The Daily Dish

Trump's Drug Price Initiative

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Eakinomics: Trump's Drug Price Initiative

Yesterday the president personally rolled out an "Advance Notice of Proposed Rulemaking (ANPRM)" regarding "International Pricing Index Model for Medicare Part B Drugs." This is DC-speak for "this is what I plan to do about high drug prices." The proposal is focused on those Medicare drugs that are administered in hospitals and physician offices ("Part B," as opposed to drugs bought at the pharmacy, or "Part D"). Currently, physicians are reimbursed 106 percent of the average sales price (ASP) for drugs they administer to their patients.

The core of the proposal is to make two changes. First, hospitals, doctors, and other providers will be reimbursed a fixed fee to cover the cost of administration. Notice that with the fixed fee (instead of 6 percent of the drug's ASP), they have no incentive to seek higher drug prices. Second, they will purchase the drugs from any drug vendor who wants to get into the business of buying from pharmaceutical manufacturers and selling to the hospitals and physicians. For every sale, the vendor will be paid 126 percent of the International Price Index (IPI) for the drugs. Notice that the vendors have every reason to negotiate low prices (and pocket the difference with the fixed 126 percent of the IPI) with the manufacturers.

Now comes the important part. As a stylized fact, drug prices are lower around the globe than in the United States; the price in the U.S. is about 180 percent of the average overseas. So, taken at face value, the change is an enormous cut in prices in the United States and pressure for negotiation down. What can a drug maker do? Raise prices abroad to make up the difference. The system — in principle — is supposed to move toward equalizing prices, retaining sufficient profitability for pharmaceutical companies, and spreading the (expensive) costs of research and development more equally across the globe.

As an example, suppose a drug is sold for $200 in the United States and $100 abroad. In simple terms, the drug company is paid $300 for the two sales and Medicare is paying $212 for the treatment. If the new reimbursement is immediately applied, the hospital in the United States will get the fixed fee, say $12. The vendor will get $126 so Medicare pays a total of $138 and saves money. The vendor will be willing to pay $126 or less to the drug company; let's say they bargain down to $120. Suddenly revenue to the drug manufacturer is only $220 instead of $300.

This cannot persist.

The Trump Administration's dice roll is that the drug manufacturer can get the international price and domestic price to equalize at $150. If so, research and development can continue as before. At that price, Medicare is paying only $201 (126 percent of $150 plus $12) — less than the $212 currently. And the vendors can compete to be the supplier and keep the markup from $150 to $189.

But that is a BIG if. Countries around the globe have low prices because they have consistently told manufacturers to take the low price or simply not be able to sell. That is one reason that 90 percent of new drugs

are available to U.S. patients, but only two-thirds are available in the U.K., one-half in France and Canada, and one-third in Australia. If international prices don't change, the new formula will effectively import their price controls to the Medicare system. With artificially low prices, the money will have to come from somewhere else — commercial insurers in particular — or drugs will simply not be available and U.S. patients will pay in the most fundamental terms.

There are a million other details and questions about the proposed demonstration — measuring prices accurately, picking the comparison countries, deciding which drugs will be in the demo, deciding which areas will be in the demo, and so forth. Those will all matter. This is a dramatic and risky proposal that needs a lot of specifics and details to be truly assessed well.