HFM MAGAZINE: MARCH 2016

‘Negotiating’ Drug Prices for Medicare

EYE ON WASHINGTON: GAIL R. WILENSKY

SINCE THE MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT (ALSO CALLED THE MEDICARE MODERNIZATION ACT, OR MMA) WAS PASSED IN 2003, DEMOCRATS HAVE BEEN ARGUING THAT MEDICARE SHOULD BE ABLE TO “NEGOTIATE” DRUG PRICES, USING THE POWER OF THE FEDERAL GOVERNMENT AS A MAJOR PURCHASER TO PRODUCE LOWER PRICES THAN WOULD OTHERWISE OCCUR.

Somewhat more surprisingly, Donald Trump, currently campaigning for the Republican nomination for president, has joined the call for Medicare to be given the power to negotiate drug prices. Although having the government negotiate lower prices sounds intuitively appealing and reasonable to many people, it is important to understand why this part of Medicare, referred to as Part D, was structured the way it was and what this call for increased power for Medicare might actually involve.

Part D Medicare—the Outpatient Prescription Drug Benefit

The passage of the MMA brought what had been regarded as a missing piece of all modern insurance coverage—outpatient prescription drug coverage—to seniors. The controversies that had delayed the passage until 2003 involved how to structure the benefit, how to pay for it, and whether to try to fix some of Medicare’s other pressing fiscal solvency issues at the same time. Many were surprised that the Senate was able to pass its bill setting the stage for the MMA to become law, because doing so required Democratic support. (The Republican-controlled House was able to pass a bill on its own.)

Under the MMA, drug coverage is to be provided by freestanding drug plans or as part of Medicare Advantage plans. A “fall-back” public option plan is to be made available in any county with fewer than one private drug plan and one Medicare Advantage plan, but this provision has never been needed.

Unlike the rest of Medicare, which sets the prices that will be paid to various suppliers of services to Medicare beneficiaries (frequently referred to as administrative pricing), Part D relies on competitive pressures among the private drug plans to keep premium prices low. The reliance on competition rather than administrative pricing was critical to winning support from both the Republican majority and conservative Democratic leaders such as Sen. John Breaux (D-La.), whose support was key to its passage. The late Sen. Edward Kennedy’s advocacy also was important in garnering Democratic support for the bill. Kennedy did not have the same concerns about administrative pricing, but viewed this bill as the best opportunity to get a needed benefit for seniors.

Results to Date

Spending under Part D consistently has run less than Congressional Budget Office (CBO) projections. In a 2014 analysis on the effects of competition on Part D spending, CBO estimates that Part D spending in 2013 was 50 percent lower than had been originally estimated, reflecting a combination of factors apart from competition, including a slowdown in the release of new, more expensive drugs and a significant adoption of generic drugs.[a] To date, when asked to score the potential savings from giving Medicare the ability to negotiate or administratively set prices, CBO has not attested that savings will occur. In the 2014 analysis, CBO also comments that requiring mandatory rebates for low-income populations, such as occurs under Medicaid, would probably reduce spending in the short term—but in the long term, it would result in higher prices (before rebates) for new drugs, curtailing much of the savings while also eroding drug innovation.

What Would It Mean to "Negotiate" Drug Prices?

When people speak of negotiating drug prices for Medicare, I assume they mean using the same strategy for drugs that Medicare uses in other areas of health care—that is, setting prices administratively, based on a combination of historical costs and efficiencies that have been deemed achievable. The Affordable Care Act, for example, assumes a 1 percent productivity gain is achievable and reduces Medicare payment accordingly. The Centers for Medicare & Medicaid Services (CMS) knows how to execute such policy, because it does so routinely elsewhere in Medicare. In this regard, "negotiation" is a misnomer: The prices actually are administratively set and offered to suppliers on a take-it-or-leave-it basis. Most, suppliers accept these terms. To date, CBO has not expressed confidence in this strategy as a means to produce savings.

A recent *Health Affairs* blog post indicates some of the many questions that would need to be answered before attempting to proceed with a real negotiation—which neither CMS nor the U.S. Department of Health & Human Services (HHS) has ever done.[b] Which drugs would be negotiated? Would HHS be able to negotiate both the price of the drugs and the formulary design? Would the negotiated terms apply to all Part D plans? How would the actual negotiation process work? Would an independent arbitrator be used? The point here is that negotiating drug prices would be extremely challenging for an agency that has no experience with such a process.

The bigger concern is what it might mean to future innovation if this process actually were to produce substantial savings. The role of pricing in financing future innovations is a major issue in its own right that is beyond the scope of this column. But it seems to me there are other ways to achieve savings—at least for select types of drugs—that are likely to be less disruptive than either administratively setting prices or negotiating prices.

The most obvious strategy, which has shown promise to date, is to enable the U.S. Food and Drug Administration to make expedited and efficacious reviews of new and

potentially competing biologics and other high-priced specialty drugs. The presence of AbbVie Inc. and its hepatitis C treatment Viekira Pak following the introduction of Gilead Sciences' Sovaldi and Harvoni had a noticeable impact on the ability of the pharmacy benefits manager Express Scripts to negotiate a lower price for hepatitis C drugs.[c] A similar focus on expediting generic drug applications for older drugs that have been experiencing significant price increases could help in that market as well. A more aggressive strategy would be to allow Medicare to use comparative clinical effectiveness in setting drug reimbursement to encourage the use of expensive drugs only where the clinical benefits are clear.

As I mentioned in my previous Eye on Washington column, annual prescription drug spending increased less than spending on hospital care and spending on personal health care during most of the previous decade.[d] Only in the past year did spending for drugs increase more than twice as fast as spending in general.

Putting pressure on rising drug prices is appropriate. Doing so in ways that minimize the downside effects on future innovation is highly desirable.

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Footnotes

a. Congressional Budget Office, *Competition and the Cost of Medicare's Prescription Drug Program*, July 30, 2014.

b. Shih, C., Schwartz, J., and Coukell. A., "How Would Government Negotiations of Medicare Part D Prices Work?" *Health Affairs Blog. Feb*. 1, 2016.

c. Wilensky, G., "JAMA Forum: A New Focus on Prescription Drug Spending," news@JAMA, July 1, 2015.

d. Wilensky, G., "Are We Seeing an End to Slow Healthcare Spending?" *hfm*, January 2016.

Publication Date: Tuesday, March 01, 2016