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Tracking Health Reform

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Abstract Throughout his four years in office, President Trump made prescription drug pricing a focus of his policy agenda. President Trump not only used strong language to criticize the pharmaceutical industry and its practices but also introduced ambitious reform policies that had previously lacked acceptance among Republican policy makers. President Trump appears to have been successful in developing a new populist form of rhetoric that Republicans can use in support of novel drug pricing reforms such as the ones his administration considered. From a policy perspective, however, the Trump administration failed to implement any of their more ambitious reform ideas. This article considers three of the Trump administration's signature policies—state-sponsored prescription drug importation, Medicare Part B international reference pricing, and reforms to the Medicare Part D rebate system—and explores how they represent both the political ambitions and policy failures of the Trump administration. The fate of the Trump administration's prescription drug proposals also reveals lessons about innovation and access, which will be important to ongoing drug pricing reform efforts.

Keywords prescription drug pricing, health reform, Trump administration

> *They're getting away with murder. . . . Pharma has a lot of lobbies and a lot of lobbyists and a lot of power.*
> —Donald J. Trump, press conference, January 11, 2017

> *We're taking aim at the global freeloading that forces American consumers to subsidize lower prices in foreign countries through higher prices in our country. . . . At long last, the drug companies and foreign countries will be held accountable for how they rigged the system against American consumers.*
> —Donald J. Trump, White House briefing, October 25, 2018

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President Donald Trump's arguments against the pharmaceutical industry distilled consumer anger at the high prices of prescription drugs into a series of clear, understandable talking points. Large majorities of Americans believe both that the price of prescription drugs is "unreasonable" (79%) and that pharmaceutical company profits are a major factor contributing to those prices (80%). Furthermore, nearly one in four patients have difficulty affording their prescription drugs (Kirzinger et al. 2019). These high prices became a political focus of the Trump administration, which repeatedly returned to the subject.

The May 2018 "American Patients First" drug pricing blueprint began to lay out the administration's stated strategy for reducing both patients' out-of-pocket costs and overall spending (HHS 2018). During the next two-and-a-half years, the administration would propose and finalize bold regulatory policies regarding prescription drug importation, international reference pricing, and reforms to the Medicare Part D rebate system, as well as a host of smaller-scale ideas. Several of these policies, especially the international reference pricing and rebate reforms, went further than those proposed by previous administrations. The Trump administration in particular increased the prominence of these ideas among Republicans, developing new rhetorical strategies grounded in populism and nationalism to support these policies.

However, the administration largely failed as a policy matter. As of June 2021 none of these three signature executive branch initiatives has been implemented because of implementation challenges and court orders. Other smaller drug pricing reforms were blocked in court or were withdrawn before they were finalized. The administration also did not appear to support significant legislative efforts on the topic (Sachs 2020). The primary Trump administration drug pricing reform to be implemented is a voluntary demonstration project in which participating Part D plans and insulin manufacturers have agreed to provide certain insulin products for a flat copayment of $35 per month, for beneficiaries enrolled in particular enhanced Part D plans (Cubanski et al. 2020). Although this policy may be helpful for beneficiaries enrolled in those specific plans, it does not help beneficiaries needing other high-cost drugs (indeed, their premiums may rise overall), nor does it help the large majority of Americans who are not Medicare beneficiaries.

It might even be argued that the administration focused its efforts on executive-branch drug pricing policies that were designed without regard to their feasibility. Officials plainly valued the appearance of policy making and used strong rhetoric publicly against the pharmaceutical industry. But

when introducing and finalizing new regulations on the topic, the administration consistently advanced policies that were rife with legal deficiencies or implementation difficulties—challenges of which the administration was well aware at the time. The administration's relative paucity of public support for any of the several congressional initiatives being debated is also instructive.

In this article, I explore the rhetorical transformations and policy failures of prescription drug pricing reform under the Trump administration by examining three of the administration's signature policies: state-sponsored prescription drug importation, Medicare Part B international reference pricing, and reforms to the Medicare Part D rebate system. Even as the Trump administration largely failed to make real policy change on drug pricing, it nonetheless helped change the rhetorical ground on which the policy conversation is taking place. Going forward, the ways in which the Trump administration altered the conversation about innovation and access to new prescription drugs could influence the course of future drug pricing debates.

Analyzing President Trump's Signature Drug Pricing Policies

Throughout most of his administration, President Trump's drug pricing focus was disproportionately concentrated on three main policies: prescription drug importation, tying US prices to those paid abroad, and reforming the Medicare Part D rebate system. Each of these proposals drew at least some support from politicians of both parties and also communicated a clear message about the president's priorities. At the same time, these proposals ultimately did not produce meaningful change. As of June 2021, all three of these policies are tied up in litigation, and none has been implemented. Each policy idea also brought with it unique political complications that may have implications for future drug pricing reform efforts.

State-Sponsored Drug Importation Programs

The central idea behind President Trump's (2020a) drug importation plan was simple to explain: because "Americans often pay more for the exact same drugs" than do "residents of any other developed country," the Department of Health and Human Services (HHS) was instructed to take a range of actions to authorize various types of drug importation programs. Most notably, in September 2020 the Trump administration released

a final rule (following a December 2019 notice of proposed rulemaking [NPRM]), with the goal of allowing states and other institutional actors (such as wholesale distributors) to establish programs to import prescription drugs from Canada (FDA 2020).

The importation rule aimed to build on existing statutory authority from the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which provides the secretary of HHS with the legal authority to promulgate regulations allowing the importation of certain prescription drugs from Canada. But the statute first requires the secretary to "certif[y] to the Congress that the importation of this section will" both "pose no additional risk to the public's health and safety" and "result in a significant reduction in the cost of covered products to the American consumer" (21 U.S.C. § 384(l)). No HHS secretary of either party had previously made such a certification, publicly citing the safety aspect of the statute and their inability to ensure the integrity of the drug supply chain. While Secretary Alex Azar made the formally required certification, the final rule itself does not make factual findings about either drug safety or cost savings. Those responsibilities are delegated to the states proposing importation programs, which must demonstrate both elements as a condition of approval.

President Trump's focus on drug importation was politically popular, as large majorities of Americans across parties favor allowing the importation of drugs from Canada (at 78% of Democrats and 76% of Republicans) (Kirzinger et al. 2019). In Congress, Senator Bernie Sanders and several Democrats have also introduced drug importation legislation. Six states with vastly different political makeups (Vermont, Florida, Colorado, Maine, New Mexico, and New Hampshire) have all passed drug importation laws in the last few years, with dozens of others considering such bills (Sachs and Bagley 2020). Republican Governor Ron DeSantis of Florida specifically touted his discussions on the topic with President Trump, and Governor DeSantis staged a signing ceremony for Florida's law accompanied by Republican state legislators supporting the plan (Dixon and Glorioso 2019).

But as a policy matter, the Trump administration's importation rule has been a failure so far, and no state has yet received approval from HHS to create and implement an importation plan. Even if they were to receive such permission, it would be very difficult for them to be successful in implementing their program, primarily because both Canadian regulators and pharmaceutical manufacturers oppose the idea. Neither group wants the United States to free ride on the efforts they have made to obtain low prices for prescription drugs and maintain a price differential between the

two countries. Canada quickly responded to the final rule by blocking exports of some prescription drugs, and pharmaceutical manufacturers likely have the ability to use their contracts with various supply chain actors to prevent large-scale importation.

The Trump administration expected a response from these stakeholders. At the time the NPRM was released, the Food and Drug Administration (FDA) (2019) released a preliminary regulatory impact analysis of the program in which it questioned "whether this proposed rule could yield non-zero benefits," given a "potential regulatory response" in which "Canadian regulatory agencies and/or manufacturers may also limit supply to be exported to the US." Yet neither the NPRM nor the final rule mentions these challenges. The rule even relies in different ways on the cooperation of willing industry partners.

The administration's particular policy choices also created additional legal liability for the rule, which is now facing an expected legal challenge from PhRMA. Among PhRMA's (Pharmaceutical Research and Manufacturers of America) many claims is an allegation that the particular form of Secretary Azar's certification to Congress—one conditional on future information to be gathered and demonstrated by states—is not permitted under the terms of the statute. PhRMA also alleges that Secretary Azar's decision to delegate these fact-finding obligations to other agencies or stakeholders is a separate Administrative Procedure Act (APA) violation.

There are additional complications that would impact the feasibility of drug importation as a pricing solution going forward, even were a rule to pass judicial muster. Given the small size of the Canadian population and market relative to the United States' and the unlikely proposition that pharmaceutical companies would substantially increase their Canadian supplies to support importation efforts, there may simply be too small a supply of drugs to make a significant difference on pricing (NASEM 2018). Moreover, if it is not feasible to import the drugs themselves, it might simply be easier to import the lower Canadian prices. This idea—to use international reference pricing—was behind another one of the Trump administration's rhetorically transformational but practically flawed drug pricing proposals.

Medicare Part B Most-Favored-Nation Pricing

President Trump's most-favored-nation (MFN) pricing policy took inspiration from the large disparities in drug prices between the United States and other developed countries, just as his drug importation policy did.

However, instead of importing the lower-cost drugs themselves, this policy aimed to simply import those prices from countries where "governments regulate drug prices by negotiating with drug manufacturers" (Trump 2020c). In arguing in support of this policy, President Trump (2018) railed against "global freeloading" by other countries who have "rigged the system" against American patients. This rhetoric matched his nationalist framing in other substantive areas but was relatively novel for Republican politicians to use as a justification for government price negotiations. The MFN policy sought to benchmark the prices paid by Medicare Part B for physician-administered drugs to the lowest prices paid in a set of Organisation for Economic Co-operation and Development (OECD) nations, benefiting from the politically and practically difficult work to obtain those low prices done by those countries' regulators.

The Trump administration issued an interim final rule (IFR) establishing the MFN policy in late November of 2020, after the presidential election and more than two years after the first draft of the policy was released in October 2018 (CMS 2020). That 2018 proposal, taking the form of an advance notice of proposed rulemaking (ANPRM) (a precursor to a formal NPRM), differed in two key substantive ways from the IFR. First, the ANPRM was less ambitious in its price reduction targets. It proposed to benchmark Part B prices for physician-administered drugs to a target price derived from 16 other developed nations, aiming for a 30% reduction in reimbursement. The 2020 IFR went further, seeking to use as a benchmark the lowest price among OECD countries whose gross domestic product (GDP) per capita is at least 60% of the United States'. Second, though, the ANPRM was more ambitious in its efforts to restructure the Part B reimbursement system as part of its reforms. The ANPRM proposed to eliminate the existing buy-and-bill system, in which providers are reimbursed for purchasing and administering Part B drugs, in favor of a model using intermediate vendors, who would then be reimbursed for the drugs at the new, internationally referenced price. The IFR jettisoned the novel vendor model, choosing to implement the MFN rule through the buy-and-bill system, reimbursing providers themselves for applicable drugs at the MFN price only.

As with President Trump's drug importation policies, the idea of benchmarking US prices to the lower prices being negotiated abroad is broadly popular, although it is somewhat more popular among Democrats than Republicans (with polls finding that 65% of respondents support the idea, including 74% of Democrats but just 54% of Republicans) (Kirzinger et al. 2019). The comprehensive drug pricing reform bill passed in December

2019 by the House Democratic caucus, H.R. 3 (the Elijah E. Cummings Lower Drug Costs Now Act), included international reference pricing as a key pillar of the bill. And more recently, lawmakers in states across the political spectrum, including Hawaii, North Dakota, Maine, and Oklahoma, have introduced international reference pricing bills into their legislatures (Facher 2021).

Unlike the importation policy, however, the idea of using international reference pricing has faced more sustained opposition from many establishment Republicans, clashing more directly with Republican orthodoxy on markets and regulation (Dusetzina and Oberlander 2019). In a July 2019 Senate Finance Committee markup of a drug pricing package cosponsored by Republican Committee Chairman Chuck Grassley and Democratic Ranking Member Ron Wyden, Republican Senator Pat Toomey pushed for an amendment that would have prohibited the administration from finalizing the ANPRM (although the Finance Committee package itself contained no international reference pricing elements). He argued that the effect of the ANPRM would be "to import the foreign price controls of countries that restrict access to drugs," and he expressed concerns about the policy's practical impacts. The amendment failed, but on a tie vote, with 14 senators (including 13 Republicans) supporting it and 14 opposed. Additionally, at least one of the senators opposing the amendment—Chairman Grassley—stated that he shared Senator Toomey's concerns about the policy but noted that he would vote against the amendment so as not to detract from the overall goals of the package (Senate Finance Committee 2019).

Ultimately, the Trump administration failed to implement the MFN rule. Although the ANPRM was issued in October 2018, the administration never issued an NPRM, the typical next step in the rulemaking process. Instead, it moved straight to the final rule stage, declaring in the late November 2020 IFR that the MFN rule would take effect just a few weeks later (on January 1, 2021). The use of the IFR procedure created legal jeopardy for the rule as a potential APA violation: typically, "good cause" is required for the executive branch to skip the NPRM stage and avoid incorporating public feedback on a new policy. Within weeks of its release, the rule was quickly enjoined by three separate federal district courts. One judge pointedly concluded that "the reasons the government offers for dispensing with the notice and comment requirements are contrived. The real reason is that the current presidential administration is in its waning days and would not have time to enact the policy if it adhered to these requirements" (Chhabria 2020). Here, the administration's case may have

been undermined by its own delays. The administration had more than two years to finalize this policy, and it simply failed to do so.

Two additional political complications surrounding the rule are likely to impact drug pricing reforms going forward. First, in keeping with Senator Toomey's concerns, the Centers for Medicare and Medicaid Services (CMS 2020) Office of the Actuary projected that a portion of the savings from the rule "is attributable to beneficiaries not accessing their drugs through the Medicare benefit, along with the associated lost utilization." Ultimately, CMS projected that up to 19% of prescription drug utilization in Part B might be reduced over time because of patients' loss of access. This loss of access would stem from negotiating failures between Part B providers and the pharmaceutical industry: if providers could not negotiate favorable enough deals on particular products, they might choose not to offer those drugs to their patients rather than take a financial loss. Reductions in access like these are extremely unpopular with Americans (Kirzinger et al. 2019), and CMS administrator Seema Verma argued that seniors would not lose their access to medications.

Second, industry stakeholders and others (including Republican members of Congress) argued that innovation incentives would be harmed if the administration pursued this policy. Secretary Azar (2018)—himself a former pharmaceutical executive—strongly pushed back against these claims as they related to the 2018 ANPRM, arguing that industry's claims were "prima facie implausible" and "mathematically unbelievable" because of the small scale of the program relative to overall R&D investments. Although the savings would be "very substantial for American patients and American taxpayers," in his view, they "cannot . . . possibly pull out more than 1 percent of R&D" globally.

President Trump's administration declined to appeal the injunctive orders against the rule, and the various cases have been stayed for now. But President Biden's administration could attempt to restart the rulemaking process, avoiding the APA claims raised by the Trump administration's actions (Gavulic and Dusetzina 2021).

Medicare Part D Rebate Reform

Rather than acting directly on pharmaceutical companies, President Trump's administrative rule to reform the rebate process in Medicare Part D focused on pharmacy benefit managers (PBMs) and the ways in which they interact with Part D plans. Derided by Trump and the pharmaceutical industry alike as "middlemen," PBMs work on behalf of insurers

to negotiate discounts from the list prices of prescription drugs, some of which can be quite large. These rebates are often used by insurers to lower overall premiums or provide other benefits, rather than passed down to particular patients taking highly rebated drugs. As a result, in President Trump's view (2020b), "Medicare patients, whose cost sharing is typically based on list prices, pay more than they should for drugs while the middlemen collect large 'rebate' checks." The rebate rule aimed to eliminate the legal safe harbor creating the existing rebate structure, with the goal of passing along these discounts to Medicare Part D beneficiaries at the point of sale.

The Trump administration finalized the rebate rule in late November 2020, after the presidential election and nearly two years after the January 2019 NPRM on the topic. In the 2019 NPRM, the CMS Office of the Actuary projected that the rule would substantially reduce out-of-pocket costs for Medicare beneficiaries whose prescription drugs are subject to high rebates. But the actuary also projected that premiums would increase for all beneficiaries (as insurers could no longer use rebates to lower their overall premiums) and that government spending was also likely to rise, perhaps substantially (as the government subsidizes Part D premiums for many beneficiaries) (HHS 2019). Because of concerns about raising premiums and government spending, in July 2019 a White House spokesman stated publicly that "the president has decided to withdraw the rebate rule" (LaVito 2019). In July 2020, though, as part of President Trump's set of executive orders on drug pricing, President Trump (2020b) ordered Secretary Azar to "complete the rulemaking process" on the topic—but first, Secretary Azar was ordered to "confirm . . . that the action is not projected to increase Federal spending, Medicare beneficiary premiums, or patients' total out-of-pocket costs." The November 2020 final rule contained no substantive changes that would have changed the actuary's projections, but Secretary Azar did make public the required confirmation, simply stating that his experience in both industry and government supported his projection that these increases would not occur under the final rule.

The general terms of the rebate rule are politically popular. In a 2019 survey, 63% of respondents viewed PBMs as a "major factor" contributing to high prescription drug prices (Kirzinger et al. 2019). A large number of states have passed legislation aiming to regulate PBMs, ranging politically from Maine and the District of Columbia to North Dakota, Iowa, and Arkansas (Gudiksen, Chang, and King 2019). The pharmaceutical industry itself has aimed to focus public attention on PBMs rather than on its own practices, an endeavor that has seemingly been successful. President

Trump and Secretary Azar's rhetorical framing of the rule—as aiming to "eliminat[e] kickbacks to middlemen"—echoes these criticisms.

As of June 2021, the rebate rule looks to be in grave danger. It was challenged in court by the trade association representing PBMs, including on several grounds that the administration could have avoided. In particular, the PBM association argues that the rule was withdrawn (relying in part on the White House's statement) and that the APA prohibits proceeding to the final rule stage without a new NPRM after such a withdrawal. Furthermore, the association argued that Secretary Azar's "confirmation" about the impacts of the rule without further explanation as to why the rule's own actuarial projections were inaccurate rendered the rule arbitrary and capricious under the APA. The implementation of the rule has been postponed until January 1, 2023, at the earliest, with the court staying the litigation until the Biden administration decides how it plans to proceed with the case. There are strong incentives for Congress to block the rule as well, including the possibility of capturing the savings from doing so in future legislation.

The projected impact of the rebate rule on premiums and overall spending is likely to affect any future attempts to revisit the policy behind the rebate rule. Although some Part D beneficiaries are projected to experience significantly reduced out-of-pocket costs as a result of the rule, White House concern for the political implications of raising both premiums and spending just before the 2020 election reportedly led to the 2019 decision to withdraw the plan (Abutaleb et al. 2019). Future attempts at reforming the rebate system may be coupled with other drug pricing reforms that would lower prices directly, thereby lowering premiums and spending as well.

In many ways, each of these policies was designed without regard to their feasibility, practically and legally. Even putting aside the Canadian and pharmaceutical opposition to the drug importation rule, that rule devolved responsibility for creating importation programs from the federal government to the states, relying on states to gather information that is already in the possession of the federal government (and which may well be beyond states' capacity to obtain). The legal risks to using the IFR process for the MFN rule were reportedly known to the administration, yet HHS chose to pursue that last-minute route rather than using its two years of lead time to go through the standard notice-and-comment process. Similarly, the administration had more than a year to reconsider the design of the rebate rule and attempt to avoid any undesirable impacts, but instead chose to finalize the rule essentially as proposed. To be sure, the regulated

industries involved would have challenged all three policies even without these obvious procedural defects. But the administration could have developed each of these policies in ways that did not create such clear legal jeopardy for them. They did not do so.

As a whole, these policy failures suggest that the administration was focused more on the appearance of policy making rather than the substance of doing so. Further evidence for this point comes from the administration's lack of vocal public support for any of the drug pricing reform packages that were being contemporaneously debated in Congress. The Trump administration could have but did not mount a public campaign in support of the Senate Finance Committee's Grassley-Wyden package, which would have provided financial relief to seniors with high Part D out-of-pocket costs and would have insulated Medicare from drug companies raising their prices more quickly than inflation (Sachs 2019). President Trump also threatened to veto the Democratic House's drug pricing package, even though it centered around a program of international reference pricing similar to the one his own administration proposed.

Implications for Future Drug Pricing Reform

These policies and others are broadly popular. In other areas of health care reform, it is unusual to see these high levels of agreement across Republicans and Democrats. The vast majority of Democratic politicians have signed on to significant reforms to our drug pricing system, but President Trump's support for the above policies was more novel among institutional Republicans and appears to have created space for Republican politicians to embrace nationalist rhetoric on drug pricing. To be sure, there remains significant Republican opposition to the substance of many reforms, particularly international reference pricing (whether embodied by H.R. 3 or the MFN rule). But even where Republicans disagree with the specific policy, they have taken pains to repeat President Trump's rhetoric. For instance, then-Senator Kelly Loeffler (2020), facing a run-off, introduced her own health care plan that included the goal of "lower[ing] the cost of prescription drugs" by "end[ing] foreign freeloading." But unlike President Trump, her goal was not to lower drug prices in the United States by leveraging lower foreign prices. Instead, she intended to use trade negotiations to force other countries to raise their own prices (although doing so would not likely result in lower prices in the United States).

Future drug pricing reform efforts will need to grapple explicitly with the two perceived tradeoffs embodied most clearly in the MFN rulemaking debate: issues around access and innovation. First, regarding access, some

drug pricing reforms might limit patients' access to drugs, which is both highly unpopular and may have problematic health impacts. As noted above, the MFN rule was projected to result in a 19% decrease in Part B utilization over time as patients lost access through their physicians to certain medications. Although senior members of the Trump administration denied that this policy would result in this loss of access, they did not explain their reasoning. Policy makers should consider policy design considerations as they grapple with this tradeoff.

More specifically, policy makers should recognize that these access constraints will result only if pharmaceutical manufacturers themselves refuse to lower their prices to reasonable rates, actively choosing instead to withdraw from the market entirely. Some pharmaceutical executives have stated publicly that they still make profits at the much lower prices they charge in foreign countries, meaning that reducing American prices to bring them more in line with foreign prices would still be profitable for these firms. As a result, in designing drug pricing reforms, policy makers should consider the institutional powers of the entity implementing the drug pricing policy in question and how those powers could be used to limit access concerns. For instance, H.R. 3 coupled its international reference pricing approach with a large financial penalty for companies who failed to negotiate toward the benchmarked price, reducing the likelihood that manufacturers would choose to pull their products from the market rather than lower their prices.

Second, regarding innovation, the pharmaceutical industry and others will continue to argue that most, if not all, substantial drug pricing reforms will harm future innovation. Because the goal of these drug pricing reforms would be to pay less for our existing medications, the argument goes, pharmaceutical firms will be unwilling or unable to maintain their existing levels of R&D investments, meaning that they may bring fewer drugs to market going forward. Secretary Azar argued that this would not result from the international reference pricing ANPRM as a result of its small scale in the overall drug pricing system. But the Congressional Budget Office estimated that the larger-scale, Democratic-led H.R. 3 could lead to eight fewer drugs coming to market over the next decade (CBO 2019) (compared to the 100 fewer drugs the White House Council of Economic Advisers projected [CEA 2019]). Policy makers should consider different aspects of this tradeoff.

Recognizing that there is a point at which drug price reductions will translate into decreases in R&D investments, policy makers should consider whether portions of the savings from drug price reforms should be reinvested in biomedical research, to counteract the investment disincentive.

H.R. 3 took this approach, reinvesting more than $10 billion in the National Institutes of Health alone. But policy makers also should not simply either accept the pharmaceutical industry's own arguments about the scale of their innovation disincentive or allow those arguments to prevent any drug price reform. There is uncertainty not only about the scale of the amount of innovation that would be limited by these bills but also about the kind of innovation that would result. Economic literature studying the passage of Medicare Part D found that it provided a large new subsidy for pharmaceutical firms, which encouraged them to invest more in the development of products targeted at senior citizens, but also that most of this impact was concentrated among disease classes with multiple existing treatments (Blume-Kohout and Sood 2013; Dranove, Garthwaite, and Hermosilla 2014). If we were to lower prices in Part D, it is possible that the foregone drugs would have little additional therapeutic value in an already crowded class. Finally, the baseline discussion matters. The passage of Medicare Part D in 2003 was framed around providing seniors with access to insurance to pay for treatments that they previously were unable to access (Oberlander 2007). The point of these laws was not to give the pharmaceutical industry a large government subsidy, although they certainly did do that. As a result, there is no reason to think that our current level of innovation—driven by current price levels—was chosen purposefully or represents an optimal distribution of resources.

President Trump's strong public stances against the high prices of prescription drugs masked a reality of continued inaction from a policy perspective. As a result, opportunities for drug pricing reform remain available throughout the federal government as well as at the state level. As policy makers in the Biden administration and in Congress consider formulating their own drug pricing reforms, lessons about both policy and politics can be learned from the fate of prescription drug pricing reform under the Trump Administration.

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