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The Medicare Fair Prescription Drug Price Act of 2007: A Step Towards Government Interference

Greg D'Angelo

The Senate will soon vote to decide whether Medicare should be driven by market competition and consumer choice or heavy-handed government regulation and broad restrictions on market access. The immediate debate is over striking the noninterference clause that prohibits the Secretary of Health and Human Services from interfering with negotiations between drug manufacturers and private plans in Medicare Part D, but the vote will have farther reaching consequences. Providing the Secretary broad "negotiation" authority as envisioned in the Medicare Fair Prescription Drug Price Act of 2007 (S. 3) will not result in lower prices or program costs, according to the Congressional Budget Office,[1] unless the government imposes market access restrictions and other regulations. Thus, government negotiation would substitute regulation and access restrictions for market competition and consumer choice in Medicare.

The Leverage of Private Competition. Medicare Part D is currently structured to leverage the power of market competition between private plans to lower costs for beneficiaries as well as taxpayers. This structure also empowers beneficiaries to choose the coverage that best meets their needs and preferences. Private plans have the incentive and tools to negotiate with drug manufacturers and receive price concessions. Their principal tool is the establishment of formularies, or preferred drug lists, which cover some drugs and not others and favor some drugs over others. Drug manufactures provide discounts to plans in order to be placed on formularies and even grant larger price concessions to obtain preferred placement, seeking an increase in market share. Negotiating drug prices is not simply a matter of bulk purchasing; rather, it is a function of the ability to move market share toward some drugs and away from others. But under a structure with competing plan designs, consumers can select the plan that best suits their needs.

While private plans are successful in negotiating lower prices, they have a strong incentive to offer broad drug selections to beneficiaries, who have the freedom to choose drug coverage in a competitive marketplace. Primarily due to its competitive private structure, Medicare Part D has exceeded expectations. Beneficiaries are saving an average of $1,200 a year, and premiums for 2007 are expected to average $22 a month, more than 40 percent lower than originally estimated.[2] The Congressional Budget Office (CBO) has reduced its 10-year estimate of the program's cost by $265 billion.[3] Moreover, surveys consistently demonstrate that more than 80 percent of beneficiaries are satisfied with the program.[4]

The Leverage of Government Interference. Although the competition in Medicare Part D is impressive and the news keeps getting better, some in Congress are eager to interfere with this private sector model. If government were to meaningfully interfere

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(202) 546-4400 • heritage.org

with private negotiations between drug manufacturers and private plans, it would have to be willing and able to move market share, because bulk purchasing alone is insufficient to secure price discounts.

As CBO Director Peter Orszag explained after the passage of H.R. 4, the House's price negotiation bill, "Just showing up and saying 'we're from the government and would like a lower price' doesn't help very much."[5] For the government to move market share, it would have to impose a government formulary or pricing structure or some other regulatory regime. Its interference would necessarily become an exercise of government power to control prices, directly or indirectly, and exclude from the market any drug offered at a higher price. In turn, this would result in a one-size-fits-all Medicare benefit that would preclude competition between private plans and replace consumer choice with decisions handed down by Washington bureaucrats.

CBO Director Orszag has explained that the key factor in determining whether government negotiations would lead to price reductions beyond those negotiated by private firms is the leverage that the Secretary could wield to secure price concessions from drug manufacturers. But S. 3, like H.R. 4, would strike the noninterference clause but explicitly prohibit the Secretary from "requiring a particular formulary or instituting a price structure for the reimbursement of covered Part D drugs," the very tools that CBO and other independent experts explain are necessary to obtain meaningful discounts beyond the current private sector model.

In Orszag's assessment of S.3, he predicts that government negotiations would have a "negligible effect on federal spending" because the Secretary would "lack the leverage to negotiate prices across the broad rang of covered Part D drugs that are more favorable than those obtained" without the "authority to establish a formulary or other tools to reduce drug prices."[6] In a separate correspondence with Congress,[7] he elaborated on this point:

> Negotiation is likely to be effective only if it is accompanied by some source of pressure on drug manufacturers to secure price concessions. The authority to establish a formulary, set prices administratively, or take other regulatory actions against firms failing to offer price reductions could give the Secretary the ability to obtain significant discounts in negotiations with drug manufacturers. In the absence of such authority, the Secretary's ability to issue credible threats or take other actions in an effort to obtain significant discounts would be limited.

In the same letter, Orszag speculated that absent this authority "cost savings might be possible" through use of the bully pulpit if negotiations were limited to selected drugs.[8] But even so, "the impact on Medicare's overall drug spending would be limited," because the bully pulpit is already in wide use and would work only in a few instances.[9] Moreover, drug manufactures could easily make pricing adjustments to offset any potential effects.[10] Hence, the cost of government interference, in terms of

1. Congressional Budget Office, "Congressional Budget Office Cost Estimate: S. 3 Medicare Prescription Drug Price Negotiation Act of 2007," April 16, 2007.
2. Centers for Medicare and Medicaid, "Medicare Drug Plans Strong and Growing," Press Release, January 30, 2007.
3. Congressional Budget Office, "Detailed Projections for Medicare, Medicaid, and State Children's Health Insurance Program," March 2007
4. The most recent survey is Medicare Rx Education Network, "Survey Results," September 14, 2006, at *www.medicarerxeducation.org/survey/survey.htm*.
5. Mary Agnes Carey, "HealthBeat," *Congressional Quarterly*, March 12, 2007.
6. Congressional Budget Office, "Congressional Budget Office Cost Estimate, S. 3."
7. Congressional Budget Office, Letter to the Honorable Ron Wyden, "Re: Issues Regarding Price Negotiation in Medicare," April 10, 2007.
8. *Ibid.*
9. *Ibid.*
10. *Ibid.*

market uncertainty, would likely far outpace any potential benefits that may be had through such selective negotiations.

Contrary to the arguments of proponents of government interference in Medicare drug pricing, the only way for the government to outperform existing private negotiations and obtain lower drug prices and greater program savings is to broadly deny or restrict market access to drugs, for drug manufacturers and Medicare beneficiaries alike, through the use of a government formulary, a rigid pricing schedule, or the threat of arbitrary regulation. The debate about to take place in the Senate is not about the government's expected failure at attempting to purchase drugs in bulk; rather, it is the prerequisite to government control over Medicare drug pricing and, in consequence, the vast majority of the pharmaceutical market. This is because, for government "negotiation" to have the necessary impact, government regulations and access restrictions would need to replace market competition and consumer choice.

Conclusion. Without leverage over drug manufacturers or advantages over private plans already conducting negotiations, government "negotiation" alone would likely fail to deliver any savings. But the House and Senate's negotiation proposals set a dangerous precedent. Once government has the ability to interfere with prices in Medicare, especially if results from government "negotiations" are not forthcoming, the pressure to expand the government's authority—its leverage—will grow.

The toothless government "negotiation" proposed in S. 3 merely lays the groundwork for future government control of pharmaceuticals in Medicare. In deciding Medicare drug policy, policymakers should weigh the success of Medicare's structure of private competition against the real prospect of heavy-handed government interference. The consequences of Congress's choice will be far-reaching.

—Greg D'Angelo is Research Assistant in the Center for Health Policy Studies at The Heritage Foundation.