Mike Bloomberg’s Drug Price Policy

Americans pay significantly more than people in other affluent countries for prescription medicines. For some brand-name drugs, U.S. prices can be five to 10 times as much. And while it’s true that retail medicines account for only 10% of health-care spending in the U.S., they are the most profitable sector of health care. More than 60 drug makers boosted their prices again for hundreds of drugs as 2020 began, with an average increase of 5.8%.

The best way to keep drug prices down is the way other countries do it: through negotiation. The U.S. would have great leverage if were to negotiate on behalf of all the 45 million Americans who participate in the Medicare (Part D) drug insurance program. But the 2003 law that established that program forbids the government from doing so. A second reason drug prices are higher in the U.S. is that drug makers pay pharmacy benefit managers to promote their drugs over competing drugs – even if their drugs are more expensive and no more effective than those drugs. And a third reason is that brand-name drug makers engage in all sorts of shenanigans to put off competition from generics – for example by layering on extra patents.

Medicare policy also encourages high drug prices by having the government pay most of the costs after a beneficiary reaches the “catastrophic threshold.”

Mike Bloomberg will take several actions to push back and lower the price of prescription medicines in the U.S.

1. **Revise the law to authorize Medicare to negotiate with drug companies.**

   He will work with Congress to authorize Medicare to negotiate prices with drug companies. (Speaker Nancy Pelosi has already passed such legislation in the House; it is being held up in the Senate.) In this process, Mike will set an upper limit for the negotiated price at 120% of the average price among other advanced countries (as Pelosi’s bill does). The federal government could save $456 billion on Medicare over ten years.

2. **Push for Medicare to review insurers’ lists of drugs that can be prescribed and cap beneficiaries’ out-of-pocket drug spending at $2,000 annually.**

   Mike will direct Medicare to review insurers’ drug formularies to ensure that they promote the most cost-effective drugs, including generics. He will cap Medicare beneficiaries’ out-of-pocket drug spending at $2,000, to protect Americans from catastrophic drug bills. And he will redesign the benefit to give insurers and drug companies more liability above the “catastrophic threshold.” In 2015, 7.3% of seniors had at least $2,000 in out-of-pocket costs.

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4. WSJ, *Drug Prices Climb by 5.8% on Average, Less Than Last Year*. January 2020.
3. Eliminate all drug-company payments to pharmacy benefit managers.

To force drug companies to compete on the price and value of their medicines, rather than the amount of money they pay for preferential treatment, Mike will do away with all drug-company payments to pharmacy benefit managers. (These payments will lose their effectiveness in any case, once Medicare has authority to negotiate on behalf of all Medicare beneficiaries.)

4. Stop brand-name drug managers from slowing the introduction of generics.

Mike will limit each new drug to a single patent lasting 20 years. Some of that time would be taken up with clinical trials and the FDA review process, but generally a new drug would have a monopoly lasting 12 to 14 years. Then its market exclusivity would end, and generics could be made. And to make sure this process goes quickly and smoothly, Mike will also work with Congress to stop brand-name drug makers’ efforts to slow the introduction of generics.

5. Invest in drug research to help cut prescription drug prices for Americans.

Mike will leverage the federal government’s enormous investments in drug research. One in four new drugs are rooted in this publicly supported research, much of it done with funding administered by the NIH. When the intellectual property from government research is sold to drug developers, the contract should stipulate that the company will owe some level of royalties to the government if the research leads to a commercial drug. This funding could be used to lower drug prices in Part D or pay for additional research.

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