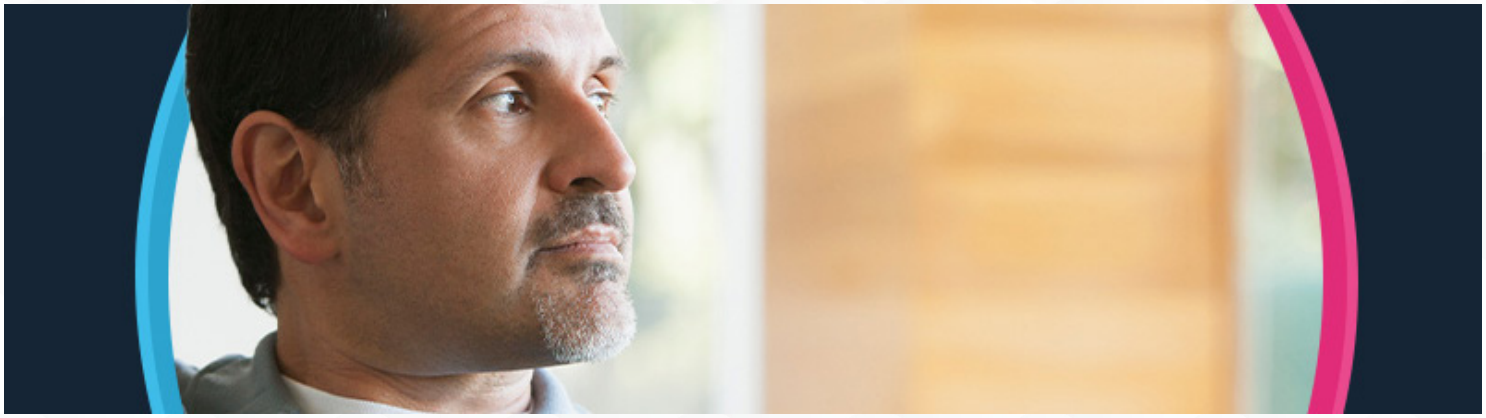
States should avoid repeating the IRA's price-setting mistakes



As states debate new proposals to regulate prescription drug prices—such as prescription drug boards or referencing federal or foreign pricing—it's critical to examine the real-world consequences of government-set prices. These proposals focus narrowly on list prices while ignoring the real drivers of patient costs—insurance design and PBM practices.

Early evidence from the federal Inflation Reduction Act (IRA) offers a clear warning: government price-setting is failing to deliver on its promises to patients while creating new risks to innovation, access, and affordability.

If the goal is truly to help patients, states should learn from the IRA's missteps—not follow the path of government price-setting.

Three takeaways state leaders should not ignore:

1. **Patients are paying more and facing fewer choices.** Since the IRA was enacted, more Medicare plans have increased utilization management and shifted costs onto patients. Avalere Health's analyses of 2025 and 2026 Part D plan formularies found Part D plans were tightening access to branded medicines, changes that could translate into fewer therapeutic alternatives within classes that contain drugs with an MFP. Today, roughly two-thirds of Medicare Part D beneficiaries are enrolled in plans that use coinsurance instead of copays, a change that exposes many patients to higher out-of-pocket costs. As a result of these shifts, about 60% of beneficiaries in those plans are projected to pay more for six of the medicines for which Medicare set the prices for 2026, underscoring how the IRA's pricing changes are already translating into higher cost-sharing for patients.

2. **Price-setting is shrinking the pipeline of future cures.** Government price-setting under the IRA has sent a chilling signal to researchers and investors. Since the IRA's passage, funding for early-stage research into small molecule medicines (including pills, tablets, capsules and liquids), which are scrutinized for price-setting just 7 years after FDA approval, has dropped by nearly 70%. These treatments are often the backbone of care for conditions like cancer, heart disease and Alzheimer's—diseases that disproportionately affect seniors. State-level price controls would compound this damage, discouraging the very innovation patients are counting on tomorrow.

3. **Clinical progress slows when the government dictates prices.** Clinical trial activity following the passage of the IRA tells the same story. New trials for small molecule medicines are down roughly 25%, and studies exploring new uses for existing medicines—often where breakthroughs occur—have fallen by as much as 45%. For cancer patients, this is especially concerning: many life-extending therapies are approved years after a drug's initial launch, just as price controls take effect under the IRA. State price-setting policies risk cutting off progress midstream.

THE BOTTOM LINE:

These takeaways are not unique to Medicare price-setting—they are inherent risks of any government price-setting approach. Price-setting creates uncertainty for patients and the supply chain while ignoring the real drivers of costs, such as unchecked PBM practices and excessive hospital markups. Many states are beginning to employ more effective tools, such as requiring health insurance companies and PBMs to share at least part of their negotiated savings with patients at the pharmacy counter, as well as protecting patient assistance and insurance design fixes, to reduce patient costs today without jeopardizing access, competition or innovation. If states want to improve affordability and access, the lesson from the IRA is simple: don't repeat a policy that's already failing patients.

Learn more at PhRMA.org/States

PhRMA
RESEARCH + PROGRESS = HOPE