Industry Update

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Access in all areas? A round up of developments in market access and health technology assessment: part 7

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In this update, we discuss the implementation progress of the Medicare Drug Price Negotiation Program, with particular focus on the second round of negotiations for 15 additional Part D drugs; explore the role of health technology assessment in US commercial health plan decision-making; and examine significant changes to pharmaceutical pricing systems in Germany, where international reference pricing has been eliminated as part of the Medical Research Act.

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The Medicare Drug Price Negotiation Program has entered a new phase of implementation, building upon the foundation established in its inaugural cycle [1]. The first negotiation cycle ended in late 2024 with ten Part D drugs having maximum fair prices effective January 2026 [2,3]. In January, the Centers for Medicare & Medicaid Services (CMS) selected 15 additional Part D drugs for the second negotiation cycle, with negotiated prices taking effect in 2027. The release of explanations regarding the first-round pricing determinations has generated concerns as to how maximum fair prices were arrived at. The CMS produced extensive documentation, and have stated they evaluate manufacturer-specific factors (including reasearch and development [R&D] costs, production expenses, federal support, patent status, and market data) alongside comparative factors against therapeutic alternatives (including therapeutic advancement, comparative effectiveness across populations, and ability to address unmet medical needs) [2,3]. However, the CMS have failed to illuminate the actual decision-making framework employed in price determinations; for example, the comparison methodology between selected drugs and their therapeutic alternatives and how these various factors were weighted. Against this backdrop of methodological uncertainty, the drugs selected for the next round include the often talked about Ozempic® (as well as Rybelsus® and Wegovy®), along with a number of oncology treatments (Table 1). Many of these drugs were expected to be included [4,5], and for a number of manufacturers this is the 2nd year of participating in pricing negotiations. Key milestones for the negotiation this year include initial price offers from CMS scheduled for 1 June 2025, with final agreements required by 30 November 2025, preceding the 1 January 2027 price implementation. Industry concerns persist, particularly regarding the program's potential effects on innovation and patient access. The 'pill penalty', which accelerates price negotiations for small molecule medications compared with biologics, remains a specific point of contention. The program's future may be influenced by political uncertainties, with the administrative change potentially affecting implementation approaches. Success will likely depend on CMS' ability to establish a more transparent methodological framework while maintaining necessary confidentiality and achieving meaningful price reductions for Medicare beneficiaries. As the program continues to evolve, stakeholders across the healthcare spectrum are closely monitoring its impacts on both medication accessibility and pharmaceutical innovation.

While the Medicare negotiation program represents a shift in federal approaches to drug pricing, understanding the broader landscape of reimbursement in the USA requires examining commercial payer practices. Unlike many European countries where centralized health technology assessment (HTA) bodies directly influence patient access

Table 1. Selected drugs for the second round of Medicare price negotiation.

Drug	Indication
Ozempic/Rybelsus/Wegovy	Type 2 diabetes and obesity/overweight
Trelegy Ellipta	Asthma and chronic obstructive pulmonary disease
Xtandi	Prostate cancer
Pomalyst	Kaposi sarcoma and multiple myeloma
Ibrance	Breast cancer
Ofev	Idiopathic pulmonary fibrosis
Linzess	Chronic idiopathic constipation and irritable bowel syndrome with constipation
Calquence	Chronic lymphocytic leukemia/small lymphocytic lymphoma and mantle cell lymphoma
Austedo/Austedo XR	Chorea in Huntington's disease and tardive dyskinesia
Breo Ellipta	Asthma and chronic obstructive pulmonary disease
Tradjenta	Type 2 diabetes
Xifaxan	Hepatic encephalopathy and irritable bowel syndrome with diarrhea
Vraylar	Bipolar I disorder, major depressive disorder and schizophrenia
Janumet/Janumet XR	Type 2 diabetes
Otezla	Oral ulcers in Behçet's disease, plaque psoriasis and psoriatic arthritis

to health technologies, the role of HTA in US payer decision-making has remained less clearly defined. US payers are not bound by the recommendations of a HTA body and rely on their own pharmacy and therapeutics committees for coverage decisions, resulting in differences in coverage between payers and decisions that may not align with HTA findings. In order to better understand the role of HTA in commercial health plan decision making, Enbright and colleagues assessed the frequency with which large US commercial health plans reference HTAs in publicly available specialty drug coverage policies [6]. The researchers analyzed over 14,000 citations of evidence in specialty drug coverage policies from 17 large US commercial health plans and found that HTAs represented only 3.2% of all cited evidence. This was significantly less than clinical guidelines (37.1%) and randomized controlled trials (30.0%). All health plans cited HTAs, however the frequency of HTA citation varied substantially across health plans (0.1–7.4%), with one plan accounting for over half of all HTA citations. HTAs from 27 HTA bodies were cited, with most of the citations coming from ex-US organizations. The largest number of citations came from HTAs from England's National Institute for Health and Care Excellence (30.7%), followed by US-based Institute for Clinical and Economic Review (17.7%), and Canada's Drug Agency (formerly the Canadian Agency for Drugs and Technologies in Health) (13.4%). Health plans differed in their citation of US versus ex-US HTAs and most cited HTAs (78.8%) included cost–effectiveness assessments. While this analysis has just investigated citations and did not look in detail as to how HTAs may have been used in decision making, Enbright *et al.* show that HTAs may be considered when formulating coverage policies in the US, and US plans cite HTAs from both ex-US and US organizations. For pharmaceutical manufacturers, these findings highlight both challenges and opportunities. It is often thought that HTA is irrelevant for US payer decision making. If the suggestion from the Enbright study is true, i.e., HTA does indeed influence decision making in the US, developing robust economic evidence may increase the likelihood of favorable coverage determinations. The relevance of ex-US HTAs to a US setting needs discussion, and as noted in the last part of this series [7], manufacturers should look to methods such as generalized cost–effectiveness analysis to demonstrate the societal value of their medicines to HTA bodies and payers to help shape the dialogue on value assessment.

Beyond developments in the US, significant changes to pricing systems, particularly in Germany, are reshaping global pharmaceutical pricing. International reference pricing (IRP) has been a cornerstone of pharmaceutical pricing policies globally, particularly in Europe. This practice involves countries setting drug prices based on those in a reference basket of other nations, using various formulas (lowest price, average, median) to establish price ceilings. IRP aims to contain pharmaceutical costs while promoting access to medicines, though its implementation varies significantly across countries both in methodological approach and effectiveness. Historically, Germany employed a sophisticated IRP approach that factored in therapeutic costs of comparable medicines and actual selling prices in other European countries, weighted by turnover and purchasing power parities. This has now been eliminated as part of the Medical Research Act [8]. Currently, ongoing benefit assessment procedures, which were launched prior to the beginning of 2025, are likely to be carried out in line with the law as it applied when they were initiated.

Therefore, it is unlikely that there will be any IRP-free price negotiations until later this year, and the implications of the removal of IRP are unlikely to be clear until then. Price negotiations without IRP will be focused on other criteria contained in the framework agreement, such as the annual costs of therapy of comparable medications and the benefit assessment by the Gemeinsamer Bundesausschuss (G-BA). The IRP policy change has been overshadowed by other elements of the Medical Research Act, most notably the opportunity for pharmaceutical companies to opt for confidential pricing agreements. To qualify for this concession, manufacturers must have R&D departments in Germany that are involved in projects with German public institutions for preclinical or clinical pharmaceutical research and also offer an additional 9% discount. As one of Europe's largest pharmaceutical markets and typically an early-launch country, Germany historically has had significant influence on drug pricing throughout Europe and globally. Many countries – including those in Europe as well as Canada, Japan and South Korea – include Germany in their IRP reference baskets. With Germany's transition toward confidential rebates, transparent price referencing becomes more difficult for other countries relying on German list prices. For pharmaceutical manufacturers, this change presents both opportunities and challenges. Companies can now negotiate confidential prices in Germany without the automatic spillover effect to other markets that reference German prices. This may preserve higher price points in some markets while offering competitive discounts in Germany. However, this depends if the confidential price is worth accepting. Launch sequencing strategies may need to evolve if more companies use confidential pricing in Germany. The move from Germany follows similar trends seen in other markets like the UK, where confidential pricing arrangements have become more common and underscores the growing limitations of IRP in an era of increasingly complex and confidential pricing arrangements. While IRP has been shown to contribute to cost containment through downward pressure on prices, the trend toward confidential agreements may gradually render traditional reference pricing mechanisms less effective, potentially requiring health systems to develop more sophisticated approaches to pharmaceutical price negotiations.

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References

1. CMS.gov. HHS Announces 15 Additional Drugs Selected for Medicare Drug Price Negotiations in Continued Effort to Lower Prescription Drug Costs for Seniors. Available at: https://www.cms.gov/newsroom/press-releases/hhs-announces-15-additional-drugs-selected-medicare-drug-price-negotiations-continued-effort-lower
2. CMS.gov. Medicare Drug Price Negotiation. Available at: https://www.cms.gov/inflation-reduction-act-and-medicare/medicare-drug-price-negotiation
3. Beattie A, Treharne C, Mardiguian S, Ramagopalan SV. Access in all areas? A round up of developments in market access and health technology assessment: part 2. *J. Comp. Eff. Res.* 12(12), e230162 (2023).
4. Vogel M, Tellier A, Conti RM. Predicting the next round of drugs for Medicare price negotiation. *Sci. Transl. Med.* 16(776), eadq5711 (2024).
5. Cousin EM, Sullivan SD, Hansen RN, Gabriel N, Kirihennedige AS, Hernandez I. Drugs anticipated to be selected for the Medicare Drug Price Negotiation Program in 2025. *J. Manag. Care Spec. Pharm.* 30(11), 1203–1210 (2024).
6. Enright DE, van Duijnhoven EG, Ollendorf DA, Chambers JD. Use of health technology assessments in specialty drug coverage decisions by US commercial health plans. *J. Manag. Care Spec. Pharm.* 31(3), 289–295 (2025).

7. Jullien Pannelay A, Gilardino RE, Ramagopalan SV. Access in all areas? A roundup of developments in market access and health technology assessment: part 6. *J. Comp. Eff. Res.* 14(3), e240239 (2025).

8. Bundesministerium für Gesundheit. Medizinforschungsgesetz (MFG). Available at: https://www.bundesgesundheitsministerium.de/service/gesetze-und-verordnungen/detail/medizinforschungsgesetz.html