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Medicare Drugs: Why Congress Should Reject Government Price Fixing

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Senator Patty Murray (D–WA), chair of the Senate Budget Committee, is offering a budget resolution claiming $275 billion in health care savings, though she provides few details.[1] But Senator Amy Klobuchar (D–MN) has introduced legislation (S. 117) that would replace today's private-sector negotiation of Medicare drug prices with government "negotiation." This approach has the backing of a broad coalition of "progressive" groups. If Washington would adopt the same government pricing schemes that prevail in, say, Britain, Canada, or the Veterans Administration (VA), they claim the budgetary savings would be enormous.

The phrase "government negotiation" suggests something like the bargaining process that characterizes routine business transactions throughout the private sector. It is nothing of the sort. The government does not *negotiate* prices; it *fixes* them. As a routine matter, if a provider either cannot or does not accept the government's fixed price, that provider is excluded from the program.

Market-Based Bidding. Medicare Part D drug prices are set by private negotiation within a robust market of intense competition among drug plans. These include Medicare Advantage plans and over 1,100 "stand alone" prescription drug plans (PDPs). Participating employers offering retiree coverage can also get a Medicare payment to offset the cost of drug coverage. Today 90 percent of Medicare enrollees have drug coverage, and most (including a disproportionately higher enrollment of minorities) are enrolled in Part D.

Like the Federal Employees Health Benefits Program (FEHBP), Medicare's per capita payment on behalf of beneficiaries is calculated on market-based bidding among drug plans for the provision of the standard level of coverage. On the basis of the *average* bid, Medicare subsidizes roughly 75 of the premium cost; in other words, a defined contribution or "premium support." Medicare beneficiaries choosing a more expensive plan pay more, and those picking a less expensive plan pay less. Low-income seniors also receive additional Medicare subsidies to offset their drug costs.

Negotiated Prices. The Medicare Modernization Act of 2003 requires a drug plan "to provide its Part D enrollees with access to negotiated prices for covered Part D drugs."[2] The federal government "may not interfere with the negotiations between manufacturers and pharmacies and PDP sponsors."

This process has impressively controlled beneficiary premium costs. As President Obama's former Centers for Medicare and Medicaid Services (CMS) Administrator Donald Berwick reported, "It's a competitive market and we're seeing effects of good competition among Part D plans."[3]

Since the inception of the program in 2006, premium costs have been remarkably stable. In 2008, contradicting almost all conventional predictions, the CMS reported that 10-year projections of Part D premium receipts would be $50 billion *lower* than original estimates.[4] Between 2011 and 2012, the average monthly Part D premium *declined* from $30.76 to $30.00.[5] For 2013, that monthly premium is expected to remain at $30.00.[6] For 2014, the CMS

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projects *lower* Part D deductibles and co-payments for the standard benefit than obtained in 2013.[7]

Bending the Cost Curve. While the universal drug entitlement adds to the long-term unfunded liability of Medicare, the competitive structure has proven to bend the projected cost curve down.

As early as 2008, the CMS reported that total Medicare Part D spending would be 38.5 percent *below* the original 10-year projections.[8] In 2011, the Medicare actuary updated the actual program costs over the period 2004–2013 and found that Medicare Part D came in at 41.8 percent below the original estimates, yielding a total savings of $264.6 billion.[9] Over the period 2006–2011, the Medicare trustees reported that the program's costs were 48 percent *lower* than their original projections.[10]

Meanwhile, the Congressional Budget Office (CBO) reduced its estimates for Medicare spending from 2013–2022. Compared to the CBO's 2012 Medicare projections, the 2013 projections are reduced by $152.4 billion over the standard 10-year period, with Part D spending projected to be $102.7 billion *less*.

In other words, Part D spending is the largest contributor to the CBO's downward revision in its updated forecast, accounting for over 67 percent of the projected savings.[11] *In no other area of federal health policy is there a record of comparable performance.*

Part D critics routinely claim that cheaper generics have eclipsed brand-name drugs, and that is the main reason for savings, not market competition. But, as James Capretta, senior fellow at the Ethics and Public Policy Center, observes, aggressive marketing of lower-cost generics by plans competing for market share makes the difference.[12] Recent international research confirms that generic penetration is greater in nations with market-based pricing than those with government-regulated drug pricing.[13]

Richer Benefits. Medicare plans offer a comprehensive range of brand-name and generic prescription drugs. In 2008, the Lewin Group found that, of the top 281 drugs covered under Medicare Part D, only 183 (65 percent) were available through the VA, while 273 (97 percent) were

1. Senator Patty Murray (D–WA), "Foundation for Growth: Restoring the Promise of American Opportunity: The Fiscal Year 2014 Senate Budget Resolution," March 2013, p. 69.
2. 42 Code of Federal Regulations § 423.104(g)(1).
3. Sarah Kliff, "What a 76-Cent Premium Decrease Says About Medicare's Future," *The Washington Post*, August 9, 2011, http://www.washingtonpost.com/blogs/wonkblog/post/what-a-76-cent-drug-premium-decrease-says-about-medicares-future/2011/08/02/gIQAZyI84I_blog.html (accessed March 17, 2013).
4. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, *Medicare Part D Chartbook*, June 13, 2008 (hereafter referred to as *CMS Chartbook*), p. 49.
5. Kliff, "What a 76-Cent Premium Decrease Says About Medicare's Future."
6. News release, "Medicare Prescription Drug Premiums to Remain Steady for Third Straight Year," U.S. Department of Health and Human Services, August 6, 2012, http://www.hhs.gov/news/press/2012pres/08/20120806b.html (accessed November 16, 2012).
7. The deductible for the standard drug coverage will drop from $325 to $310. Scott Steinke, "Part D's Standard Deductible, Co-Pays to Drop in 2014," *The Pink Sheet Daily*, February 15, 2013, http://www.elsevierbi.com/publications/the-pink-sheet-daily/2013/2/15/part-ds-standard-deductible-copays-to-drop-in-2014?=elsca1=psly$elsca2=newsltr (accessed March 17, 2013).
8. *CMS Chartbook*, p. 48.
9. The data are from the CMS Office of the Actuary, "Comparison of the Office of the Actuary's Original Title I MMA Cost Estimates to those underlying the CY 2011 Trustees Report," August 2011.
10. CMS, "2004 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," Table II.C18, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/tr2004.pdf (accessed March 17, 2013), and "2012 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds," Table III.D3, http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf (accessed November 28, 2012).
11. Congressional Budget Office, *February 2013 Medicare Baseline*, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43894_Medicare.pdf (accessed March 17, 2013), and *March 2012 Medicare Baseline*, http://www.cbo.gov/sites/default/files/cbofiles/attachments/43060_Medicare.pdf (accessed March 18, 2013). The savings were calculated as benefit spending minus premiums paid, including payments by states for Part D, from 2013 to 2022, comparing 2012 projections to 2013 projections.
12. James C. Capretta, "The Incredible Lowering of the Medicare Drug Benefit Baseline," e21, February 15, 2013, http://www.economics21.org/commentary/incredible-lowering-medicare-drug-benefit-baseline (accessed March 17, 2013).
13. Steven Simoens, "A Review of Generic Medicine Pricing in Europe," *Generics and Biosimilars Initiative Journal*, Vol. 1, No.1 (2012), pp. 8–12, http://gabi-journal.net/a-review-of-generic-medicine-pricing-in-europe.html (accessed March 17, 2013).

available through the FEHBP.[14] Roughly two of five Medicare-eligible VA enrollees get their prescriptions through Medicare Part D, and not the VA.[15]

Not surprisingly, the CBO says that striking the "non-interference" clause of the Medicare Modernization Act of 2003 would produce "savings" only if the Secretary of Health and Human Services were given the authority to restrict patient access to drugs (through a formulary) or close off the market to companies that cannot or will not comply with the government's fixed price.[16]

Better Outcomes. Medicare Part D is improving health outcomes. Heart patients, for example, secured improved access to medicines and had higher rates of adherence to prescription schedules[17] as well as reduced hospitalization and nursing home care. Researchers have also found that access to and appropriate usage of prescription drugs correlates with a decline in other medical spending, including hospital emergency room spending.[18] The CBO is now accounting for the capacity of appropriate drug usage to reduce other medical spending.[19]

Higher Satisfaction. Since its inception in 2006, senior satisfaction with the program steadily increased; a fact confirmed by several surveys. In 2008, for example, 89 percent of all seniors in Part D said they were satisfied, including 90 percent of "dual eligibles."[20] In a 2011 survey, conducted by KRC Research, nearly nine out of 10 Part D enrollees were satisfied, and more than half were very satisfied. The greatest level of satisfaction (98 percent) was found among low-income beneficiaries, while seniors with disabilities registered a satisfaction rate of 95 percent.[21]

Competition Works. Like the Heritage Foundation, principled conservatives in Congress opposed the creation of a universal drug entitlement in 2003 because it would—and did—add to Medicare's staggering unfunded liability. On the method of drug delivery, however, Congress made the right decision in creating a system based on competitive bidding, defined-contribution financing, and robust plan competition, while insulating private drug price negotiation from political interference.

Medicare Part D has exceeded expectations in the breadth of nationwide health plan participation, stable and low-cost premiums for Medicare beneficiaries, and a stunning "bend in the cost curve" unique in the health sector of the economy. Competition works.

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14. The Lewin Group, "Comparison of VA National Formulary and Formularies of the Highest Enrollment Plans in Medicare Part D and the Federal Employee Health Benefit Program," prepared for PhRMA, December 10, 2008, p. 1.
15. Greg D'Angelo, "The VA Drug Pricing Model: What Senators Should Know," Heritage Foundation *WebMemo* No. 1420, April 11, 2007, http://www.heritage.org/research/reports/2007/04/the-va-drug-pricing-model-what-senators-should-know.
16. "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." Congressional Budget Office, letter to Senator Ron Wyden (D–OR), "Re: Issues Regarding Price Negotiation in Medicare," April 10, 2007.
17. J. M. Donahue et al., "The Medicare Drug Benefit (Part D) and Treatment of Heart Failure in Older Adults," *American Heart Journal* (July 2010), p. 2, http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2898511/pdf/nihms-204918.pdf (accessed March 17, 2013).
18. J. M. McWilliams, "Implementation of Medicare Part D and Nondrug Medical Spending for Elderly Adults with Limited Prior Drug Coverage," *Journal of the American Medical Association*, Vol. 306, No. 4 (July 27, 2011), p. 402–409.
19. The CBO decision follows its review of the latest professional literature. See Congressional Budget Office, "Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services," November 2012, http://www.cbo.gov/publications/43741 (accessed March 17, 2013).
20. *CMS Chartbook*, p. 30.
21. KRC Research, "Seniors Opinions about Medicare Rx: Sixth Year Update," October 2011, http://www.krcresearch.com (accessed March 18, 2013). In 2011, KRC survey found that only 11 percent of respondents were not satisfied. The high rates of enrollee satisfaction in Medicare Part D have been consistent since March 2006. Since the fall of 2007, more than half of enrollees have described themselves as being "very satisfied" with the program.