

Chapter 5

Preserving Successful Private Drug Negotiations

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Democratic Prescription for Change: Help close the “donut hole” by dedicating the cost savings from price negotiation toward ending the coverage gap.

—OFFICE OF INCOMING HOUSE SPEAKER NANCY PELOSI (D-CA)

The new congressional leadership intends to strike the “non-interference” provision of the Medicare Modernization Act of 2003, potentially allowing the government to fix drug prices for Medicare beneficiaries through “negotiations” with pharmaceutical companies. By providing for the Part D drug benefit to be delivered by private plans, Congress initially chose the mechanism that best balances the competing considerations of drug costs and drug access. Initial data from the first year of the program indicate that seniors’ access to needed pharmaceuticals has been expanded and the massive cost of the benefit has been restrained somewhat. Further, research from the government’s Centers for Medicare and Medicaid Services shows that allowing government “negotiation” is unlikely to reap savings. Rather than risk limiting seniors’ broad access to prescription drugs, Congress should reconfigure Part D’s benefit design to save money while better meeting seniors’ needs.

Better than Expected

It is true that the new Medicare Part D benefit was an unwise creation that further exacerbates America’s massive entitlement spending problem. But its design offers proof that market-based solutions can trump government-run programs.

Congress included the “non-interference” provision when it created the new Medicare Part D prescription drug entitlement as part of the Medicare Modernization Act of 2003 (MMA). The provision explicitly prohibits the government from interfering with price negotiations between drug makers, pharmacy benefit managers (PBMs), and sponsors of prescription drug plans.

The Centers for Medicare and Medicaid Services (CMS) has noted that average monthly premiums for the first year of the program were nearly 40 percent less than originally projected, or around \$24 instead of \$37. Also, according to CMS, “Medicare Part D expenditures are now projected to be \$34 billion lower over five years (2006–2010) than in the President’s Budget.”¹ It is true, however, that not all of that difference is due to price negotiations by PBMs and private Part D plans. CMS acknowledges that some of the projected savings result from the difference between actual enrollment and previous enrollment projections.

However, CMS also projects that “State payments for a portion of the costs for drug coverage for Medicare–Medicaid ‘dual eligible’ beneficiaries that the states would have incurred under Medicaid are projected to be more than 25 percent lower than had been projected one year ago.” Under MMA, dual-eligible seniors previously receiving drug coverage through Medicaid began receiving their drug coverage through the new Medicare Part D program this year. As part of that transfer, MMA provided for the anticipated savings to state Medicaid programs to be “clawed-back” through offsetting payments by the states to the federal government. CMS’s projection that those offsetting state payments will be *less* than originally anticipated indicates that the private Part D plans are doing a better job than

1. Centers for Medicare and Medicaid Services (CMS), “Medicare Part D Spending Projections Down Again, Part A and Part B Increases Highlight Need for Further Reforms,” July 11, 2006, at www.cms.hhs.gov/apps/media/press/release.asp?Counter=1895.

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Medicaid of restraining drug prices and managing drug utilization. If true, this would mean that the Part D approach of relying on private plans to deliver the benefit is performing significantly better than the Medicaid system of government-administered drug benefits coupled with a mandatory “best price or 15 percent rebate” on drug prices.

This experience tends to confirm the Congressional Budget Office’s (CBO) 2004 conclusion on non-interference:

[S]triking the [non-interference] provision would have a negligible effect on federal spending because CBO estimates that substantial savings will be obtained by the private plans and that the Secretary [of HHS] would not be able to negotiate prices that further reduce federal spending to a significant degree. Because they will be at substantial financial risk, private plans will have strong incentives to negotiate price discounts, both to control their own costs in providing the drug benefit and to attract enrollees with low premiums and cost-sharing requirements.²

This is significant. There is good evidence that were Congress to apply the Medicaid approach of government purchasing and statutory price restrictions to Part D, it would be unlikely to achieve additional savings.

An Erroneous Assumption

Congressional champions of government price negotiations say that Medicare could leverage its bargaining power on behalf of 42 million beneficiaries to secure lower prices. With government’s monopsony clout, they assert, it could generate real savings, enabling Congress to close existing gaps in drug coverage.

But Medicare does not, in fact, have market power that is greater than existing private-sector pharmacy benefit managers and thus will be ineffective at securing prices lower than those already achieved through existing private-sector arrangements. PBMs cover approximately 217 million individuals, or 76 percent of the population, with the largest, Caremark, covering 80 million. Medicare could cover 42 million at most, but today only covers 22.5 million in Part D.³

By allowing Medicare beneficiaries to buy private plans that contract with PBMs, Congress enables Medicare beneficiaries to take advantage of the large market clout of the private sector, where PBMs are already successfully providing drug benefits for millions of Americans. Moreover, market clout is less important than market positioning and negotiating power when attempting to assure optimum prices and access to pharmaceuticals.

Among the incoming House majority’s policy priorities is to re-enact, and stick to, pay-as-you-go budgeting (PAYGO), which makes it difficult for Congress to enact new entitlement spending without offsetting the expense elsewhere in the budget. However, the new Congress also hopes to close the “doughnut hole” gap in Part D coverage, an expensive proposition that it hopes to offset with savings from lower drug prices due to government negotiation. But if these savings are not forthcoming, as is likely, Congress will have to try a tougher approach.

Denying Seniors Access to Drugs

If it is allowed, government “negotiation” with drug makers would not be negotiation in the common meaning of the term but rather fixing prices below those reductions already achieved in the market in order to get, on paper at least, larger discounts than PBMs do today. To achieve those additional savings, Congress would need to wield a hammer that is unavailable to PBMs. And the only real tool the government has that private plans do not is the abil-

2. Congressional Budget Office, “Estimate of the Effect of Striking the ‘Noninterference’ Provision as Added by P.L. 108–173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,” at www.cbo.gov/showdoc.cfm?index=4986&sequence=0.

3. Centers for Medicare and Medicaid Services (CMS), “Part D Enrollment Data,” June 14, 2006, at www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp.

ity to deny all seniors access to specific drugs if the manufacturers refuse a government-set price. This would be, in effect, a price control scheme, enforced by denying patients access to drugs. The effectiveness of this approach would depend on Congress's willingness to deny seniors access to some, or even many, prescription drugs.

Price controls—that is, fixing prices below the equilibrium price obtained in the market—are indisputably counterproductive. In this case, it would surely mean fewer drugs available to seniors, fewer innovative drugs developed in the future, and higher drug prices for consumers in the non-controlled private markets, who would be on the receiving end of the cost shifting that always accompanies government price control strategies. It could even result in higher overall program costs due to the substitution of less effective drugs and would impose new costs on seniors who would have to obtain denied drugs themselves.

A Better Policy

There is a much better way to save money and close the gap—the “doughnut hole”—in coverage. First, however, Congress should retain the current cost-saving benefits of private-sector negotiation and avoid the unintended complications associated with a scheme of government price-fixing that promises to repeat the same painful lessons of past attempts at price-fixing.

Second, Congress should provide seniors with a more rational benefit design. Congress can reconfigure the minimum Part D benefit design so that the doughnut hole is replaced with a higher front-end deductible and 50/50 cost sharing up to the existing catastrophic limit. These changes can be structured so that seniors experience no greater total out-of-pocket costs than they do under the present benefit design, while also better targeting financial assistance to those who need it most.

Moreover, Medicare drug costs could be further reduced by making coverage subsidies less generous for seniors above 150 percent of the official federal poverty line. Heritage Foundation analysts have developed a model of different options for deductibles and co-payments which shows the savings of different options over a ten-year period.

Finally, Congress should encourage even more seniors to enroll in Medicare health plans that integrate the drug benefit with other benefits. This integration ensures greater efficiency and can generate savings in the overall costs of the program itself by encouraging, as appropriate, the substitution of drug therapies for other Medicare-covered services, such as doctor visits and hospitalization.

Conclusion

Congress is right to look for savings in the new Part D drug benefit. Eliminating private negotiation with pharmaceutical firms, however, will not save money and risks denying seniors access to crucial drugs. Instead, Congress should retain the benefits of private-sector negotiation and rethink Part D's benefit design in order to eliminate the doughnut hole and to better target needy seniors.