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H.R. 4: A Confusing and Contradictory Prescription for Medicare Drugs

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The House of Representatives is poised to enact a confusing and contradictory Medicare drug policy. Under the Medicare Modernization Act of 2003, the Secretary of Health and Human Services is forbidden from interfering with private sector price negotiations for pharmaceuticals in Medicare Part D. With the Medicare Prescription Drug Price Negotiation Act of 2007 (H.R. 4), sponsored by Rep. John Dingell (D-MI) and backed by the new House leadership as part of its 100-Hours agenda, Congress would substitute government negotiation of drug prices for existing private sector negotiations. As the Congressional Budget Office has confirmed, however, government negotiation would not result in lower program costs relative to private negotiations. H.R. 4 does leave the door open, however, to government using its other regulatory powers to intimidate drug makers into granting greater price concessions.[1]

Today's Competition Benefits Seniors

Medicare Part D is structured to leverage the power of competition to drive down costs while ensuring seniors have the drugs that they need. In Medicare's existing drug competition model, private health plans secure discounts through the establishment of their formularies that cover some drugs and not others and may favor some drugs over others. Pharmacy Benefit Managers (PBMs) negotiate on behalf of private plans and make deals with drug companies when they decide the price is appropriate for the competitive market. When PBMs decline to purchase certain drugs, the drug companies can negotiate with other private drug plans to offer their drugs. And if one plan's drug formulary omits a needed drug, or if a drug's formulary price is not competitive, seniors can choose a different drug plan. The drug formularies of any health plan, therefore, are subjected to the tough test of a competitive market, where private health plans compete with one other for consumers' dollars.

With intense market competition—a reality in the new Medicare Advantage and Prescription Drug Plan programs—insurers have a powerful incentive to respond to consumers' needs and to maintain broad access to affordable drugs. Accordingly, Medicare beneficiaries today have broader access to the right drugs at the best prices through real, competitive market forces—perhaps more so than any other group of Americans.

Private competition and negotiation has worked well beyond expectations. Because of tough negotiations between private health plans and pharmaceutical companies, intense market competition has led to low prices and good drug selections for seniors, as well as substantial savings for taxpayers.

Based on Centers for Medicare and Medicaid Services (CMS) data, senior and disabled Americans

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have saved, on average, an estimated $1,100 dollars in drug expenses per year under Part D.[2] Average monthly Medicare drug premiums are roughly 40 percent below initial projections,[3] and program costs over 10 years are estimated to be 30 percent less than expected. This adds up to a total savings of $189 billion dollars,[4] most of which is directly attributable to lower drug costs due to successful private negotiations.[5]

Introducing Government "Negotiation"

Part D's performance is impressive, but House leaders nonetheless believe that the government can do better than the market in pricing and distributing pharmaceuticals, and secure even deeper savings, if it is able to negotiate drug prices. Moreover, they believe that they can accomplish lower drug program costs and lower prices for beneficiaries without limiting beneficiaries' access to drugs through a government formulary.

H.R. 4 contains several key provisions. It would require the Secretary of Health and Human Services (HHS) to intervene in drug price negotiations and negotiate the price paid by private health plans to pharmaceutical companies.

It then strikes the current law that the Secretary "may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs." In its place it substitutes that nothing about the requirement for the Secretary to negotiate prices "shall be construed to authorize the Secretary to establish or require a particular formulary."

Formularies are often used to control drug costs. Most notable, in this respect, are the restrictive formularies of the Veterans Administration drug program, which is often touted as a model for Medicare drug pricing. By denying all of its beneficiaries access to certain drugs, the VA can force drug manufacturers who want to be on the formulary to make deeper price concessions.

Finally, the Secretary would be required to report to Congress on the status of his negotiations with pharmaceutical companies to achieve lower drug prices on June 1, 2007, and every six months thereafter.

In sum, H.R. 4 would require the Secretary to negotiate directly with pharmaceutical companies to secure lower drug prices but deny him the use of a drug formulary, which is the principal means of negotiating lower prices.

H.R. 4's negotiations, then, would not bring savings; savings could come only from denying seniors access to drugs from manufacturers unwilling to accept the government-set price—a door that the legislation's vague language leaves ajar.

In two analyses, the nonpartisan Congressional Budget Office (CBO) has denied the likelihood of reduced spending or significant savings through federal price negotiation alone. Moreover, current HHS Secretary Michael Leavitt doubts he can outperform existing private plan negotiations while retaining Medicare beneficiaries' existing broad access to drugs.[6] Concerning the impact of H.R.4, CBO confirms the Secretary's assessment:

1. H.R. 4 does not specify what else the Secretary of Health and Human Services might do, so the Congressional Budget Office cannot score any effects.
2. "Strong competition and beneficiary choices result in drug coverage with lower costs than predicted last year," Centers for Medicare and Medicaid Services, August 15, 2006, at */www.cms.hhs.gov/apps/media/press/ factsheet.asp?Counter=1946& intNumPerPage=10& checkDate=&checkKey=&srchType=&numDays=3500&srchOpt=0& srchData=&keywordType=All& chkNewsType=6&intPage=&showAll =&pYear=&year=&desc=false& cboOrder=date.*
3. "Medicare Part D Spending Projections Down Again, Part A and Part B Increases Highlight Need for Further Reforms," Centers for Medicare and Medicaid Services, July 11, 2006, at *www.cms.hhs.gov/apps/media/press/release.asp?Counter=1895.*
4. United States Department of Health and Human Services (HHS), "Projected Medicare part D Costs Drop By 30 Percent," News Release, January 8, 2006, at *www.hhs.gov/news/press/2007pres/20070108.html.*
5. The remaining difference in projected costs is principally explained by the differences between actual enrollment and earlier enrollment projections.
6. Mike Leavitt, "Medicare and the Market," *The Washington Post*, January 11, 2007, at *http://www.washingtonpost.com/wp-dyn/content/article/2007/01/10/AR2007011002020.html?nav=rss_opinion/columns.*

> CBO estimates that H.R.4 would have a negligible effect on federal spending because we anticipate that the Secretary would be unable to negotiate prices across the broad range of covered part D drugs that are more favorable than those obtained by PDPs under current law.[7]

Risk-bearing private plans, however, have both the "tools and the incentives to negotiate drug prices that the government, under the legislation, would not have. H.R. 4 would not alter that essential dynamic." [8]

How Government "Negotiation" Might Work

The potential for government "negotiation" to extract lower drug prices would depend on the HHS Secretary's ability and willingness to say "no deal" to a pharmaceutical company and pursue an alternative course of action, such as denying reimbursement for their drugs. That, as opposed to Medicare's market clout, is what ultimately determines negotiation power. But with Medicare then serving as the sole—or monopsony—purchaser for beneficiaries, government "negotiation" would not be negotiation as it is used in the private sector; rather government "negotiation" would become an exercise of government power to fix prices and exclude from the market any company offering a drug at a higher price. In effect, this exclusion would be a de facto price control scheme, because the government could deny pharmaceutical companies access to the millions of seniors and disabled citizens who comprise the Medicare market.

Conclusion

Despite promises from the House leadership that the government can deliver lower drug prices and reduce drug spending, H.R. 4 will deliver on neither unless it denies seniors access to drugs. As CBO has confirmed once again, there is no tangible evidence that congressional repeal of the non-interference clause would yield savings superior to the existing system of competition and private negotiations.

The federal government cannot really "negotiate" drug prices in the Medicare program; it can only "set" prices, which it does today for hospital and physician payment and other medical goods and services delivered through Medicare. But government price setting is only as effective as the accompanying enforcement mechanism. H.R. 4 would remove the existing clear prohibition against government price setting. It instead tells the Secretary of Health and Human Services to go out and negotiate, but immediately caveats that command with vague language that leaves unclear whether the Secretary has anything to negotiate with. Finally, it tells the Secretary to report back at regular intervals on the success of his "negotiations." Not surprisingly, CBO projects that this charade will not result in savings. H.R. 4 is a prescription for failure.

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7. Letter from Donald B. Marron, Acting Director of the Congressional Budget Office, to Rep. John Dingell (D-MI), Chairman of the Committee on Energy and Commerce, U.S. House of Representatives, January 10, 2007, p.1.
8. *Ibid*, p. 2.