



The Daily Dish

Drug Pricing (Again)

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Monday the president took to the microphone to build support for this Build Back Better Act (BBBA), specifically the drug pricing reforms: “Today, I’d like to talk about how we’re going to help millions of Americans protect and preserve their health and live with the dignity of knowing that they can care for themselves and their loved ones, all by making the cost of prescription drugs much more reasonable.”

He then pivoted to the most common assertions regarding drug pricing: “Here in America, it will not surprise you to know that we pay the highest prescription drug prices of any developed nation in the world. Let me say that again: We pay the highest — highest prescription drug prices of any developed nation in the world. That may surprise you — what may surprise you is we pay about two to three times what other countries pay for the same drug.”

The problem is that these sweeping assertions are not true. Generic drugs are cheaper in the United States than elsewhere, and something on the order of 90 percent of prescriptions are filled with generics. Brand-name, on-patent drugs can be very expensive, but not every drug is a problem. Instead, the problems are isolated to a relatively small number of specialty (largely cancer) drugs. If one wants to get the treatment right, it is important to get the diagnosis correct. The notion of every drug being mispriced is too sweeping and invites the mistaken, one-size-fits-all approaches that have prevailed to date.

What *are* the proposals on the table at this point? There are [four main areas](#). The first is to cap the out-of-pocket cost for insulin. This is pure price-fixing and panders especially to the seniors in Medicare. Price-fixing has a long track record of policy failure across the issue areas.

The second is a redesign of the Part D drug benefit. (See Tara O’Neill Hayes’ proposal [here](#).) This would cap total out-of-pocket cost for seniors (good idea) and sharpen the incentives for Part D plans, prescription drug benefit managers, and manufacturers to bargain aggressively by putting the private sector on the hook for more of the Part D costs.

The third is [inflation penalties](#) such that a drug company must provide to the government any revenue that stems from price increases above the rate of general inflation – a 100 percent tax on prices above the general inflation rate. Notice that this includes drug sales in the commercial market, as well as in government programs, such as Medicare and Medicaid. That’s a sweeping intervention.

Finally, there is the “[negotiation](#)” in Parts B and D that are enabled by a tax of up to 95 percent on the domestic sales of drugs by manufacturers that the Secretary of Health and Human Services deems as failing to negotiate in good faith. That’s simply an abuse of tax policy. There is no pretense of revenue-raising; it is simply a cudgel with which the Secretary can force prices even further below the 40 to 75 percent of the average manufacturer’s price (AMP) that the legislation imposes as a cap. The tax enables the negotiation on 10 to 20 drugs (depending on the year) that cost Medicare a lot of money. But it would be in statute and the temptation to increase the number of drugs in negotiation will be overwhelming.

While the Part D redesign is valuable, the remaining three get steadily worse.

The final point is that these policies would do the wrong thing in part because they would be enacted on a partisan basis. If Congress were to pursue bipartisan reforms, under regular order, there would be two advantages. First, the proposals would reflect the input from both sides and would likely be less sweeping and more focused on the problem areas. Second, the laws would have buy-in from both sides and be politically more durable. If the BBBA becomes law, it also becomes a target for repeal – like the Tax Cuts and Jobs Act and Affordable Care Act before it.