The Daily Dish

Regulation and Drug Prices

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Eakinomics: Regulation and Drug Prices

Nearly everyone expects Congress to do "something on drug prices" this year, although exactly what is far from clear. Recall, however, that the administration has already launched a broad initiative (its "Blueprint") to address the drug pricing issue. A signature — and contentious — element of this is its proposed demonstration project on reimbursements in Part B. Perhaps lost in the end-of-year, government shutdown, New Year, New Congress noise is the fact that comments on this proposal were due to the Department of Health and Human Services (HHS) by December 31, 2018. AAF's Tara O'Neill Hayes responded to the request with this thoughtful submission.

Recall that, at present, when Medicare beneficiaries receive drugs in a hospital, doctor's office or similar setting (as opposed to getting drugs at the pharmacy), the provider is reimbursed the Average Sales Price (ASP) of the drug in market transactions, plus 6 percent to cover the cost of administering the drug. There are two complaints with this system. First, there may be nothing "right" about the ASP and Medicare provides no incentives to get acquisition costs any lower. Second, the 6 percent administration fee may bear no correspondence to the actual cost of episode, and also rewards the provider for picking a higher ASP drug over a cheaper one.

The administration's approach is to implement a demonstration project through the Center for Medicare and Medicaid Innovation (CMMI) to test a new reimbursement model for Medicare Part B. A key part is to set reimbursement at a fixed percentage of a new International Price Index (IPI) based on the average price of a drug in selected other countries (14 are listed in the original description). This demonstration project will apply to selected drugs and all providers within the selected geographic areas; areas will be chosen to account for 50 percent of annual Medicare Part B drug spending.

The threshold consideration is whether it is desirable to use a CMMI demonstration in this way. (It is certainly possible; Congress gave away the store when it created CMMI under the Affordable Care Act.) Of course, it is not merely a "demonstration" or a "project" when the goal is to affect one-half of Part B spending. As a matter of principle, something this significant should be done via legislation. At some level, however, the administration needs to "go big." After all, the whole idea is that tying reimbursement to IPI will result in much lower payments to drug manufacturers, unless overseas sale prices rise. The bigger the affected spending, the bigger the impact on drug companies, and the greater the incentive to have higher prices abroad. The desire for success is at odds with first principles.

Regardless, the proposal doesn't look like it will be successful in affecting drug prices. Instead, it will simply be a fiat reduction in the Part B payments. As Hayes points out, this carries three health policy implications:

- Restricted access to existing medicines. The 14 countries in the IPI on average have access to only 48 percent of the new drugs developed in the past eight years, and it took an average of 16 months after their initial global launch for those drugs to become available in those 14 countries. Mimicking these countries may mean reduced access.

- Reduced innovation for future advancements and new medicines. The cut of roughly $9 billion in reimbursements means fewer new medicines may be developed each year if drug manufacturers are unable to recoup these lost revenues in other markets.
- Cost-shifting to other health insurance markets and federal programs. Drug manufacturers will instead attempt to recoup their reduced reimbursements in other health care markets in the United States, namely the employer-sponsored insurance market.

One reaction among conservatives has been to dismiss the proposal on ideological grounds, especially the idea that it simply "imports price controls." My concern is that it won't work.