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Pegging US Medicare prices to international index not the easy answer it looks

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The price isn't the real price, even in overseas markets. And if the US government is serious about drug price reductions, should it return to the idea of direct negotiations between drug makers and Medicare?

The Trump administration's plan to reduce Medicare's drug expenditures is an alluringly simple one – peg the price to what the socialised health systems in other advanced economies pay. On its face, it is not a bad idea, since it would achieve an estimated 30% reduction while remaining tied to a plausible metric.

But because confidential rebates are being used in price negotiations with many countries, list prices in those territories are not a good indicator of the real prices being paid any more than they are in the US. Meanwhile, the concept being advanced by the administration once again disregards a powerful idea for achieving price reductions – direct negotiations between drugmakers and Medicare's leadership.

The end of buy and bill?

The new proposal deals with drugs reimbursed under Medicare part B. These are physician-administered agents, typically injected or infused speciality drugs, for which Medicare reimburses the practice at list price plus a 6% markup. Physician practices must buy the drug and bill Medicare once it has been given to the beneficiary.

Part B drugs have been a particular sore point, since unlike self-administered drugs covered by part D of the programme, there is no price negotiation or formulary management, and thus little cost control.

What the Centers for Medicare and Medicaid Services (CMS) proposed last week was a demonstration programme under which vendors would negotiate with pharma companies to acquire drugs for physician practices and be reimbursed directly at a rate based on an International Pricing Index (IPI). The IPI is developed from prices in 16 countries – 14 in Europe, plus Japan and Canada.

A gradual five-year price reduction down to IPI levels would save 30% a year, the CMS says – a significant saving when you consider part B drugs cost $26bn in 2016. Accompanying the proposed regulation was a report in which the CMS claimed basing US prices on the IPI would save Medicare $8bn a year for the top 20 drugs in Part B.

Among those drugs in the top 20 were five subject to biosimilar or generic competition in Europe but not in the

US – Rituxan, Neulasta, Remicade, Herceptin and Alimta – which accounted for $2.8bn of the claimed $8bn in savings. So this is as much an argument in favour of changing US laws to speed biosimilar uptake as it is in favour of setting prices based on international counterparts.

Naturally, the biopharma sector has opposed this proposal, characterising it as “price controls” and saying it would slow innovation.

Does anybody know what the price is?

The international pricing benchmark proposal comes at a time when many countries are increasingly engaging in confidential rebates in order to fulfil policy goals like value-based pricing. This calls into question the reliability of the data the CMS used to claim 30% savings, and indeed whether its IPI would be an accurate reflection of what is paid.

“They’re looking at something that’s probably not the real price,” Steven Morgan, a professor of health policy at the University of British Columbia, told *Vantage*.

Professor Morgan has published research indicating that health systems in 11 of 13 advanced economies have signed confidential rebating contracts with pharmaceutical manufacturers. One that does not, Austria, believes that to do so would “make it impossible for doctors to comply with Austrian law requiring them to consider cost-effectiveness when prescribing”.

Therefore, he concludes that this proposal would have the effect of lowering list prices toward an international norm and squeeze the return that pharmacy benefit managers can gain by achieving steep rebates. “That’s probably not going to affect the net of rebate prices that manufacturers are going to get,” Professor Morgan said.

“Everybody knows these that these international reference prices are not value for money and you still need a negotiator,” he added.

A more potent tool for lowering prices, he said, would be direct negotiation between Medicare and drug manufacturers , something President Donald Trump flirted with before abandoning it (*Fickle Trump showers disappointment on biopharma's golden day, January 12, 2017*). David Mitchell, president and founder of Patients for Affordable Drugs, agrees with Professor Morgan.

> We support HHS @secazar's international reference Rx price plan, and we support going further w/direct Medicare Rx price negotiation. This piece from Thomas Bollyky, Council on Foreign Relations, explains why patent reform must also be priority https://t.co/gc2WCQDv3i
>
> — David Mitchell (@DavidP4AD) October 29, 2018

In all likelihood, even the milder concept of IPI bench marking will be subject to intense opposition from industry and even from some of Mr Trump’s Republican congressional allies. Getting it imposed by early 2020, as the CMS envisions, will be a big task. With scrutiny, it will probably become more clear that an international price benchmark will need to be at best refined if it is to be a useful measure on which to base US prices.