



Weekly Checkup

Importing Drug Price Controls

CHRISTOPHER HOLT | JUNE 21, 2019

This week, Senate Finance Committee Chairman Chuck Grassley made news when he [publicly opposed](#) a Trump Administration proposal to tie Medicare payments for drugs to the prices paid by other countries. Senator Grassley's opposition is not surprising, for several reasons.

Critics of drug pricing have long pointed to the Medicare Part B program as an example of where the government pays too much for drugs. While most Medicare beneficiaries get most of their drugs through the Part D program, physician-administered drugs are reimbursed through Part B. These drugs do not face the same competitive pressures that mark the Part D program, and critics often complain that the government is left in the position of paying any price a drug company wants, regardless of value.

In reality, Part B reimburses physicians for the drugs at the average sale price of the drug nationwide, plus a 6 percent add-on payment to cover physician costs and services. As a result, **the price Medicare pays is influenced by market factors and competition, albeit in a limited form.** This structure does create a perverse incentive for doctors to prescribe more expensive drugs, however, and this is one problem that the Trump Administration is looking to solve.

In October 2018, the president announced an Advance Notice of Proposed Rulemaking (ANPRM) that would reform the Medicare Part B program in a couple of ways. First, the proposal would replace the 6 percent payment with a fixed fee. This step would mitigate any incentive for providers to prescribe higher cost drugs as a way of enhancing their add-on payment. But the administration was not content with this change. **Second, and problematically, the proposal would establish an International Price Index (IPI) for Part B drugs and limit reimbursement for drugs administered through Part B to 126 percent of the IPI.** The IPI, as currently proposed, would consist of 16 countries. Part Bs payments would be based on an average of the prices that these countries pay for a particular drug.

AAF's Tara O'Neill Hayes has written detailed [comments](#) on the problems with this proposal. But here are three pressing concerns. **First, this proposal is in effect government price setting by a different name.** Most, if not all, of the countries being considered for inclusion in the index engage in some form of government price setting for drugs, and many also have their own indices which in turn reference other countries that are hardly comparable economically to the United States. Importing other countries' imported price controls isn't really different from instituting price controls ourselves. And implementing price controls, even indirectly, would be a fundamental shift in the way the U.S. government has always engaged with health care and markets more broadly.

The second issue with IPI is one of access. As Hayes’ notes in her comments, “in the 14 countries being considered by [the Centers for Medicare & Medicaid Services] for the IPI, only 48 percent of all new medicines and 57.1 percent of new cancer medicines are available, and it takes an average of 16 months and 17.8 months, respectively, for access to those medicines to be gained.” In contrast, in the United States 89 percent of all new medicines and 96 percent of new cancer medicines are available within three months. **Other countries can limit their drug spending, in part, because they are willing to say no to innovative treatments for their citizens in the interest of their budget constraints. But to date, Americans have not been willing to let their government make this tradeoff.**

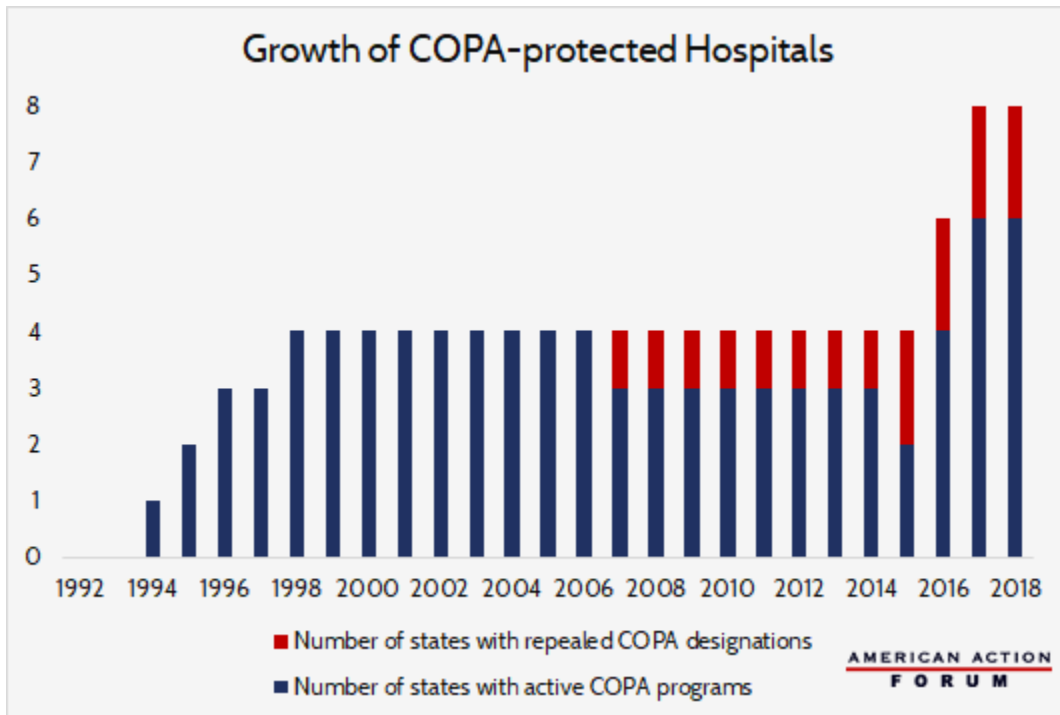
Finally, it’s just not clear that the IPI would meet it’s stated objective of forcing other countries to pay a larger share of drug costs. Presently the United States does, in effect, subsidize pharmaceutical research and development for the rest of the world through our higher drug costs. But it’s unlikely that the IPI will empower drug companies to negotiate higher payments from other countries. The more likely outcome is that the United States will simply pay less and no one will make up the difference, leading to decreased access to both current and future treatments.

Chairman Grassley’s decision to oppose the IPI proposal publicly shouldn’t surprise anyone. The real surprise is that it took this long, and that more members of Congress haven’t joined him.

CHART REVIEW

Ryan Haygood, Health Care Policy Intern

On Tuesday, the Federal Trade Commission (FTC) hosted a [series of panels](#) on Certificate of Public Advantage (COPA) laws, webs of regulation which some states have offered to large hospital systems in exchange for antitrust immunity. Though the panelists differed about the proper role of COPA protections, they agreed that these state regulatory schemes are extraordinarily difficult to implement and [often ineffective](#). Some worry, too, that hospitals whose merger would ordinarily bring FTC action may accept COPA regulation only to later lobby for its repeal – a scenario that has now happened in two states – leaving behind an unregulated legal monopoly that’s nearly impossible for the FTC to unscramble. Although these schemes are still uncommon, they’re gaining attention, with four states granting COPA designations to hospitals since 2016 and [Texas](#) passing COPA provisions just this year.



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WORTH A LOOK

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[Modern Healthcare](#): Senate health bill includes pay cap for surprise bill disputes