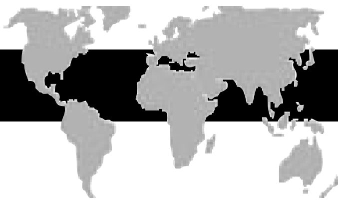

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Medicare: Negotiated Drug Prices May Not Lower Costs

by Alain Enthoven and Kyna Fong

Rep. Nancy Pelosi has promised that within its first 100 hours the Democrat-controlled House will repeal the ban preventing Medicare from negotiating directly with pharmaceutical companies. She must expect this legislation to bring down drug prices dramatically. However, it is not obvious that allowing the government to negotiate with pharmaceutical companies will lead to lower prices than those achieved by private drug plans. There are several good reasons why not.

Market Power versus Bargaining Power. Negotiations are a bargaining process. The relative balance of bargaining power determines at which price the deal is struck.

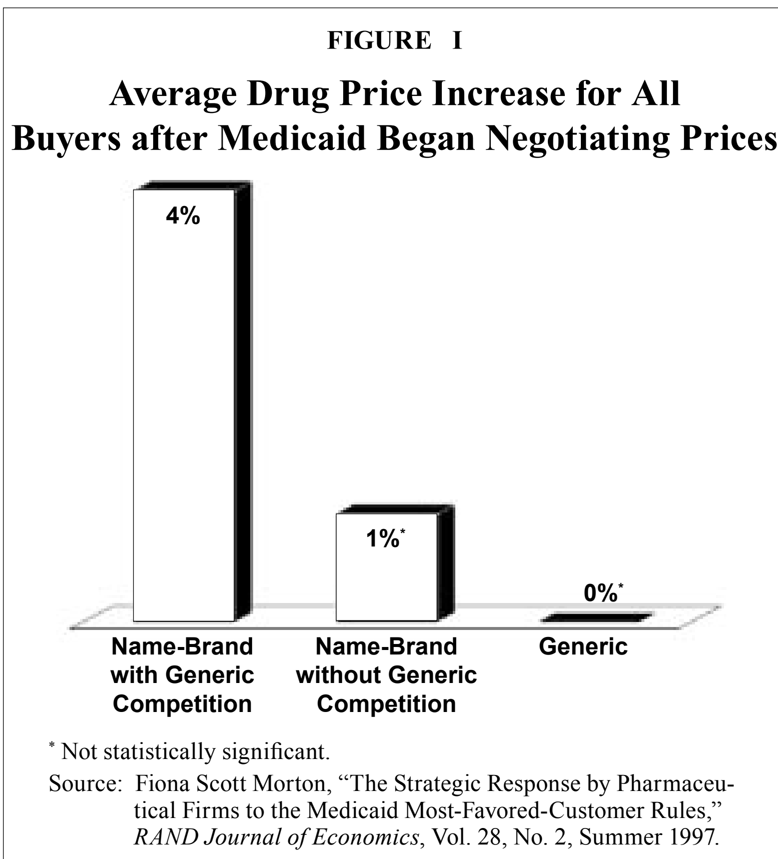
People often confuse market power with bargaining power. The thinking goes, the larger the share of the market the buyer represents, the greater the bargaining power and thus the lower the prices negotiated. That line of reasoning fails with drugs, however, because the seller is frequently a monopolist with an exclusive patent. That means the seller cannot be threatened with replacement by a substitute. Instead, the only threat is that the two sides fail to agree and the drug is withheld from the market.

Rather than market share, a party's bargaining power is determined simply by the ability to say no — to walk away from the table without an agreement. Whether the government or a private drug plan has greater bargaining power is not clear. Who can walk away more easily and declare some brand-name drug will not be covered on the formulary? Private plans like Kaiser Permanente or UnitedHealth Group are able to negotiate deep discounts with pharmaceutical companies precisely because of the plans' ability to say no — to pay for some drugs and to exclude others, allowing the market to judge the resulting formulary. But when the government negotiates, there are few drugs it can exclude without facing political backlash from doctors and the Medicare voters.

Price Discounts. If the government acts as one large buyer for Medicare, the cost to pharmaceutical companies of granting discounts becomes greater. As a result, drug companies are not able to offer discounts to the government as large as they have previously offered to some individual plans. When individual private drug plans are negotiating with pharmaceutical companies, those companies have the power to "price discriminate," charging lower prices to some plans and higher prices to others. This ability makes large discounts possible for some plans. Government consolidation of demand into one entity that is given a single discount is similar to forcing all discounts to all drug plans to be the same. Other things equal, this leads to higher, not lower, prices.

FIGURE I

Average Drug Price Increase for All Buyers after Medicaid Began Negotiating Prices



* Not statistically significant.

Source: Fiona Scott Morton, "The Strategic Response by Pharmaceutical Firms to the Medicaid Most-Favored-Customer Rules," *RAND Journal of Economics*, Vol. 28, No. 2, Summer 1997.

Medicaid Discounts. Experience with Medicaid shows what can happen when one buyer's price discount is linked to the discounts of other buyers. Medicaid's best-price rule states roughly that Medicaid will be granted the lowest price offered to any drug buyer. If that price is not low enough, Medicaid receives a fixed discount off the average price. In effect, the best-price rule transforms all privately negotiated discounts into public discounts for Medicaid.

Research by academics, along with a slew of anecdotal press reports, suggests that since the passage of the Medicaid best-price rule in 1990, prices paid by the private sector have risen. According to research by Yale University economist Fiona S. Morton, the best-price rule

has had a small but noticeable effect on the prescription drug prices paid by non-Medicaid purchasers:

- Prices paid by the public for brand-name drugs with generic competitors have increased an average of more than 4 percent. [See Figure I.]
- Price increases have been highest for drugs for which Medicaid purchases comprise a larger share of sales.
- Drug discounts to non-Medicaid buyers have fallen.
- Manufacturers have also compensated for the lower prices granted to Medicaid by changing product mix and pricing strategy (for instance, by reducing per-unit price breaks on larger drug packages).

By the end of the first year under the best-price rule, federal, state and local governments saved an estimated $150 million per quarter in Medicaid expenditures. But given the resulting price increases for non-Medicaid buyers — including other government drug purchasers, such as the Veterans' Administration (VA) — the savings to society are not at all clear.

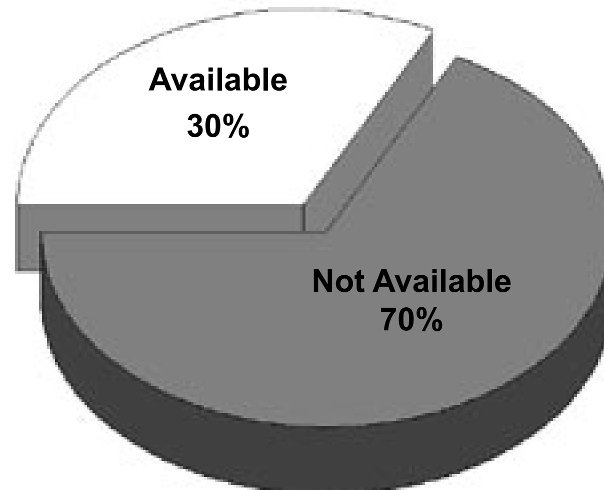
Restricting Access to Drugs. What about the argument that government negotiations lead to lower prices in Canada, Britain and other countries? While those governments may obtain lower prices than the public pays in the United States, the real question is the following: Do those governments negotiate lower prices than what would be negotiated if smaller groups of buyers were able to deal individually with pharmaceutical companies?

In other countries health care systems also lower their drug bills by controlling entry and restricting formularies. But with the expansion of the Internet and unrestrained information flow, patients are challenging these restrictions. A well-publicized legal battle by a woman against a British National Health Service (NHS) decision not to cover Herceptin for early-stage breast cancer has compelled the NHS to reverse its original decision and offer coverage for that drug.

In the United States, the VA's tight control over drug costs is often cited as a model for Medicare to follow. However, it is important to recognize that the main tool the VA employs to control drug costs is restricting the set of drugs that are covered. As a result, less than one-third of the drugs available to Medicare patients are available to VA patients. [See Figure II.]

FIGURE II

Availability to VA Patients of 4,300 Drugs Covered by Medicare



Source: David Blumenthal and Roger Herdman, eds., *Description and Analysis of the VA National Formulary* (Washington, D.C.: National Academy Press, 2000); and "Observers Predict Shake Up in PDP Market in 2007," FDC Reports, *Medicare Drug Reimbursement Guide*, Vol. 2, No. 5, November 2006.

Government Interference. Finally, one may consider the possibility that, rather than have the market determine prices, perhaps the government can do better by setting reimbursement levels itself. But how can the government determine what prices appropriately reimburse pharmaceutical companies for their research and development efforts? How can the government determine what prices will encourage the right levels of future innovation?

Government interference and negotiations inevitably encourage private parties to try to influence the process through political lobbying and campaign contributions — activities at which pharmaceutical companies have proven quite adept.

Conclusion. Congressional Democrats need to be careful in trying to make the logical leap from market share to bargaining power. Empowering the government to negotiate with pharmaceutical companies is not necessarily equivalent to achieving lower drug prices. In fact, neither economic theory nor historical experience suggests that will be the outcome.

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