Government Price Negotiating Authority for Prescription Drugs
NBCH Member Issue Primer
January 2007

The Issue:

The 2003 Medicare Prescription Drug, Improvement and Modernization Act, effective January 1, 2006 created an outpatient prescription-drug benefit, Medicare Part D. For the first time, the federal government is paying for the prescription medicines used by Medicare-eligible Americans. However, the Part D benefit differs from other federal and state drug programs, which mandate specific price discounts from pharmaceutical manufacturers. Instead, private-sector pharmacy benefit managers (PBMs), such as Medco, Blue Cross, Express Scripts and Aetna, negotiate with drug companies to set prices and formularies for enrolled patients.

Despite its passage in 2003, the Part D benefit continues to solicit hard, partisan feelings regarding a number of issues which include the cost, the "donut-hole", means-testing, access and administrative technicalities. One of the major areas of disagreement is **whether or not the federal government should have the authority to negotiate the terms and pricing for prescription drugs directly with manufacturers.** Complicating this is the escalating price of prescription drugs, not just for Medicare beneficiaries, but for all Americans. This reality has created additional concern by federal lawmakers in both parties about access to cost-effective, quality care.

Because the Part D drug benefit is projected to cost hundreds of billions of dollars over the next decade, some policymakers have called for "reining-in" the Part D program, namely by requiring federal negotiation of prescription drug prices. Such a change would use the purchasing power of the federal government to force prices below those that would be negotiated by the private sector.

Current Status:
Incoming House Ways and Means Health Subcommittee Chairman, Pete Stark (D-CA) said that his subcommittee will begin the legislative session with oversight hearings on the Medicare Part D prescription drug benefit. Speaker-elect Pelosi said the Democrats' first 100 legislative hours, from Tuesday, January 9 through Thursday, January 18, 2007, will include a bill to give the government the authority to negotiate drug prices. The Bush administration opposes the move, contending it is not needed because drug benefit costs have been less than originally estimated.

Pro/Con Positions on Government Price Negotiating Authority

Arguments For:

- **Medicare Can Command Low Prices:** With Medicare Part D's estimated 22.5 million enrollees in 2007[1], it's the nation's largest prescription drug buyer and should be able to command the best prices while protecting beneficiaries from escalating costs. Several studies have shown that Medicare price negotiating authority would produce enough savings to negate the infamous coverage donut-hole.[2]
- **Rx Costs Limits Access to Poor & Uninsured Americans:** Typically, brand name drugs are expensive, which is overwhelming for the 47 million uninsured Americans in this country, along with many of the 22 million elderly and disabled Americans enrolled in the Medicare Part D program in 2007. Correspondingly, high initial drug costs offer manufacturers large profits, but also encourages investment in research and development of drugs to treat even rarer diseases. After these medicines lose their patent protection (in about two decades) patients and insurers finally gain access to cheaper generic drugs. Drugs need to be cheaper at the front end, as well as the back end of the system.
- **Medicare Responsibility to Control Costs & Improve Access:** Some lawmakers contend that market-based purchasing strategies need to be implemented within the Part D benefit. Medicare has the ability and responsibility to negotiate directly with drug manufacturers on the price of covered drugs. This action can set a benchmark of price and negotiation standards within the insurance industry.
- **Medicare Should Be a Pharmacy Benefit Manager (PBM):** With over 22 million enrollees, the government's market strength as a PBM would be much greater than the private-sector managers already serving Medicare beneficiaries. Medicare should operate its own drug benefit, negotiating drug prices for this program like contracted PBMs currently do on its behalf and enroll Medicare beneficiaries directly. Though, an "official" Medicare Formulary should be avoided, since having one set formulary that all private plans must follow could jeopardize cost and access. With one set formulary, either drugs needed will not be covered or the formulary will be all inclusive and thereby not achieve price discounts.
- **Price Controls Could Provide a Positive Trickle-Down Effect:** When private plans establish preferred drug lists, they secure better prices by favoring one manufacturer's products over others. A national buyer/negotiator could get better results and establish prices for drugs that would apply to all drug plans and HMOs working with Medicare beneficiaries.
- **Value-Based Purchasing to Complement Part D Price Controls:** Regardless of price controls, Medicare needs to continuously monitor the Part D benefit to evaluate its effectiveness, efficiency and overall progress. In this regard, NBCH strongly encourages Medicare to consider integrating value-based benefit design (i.e. lowering beneficiary costs of certain prescription drugs resulting in a reduction of overall program expenditures and/or improvement in health outcomes for beneficiaries) into the Part D benefit, or at least a demonstration project to determine the feasibility of this concept. Value-based benefit design, particularly at the outpatient drug benefit level, has become widespread among private sector employers, but the cause needs the leadership and extensive implementation that only the federal government can provide. NBCH believes that a good starting point for value-

based benefit design should be a set of core principles, which recently were developed by an experienced group of NBCH members NBCH developed these principles [3] to help guide responsible health benefit design by serving as a guidepost for both public and private employer decisions moving forward.

- **Government Should Lead Consumer-Focused Health System:** Congress and the Administration should provide tools and resources to help consumers make better health care decisions and allow them to shop for the best combination of price and coverage across state lines. Transparency and public reporting of health care information is essential to health care reform and value-based purchasing. NBCH supports the Centers for Medicare and Medicaid Services in its continued progress in the collection and distribution of health care data, including cost and price information, as well as its groundbreaking efforts, such as the President's Purchaser Executive Order.

Arguments Against:

- **Medicare Market Clout Questionable:** Despite over 22 million beneficiaries enrolled for 2007, the government really does not have the market strength of the private sector pharmacy benefit managers that had over 195 million enrollees among the top three[4] in 2004 alone. Private competition in Medicare Part D has led to lower prices and more choices for seniors and to savings for taxpayers. [5]
- **Medicare Has Little PBM Experience:** Medicare has insufficient experience managing outpatient drug benefits. When government officials do "negotiate" drug prices, such as through the Veterans Administration and Medicaid programs, it sets a price below the market level, which reduces the supply or restricts the choice of drugs beneficiaries can access. The Part D benefit does not give the government the ability to set a "Medicare Formulary." Medicare needs to be able to dictate/leverage what drugs are going to be included on the benefit formulary in order to effectively negotiate prices (i.e. Take a drug off formulary as punishment)
- **Price Controls Jeopardize Research & Development:** In the short term, federal price negotiations would allow some consumers to receive medicines at lower prices, or, alternatively, would yield savings for federal taxpayers. The longer-term impact of government price-negotiation, however, is likely to be negative and immense, since the government would have an incentive to favor price reductions at the expense of more-inclusive drug formularies. This would result in the exclusion of other drugs and correspondingly lower drug prices below those that otherwise would be set by the market. This, in turn, would reduce incentives for the capital market to invest in the research and development of new medicines. According to research conducted by Manhattan Institute's Center for Medical Progress, investment in new drug research and development would decline by approximately $10 billion per year through 2025.
- **Competition is Good for Consumers:** The intense competition that takes place among health plans offering Part D drug coverage today is good. As an example, when the program started last year, Medicare officials projected that the average monthly premium would be $37. In fact, it declined to less than $24. According to Medicare officials, private health plans are securing serious discounts, and the benefits are generous, particularly for poor seniors. Without competition, price controls can lead to cost-shifting to other population segments, in both the private and public sector. Currently, the government links the price it will pay to the prices paid by other public and

private purchasers. However, instead of lowering the price paid by government, such a strategy may result in higher overall prices charged to private buyers. This appears to be what happened in Medicaid.

- **Policy Alternatives to Price Controls:** Medicare needs to adopt a more market-based approach to controlling Part D benefit costs by continuously evaluating the effectiveness, efficiency and overall progress of the program. In this regard, NBCH strongly encourages Medicare to consider integrating value-based benefit design (i.e. lowering beneficiary costs of certain prescription drugs resulting in a reduction of overall program expenditures and/or improvement in health outcomes for beneficiaries) into the Part D benefit, or at least a demonstration project to determine the feasibility of this concept. Value-based benefit design, particularly at the outpatient drug benefit level, has become widespread among private sector employers, but the cause needs the leadership and extensive implementation that only the federal government can provide. NBCH believes that a good starting point for value-based benefit design should be a set of core principles, which recently were developed by an experienced group of NBCH members. NBCH developed these principles [6] to help guide responsible health benefit design by serving as a guidepost for both public and private employer decisions moving forward.
- **Government Should Lead Consumer-Focused Health System:** Congress and the Administration should provide tools and resources to help consumers make better health care decisions and allow them to shop for the best combination of price and coverage across state lines. Transparency and public reporting of health care information is essential to health care reform and value-based purchasing. NBCH supports the Centers for Medicare and Medicaid Services in its continued progress in the collection and distribution of health care data, including cost and price information, as well as its groundbreaking efforts, such as the President's Purchaser Executive Order.

Related Statistics:

- **2005 Total National Spending on Health Care:** $2 trillion, 16% of Gross Domestic Product
- **2005 Total National Rx Spend:** $200.7 billion
- **2005 Pharmaceutical R&D Spending:** $51.3 billion
- **2006 Total Medicare Rx Spend**: $31 billion
- **2007 Total Beneficiaries Covered By Medicare:** 41 million
- **2007 Total Beneficiaries Covered by Medicare Part D:** 22.5 million
- **2006 Part D Monthly Premium:** $37 average
- **2007 Part D Monthly Premium:** $27.35 average
- **2007 Part D Participating Plans:** 3,870 approximately
- **2007 "Donut-Hole" Coverage Threshold:** The coverage gap during which people have to pay 100 percent of the cost of their drugs while continuing to pay premiums for drug coverage. From $2,400 to $5,451 ($3,051 total responsibility).

[1] Kaiser Family Foundation, "Benefit Design and Formularies of Medicare Drug Plans: A Comparison of 2006 and 2007 Offerings," http://profile.kff.org/medicare/7589.cfm.

---

[2] Asclepios, "People Struggle to Afford Their Drugs While Pharmaceutical Companies Rake in Billions,"July 20, 2006, Volume 6, Issue 29.

[3] National Business Coalition on Health , "Promoting Consumerism Through Responsible Health Care Benefit Design," November 2006, http://www.nbch.org/resources/policypapers.cfm.

[4] Manhattan Institute for Policy Research, "The Human Cost of Federal Price Negotiations: The Medicare Prescription Drug Benefit and Pharmaceutical Innovations, Medical Progress Report No. 3, November 2006.

[5] Office of the Actuary, Department of Health and Human Services, "Medicare Part D Spending Projections Down Again," July 11, 2006, http://www.cms.hhs.gov.

[6] National Business Coalition on Health , "Promoting Consumerism Through Responsible Health Care Benefit Design," November 2006, http://www.nbch.org/resources/policypapers.cfm.