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The Pros and Cons of Allowing the Federal Government to Negotiate Prescription Drug Prices

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Summary

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) expressly forbids the Secretary of Health and Human Services (HHS) from negotiating the price of prescription drugs on behalf of Medicare beneficiaries. This report outlines the arguments for and against allowing the federal government to negotiate prescription drug prices on behalf of Medicare beneficiaries. This report will be updated, as needed.

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) establishes a prescription drug benefit for Medicare beneficiaries under Part D, beginning in 2006. One provision of MMA expressly forbids the Secretary of Health and Human Services (HHS) from negotiating the price of prescription drugs on behalf of Medicare beneficiaries.[1] The MMA establishes that Medicare beneficiaries will receive the prescription drug benefit through private organizations, typically insurers or similar risk-bearing organizations, that sponsor prescription drug plans (PDPs). The PDPs (or their agents) will negotiate prices with the drug manufacturers. In theory, the competition among the PDPs will create strong incentives to negotiate price discounts, since the PDPs will want to provide the drug benefit to Medicare beneficiaries as efficiently as possible while simultaneously attracting enrollees through low premiums and cost-sharing requirements.

This report discusses the pros and cons of allowing the federal government to negotiate for lower prescription drug prices on behalf of Medicare beneficiaries. After a brief background on the issue, the report analyzes the arguments commonly raised on

[1] Section 1860D (i) reads, "NONINTERFERENCE. — In order to promote competition under this part and in carrying out this part, the Secretary — (1) may not interfere with the negotiations between drug manufacturers and pharmacies and PDP sponsors; and (2) may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs." The conference report adds that, "Conferees expect PDPs to negotiate price concessions directly with manufacturers." (H.Rept. 108-391, p. 461)

both sides of the debate, including a discussion of the relevance of the experience of the Department of Veterans Affairs (VA) in negotiating lower prices for prescription drugs.

Background

The question of whether or not to allow the federal government the authority to negotiate prices for Medicare beneficiaries arises as a consequence of price discrimination on the part of pharmaceutical manufacturers. The pharmaceutical companies price discriminate by selling the same commodity (prescription drugs) to different segments of the market at different prices. This practice exists in part because the manufacturers may have monopoly power, through their patents,[2] and in part because of the numerous channels of distribution from manufacturer to consumer (patient). Patents can provide pharmaceutical manufacturers with a monopoly on their innovations making them the sole provider of the product for the duration of the patent, currently twenty years from the date of filing of the patent.[3] As a result, the drug companies can and do charge different prices to various buyers and market segments. Buyers facing a monopolist must decide whether to accept the price offered or not to purchase the commodity at all.[4] In the case of prescription drugs, the buyers (wholesalers, pharmacy benefits managers (PBMs), pharmacies, etc.) negotiate the best price they can for the quantity they wish to purchase.

Arguments in Support of Allowing the Federal Government to Negotiate Drug Prices

The main argument advanced by advocates for granting the federal government the power to negotiate is that lower prices for prescription drugs could be obtained and passed on to Medicare beneficiaries. By using the market power of roughly 41 million Medicare beneficiaries, proponents argue that the pharmaceutical companies would provide deep discounts to the federal government in order to prevent the loss of a significant portion of their market.

The magnitude of the discount that the federal government might be able to negotiate is uncertain. At one extreme, the experience of the Secretary of VA in negotiating discounted prices is often cited as an example of the types of discounts that might be available to Medicare should the Secretary of HHS negotiate on behalf of Medicare

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[2] See, for example, CRS Report RL32377, *The Hatch-Waxman Act: Legislative Changes Affecting Pharmaceutical Patents*, by Wendy Schacht.

[3] Because new pharmaceuticals need to be developed, tested, and approved before they can be brought to market, products may not be commercially available until well into the patent life.

[4] Where alternate products or substitutes exist, for instance, when generic drugs are available or if there are other patented brand name products that can be considered therapeutic substitutes, the monopolists' power to charge monopoly (profit-maximizing) prices and to price discriminate diminishes.

beneficiaries.[5] Through its negotiated contracts, VA obtains at least a 24% discount off the manufacturers' most favored commercial (non-federal) price for patented products.[6] The Government Accountability Office (GAO) found that average VA-negotiated prices are less than 50% of the non-federal average manufacturer's price.[7]

There are substantial differences between Medicare and VA that draw into question whether one experience is indicative of the other. VA is a direct provider of care and has its own health care facilities. As a result, VA has a centralized formulary, warehouses and a distribution network to transport supplies and materials, including prescription drugs, to the facilities. The VA, through its health care system, is the purchaser of prescription drugs. In contrast, the Medicare program is an insurer that pays for care that is delivered to covered beneficiaries in a myriad of sites. Under the new Part D, which relies on prescription drug plans (PDPs) or Medicare Advantage managed care plans offering a prescription drug benefit (MA-PDs) to provide the drug benefit, Medicare is one step further removed in its relationship with the beneficiary.

There may also be an efficiency argument for allowing the federal government to act as the main or sole negotiator. The many transactions involved in bringing prescription drugs from the manufacturer to the patient each present opportunities for affecting the final price of the drug, as reflected in the substantial variation in retail prices. Cash customers who buy drugs at retail pharmacies without insurance, or who are later reimbursed by an insurer (such as Medicare) are conducting the last in a series of transactions: prescription drugs are sold by a manufacturer to a wholesaler or other entity, who in turn sells the product to a retailer such as a pharmacy, where most non-institutionalized people acquire prescription drugs. If the retail pharmacy is being paid by a pharmacy benefit manager (PBM), the PBM negotiates the prices it will pay for each drug.[8] Each transaction requires a mark-up from the previous price in order to cover the handling and administrative costs, in addition to any profits. Having a single negotiator might lead to the elimination of some steps in the distribution chain.

Another consequence of the federal government negotiating drug prices is that prices might be more consistent and less variable across all beneficiaries. In contrast, under MMA, beneficiaries who belong to different PDP/MA-PD plans could face different prices, depending on what the individual organizations negotiate and pass on to

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[5] P.L. 102-585, the Veterans Health Care Act of 1992, authorizes the Veterans Affairs Secretary to negotiate prices for covered drugs on behalf of the Department of Defense, the Public Health Service (including the Indian Health Service) and the Coast Guard, in addition to Veterans Affairs.

[6] New generic manufacturers are not held to this restriction when patents expire, but the discount on the original product remains.

[7] U.S. GAO, *Drug Prices: Effects of Opening Federal Supply Schedule for Pharmaceuticals Are Uncertain*, Washington, June 1997 [GAO/HEHS-97-60].

[8] Pharmacy benefit managers (PBMs) are companies that administer prescription drug benefits for health care plans. Administrative services include adjudicating claims and managing costs. PBMs typically provide and manage networks of pharmacies willing to accept negotiated discounts on drug prices and dispensing fees and may encourage the use of mail-service pharmacies as a cost reduction technique. Clinical services include drug utilization review to prevent potentially dangerous drug interactions.

beneficiaries in savings. The recent experience with the Medicare prescription drug discount cards suggests that having a plethora of choices is not universally viewed as a positive outcome.

Arguments Against Allowing the Federal Government to Negotiate Drug Prices

Detractors who oppose allowing the federal government to negotiate drug prices present several philosophical and pragmatic arguments against this proposal. Critics assert that the resulting discounts would not be significant; that the involvement of the federal government would result in a more limited choice of drugs available at discount; that the overall long-term effect of prescription drug discounts might be detrimental to the non-Medicare population; or that the government would use its collective power to drive down prices to the extent that research and development would suffer, resulting in less innovation and fewer new products being brought to market.

Some critics doubt whether the discounts that the federal government might obtain would be substantially different from those that private sector companies can or might be able to negotiate. Large PBMs, such as Advance PCS (75 million covered individuals), Medco Health Solutions (65 million) and Express Scripts (57 million) have significant market power and an established track record negotiating prescription drug discounts for large populations. For these reasons, critics claim that allowing the PBMs to negotiate on behalf of Medicare beneficiaries would produce savings at least as great as anything that the federal government could negotiate.[9] The Congressional Budget Office (CBO), at the request of congressional leaders, examined the effect of striking the "noninterference" provision and estimated that it would have a negligible effect on federal spending.[10] Similarly, the Chief Actuary at the Centers for Medicare and Medicaid Services (CMS) concluded that giving the Secretary the ability to directly negotiate prescription drug prices might not produce additional savings over what private plans negotiate. Both CBO and the CMS Chief Actuary determined that the price concessions extracted by the federal government might not exceed those that private plans might achieve.

Proponents of a market-based, decentralized approach also believe that having a variety of organizations negotiating different prices will result in more choices available to Medicare beneficiaries and, therefore, better patient outcomes. Instead of being limited to the discounted drugs Medicare negotiates, discounts for the plentitude of organizations offering prescription drug plans will result in a broader range of drugs being discounted.

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[9] One counter argument to this point is that while large PBMs may cover more individuals than the Medicare program, Medicare beneficiaries consume more prescription drugs per capita than those under 65, so the Medicare market represents a greater share and therefore, more "clout."

[10] Letter from CBO to the Honorable William H. Frist, M.D., *Estimate of the Effect of Striking the "Noninterference" Provision as Added by P.L. 108-173, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,* Jan. 23, 2004, [http://www.cbo.gov/showdoc.cfm?index=4986&sequence=0]

Beneficiaries will then be able to choose the plan that best meets their individual prescription drug needs and acquire them at competitive market prices.

Because of the complex network of relationships in drug prices, the effect of changing one price, such as negotiating a discount for Medicare beneficiaries, may have indirect consequences on other prices. In the long run, critics argue while drug prices paid by Medicare beneficiaries may fall, overall drug prices may increase for other consumers, specifically for the under-65 population. Under this argument, pharmaceutical companies who lose the ability to set discriminatory prices in one segment of the market would adjust by increasing the prices they charge to other segments. In particular, VA-negotiated prices could increase substantially, affecting the VA/DoD population. The success of this strategy is uncertain, but would depend in part on the price sensitivity of demand in the other segments of the market.

Finally, those who oppose government involvement in prescription drug price negotiations claim that the government would be setting prices, not negotiating. They cite the experience in other parts of the Medicare program, where provider reimbursement under Parts A and B are set by the Medicare program, and claim that the federal government would impose a similarly rigid pricing schedule on the prescription drug market. Pharmaceutical manufacturers have stated that research and development will suffer if retail prices are diminished and returns from investment are squeezed. While this is undoubtedly true in the extreme, there is very little evidence that quantifies the degree to which reductions in retail prices would lead to fewer new products being introduced.