Drug Pricing Lab
Memorial Sloan Kettering

Drug Pricing Lab Data Brief

Remdesivir less expensive for 'government programs.' Not so fast.

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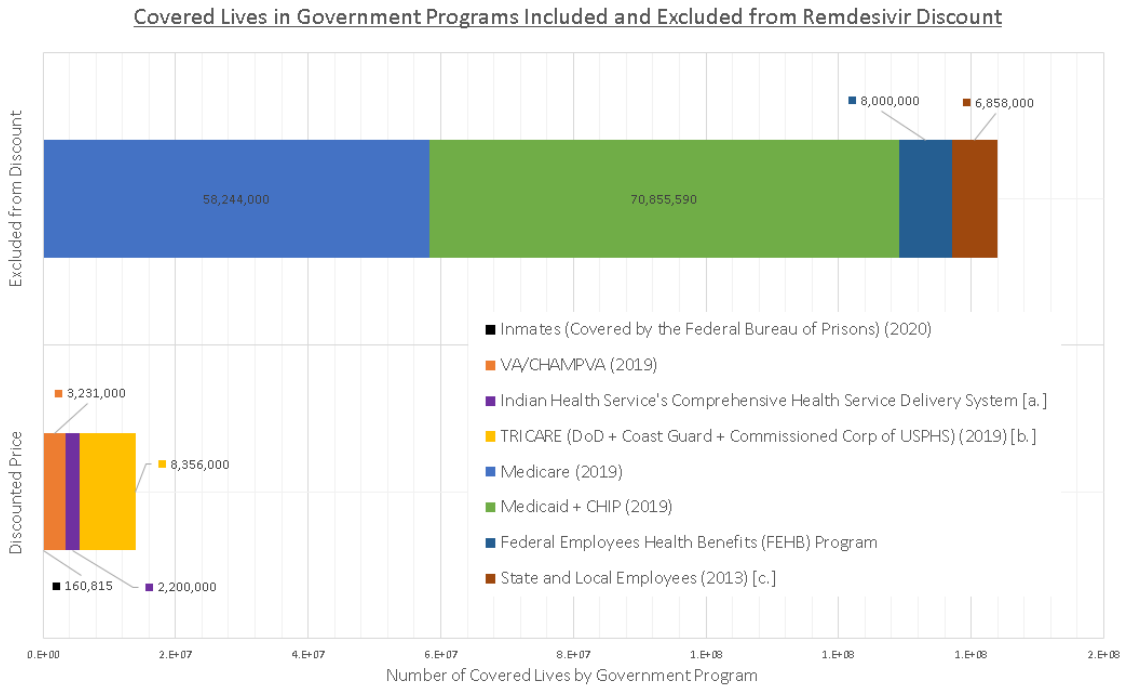
Yesterday Dan O'Day, the CEO of Gilead, promised on CNBC and in an open letter that Remdesivir would have a lower 'government price' ($2,340) than 'private insurer' price in the US ($3,120) for a five day course. Other countries will get the lower of these prices too. O'Day's claim was translated in the WSJ that the discount would apply to the Medicare program, and in STAT and by ICER as it applying in Medicaid. These stories were later corrected as the discount will exclusively go to a smattering of smaller government programs (chart). Even if Gilead wanted to provide discounts to the programs that people assumed were included in their statement, they cannot.



Sources: Inmates[1], VA/CHAMPVA[2], TRICARE[2], Medicare[2], Medicaid + CHIP[3], Federal Employees Health Benefits Program[4], Indian Health Service[5], and State and Local Employees[6].

[1] The Indian Health Service is responsible for providing federal health services to American Indians and Alaska Natives via a comprehensive health service delivery system[7,8].
[2] TRICARE's covered lives includes those covered through the U.S. Coast Guard and the Commissioned Corps of the U.S. Public Health Service[9].
[3] Estimation from a 2013 study of state health insurance plans[6].

Medicare and Medicaid do not buy drugs for inpatient care:

Medicare and Medicaid neither purchase drugs nor reimburse for them when they are given to inpatients, and Remdesivir is a treatment for inpatients. With occasional exceptions these insurance programs pay lump sums for all-inclusive care for the patient – an amount that goes up and down based on how severe the patient's diagnosis is, but not how costly an individual patient is. This 'diagnosis based' payment is the standard across Medicare and the predominant form of payment in Medicaid, with a few Medicaid states breaking payments into all-inclusive *per diem* fees instead. Hospitals use these payments to cover their costs – sometimes they spend less than the amount, sometimes more, but it all works out in the end is the theory.

Gilead could have done better, and still can:

If Gilead wishes to discount Remdesivir to the full array of government programs, rather than a smattering of small ones, the company has two options.

1. It could simply lower its price in the US the 'government rate'. This would functionally avail hospitals of the lower price for the treatment, which would flow through as savings to Medicare and Medicaid as payment rates are routinely reset based on costs along with helping hospitals that are currently far more financially strapped than Gilead in the midst of this pandemic. This would also put the treatment's price at parity across the globe, which has a certain logic given the pandemic itself is global.
2. It could work with the Centers for Medicare and Medicaid Services to arrange for after the fact rebates to the Federal Medicare program, the FEHBP, state Medicaid programs, and other government insurance programs for those beneficiaries who receive Remdesivir treatment. After the fact reconciliation would require a very substantial effort however, as hospitals do not routinely report what treatments were given during inpatient stays. So maybe the company should just choose option 1.

References

1. Federal Bureau of Prisons. Inmate Age Statistics. https://www.bop.gov/about/statistics/statistics_inmate_age.jsp. Updated June 27, 2020. Accessed June 30, 2020.
2. United States Census Bureau. Health Insurance: Tables 2018-forward: H-02 Health Insurance Current Coverage Status and Type of Coverage by Selected Characteristics: 2019. https://www.census.gov/data/tables/time-series/demo/income-poverty/cps-hi/hi.html. Accessed June 30, 2020.
3. Medicaid.gov. Updated December 2019 Applications, Eligibility and Enrollment Data. https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html. Updated June 22, 2020. Accessed June 30, 2020.
4. U.S. Office of Personnel Management. Healthcare Reference Materials: FEHB Program Handbook Introduction. https://www.opm.gov/healthcare-insurance/healthcare/reference-materials/fehb-handbook/#:~:text=General%20Overview,family%20members%2C%20and%20former%20spouses. Accessed June 30, 2020.
5. Indian Health Service: The Federal Health Program for American Indians and Alaska Natives. For Patients. https://www.ihs.gov/forpatients/. Accessed June 30, 2020.
6. The Pew Charitable Trusts and the John D. and Catherine T. MacArthur Foundation. State Employee Health Plan Spending: An examination of premiums, cost drivers, and policy approaches. https://www.pewtrusts.org/~/media/assets/2014/08/stateemployeehealthcarereportseptemberupdate.pdf. Published August 2014. Accessed June 30, 2020.
7. Indian Health Service: The Federal Health Program for American Indians and Alaska Natives. Three Things You Should Know. https://www.ihs.gov/aca/thingstoknow/. Accessed June 30, 2020.
8. Indian Health Service: The Federal Health Program for American Indians and Alaska Natives. About IHS. https://www.ihs.gov/aboutihs/. Accessed June 30, 2020.
9. Eligibility. TRICARE. https://eligibility.com/tricare#:~:text=Generally%2C%20you%20are%20eligible%20for,National%20Guard%20or%20Reserve%20member. Published September 25, 2017. Accessed June 30, 2020.