BY ANY OTHER NAME: PRICE CONTROLS ARE PRICE CONTROLS

Dan Savickas
Federal Affairs Manager

FreedomWorks

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Introduction

Many conservatives and right-of-center political analysts are rightly upset about Health and Human Service Secretary Alex Azar's proposal to tie drug prices in the United States to those in foreign nations. Such a proposal would make our healthcare system dependent on the whims of nations that subscribe to command and control economic models. There is also the stark reality that imposing price controls does not fix any underlying issues that caused prices to be high in the first place.

What critics and proponents of this international pricing index (IPI) can agree on is that the issue of high prescription drug prices must be addressed. It was the late William F. Buckley who once opined, "A conservative is someone who stands athwart history, yelling, 'Stop,' at a time when no one is inclined to do so, or to have much patience with those who so urge it." Given the urgency of the issue at hand, many are eager to avoid having such a description be applied to them. Thus, many have taken it upon themselves to offer their own alternatives to the IPI.

One such proposal was put forth by Avik Roy, the President of the Foundation for Research on Equal Opportunity (FREOPP). Roy titles his alternate approach the "Market-Based International Index" (MBII). The MBII makes minor tweaks to the IPI by adding and subtracting certain nations from the list of benchmarks and weighting them based on the nations' perceived adherence to market principles.

While both the desire to put forth an affirmative solution and the desire to align healthcare policy in the United States with market principles are admirable goals, the MBII falls short in numerous respects. Perhaps in a vacuum, where the only two choices available to Congress were the IPI and the MBII, the MBII might be an acceptable policy prescription. However, this is not the present reality. The U.S. by no means must resign itself to international reference pricing as a model for setting prescription drug prices. In fact, it should avoid doing so.

The analysis in the pages to follow will explain why policymakers should not subscribe to international reference pricing as a potential solution. It will also reveal some misconceptions about the supposed free-market credentials of certain foreign nations that comprise the bulk of the MBII, and it will show that, while well-intentioned, that the MBII does not live up to its name.

The "Market-Based" International Index

Reading through Roy's impassioned case for his MBII framework, one cannot help but call to mind the lament of Juliet Capulet in Shakespeare's tragedy, *Romeo and Juliet*: "Tis but thy name that is my enemy... What's in a name? That which we call a rose, by any other name would smell as sweet." On this point, Ms. Capulet gets to the heart of the matter. Changing something's name does not change its nature, even if you make some minor adjustments. Merely calling this new index "market-based" does not make it so.

To his credit, Roy spends a good portion of his analysis diagnosing some very real issues with the Trump administration's IPI. He also acknowledges that the current Medicare Part B system is anything but a free market vision for healthcare.[1] This is the correct free market position.

Under the current system, physicians receive a 6 percent commission on drugs used in Medicare Part B. This system, known as "ASP+6" (with ASP standing for "average sales price"), distorts price competition and creates a perverse incentive for physicians to prescribe higher price drugs. It also decreases patients' sensitivity to price. On this, there is no daylight between Roy and champions of the free market. The status quo is unacceptable and undermines market competition.

Roy also identifies one of the major problems inherent in Medicare. He points out, "In any true market, the prospective buyer has the option not to buy: a feature that is essential to generating a true price signal. This is mostly absent from Medicare."[2] He correctly identifies the market-oriented position; however, the solution is not as simple as he outlines. Given that Medicare is a government-run, single-payer program and is, thus, a state actor, it is tough to give the program the same negotiating power as a private actor. Government is force and monopolizes the coercive apparatus in any nation. Any negotiation would be skewed from the very beginning. In a better world, with a more privatized approach, such negotiation would be part of the solution. However, it is tougher with Medicare.

The FREOPP analysis spends a substantial amount of time attempting to disprove the free-market bona fides of the existing Medicare system and less trying to affirm those of the MBII. Roy seems to be under the impression that free marketeers champion the current system. This is largely not the case.

Much of the criticism of the IPI has centered around the fact that it includes countries with single payer systems, countries that deploy price controls, and countries that have severe access problems when it comes to new therapies. Roy, in making his case for his MBII, says that "not all" advanced nations suffer from the three aforementioned drawbacks to a healthcare system. This is undeniably true and, as Roy points out, many successful pharmaceutical companies operate out of Europe and Japan.[3] However, there are countries that do suffer from those issues

[1] Roy, Avik, "What Medicare Can Learn From Other Countries on Drug Pricing," Foundation for Research on Equal Opportunity, Jan. 11, 2019. https://freopp.org/what-medicare-can-learn-from-other-countries-on-drug-pricing-bf298d390bc5

[2] Ibid

[3] Ibid

that are nonetheless included in both the IPI and the MBII. More on that later.

Finally, the affirmative solution comes along. Roy titles a section of his analysis, "What an ideal Medicare prescription drug market would look like." At first glance, there is very little that might give a red-blooded libertarian pause. This ideal market includes proposals to allow more insurers to compete to give the same benefits as Medicare Part B. It also calls for drugs that treat the same diseases to compete directly in terms of price and clinical value. Each of these proposed solutions embodies free market principles of competition.[4] However, the issue finally comes when he reaches the proposal that will supposedly bring about this change: "Benchmark Medicare Part B's reimbursement rates to those of countries where the above principles are applied."[5]

This is where the Roy's proposal goes downhill. Metaphorically, say a man named Joe runs a nice Italian restaurant. However, a man named Nicholas down the road also has a nice Italian restaurant, but the food is cheaper because he's able to make it at a lower cost. If Joe wants to bring down his prices, he could just set them to match those at Nicholas' restaurant. However, he'd stop turning a profit and go out of business. This is the essence of what international reference solutions are proposing. The real solution for Joe, in this metaphor, would be to adopt some of the features of Nicholas' restaurant so he can cut his costs and bring his prices down.

The MBII differs from the IPI in that it has a different "bucket" of countries on which it bases its prices. The MBII correctly acknowledges that the IPI's reference nations were selected arbitrarily and includes some countries with socialist policies. The MBII strips out these nations and uses a tiered system. However, the issue remains the same: it is still an international reference proposal.

There are four Tier 1 countries in the MBII: Switzerland, Singapore, the Netherlands, and Denmark. These, according to Roy, are the most market-oriented developed nations and are thus ideal candidates to lead the way in this pricing index. These four nations comprise 60 percent of the MBII's formula.

Despite being more market-oriented than many other developed nations, these four countries also pose serious issues as a benchmark for the United States. They face different realities and, in some cases still impose some harsh command and control policies. In some cases, these countries actually demonstrate quite clearly why an international reference model is the wrong approach to the problem of high prescription drug prices.

Switzerland

The MBII begins with Switzerland. The case for its inclusion in Tier 1 is very simple. It has a market-based universal system. There is considerable decentralization. Every

[4] Ibid
[5] Ibid

Swiss citizen purchases private coverage on the individual market. Roy also notes that Switzerland is home to two large pharmaceutical companies and that due to the market principles applied in Switzerland, many drug companies house their European headquarters within Switzerland. It would seem to be a dream come true for a policy analyst looking for a market-based system on which to base U.S. prices.[6]

However, Switzerland's system is hardly applicable to the U.S. The decentralization that exists in Switzerland comes from the fact that each of that nation's 26 cantons (member states of the Swiss Confederation) has its own constitution and carries many responsibilities when it comes to making healthcare policy. They make various decisions that fit their unique needs and those of their citizens.[7]

At first blush, this system seems analogous to the federalist system in the United States. Under the Tenth Amendment to the U.S. Constitution, states have wide flexibility on policy, just as the Swiss cantons do. However, the reason the framers of the U.S. Constitution instituted the Tenth Amendment was so that states could set policy that fits their specific needs, in recognition that the national government may not always be best suited to meet those needs. In a similar way, there should be a recognition that the needs of a foreign country differ as well. Just as it would not be in the best interests of the Swiss cantons to base their health policy off of the United States, the inverse is also true.

Furthermore, there is plenty of reason to take pause when considering the Swiss system as a preferable alternative. Roy frequently cites how disproportionately high healthcare costs are in the U.S. However, in graphics, Switzerland is often absent. That is likely because Switzerland consistently ranks second to the U.S. in terms of healthcare spending as a percentage of GDP.[8] Modeling off of the Swiss system would only decrease prices in the U.S. marginally, given that they also struggle with healthcare spending problems.

There are also aspects of the Swiss system that frighten proponents of the free market. Despite Roy's assertion that he had cut out socialist systems, and those that impose price controls from the MBII, Switzerland nonetheless imposes price controls of its own. The Swiss Federal Office of Public Health (FOPH) forces generics to sell for a price 20 percent to 50 percent below the original branded drug. FOPH also makes coverage decisions based on cost, which is an indirect price control.[9] This is a point that Roy acknowledges in passing in touting the benefits of the Swiss system, but never addresses head-on.

There is very little doubting the fact that Switzerland's healthcare system is, in fact, far more market-oriented than those in countries like Canada or the United Kingdom. However, that does not make it a model for market capitalism. While Roy spends a considerable amount of time in his analysis picking apart the deficiencies and non-market aspects of the U.S. system, he fails to apply the same level of

[6] Ibid
[7] Sturny, Isabelle, "The Swiss Health Care System," Commonwealth Fund, Swiss Health Observatory. https://international.commonwealthfund.org/countries/switzerland/
[8] Sawyer, Bradley and Cox, Cynthia, "How does health spending in the U.S. compare to other countries?", Peterson-Kaiser Health System Tracker, Kaiser Family Foundation. https://www.healthsystemtracker.org/chart-collection/health-spending-u-s-compare-countries/#item-start
[9] Sturny, "The Swiss Health Care System".

analysis towards the countries he places in his index.

Switzerland, despite instituting its own version of price controls, is unable to significantly lower its cost. It remains the second highest developed nation in the world in terms of cost. If the U.S. were to feature Switzerland prominently in any international pricing index proposal, whether it be Roy's or the administration's, we would be importing their failures and not even significantly reducing prices. Anyone seeking to address the issue at hand should steer clear of Switzerland and instead look to learn from the aspects that work and those that don't in the Swiss system.

Singapore

Singapore features quite prominently in the MBII. This should not come as a surprise to Roy's readers. Since 2012, Roy has called Singapore's healthcare "arguably, the most market-oriented system in the world."[10] Indeed, Singapore's capitalist reforms, soaring GDP per capita, and rapid economic growth have drawn the admiration of many free-market advocates across the U.S. and around the world.

The Singapore model is a tripartite system. The first plank is called *MediSave.* This is a medical savings program, where workers contribute a percentage of their earning to a savings account to pay for their care. Savings are tax-exempt, and employers match contributions. *MediShield* is a catastrophic health insurance plan in which enrollment is automatic and mandatory. Premiums can be paid through the *MediSave* account if necessary. Lastly, MediFund is a last resort program for the needy. The government can only spend the previous year's investment income to fund the program.[11]

Again, at first glance, Roy makes a compelling case for the free market credentials of the Singaporean system. Health savings accounts have been a pillar of the free market approach to healthcare for years. People should be able to save their own money and shop around for the most affordable, effective options for themselves. However, upon deeper examination, the level of government coercion inherent in this system is particularly astounding.

MediSave is mandatory. This is not a voluntary health savings account where patients put in what they need. Residents of Singapore are required by law to contribute *nine percent* of their income to this program.[12] This is essentially a tax. At the very least, it is a glaring example of nanny state government determining what are the best practices for the citizenry. Free marketeers rightly lambasted the Obama administration for its individual mandate and cheered when it was repealed in the Tax Cuts and Jobs Act. A government mandate that dictates what an entire nation must do with almost one-tenth of their paychecks makes the individual mandate look light-handed.

[10] Roy, Avik, "Singapore's Market-Based Health Care System Puts America's to Shame," Forbes Opinion, Mar. 9, 2012,https://www.forbes.com/sites/theapothecary/2012/03/09/the-myth-of-free-market-american-health-care/#7d65eb62a4f0

[11] Liu, Chang and Haseltine, William, "The Singaporean Health Care System," Commonwealth Fund, Access Health International, https://international.commonwealthfund.org/countries/singapore/

[12] Ibid.

Furthermore, as was mentioned earlier, enrollment in *MediShield* is mandatory. Let's recall a quote from Roy's analysis invoked earlier on: "In any true market, the prospective buyer has the option not to buy." In Singapore, residents do not have the option not to dedicate their income to *MediSave*, nor do they have the option not to enroll in *MediShield*. Yet, Roy, in the very same paper, tries to make the case that Singapore is a thriving free market system that the U.S. should emulate. These claims cannot coexist.

It should also be noted that it is not feasible to apply Singaporean methods in the United States. Take, for example, the third plank of their system, *MediFund*. This system may only be funded with the previous year's investment income. A bad investment year or an economic downturn could leave the nation in a horrific pickle. Singapore has outpaced the U.S. in terms of GDP growth rate every year since 2002 (with the exception of 2015). The consistent strength of their economy is what keeps this system afloat. During that same 15-year period, the U.S. has not eclipsed four percent annual GDP growth. Meanwhile, Singapore exceeded four percent ten different times.[13] It is not realistic to expect the U.S. could duplicate those results and mimic Singapore's costs without devastating economic consequences.

Singapore also faces different cultural realities. Only 15 percent of people in Singapore drive cars due to the cost the government imposes on doing so. Drug dealers are executed in Singapore, and almost all gun ownership is outlawed. "Sin taxes" on cigarettes and alcohol are through the roof. If the U.S. wholesale eliminated cars, alcohol, smoking, and guns it might be reasonable to expect that healthcare expenditures would be low as well.[14] Unfortunately, such social engineering would not fly in the U.S. and it is unreasonable to expect the U.S. could copy Singapore's prices without making any other changes.

Netherlands

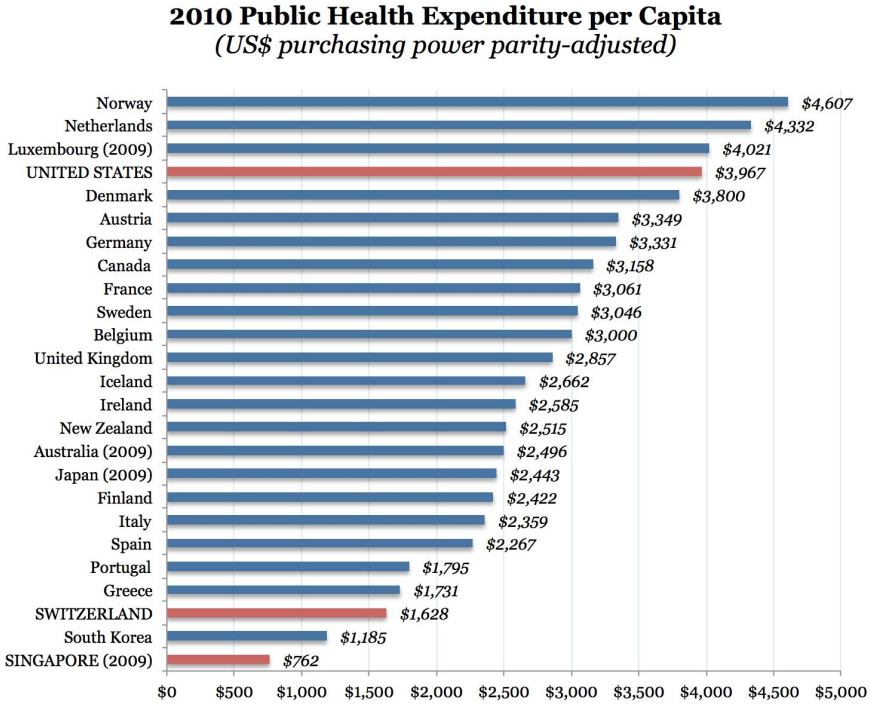
As with its two predecessors, there is a decent case to be made on the surface that the Netherlands operates under a free market system. Roy points out that the Netherlands operates with multiple private insurers who compete for market share. Drug formularies are managed by insurers and negotiations take place in the private sector.[15] On its face, it seems that the Netherlands is another well-qualified candidate to be included in such an index.

Even in Roy's write up on the Netherlands, he acknowledges, "The government [of the Netherlands] protects against monopoly drug pricing by setting price ceilings."[16] Price ceilings, price floors, and everything in between is price control, whether the FREOPP wants to recognize that fact or not. Importing the Netherlands' prices to the U.S. market would be importing their price controls, regardless of whether it's a limited ceiling to prevent monopoly pricing or a full-blown government takeover of the sector. It is still a price control.

[13] World Bank Data
[14] Klein, Ezra, "Is Singapore's 'miracle' health care system the answer for America?", Vox, Apr. 25, 2017, https://www.vox.com/policy-and-politics/2017/4/25/15356118/singapore-health-care-system-explained
[15] Roy, "What Medicare Can Learn".
[16] Ibid.

This is not the only price fixing mechanism employed by the Dutch government. The government places reimbursement caps on low priced generic drugs to keep the average drug price down across the country.[17] This is another market distortion that keeps average drug prices down. If the U.S. were to index its drug prices based on the Netherlands, such a distortion would, in turn, warp the prescription drug market in the U.S. as well. This should be antithetical to the goals of any "market-based" index.

In Roy's own 2012 article about how other free-market healthcare systems "put America's to shame," he provides a handy chart on public health expenditure per capita:



He uses the chart to promote the virtue of the aforementioned Singaporean model. However, if he is using such data as a measuring pole, it is important to note that the Netherlands dwarfs even the U.S. in this regard. The Dutch system is a costly one.[18]

Circling back to one of Roy's earliest arguments in favor of his MBII, he claimed that not all advanced countries in Europe have access problems to medicine. That is very much the case. However, the Netherlands is not one such country. According to Dutch healthcare experts, "Reimbursement for expensive drugs has to be negotiated between hospital and insurer; there is some concern, however, that this and other factors may limit access to expensive drugs in the near future."[19] For this, and any number of the other reasons cited above, Roy should have immediately disqualified the Netherlands from inclusion in his MBII based on the criteria he himself set for his analysis.

[17] Wammes, Jeurissen, Westert, and Tanke, "The Dutch Health Care System," Commonwealth Fund, Radboud University Medical Center, https://international.commonwealthfund.org/countries/netherlands/
[18] Roy, "Singapore's Market-Based Health Care System".
[19] Wammes, Jeurissen, Westert, and Tanke.

Denmark

Denmark presents the most bizarre assortment of considerations when analyzing it as a candidate for an international index. First and foremost is the fact that Denmark is an openly single-payer system. This is not a fact from which Roy hides in his analysis. He does, however, add that Denmark "does not regulate prescription drug prices." Thus, he is willing to overlook their socialist system and grant them inclusion.

Denmark actually used to base their drug prices on an external reference system. In 2005, they instituted a reform that abandoned that approach. Instead, they now use a system where it is based on the price of the cheapest domestic substitute.[20] The prescription drug pricing system that Roy touts as unregulated and deems worthy of inclusion in a proposed index that would set drug prices in the United States has actually explicitly rejected the type of system he is now proposing. The beneficial results he wants to emulate is the product of moving away from international reference pricing, not towards it. Roy should take note.

In their analysis of the Danish reform, Kaiser, et al., made the following observation about the new Danish system:

> *"Since Danish prices were comparatively low in Europe, [the international index] kept the Danish price level up. Secondly, since the reform, Danish patients have had to pay the full difference between the retail price and the reference price 'out-of-pocket' when buying a product that is not the least expensive one. This makes patients more price-sensitive and leads to tougher competition among firms in the market."*[21]

This is the type of free-market competition to which Roy alludes throughout his analysis. Such competition and price sensitivity is not the product of indexing prices to other nations. In fact, it is just the opposite. Such results came only after they forsook that approach that Roy now seeks for the U.S.

Evidently, however, Denmark has begun to miss its external reference pricing system. There began some rumblings around late last year that the Danish Ministry of Health intends to introduce a proposal that would return the country to an external reference pricing system.[22] One can hardly be surprised that the Danes have bristled at their current market system. They are, after all a single-payer country at heart.

If Denmark were to make such a change, it would create an untenable feedback loop. The nations Roy sought to exclude from his MBII will now be included indirectly. They will impact the Danish prices, which will, in turn, impact the U.S. prices. This is the trouble with international indices. It leaves the country that implements them at the mercy of the rest of the world. Denmark is a fantastic case to show exactly why, for multiple reasons, an external reference pricing system should be avoided.

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[20] Kaiser, Ulrich, Ronde, Thomas, and Ulrich, Hannes, "Drug pricing reforms: the Danish experience," European Pharmaceutical Review, https://www.europeanpharmaceuticalreview.com/article/30915/drug-pricing-reforms-the-danish-experience/

[21] Ibid.

[22] Gantzhorn, Martin and Bjerrum, Emil, "Announcement of proposal on external reference pricing system on medicinal products," Bech-Bruun, https://www.bechbruun.com/en/news/2018/denmark- announcement-of-propos0al-on-external-reference-pricing-erp-system-on-medicinal-products

Conclusion

Roy changed the countries included in the IPI for his proposal. He gave it a new name and attempted to square it with the free market. It was a well-researched, admirable effort on his part. Unfortunately, his research and framing cannot change the reality that international pricing indices are, at the very core, anti-market.

Even if one were to accept that an index of this sort could be aligned with the principles of the free market, there are far too many international variables to consider. Even the foreign nations that appear on the surface to be the most market-oriented in all the land employ coercion and have key flaws that make it counterintuitive to try and import those approaches to the U.S., which faces its own set of unique challenges.

Instead of wholesale adopting the prices of other nations, analysts should take the time to look at which aspects of foreign systems incorporate market principles. Then, delve deeper into those programs to see which might be applicable to the U.S. and which might only thrive under a very limited set of circumstances. Creating an index that puts our system at the mercy of over a dozen others is an approach whose greatest flaw might just be that it is entirely lacking in nuance. High prescription drug prices are issues that each family struggles with and the consequences of not being able to pay a bill can be devastating. America's policymakers owe it to these families to do the hard work and research to get this right.

Dan Savickas

Federal Affairs Manager