and regulatory information, and
- Any pricing dispute that could arise are resolved.

These costs can be approximated by evaluating typical staffing, office, and technology costs for government agencies in Nevada. This analysis assumes that the number of staff required to enforce and administer the MFP in the state will be 15 full-time equivament employees—matching state budget dollars spent on the rate review and rulemaking activity of the state Insurance Division.

Starting with salary costs, according to talent.com, the average salary for a government worker in Nevada is $70,003.[4] According to the Bureau of Labor Statistics, the costs of benefits and taxes comprise 38.4 percent of the total compensation package for an average employee.[5] Adding the additional expense of $43,650 per employee for benefits and taxes to the average government worker salary of $70,003, the average total compensation required for staffing the government agency enforcing the MFP would be $113,653 per employee, see Table 1. Across a staff of 15 people, the total annual costs would be $1.7 million. Should fewer employees be required, the costs will be less; should more employees be required (e.g. if staffing levels matched the Office of Labor Commissioner's 22 full-time equivalent jobs, for instance) the costs would be higher.

Table 1. Potential Labor Costs to Enforce MFP Assumed Staff of 15 People

		COST	SOURCES
(1)	Median Salary, NV Government	$70,003	https://www.talent.com/salary?job=government&location=nevada
(2)	Benefits and Taxes	$43,650	https://www.bls.gov/news.release/pdf/ecec.pdf
(3)	Total	$113,653	(1) + (2)
(4)	Number of Employees	15	Assumption
(5)	**Total Labor Costs**	**$1,704,795**	**(3) * (4)**

Other expenses to administer and enforce an MFP in Nevada include rent, utilities, office expenses, supplies, travel, and technology expenses. While these costs are difficult to quantify, the budget for the Office of Labor Commissioner provides some guidance. Based on Nevada's 2023-2025 Executive Budget, the Governor recommended a $1.9 million expenditure for personnel costs out of a total budget of $2.5 million.[6] Applying this ratio to the estimated $1.7 million in salaries and benefits costs indicates that the total annual budget to administer and enforce the MFP would be around $2.3 million annually, see Table 2.

Table 2. Potential Annual Cost Requirements to Enforce MFP Assumed Staff of 15 People

	ANNUAL EXPENSES
Salaries and Benefits	$1,704,795
All Other Costs (supplies, utilities, travel, etc.)	$560,471
Total	**$2,265,266**

In addition to these annual costs, the state will need to make significant capital investments to create the necessary technological infrastructure. At the federal level, the Centers for Medicare & Medicaid Services (CMS) has announced a $17.4 million contract to develop the IT and telecom applications to support the MFP negotiation and administration process nationally.[7]

Since CMS acts as a payer and a regulator, they are uniquely situated to obtain claims level data. It is not clear that the state of Nevada would be able to obtain the proper claims data to administer the MFP reference pricing across all payers in Nevada. Even if they were able to obtain these data, the capital investment would be significant and the state would likely require tailored technologies to ensure they can properly identify the eligible claims and ensure compliance with the MFP. Due to these considerations, developing this IT system will likely be a multi-million-dollar endeavor.

It is important to note that the actual state expenditures allocated to administering the MFP if the proposal were adopted will vary from these estimates should the number of employees required, their compensation, or the other administrative costs vary from the assumptions made here. The cost estimates demonstrate an important reality, however; adopting the MFP in Nevada will impose millions of dollars in costs on the state that needs to be adequately considered.

State Adoption of MFP Does Not Lower Patient Costs

Nevada's adoption of the MFP price controls will not reduce patient out-of-pocket costs. Patient costs are based on their specific insurance designs, which typically include copay and coinsurance obligations.

Copays are fixed costs that patients are required to pay every time they purchase a medicine. By definition, patients with $20 copays owe $20 every time they purchase their drugs. These fixed costs are set by insurance companies and will typically vary depending on which tier of the formulary (or list of approved drugs) that an insurer designates the drugs. Since these are fixed costs determined by the insurer, adopting the MFP price will not change patient out-of-pocket copays.

Coinsurance obligations are more complicated. Typically, coinsurance obligations are set as a percentage of drug list prices, which are set nationally. The growth in list prices is artificial in the sense that it does not reflect the prices the manufacturers – the supply side – receive nor the prices that the payers (e.g. insurance companies or Medicaid) – the demand side – pay. Deducted from list prices are all the discounts and rebates that drug manufacturers pay to payers and PBMs and other third parties. Based on data from Drug Channels, the total value of the discounts reached $334 billion in 2023 and grew 12 percent on an average annual basis between 2018 and 2023.[8]

> "Because adopting the national MFP mandates at the state level does not change patient copay or coinsurance obligations, the MFP will not reduce patient out-of-pocket costs for drugs – failing to achieve one of the primary justifications for adopting the policy.

The problem arises because patients do not benefit from most of these concessions. In fact, their costs are inflated when list prices grow because patient coinsurance costs are typically tied to the growth in the artificial list prices. Since the incentives of the distorted rebate system encourage growing list prices to accommodate PBMs' demand for even faster growing rebates and discounts, patients are too often burdened with significantly higher coinsurance obligations.

This distorted system is the prime driver of patient drug affordability problems. The consequences are even more severe for patients who lack insurance since they are often responsible for paying the full, yet artificial, list price of the drug.

Adopting the MFP at the state level would not change the disincentives driving up list prices. Nor does adopting the MFP alter the coinsurance percentages for patients in Nevada. Due to these realities, the MFP may benefit payers, but it will not benefit patients. Because adopting the national MFP mandates at the state level does not change patient copay or coinsurance obligations, the MFP will not reduce patient out-of-pocket costs for drugs – failing to achieve one of the primary justifications for adopting the policy.

State Adoption of MFP Risks Patients' Access to Drugs

The MFP policy would also put in-state patients at additional health risks while threatening to increase overall healthcare spending in the state. These adverse consequences result because the policy fails to account for how pharmacies, hospitals, and other healthcare facilities purchase medicines.

Nevada's healthcare facilities purchase their medicines from national (or regional) organizations based on the national prices, which (if the price control policy is going to be relevant) will be higher than the negotiated price (e.g., the MFP). This gap means that the costs for pharmacies, hospitals, clinics, and doctor's offices to acquire medicines will be potentially higher than the MFP payment that they will be able to obtain from the payers as reimbursement. Consequently, healthcare facilities in Nevada will face a very real risk that they will lose money when prescribing the price-controlled medicines – an unsustainable position. The consequence will be reduced access to these price-controlled medicines for many Nevadans – or residents of any other state that were to implement the same policy.

The consequence from patient nonadherence to their medicines – patients not taking their medicines as prescribed by their healthcare provider – provides a sense of the potential costs Nevada could experience. In a 2023 study of U.S. patients, the authors found that

> *medication nonadherence—when patients fail to take their medication as prescribed—has numerous consequences: increased rates of comorbid diseases, more hospitalizations, avoidable deaths, and greater health care expenditures. In the United States alone, medication nonadherence is responsible for an estimated 10% of hospitalizations and 125,000 avoidable deaths each year. Nonadherence is associated with significantly more annual inpatient health system days, ranging from 1.2 to 5.7 more days per year, depending on the condition. Nonadherent patients experience 27% more hospital visits than adherent patients.*
>
> *Medication nonadherence also carries a significant financial burden on the US health care system, which spends up to $300 billion per year in additional hospitalizations, outpatient visits, and other additional medical costs. The typical nonadherent patient requires 3 extra medical visits per year, increasing per-patient treatment costs by $2,000 per year. Medical complications arising from nonadherence result in further annual expenditures per patient: $9,204 for cardiovascular disease, $11,052 for mental health, and $6,310 for diabetes.*[9]

The implication for adopting MFP in Nevada is dire. Lost access to innovative medicines will cause patients to need more doctor visits and more and longer hospital stays. Treatment costs will also increase; all while health outcomes are worsening and the number of avoidable deaths is increasing.

The broader U.S. patient community would also be harmed should Nevada, or any state, adopt the MFP because such a policy expands the reach of the federal price control efforts. Broader applicability of the federal price controls further reduces the ability of drug innovators to cover the cost of capital associated with the long and risky drug development process. With a lower expected ability to cover these costs, the incentive to develop new medicines to help patients living with diseases that do not have effective treatments is reduced. The lower incentive will ultimately lead to even fewer innovative drugs.

Federal Price Controls on Drugs Impose Costs on All Americans

Having reviewed the additional adverse impacts on patients from states adopting the MFP, it is useful to review the broader adverse consequences the MFP negotiation process creates. This negotiation process worsens healthcare outcomes in the U.S. by disincentivizing continued innovation, increasing costs on patients, and raising overall healthcare spending (which is ironic given the goals of the entire negotiation process). Adding to the negative impacts, the effective drug price controls will reduce overall macroeconomic growth.

Disincentivizes Innovation and Competition

Following the conclusion of the first round of ten drugs, the negotiated drug price savings were actually underwhelming. HHS noted that the "negotiated prices range from 38 to 79 percent discounts off of list prices."[10] The focus on list prices misses the point because Medicare Part D plans do not pay list prices. They pay net prices, which are the list prices minus all negotiated discounts and rebates – negotiations between PBMs on behalf of private insurers and the manufacturers have been occurring for years prior to the IRA. According to Drug Channels, the average reduction in major manufacturer list prices in 2023 was 52.1 percent.[11] Consequently, the reduction in list prices that resulted from this year's negotiations by HHS were similar to the negotiated reductions in list prices that already occur.

The negotiations were still devastating because the federal government has established the means and methodology to impose uneconomical price controls on any innovative drug it chooses anytime in the future. The risk and uncertainty that accompany this new power drives the widely held concern that the IRA will reduce the number of new drug innovations brought to market. For instance, according to the USC Schaeffer Center for Health Policy & Economics,

> *The IRA is expected to reduce revenue to pharmaceutical manufacturers from the combined effects of drug price negotiation, inflation rebates, and required manufacturer discounts. Taken together, these provisions have been estimated to lead to an approximately 31% decrease in U.S. pharmaceutical revenues through 2039 and result in 135 fewer new drug approvals during the same period.*[12]

An analysis of the adverse consequences of the negotiation process by the Boston Consulting Group noted that these negative impacts will not be felt evenly across different disease areas.

> *While the IRA will reduce the return on R&D overall, the impact is likely to be uneven across different disease areas. Biopharma and biotech companies will need to adapt their R&D strategies accordingly.…*
>
> *Certain therapeutic areas, such as oncology and metabolic disorders, have proportionately more older patients and are thus going to be more affected than others. Pharma leaders and investors will need to reevaluate their disease area priorities and decide if the IRA provisions warrant a course correction.*[13]

These new risks that analysts have identified are already being seen in practice. As the *Wall Street Journal* editorial board notes,

> *Charles River Laboratories, a top research contractor that helps drug makers with clinical trials… warned in its quarterly earnings report that pharmaceutical companies are slashing research and development owing to the IRA's drug price controls.*
>
> *"There are profound cuts" at pharmaceutical companies that reflect a "rapid deterioration" of their business, CEO James Foster said. He added: "A lot of these decisions have been taken relatively recently and probably more to come and haven't been taken yet."*[14]

The reality that innovative research budgets have been "slashed" is terrible news for patients living with diseases such as Alzheimer's or many devastating cancers such as pancreatic and ovarian cancer. The chances that an efficacious treatment will soon become available are now lower. The unintended consequences go beyond the innovative market as well.

As demonstrated by the competitive biologics market, U.S. patients benefit from the current competitive environment that incentivizes the dual goals of continued innovation and broad affordability. Thanks to innovative biologic medicines, which are medicines made from living organisms, we now have more efficacious treatments for cancers and autoimmune diseases. Developing biologic medicines is exceptionally complex and costly, and as discussed above, it is widely recognized that the MFP disincentivizes continued innovation. Less discussed, the MFP also disrupts the competitive process for high-cost biologics.

Competitors to high value originator biologic medicines, known as biosimilars, have significantly reduced costs for patients once the originators' exclusivity period has expired. On average, biosimilar competition has reduced average prices by around 56 percent.[15] The combination of a defined exclusivity period followed by a robust competitive environment successfully promotes the dual, but potentially conflicting, goals of innovation and widespread affordability.

> "By lowering the expected returns, the MFP undermines the vibrancy of the competitive biosimilar market.

Due to the complexity of biologic medicines, developing biosimilars is also costly – the estimated cost of developing an approved biosimilar is between $100 million and $300 million.[16] Adding to the burden, the development process can take upwards of six to nine years. The large costs and lengthy development process increase the financial risks for developing these competitive medicines.

Potential IRA price controls add an additional unknown on biosimilar manufacturers – the biosimilar manufacturer does not know whether the federal government will impose restrictive price controls on the originator biologic when it is deciding whether to invest the millions of dollars into the lengthy biosimilar development process. Depending on its restrictiveness, the MFP could undermine the financial viability of investing in the long and costly biosimilar development process. This unknown creates an additional risk that lowers the expected potential return from developing biosimilars. By lowering the expected returns, the MFP undermines the vibrancy of the competitive biosimilar market.

This is troubling because biosimilars have already demonstrated their efficacy at striking the important balance between improving drug affordability today while incentivizing continued innovation for tomorrow. The ability to reasonably strike this balance stands in stark contrast to price controls that reduce prices by undermining the incentive to develop innovative medicines and, therefore, do not create the same benefits that efficient competition has demonstrated.

Imposes Costs on Patients and the Healthcare System

Imposing the MFP would also compound the problems afflicting the broader healthcare system, including the market for innovative drugs. Many of the healthcare system's problems, including rising unaffordability and declining quality, are caused by the current third-party payer system that empowers bureaucrats over doctors and patients.

As the size and power of administrative intermediaries has grown, their influence over fundamental healthcare decisions has expanded. This expansion of intermediaries' influence has come at the expense of patients and their doctors. Consequently, payers' preferences are prioritized over patients, payers' policies are substituted for doctors' expertise, and both patients and doctors are overwhelmed with excessive administrative costs. The problems of rising costs and declining quality are the inevitable consequences.

In the case of innovative medicines, the growth of numerous drug intermediaries such as Pharmacy Benefit Managers (PBMs) has plagued the drug pricing system with adverse and misaligned incentives. Patients bear the burden through greater access restrictions and a shifting of the costs from payers to patients. By introducing a whole new layer of intermediaries – in this case price setting government bureaucrats – the IRA worsens this situation.

The goal of the new government price setting committee in the *price negotiation* is, allegedly, to establish value-based prices for medicines. But, if measured correctly, the value of many medicines is high. Take hepatitis C as an example. The annual medical costs for treating hepatitis C before efficacious medicines were introduced were as high as $63,000 for patients that developed liver cirrhosis.[17] Should a liver transplant have been necessary, the costs would have approached $600,000. There are also significant non-medical costs imposed on patients, their families, and their caregivers, including large psychological and physical costs. These costs may be harder to quantify but are no less real.

Thanks to innovative medicines such as Sovaldi, treatments can now cure this disease. Not only are patients now spared the burden of the disease, but overall healthcare spending is also lower because costly surgeries and long-term hospital stays can now be avoided. And these beneficial impacts on costs are not unique to hepatitis C. A study by the Congressional Budget Office (CBO) also found that there is a beneficial impact from drug innovation on overall healthcare spending.

> "An efficient drug pricing system (something we currently do not have) ensures that the prices of medicines reflect their underlying value.

According to the CBO, "after reviewing recent research, the Congressional Budget Office estimates that a 1 percent increase in the number of prescriptions filled by beneficiaries would cause Medicare's spending on medical services to fall by roughly one-fifth of 1 percent."[18] Given that pharmaceutical spending only accounts for approximately 10 percent of total national health expenditures, the 0.2 percent reduction in spending on medical services is often a higher dollar value of savings relative to a 1 percent increase in drug spending.

The hepatitis C case exemplifies that drug innovation often simultaneously improves patients' health outcomes while also lowering overall healthcare spending by reducing the need for more expensive medical services. When working properly, the prices of treatments should reflect this tremendous value that these medicines provide patients and their families – value-based prices.

An efficient drug pricing system (something we currently do not have) ensures that the prices of medicines reflect their underlying value. The MFP negotiation process pushes the pricing system further away from this ideal by empowering a government price setting bureaucracy whose incentives are to price drugs cheaply, particularly for high valued drugs that may have exceptionally expensive prices. This creates a bias to undervalue innovative treatments that both jeopardizes patients' access to some of the most promising new therapies – as is the case in the OECD countries that widely employ drug price controls – and risks higher overall healthcare expenditures.[19]

Harms Economic Growth

Disincentivizing continued drug innovation will also impose large costs on the broader economy due to the innovative biopharmaceutical industry's large economic contributions. A 2023 economic impact analysis of the industry found that between 2018 and 2021,[20]

- The number of people employed by the industry grew 16.8 percent and total remuneration for the industry grew 31.2 percent equaling $54 billion in 2021.
- The industry has grown faster than U.S. GDP every year since 2018.
- As of 2021, the industry created 1.53 percent of total U.S. GDP and 9.9 percent of the manufacturing sector's contribution to GDP.
- Accounting for the economy's interconnectedness, the industry, either directly or indirectly, supports nearly 1.5 million jobs.

The large disincentives against continued innovation created by the IRA risks future research and development investments. Fewer R&D efforts jeopardize continued growth in these economic contributions. The result will be slower overall economic growth, less job creation, and decreases in income growth. Worse, depending on the severity of the disincentives, the reduction in R&D efforts could be severe enough to cause an actual reduction in the current economic contributions of the industry.

Conclusion

The Inflation Reduction Act tilts the negotiation balance so far in the government's favor that it effectively empowers the Secretary of Health and Human Services to impose price controls on drugs used by patients in Medicare. Drug price controls inevitably impose large costs on patients, and Medicare's process to establish maximum fair prices is no different.

Expanding the reach of the MFP to other markets beyond Medicare compounds these costs. Not only would this policy further disincentivize future innovation, but it would also impose additional costs on in-state residents without reducing out-of-pocket obligations for most residents. These costs include additional expenditures by the state to implement the proposal for non-Medicare markets, decreased access to medicines, potential losses on healthcare clinics and hospitals, and reduced health outcomes.

The high costs that will inevitably result argues against adoption of the federal maximum fair price (MFP) for drugs at the state level.

Endnotes

1 "Chair Rodgers: The Biden-Harris Price-Setting Scheme Raises Costs on Seniors" U.S. House Energy & Commerce Committee, August 15, 2024, https://energycommerce.house.gov/posts/chair-rodgers-the-biden-harris-price-setting-scheme-raises-costs-on-seniors.

2 "U.S. Department of Health and Human Services, Fiscal Year 2024 Budget in Brief" U.S. Department of Health and Human Services, https://www.hhs.gov/sites/default/files/fy-2024-budget-in-brief.pdf.

3 "State of Nevada Executive Budget: 2023-25 Volume 1" Governor Joe Lombardo, https://budget.nv.gov/uploadedFiles/budgetnvgov/content/StateBudget/2024-2025/State_of_Nevada_Executive_Budget_2023-2025.pdf.

4 Talent.com, https://www.talent.com/salary?job=government&location=nevada.

5 Bureau of Labor Statistics, https://www.bls.gov/news.release/pdf/ecec.pdf.

6 "State of Nevada Executive Budget: 2023-25 Volume 1" Governor Joe Lombardo, https://budget.nv.gov/uploadedFiles/budgetnvgov/content/StateBudget/2024-2025/State_of_Nevada_Executive_Budget_2023-2025.pdf.

7 See: https://www.fpds.gov/ezsearch/search.do?indexName=awardfull&templateName=1.5.3&s=FPDS.GOV&q=PIID%3A%2275FCMC25FJ001%22%20%20REF_IDV_PIID%3A%22GS35F-303GA%22&x=16&y=11

8 Fein AJ "PBM Power: The Gross-to-Net Bubble Reached $334 Billion in 2023—But Will Soon Start Deflating" *Drug Channels,* July 16, 2024, https://www.drugchannels.net/2024/07/pbm-power-gross-to-net-bubble-reached.html.

9 Allaire BT, Tang Y, Neuwahl S, Buell N, Blackburn H, Lankford M, Palombo C, Khavjou O. Does access to free medication reduce health system costs? An evaluation of the Dispensary of Hope program. *J Manag Care Spec Pharm.* 2023 Feb;29(2):187-196. doi: 10.18553/jmcp.2023.29.2.187. PMID: 36705283; PMCID: PMC10387945.

10 "Negotiating for Lower Drug Prices Works, Saves Billions" U.S. Department of Health and Human Services Press Release, August 15, 2024, https://www.hhs.gov/about/news/2024/08/15/historic-first-biden-harris-administration-successfully-negotiates-medicare-drug-prices-delivers-promise-lower-prescription-drug-costs-american-seniors.html#:~:text=In%20a%20historic%20moment%20that,10%20drugs%20selected%20for%20negotiations.

11 Fein AJ "Gross-to-Net Bubble Update: 2023 Pricing Realities at 10 Top Drugmakers" *Drug Channels,* July 23, 2024, https://www.drugchannels.net/2024/07/gross-to-net-bubble-update-2023-pricing.html.

12 Millman J "Mitigating the Inflation Reduction Act's Adverse Impacts on the Prescription Drug Market" USC Schaefer Center for Health Policy and Economics, April 13, 2023, https://healthpolicy.usc.edu/research/mitigating-the-inflation-reduction-acts-potential-adverse-impacts-on-the-prescription-drug-market/#:~:text=Taken%20together%2C%20these%20provisions%20have,approvals%20during%20the%20same%20period.&text=Lowered%20revenues%20may%20lead%20to,for%20follow%2Don%20drug%20innovation.

13 Shah S, Meyers J, Kirby M, and Chen L "Navigating the Inflation Reduction Act's Impact on Drug Pricing and Innovation" Boston Consulting Group, September 14, 2023, https://www.bcg.com/publications/2023/navigating-inflation-reduction-act-impact-on-drug-pricing-innovation.

14 Editorial Board "Drug Price Controls Mean Fewer Cures: The Inflation Reduction Act is already causing cuts in R&D spending for new medicines" *The Wall Street Journal,* August 14, 2024, https://www.wsj.com/opinion/inflation-reduction-act-drug-price-controls-james-foster-charles-river-laboratories-joe-biden-kamala-harris-0e3af291?mod=opinion_lead_pos1.

15 Winegarden W "Biosimilar Competition Lowers Patient Drug Costs, New Competition Will Bring Even More Savings" Pacific Research Institute, Center for Medical Economics and Innovation, June 11, 2024, https://medecon.org/new-issue-brief-biosimilar-competition-lowers-patient-drug-costs-new-competition-will-bring-even-more-savings/.

16 Fontanillo M, Körs B, and Monnard A "Three imperatives for R&D in biosimilars" McKinsey & Company, August 19, 2022, https://www.mckinsey.com/industries/life-sciences/our-insights/three-imperatives-for-r-and-d-in-biosimilars.

17 Mattingly TJ, Love BL, & Khokhar B "Real World Cost-of-Illness Evidence in Hepatitis C Virus: A systematic review" *PharmacoEconomics* 38, 927–939 (2020). https://doi.org/10.1007/s40273-020-00933-3

18 "Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services" Congressional Budget Office, November 2012, https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/MedicalOffsets_One-col.pdf.

19 Blankart K, Naci H, Chandra A. Availability of New Medicines in the US and Germany From 2004 to 2018. *JAMA Network Open.* 2022; 5(8): e2229231. doi:10.1001/jamanetworkopen.2022.29231

20 Stoner R and Dutra J "BioPharma Economic Impact on the US Economy" Secretariat, April 2023, https://ei.com/wp-content/uploads/2023/05/BioPharma-Economic-Impact-on-the-US-Economy.pdf.

About the Author

Wayne Winegarden

Wayne H. Winegarden, Ph.D. is a Senior Fellow in Business and Economics at the Pacific Research Institute and director of PRI's Center for Medical Economics and Innovation. He is also the Principal of Capitol Economic Advisors.

Dr. Winegarden has 25 years of business, economic, and policy experience with an expertise in applying quantitative and macroeconomic analyses to create greater insights on corporate strategy, public policy, and strategic planning. He advises clients on the economic, business, and investment implications from changes in broader macroeconomic trends and government policies. Clients have included Fortune 500 companies, financial organizations, small businesses, state legislative leaders, political candidates and trade associations.

Dr. Winegarden's columns have been published in the *Wall Street Journal, Chicago Tribune, Investor's Business Daily,* Forbes.com, and Townhall.com. He was previously economics faculty at Marymount University, has testified before the U.S. Congress, has been interviewed and quoted in such media as CNN and Bloomberg Radio, and is asked to present his research findings at policy conferences and meetings. Previously, Dr. Winegarden worked as a business economist in Hong Kong and New York City; and a policy economist for policy and trade associations in Washington D.C. Dr. Winegarden received his Ph.D. in Economics from George Mason University.

About PRI

The Pacific Research Institute (PRI) champions freedom, opportunity, and personal responsibility by advancing free-market policy solutions. It provides practical solutions for the policy issues that impact the daily lives of all Americans, and demonstrates why the free market is more effective than the government at providing the important results we all seek: good schools, quality health care, a clean environment, and a robust economy.

Founded in 1979 and based in San Francisco, PRI is a non-profit, non-partisan organization supported by private contributions. Its activities include publications, public events, media commentary, community leadership, legislative testimony, and academic outreach.

Center for Business and Economics

PRI shows how the entrepreneurial spirit—the engine of economic growth and opportunity—is stifled by onerous taxes, regulations, and lawsuits. It advances policy reforms that promote a robust economy, consumer choice, and innovation.

Center for Education

PRI works to restore to all parents the basic right to choose the best educational opportunities for their children. Through research and grassroots outreach, PRI promotes parental choice in education, high academic standards, teacher quality, charter schools, and school-finance reform.

Center for the Environment

PRI reveals the dramatic and long-term trend toward a cleaner, healthier environment. It also examines and promotes the essential ingredients for abundant resources and environmental quality: property rights, markets, local action, and private initiative.

Center for Health Care

PRI demonstrates why a single-payer Canadian model would be detrimental to the health care of all Americans. It proposes market-based reforms that would improve affordability, access, quality, and consumer choice.

Center for California Reform

The Center for California Reform seeks to reinvigorate California's entrepreneurial self-reliant traditions. It champions solutions in education, business, and the environment that work to advance prosperity and opportunity for all the state's residents.

Center for Medical Economics and Innovation

The Center for Medical Economics and Innovation aims to educate policymakers, regulators, health care professionals, the media, and the public on the critical role that new technologies play in improving health and accelerating economic growth.

Free Cities Center

The Free Cities Center cultivates innovative ideas to improve our cities and urban life based around freedom and property rights—not government.

PACIFIC RESEARCH INSTITUTE

www.pacificresearch.org

MAILING ADDRESS
PO Box 60485
Pasadena, CA 91116

Tel 415-989-0833

SACRAMENTO OFFICE
2110 K Street, Suite 28
Sacramento, CA 95816
Tel 916-389-9774

PASADENA OFFICE
680 E. Colorado Blvd., Suite 180
Pasadena, CA 91101
Tel 626-714-7572

CONNECT WITH US

facebook.com/pacificresearchinstitute

@pacificresearch

youtube.com/pacificresearch1

www.linkedin.com/company/pacific-research-institute

pacificresearchinstitute