WebMemo
Published by The Heritage Foundation
No. 1270
December 1, 2006

Why the New Congress Should Not Fix Drug Prices

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In the first hundred hours of the 110th Congress, the new Congressional leadership is expected to introduce legislation to fix the prices of prescription drugs in the massive Medicare drug entitlement program. The Medicare drug benefit is a costly entitlement, and its design, particularly the congressionally ordained gaps in coverage, has no analogue in the private markets. But government price fixing is not a viable solution to any of these shortcomings.

While the design of the drug entitlement has its flaws, the basic structure, in which private plans compete free of government interference, is a constructive feature of the Medicare program. In devising this framework, Congress initially acknowledged that market competition and consumer choice are necessary to ensure that seniors have access to quality pharmaceuticals at affordable prices. Thus far, the performance of the drug program has ratified that initial assumption—in the first year alone, the projected average monthly drug premiums dropped by nearly 40 percent.[1] A government-controlled Medicare drug purchasing program, in contrast, would prove ineffective, inflexible, and unresponsive to the highly diverse personal needs of America's seniors.

What the Research Shows

Those who advocate fixing prescription drug prices in Medicare believe that the federal government should suspend negotiations between private-sector health plans and drug companies in favor of government "negotiation" of drug prices. According to advocates of price fixing, the government would do a better job of delivering a broad range of high-quality pharmaceutical products to the 38 million seniors enrolled in Medicare drug program.[2] One crucial assumption underlying this argument is that Medicare has superior "market clout" and would be uniquely disinterested in providing quality drugs to seniors. This assumption is incorrect for three reasons:[3]

- **Medicare's market clout is, in fact, inferior to that of the largest existing pharmacy benefit managers (PBMs)**. As of 2004, Advance PCS covered 75 million individuals, Medco Health Solutions covered 65 million, and Express Scripts covered 57 million. Medicare covers 38 million individuals. By allowing Medicare beneficiaries to buy into these and other existing PBMs, Congress enables these beneficiaries to take advantage of the even larger "market clout" of the private sector, where PBMs are already successfully providing drug benefits for millions of Americans. The government would not do a better job, at least not without adversely affecting the quality of patient care for Medicare beneficiaries.

This paper, in its entirety, can be found at:
www.heritage.org/research/healthcare/wm1270.cfm

Produced by the Center for Health Policy Studies

Published by The Heritage Foundation
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Washington, DC 20002–4999
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- **Medicare's experience in managing drug benefits is inferior to that of private sector alternatives**. Private health plans have decades of experience in managing drug programs, but the Medicare bureaucracy has no experience buying outpatient prescription drugs. Unlike traditional government management of drug programs, which relies on such negative strategies as market access restrictions, one positive feature of the Medicare drug entitlement is that it allows Medicare beneficiaries to choose between competing private prescription drug plans. Accordingly, competing health plans have to respond to consumer pressure both to keep costs down and to maintain access to a broad range of drug therapies. In fact, this is precisely what has happened during the past year. With competitive private health plans, Medicare patients have the best access to the right drugs at the best prices through market forces.
- **Government intervention will undermine quality and patient choice**. If the government were to override the existing private sector negotiations among PBMs, pharmacies, and drugs companies, it would override their decisions, effectively making the PBMs irrelevant. In order to be more effective than PBMs, the government would have to tell drug makers to accept what it offers to pay or risk not having their drug available in Medicare. In fact, this is standard practice in government-run drug programs, such as Medicaid and the Veterans Administration program, which are often held up as models for government drug pricing.[4] If the Medicare drug program adopts this practice, certain patients could be left without the drug that works best for them because they would no longer have access to competing plans in the private market. Faced with that circumstance, patients would be reduced to the time-consuming process of lobbying Congress to have specific drugs included in any Medicare offering, or pressuring Congress to intervene with the Medicare bureaucracy to ease or eliminate any administrative restrictions that would obstruct or compromise the availability of certain drugs. These are common problems with government-administered drug programs, and cost pressures would only aggravate these problems.

The belief that using Medicare's "market clout" to determine the price and availability of drugs is more effective than private sector arrangements is groundless. Medicare's clout is not superior to today's private sector arrangements, and its administrative determinations cannot serve as a substitute for the efficient operation of real market forces. By allowing government to interfere, or supersede, existing private sector price negotiations, policymakers would be replacing already functional negotiations between private insurance plans, pharmacists, and drug companies with a more rigid system of government price fixing. Government interference would also subordinate the interests of individual patients to the vicissitudes of the Congressional budgetary process.

Forecasting the Inevitable Results of Government Control

Striking the right balance between drug price and availability is a complicated, sensitive, and difficult enterprise. There is no reason to put one's faith in the Members of Congress—or the Medicare bureaucracy that acts on their behalf—who think that they can improve, or even marginally mimic, what the existing market is already successfully doing.

1. The 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 *http://www.cms.hhs.gov/apps/media/press/release.asp?Counter=1895*.
2. The Centers for Medicare and Medicaid Services (CMS), "Part D Enrollment Data," June 14, 2006, at *http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp#TopOfPage*.
3. Edmund F. Haislmaier, "Compromising Quality: The High Cost of Government Drug Purchasing," Heritage Foundation *Backgrounder* No. 1764, May 25, 2004, at *http://www.heritage.org/Research/HealthCare/bg1764.cfm*.
4. Derek Hunter, "Government Controls on Access to Drugs: What Seniors Can Learn from Medicaid Drug Policies," Heritage Foundation *Backgrounder* No. 1655, May 27, 2003, at *http://www.heritage.org/Research/HealthCare/bg1655.cfm*.

Whenever the government is the single, or monopsony, purchaser of a product, "negotiations" become limited and essentially amount to price controls. Government officials, inevitably operating on imperfect information, demand a price that does not reflect market conditions, and suppliers either concede and accept the artificial price or walk away from the table by not bringing valuable drugs to the market. Thus, government fixes prices.

Price controls would have serious consequences for patients. If only lower priced and less effective drug alternatives are available, costs will rise due to over-utilization of drugs on the market and added physician and hospital visits. If Congress ultimately requires companies to stay at the table and "negotiate," drug prices would likely rise higher than the current equilibrium price for other consumers, because companies would cost-shift and raise wholesale prices to moderate their anticipated losses. In either scenario, government intrusion into the pharmaceutical marketplace would significantly deter private sector innovation and produce vast, incalculable costs by inhibiting medical progress and undermining decisions regarding clinical appropriateness that had previously been made by patients and doctors.

The devastating effects of price controls have been well documented by researchers at The Heritage Foundation and prominent economists worldwide.[5] The adverse effects of government drug pricing can also be seen in Medicaid, the Veterans Administration program, as well as in other countries whose governments engage in price fixing.

Conclusion

Fixed prices often appear politically expedient, but they generate significant financial and human costs. There are ample ways to improve the current Medicare drug program without obstructing the supply of new and innovative drugs for America's seniors.

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5. Derek Hunter, "Guaranteed Future Pain and Suffering: The Recent Research on Drug Price Controls," Heritage Foundation *WebMemo* No. 908, November 3, 2005, at *http://www.heritage.org/Research/HealthCare/wm908.cfm.*