

Medicare and the Politics of Prescription Drug Pricing

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The enactment of a new Medicare drug benefit is a milestone in U.S. health policy. Medicare is the nation's largest health insurer (presently providing coverage for 35 million elderly and six million disabled Americans) and as such, its potential influence on prescription drug pricing is enormous. Moreover, Medicare's market power will only grow over time; as the baby boomers retire into Medicare, the program's enrollment will swell to 70 million by 2030. Clearly, then, Medicare's size and scope give it the power to negotiate or impose lower drug prices for its beneficiaries.

The political question is whether Medicare will exert this influence to control drug prices or, alternatively, will Medicare's payment policies exacerbate already rising drug prices? The recently passed Medicare drug benefit legislation appears to offer a clear answer: the federal government will not challenge the political power and economic influence of the drug industry. But Medicare's political history suggests that this outcome may well prove fleeting.

The Politics of Controlling Drug Costs

To be sure, the Medicare drug benefit legislation is in many respects a major political triumph for the pharmaceutical industry. Rather than incorporating drug coverage as part of the traditional Medicare program, the law relies on private plans (including Pharmaceutical Benefits Managers or PBMs) to deliver the drug benefit. In addition, the legislation specifically prohibits the federal government from interfering in negotiations over prices between these private plans and drug companies. Finally, provisions in the original House bill that would have legalized the re-importation of drugs from Canada were badly weakened in the final legislation. Not only then, did the drug industry escape the specter of price controls and re-importation, it gained access to a lucrative and growing market in the Medicare population, a population that heavily utilizes medications for chronic conditions such as blood pressure, cholesterol, and arthritis.

The success of the pharmaceutical industry in shaping the Medicare drug benefit legislation is a classic political science story of concentrated and diffuse interests. The drug industry is well organized, well-funded, and has the resources and expertise

to monitor legislative developments. Their bottom line was at stake in this legislation—threatened both by Medicare price controls and re-importation—and, consequently, they had a concentrated interest in political action to preserve a status quo that they literally profit from. This is a microcosm of the same political dynamic that, thus far, has made it politically impossible to overcome opposition by medical providers and insurers to cost control and universal coverage in American health reform.¹

In contrast to the pharmaceutical industry's political activism, there is little organized political constituency at the national level for controlling drug costs. American consumers may be footing escalating bills for drug expenses and public opinion may favor re-importation, but consumers are a diffuse interest group that is largely unorganized and inattentive to the complexities inherent in legislation like the Medicare drug bill. Consumer groups such as Families USA and Public Citizen do fight for lower drug prices, but they are badly outgunned in terms of funding, organization, and political contacts by lobbying groups such as the Pharmaceutical Research and Manufacturers of America (PhRMA). The AARP does possess the resources to compete with PhRMA and could have fought for tighter cost controls in the Medicare drug benefit to protect the interests of seniors. However, AARP's desire to pass an imperfect Medicare drug benefit rather than risk getting no benefit along with their desire to demonstrate a willingness to work with a Republican Congress and President that appear likely to be re-elected, meant that the group remained reluctant to use its leverage to secure legislative provisions for controlling drug prices.

In political terms, then, the debate over pricing in the Medicare drug bill was a one-sided affair and it is hardly surprising that the pharmaceutical industry got what it wanted. However, this was more than a simple case of a powerful lobby throwing its weight around. The Republican majorities in Congress, as well as the Bush Administration, oppose price controls on ideological grounds, quite apart from any financial and political ties to drug companies, as an unwarranted intrusion by the federal government into the private sector. These beliefs fit squarely with providing the Medicare drug benefit through private plans and leaving cost control of drug prices to market competition and negotiation by private plans.

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Déjà Vu All Over Again

What is so striking about the 2003 Medicare drug benefit legislation are the similarities to the original 1965 Medicare bill. Indeed, the 1965 bill openly declared that it would not infringe on the power of hospitals and physicians. Section 1801 of the Medicare law, “Prohibition Against Any Federal Interference,” announced that: “Nothing in this title shall be construed to authorize any federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person.”²

In other words, at Medicare’s birth the federal government explicitly abdicated its authority to regulate healthcare providers and endorsed the status quo. This permissive attitude was born largely of political considerations. Medicare’s architects wanted, above all else, to secure a smooth “take off” for Medicare and demonstrate that a federal health insurance program could work as a prelude to national health insurance. Concerned about threats of a provider boycott, they hoped to reassure hospitals and doctors about federal intentions by copying Medicare’s reimbursement and administrative policies from lenient private insurance standards. The result was that in 1965 Medicare wrote what amounted to a blank check to hospitals and physicians, paying for Medicare patients on a basis of “reasonable costs” and “reasonable charges” that was retrospective, generous, and that privileged political conciliation over fiscal control.

In addition, rather than directly administer Medicare, in 1965 the federal government contracted with fiscal intermediaries and carriers—usually Blue Cross and Blue Shield plans—to implement the program and handle much of its day-to-day operations, including claims processing and reimbursement. This created an administrative buffer to shield hospitals and physicians from the government, and assured that they could work with private insurers who they already had comfortable relations with (and who had little record of exercising independence from medical providers).

Reversal of Fortune

The original Medicare law, then, ceded a substantial amount of the regulatory authority available to federal administrators to the private sector, and made no effort to control program spending, in order to placate medical providers and secure their cooperation in a new federal program. That is, of course, the same political recipe contained in the 2003 Medicare drug bill, complete with explicit limits on federal control and reliance on private intermediaries

(yesterdays carriers are today’s PBMs). And just as the 1965 Medicare bill enriched hospitals (in the process fueling medical care inflation for the whole system), drug companies can look forward to a windfall from the Medicare drug benefit (fueling higher national drug expenditures).

Or can they?

Medicare’s history provides some sobering lessons for America’s pharmaceutical companies. After all, long before the political rise of the pharmaceutical industry, the American Medical Association was once considered politically untouchable. Yet the blank check that Medicare paid hospitals and physicians was cancelled unilaterally by the federal government in the 1980s. As federal deficits rose, policymakers were no longer willing to tolerate increases in Medicare spending. Medicare reform arrived in the name of fiscal responsibility. In 1983, Medicare adopted the Prospective Payment System for hospitals and in 1989, Congress enacted the Medicare Fee Schedule for physicians. Both reforms were highly technical and shrouded in appeals to efficiency, competition, and fairness. But at root they were systems of administered pricing and their enactment represented a profound political defeat for medical providers. Over the past two decades, Medicare has successfully used its market power to lower its payments for medical services below the prices paid by private payers and to control the rate of growth in program spending.

Notably, both the Prospective Payment System and Medicare Fee Schedule were enacted with the support of Republican presidents (Reagan and the first President Bush, respectively). This should give pause to those who assume that Republican political majorities guarantee the absence of cost control through federal regulation. In the past, fiscal exigency has overwhelmed ideology as conservative Republicans have supported price controls in Medicare: in the context of federal deficits, conservatives paradoxically sometimes support expanding the scope of federal regulatory authority in order to shrink the size of government (in terms of spending).

Conclusion

Once the federal government begins paying for a medical service, it gains a strong incentive to control the price of that service. Fear of that eventuality is exactly why the pharmaceutical industry traditionally opposed a Medicare drug benefit. In coming years the enactment of the Medicare drug benefit may not look like an affirmation of the drug industry’s political power, but as a turning point in the politics of drug pricing, like one that unleashes a predictable cycle of high costs, budgetary pressures, and ultimately, federal price controls for prescription drugs.

REFERENCES

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