Insight

Comparing the Recent Drug-Pricing Reform Proposals

TARA O’NEILL HAYES | DECEMBER 10, 2019

If lawmakers’ desire to lower drug prices can be measured by the number of bills they introduce, it seems fair to say their desire is strong. In the past few days, a number of bills have either been introduced or re-introduced, while another will be formally considered this week. At least two of the bills have bipartisan support, and a third, while introduced only by Republican members of Congress, consists largely of provisions that have previously garnered bipartisan support. These bills include 70 distinct measures intended to reduce spending on prescription drugs in one way or another.

These bills are:

- **S. 2543**, the Prescription Drug Pricing Reduction and Health and Human Services Improvements Act, a bipartisan bill from the Senate Finance Committee;
- **S. 1895**, the Lower Health Care Costs Act, a bipartisan bill from the Senate Health, Education, Labor, and Pensions (HELP) Committee;
- **H. R. 19**, the Lower Costs, More Cures Act, from the House Republicans of the Energy and Commerce, Ways and Means, Education and Labor, and Judiciary Committees; and
- **H. R. 3**, the Lower Drug Costs Now Act, from Speaker Nancy Pelosi, which will be considered this week and which includes what would arguably be the most sweeping changes to how the United States pays for drugs to date—including implementing federal negotiation of drug prices.

This analysis compares these bills and notes the most significant reforms they are proposing. While there are unique parts to each bill, the bills’ provisions overlap significantly.

**Past AAF Analyses of These Drug-Pricing Reform Proposals**

A summary of the original version of the Senate Finance bill can be found here; aside from tweaks to the Medicare Part D benefit design reforms, the revised bill is largely similar to the original. A summary of the drug pricing provisions originally included in the Senate HELP legislation is here; this legislation also includes provisions to address surprise billing and a number of public health measures.[1] Most of the provisions included in H.R. 19 can be found in either the Finance or HELP packages or were included in various other bills previously considered by Congress. Further, many of the provisions in these bills are similar to proposals that the administration has put forward.

**Most Notable Reforms**

*Federal Negotiation of Drug Prices*
H.R. 3 includes new authorities for the Secretary of Health and Human Services to negotiate the price of drugs directly, using as a benchmark a weighted average of the international prices of such drugs, as explained here. This proposal is similar to a proposal from the administration to establish an International Pricing Index. The bill would authorize the secretary to negotiate prices on up to 250 drugs annually (the 125 most expensive drugs provided under each Medicare Part B and Part D).

Medicare Part B and Average Sales Price

Most of the Medicare Part B provisions focus on tweaks to the average sales price (ASP) payment methodology used for provider-administered drugs, with the changes seeking to encourage the use of lower-cost drugs, including biosimilars. One unique provision of note from H.R. 19 is section 103, which provides for variation in the Medicare Part B ASP payment rate based on the drug’s price per beneficiary. If a drug’s per beneficiary charge ranks in at least the 85th percentile, the Medicare payment would be reduced to 104 percent of ASP (rather than the currently standard 106 percent). For drugs ranked in the 70th to 84th percentiles, payment would continue to be 106 percent of ASP. For drugs in the 50th to 69th percentiles, payment would increase to 108 percent of ASP. Finally, for the half of drugs with the lowest per beneficiary charges, payment would increase to 110 percent of ASP.

The Benefit Structure of Medicare Part D

The most significant Medicare Part D provisions are those that would reform the benefit structure, similar to the proposal first put forward by AAF in 2018. S. 2543, H.R. 3, and H.R. 19 all include such a reform, with some differences. The key components included in each of these proposals include providing beneficiaries an out-of-pocket cap, reducing the government’s reinsurance liability in the catastrophic phase, and requiring drug manufacturers to pay a share of the costs incurred in the catastrophic phase.

While each of the proposals sets slightly different parameters (which will result in substantial differences in the impact, particularly to the pharmaceutical industry), the various proposals are now more similar to each other than when originally introduced. The most significant change was a tweak to the Senate Finance bill which now would require drug manufacturers to cover a share of the costs in the initial coverage phase (7 percent) in addition to their liability in the catastrophic phase (now set at 14 percent). H.R. 3 would require manufacturers to cover 10 percent of costs in the initial coverage phase and 30 percent in catastrophic, while H.R. 19 would require a 10 percent manufacturer liability in both phases.

Other Notable Reforms

Finally, other measures include provisions aimed at increasing price transparency (including around discounts and rebates obtained by pharmacy benefit managers); increasing competition in the supply of drugs by making it easier for new products to come to market; and reforms to the Medicaid Drug Rebate Program.

Comparing Specific Provisions
Below is a comparison of the various bills showing, by section number, the significant overlap and few areas of uniqueness. Some of the areas where there is a lack of unanimous overlap is a function of a particular committee’s lack of jurisdiction rather than a lack of support for such a provision. Shaded blocks (found in the attached PDF at the end) or bolded numbers (below) denote areas where the bills include similar, but slightly different, provisions; otherwise, the provisions are identical or nearly identical.

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[1] The surprise billing provisions have been revised since this summary from AAF was written in July 2019 to reflect a bipartisan, bicameral compromise. The new provisions include the establishment of an in-network
benchmark rate upon which patients’ cost-sharing would be based, as well as the option for parties to use an independent dispute resolution (binding arbitration) for bills exceeding $750.