Insight

Medicare Part D: Why Altering the Non-interference Policy is Likely to Lead to Higher Costs

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On November 30, 2017, the National Academy of Sciences (NAS) released a report recommending that the federal government should "directly negotiate prices with producers and suppliers of medicines" for federal health programs, as well as state health programs that choose to participate.[1] This is a somewhat surprising recommendation, because the report itself acknowledges that previous attempts to reduce drug prices through federal intervention have had the opposite effect.[2]

In recent years, the most common context in which similar proposals have been made is Medicare Part D, a prescription drug program for senior citizens and the disabled.

Medicare Part D is a tremendously successful program, with costs that run less than half the original projections and high levels of patient satisfaction. For example, in 2004, the Congressional Budget Office (CBO) projected that Part D spending in 2012 would be $122.8 billion. A year later, CBO increased its projection for 2012 Part D spending to $126.8 billion. Actual 2012 Part D spending was $55.0 billion—55 percent below the original forecast, and 57 percent below the peak forecast.[3] Furthermore, this is not the result of skimping on coverage or services; survey data continues to indicate that approximately 90 percent of beneficiaries are satisfied with their Part D plans and coverage, that their plan is convenient to use, and works well.[4]

The majority of Medicare beneficiaries obtain most of their outpatient prescription drugs through the Medicare Part D program, established by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and launched in 2006. Unlike Medicare's approach to physician and hospital services, the Part D program calls on health insurance companies, both non-profit and for-profit, to submit competitive bids for drug coverage plans meeting certain minimum requirements. Medicare beneficiaries then choose the plan they most prefer. The government pays about three-fourths of the average plan's bid price towards whichever plan each beneficiary selects, with the beneficiaries paying the difference between the government subsidy and the price of the plan they select (unless they are in the Low-Income Subsidy program, in which case they pay less, or sometimes nothing). Because the government's payment depends on the insurance companies' bids, the competition among plans for beneficiaries reduces the amount of the subsidy and therefore saves taxpayers money.

Nevertheless, there is continuing pressure to change the program. At present, the insurance companies that sponsor Part D drug plans negotiate with drug manufacturers, usually through pharmacy benefit managers (PBMs) that provide similar services for health insurance companies outside of the Medicare sector. The federal government is not directly involved in these negotiations; this policy is referred to as "non-interference." The government's role is to set minimum coverage requirements, calculate the average bid, and hold plan sponsors to their commitments to beneficiaries—but not to interfere in interactions between plan sponsors, pharmacies, PBMs, and drug manufacturers. These interactions are a major source of the lower-than-expected costs of the program.

Some current legislative proposals, and the recommendations of the recent NAS report, would allow or require the federal government to intervene to reduce prescription drug costs by negotiating directly with drug manufacturers to determine prices paid by Part D plans. There are three primary reasons to doubt that these approaches would either lower patients' cost or improve patients' access to effective drug treatments.

First, there is no evidence that the federal government is better at negotiating prices or controlling costs than anybody else. Numerous examples abound, some of which are legendary: the U.S. Navy's newest aircraft carrier cost more than double its original budget,[5] the Joint Strike Fighter is even further over budget (despite an original design approach specifically chosen to save money),[6] and a federally funded high-speed rail project is projected to have a 50-percent overrun when construction has only just begun.[7] This is not a new problem: in the early 1800s, the Erie Canal ran 46 percent over budget, and in the early 1900s the Panama Canal was 106 percent over budget.[8] In each case, the federal government was (and in some cases, still is) negotiating with an outside entity over the price of something. And in each case, that outside entity managed to extract a higher price than expected. Compare these outcomes to Medicare Part D, in which private-sector negotiators, competing among themselves for a share of business where consumers made their own decisions, managed to cut costs by 51 percent.[9]

Second, the federal government's actions in the prescription drug market could create drug shortages and discourage research into new drugs. When the federal government negotiates prices for an existing product (rather than, say, a fighter plane that still needs to be developed), the government is in a position to make a "take-it-or-leave-it" offer, which, if rejected, could lead to the drug becoming unavailable to a particular patient population. This sets up an untenable situation in which drug manufacturers, and perhaps patients, lobby for a higher price to ensure that a drug remains available, and other taxpayers and perhaps other patients competing for the same federal dollars lobby for a lower price, perhaps at the expense of availability. If an important drug becomes unavailable, or if the federal government extracts a price that fails to recover the manufacturer's research and development costs (even if it recovers manufacturing and distribution costs), drug companies will consider this outcome when making future research decisions.

The Tufts Center for the Study of Drug Development estimates the average cost of developing a new drug to be $2.6 billion;[10] while not everyone agrees with that estimate, few dispute that drug development is an expensive undertaking. A critical factor in the development of new treatments is the decision-making process of drug developers: Before investing in a new and expensive research program, companies need to have some estimate of the ultimate revenue that might result from that drug. Because drug development is often unsuccessful, and estimates of future revenue are imprecise, companies will not embark on expensive research projects unless there is a substantial likelihood that they will make back their research costs, as well as manufacturing and distribution costs, plus some profit. If the federal government makes a habit of dictating prices that are too low, drug companies will have no choice but to reduce their research, slowing or stopping the flow of new treatments. While low, government-mandated drug prices might look good from a short-term budget standpoint, they threaten to harm patients over the long term.

The results of the federal government's past failures to reduce drug prices through regulation give us a third reason to doubt the efficacy of federal price regulation. The Omnibus Budget Reconciliation Act of 1990 required that Medicaid programs be given outpatient prescription drugs at either the lowest price offered to any buyer, or a fixed percentage discount off the average manufacturer price (12.5 percent for 1991 and 1992, 15 percent thereafter).

Faced with the prospect of having to reduce prices for the entire Medicaid program to the lowest price charged to anyone else, drug companies responded by reducing discounts and rebates for other purchasers, such as pharmacies, hospitals, and private-sector insurance plans. This had the effect of changing the reference prices against which the Medicaid discounts were calculated. So although the intent of the law was to reduce prices paid by taxpayers for drugs needed by Medicaid patients, the actual result was higher prices for most other buyers (including other government payers) with minimal savings to Medicaid.[11] When considering the wisdom of attempting to reduce drug prices by passing laws, it is worth nothing that congressional proponents of this law were surprised by this result, having failed to consider the possibility that sellers would change the prices to other buyers when those prices were used to calculate prices charged to Medicaid.[12]

The increased prices to non-Medicaid purchasers ironically included other government purchasers. The federal government saved very little in the Medicaid program, but ended up paying higher prices for drugs through the Veterans Health Administration and other federal health programs. In 1992 and 1993, Congress responded by excluding prices paid by public hospitals and the VA from the Medicaid calculation, allowing those entities to negotiate discounts from drug manufacturers without adversely affecting those manufacturers' revenue from Medicaid.[13] However, there has been no similar relief for other purchasers, including health plans for the non-elderly and Part D plans (not to mention private-sector payers).

Medicare Part D's competitive bidding system, including its "non-interference" provisions, produced lower-than-expected prescription drug expenditures and lower-than-expected program costs. Other attempts to reduce drug prices have instead produced higher prices, and perhaps higher levels of total spending, both for government programs and other payers. The solution to high drug prices is not to tamper with the one successful prescription drug program, much less transfer the cost experiences of other federal programs to drug prices. Instead, we should be looking for ways to reproduce the success of that program in other contexts by looking for ways to increase competition among drug companies and health plans to reduce prices and improve access for patients.

[1] National Academies of Sciences, Engineering, and Medicine. 2017. *Making Medicines Affordable: A National Imperative*

. Washington, DC: The National Academies Press. https://doi.org/10.17226/24946, pp. 118-19.

[2] *Ibid.*, p. 102

[3] Douglas Holtz-Eakin and Robert Book, "Competition and the Medicare Part D Program," American Action Forum, September 11, 2013, at https://www.americanactionforum.org/research/competition-and-the-medicare-part-d-program.

[4] Medicare Today, 2017 Senior Satisfaction survey (see also previous years), http://medicaretoday.org/wp-content/uploads/2017/08/2017-Senior-Satisfaction-Survey-Fact-Sheet.pdf

[5] Kathy Adams, "Newport News shipyard gets $5.1B contract for carrier Ford," *The Virginian-Pilot*, Sept. 11, 2008, at https://pilotonline.com/business/newport-news-shipyard-gets-b-contract-for-carrier-ford/article_e6896f50-7dfa-5daa-a4c8-563a2e5b1d6e.html, and Ronald O'Rourke, "Navy Ford (CVN-78) Class Aircraft Carrier Program: Background and Issues for Congress," Congressional Research Service #RS20643, at https://fas.org/sgp/crs/weapons/RS20643.pdf.

[6] Jim Wolf, "Price of Lockheed's F-35 fighter soars," Reuters, March 11, 2010, and Joseph Trevithick, "The F-35 is still horribly broken," The Week, February 26, 2016, at http://theweek.com/articles/605165/f35-still-horribly-broken. Recent cost decreases still leave the program at well over double the original budget.

[7] Katy Murphy, "Confidential report: California bullet train could cost billions more than expected," *The Mercury News*, Jan. 11, 2017, at http://www.mercurynews.com/2017/01/13/confidential-report-california-bullet-train-could-cost-billions-more-than-expected.

[8] Chris Edwards and Nicole Kaeding. "Federal Government Cost Overruns," Sept. 1, 2015, in *Downsizing the Federal Government*, at http://www.downsizinggovernment.org/government-cost-overruns.

[9] In 2004, the Congressional Budget Office projected that Part D's cost for the year 2012 would be $112.8 billion. That projection was revised upward in 2005, then downward every year thereafter. Actual costs in 2012 were $55 billion. See Holtz-Eakin and Book (2013) for details.

[10] Joseph A. DiMasi, Henry G. Grabowski, and Ronald W. Hansen, "Innovation in the pharmaceutical industry: New estimates of R&D costs," *Journal of Health Economics*, 2016 May;**47**:20-33, DOI: 10.1016/j.jhealeco.2016.01.012, at http://ac.els-cdn.com/S0167629616000291/1-s2.0-S0167629616000291-main.pdf?_tid=55929a82-61f6-11e7-82f3-00000aacb35e&acdnat=1499309808_aba8bf63901ee8673835bc7c4cef25cd.

[11] "Medicaid: Changes in Best Price for Outpatient Drugs Purchased by HMOs and Hospitals," General Accounting Office, August 1994, GAO/HEHS-94-194FS, at http://archive.gao.gov/t2pbat2/152225.pdf.

[12] Robert Pear, "Medicaid is Denied Discounted Drugs Despite a New Law," *New York Times*, Feb, 18, 1991, at http://www.nytimes.com/1991/02/18/us/medicaid-is-denied-discounted-drugs-despite-a-new-law.html?pagewanted=all.

[13] “The Best Price Requirement of the Medicaid Rebate Program,” Academy of Managed Care Pharmacy, June 2009, at http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=18692.