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Long on Rhetoric, Short on Policy

Government “Negotiation” Will Not Work For Medicare Prescription Drugs

“Opponents of the Medicare drug benefit have misrepresented the non-interference clause language. That language doesn’t prohibit Medicare from negotiating with drug makers. It prohibits the government from interfering in the negotiations that are actually happening.”

— Senator Charles Grassley (R-IA), January 9, 2007

Executive Summary

- Just one year ago, Medicare began helping millions of senior citizens with prescription drug expenses under the Part D drug benefit program. The program is already exceeding expectations: costs are lower than expected, and, for 2007, more drugs are being covered by the participating private drug plans than last year. Most importantly, more than 80 percent of enrolled seniors are satisfied with the program.
- Private competition and competitive private drug price negotiation have fueled this success. But Democrats’ proposals are threatening to remove the linchpin of the program by forcing the federal government to interfere in the private negotiation process.
- Government negotiation will not result in lower prices and will harm the success of the program. Expert government economists find no savings from Democrats’ proposals.
- The first proponents of relying on private negotiation and prohibiting government interference in Medicare drug benefit bills were Democrats. Why do they now seek to reverse the “non-interference” language they first authored?
- Democrats are using a misleading economic justification: they claim “buying in bulk” reduces prices. However, conducting drug price negotiation is very different from mass-purchasing paper towels.
- While the program can be improved, forcing government interference threatens the success of this landmark program. According to bipartisan polling, 75 percent of American voters prefer private negotiation because it preserves access and choice for seniors.

Introduction

The Medicare Part D prescription drug program began one year ago and is already meeting and exceeding expectations. Previously, the only seniors who received government assistance with their often costly medications were the poorest seniors. Today, more than 30 million seniors are benefiting from significant savings on their medicines as well as unlimited drug insurance should their annual drug costs become extraordinary.

The core principle of the program is that seniors deserve as much choice and access to medication as possible while keeping their benefits affordable – that seniors should be able to choose the best drug benefits package for their own individual needs and situations. Part D provides that opportunity through the various private drug plans that deliver a variety of benefits to seniors. These plans are negotiating deep discounts from pharmaceutical manufacturers and are providing high overall value.

The evidence that the Medicare prescription drug program is working well has been very widely reported recently.¹ What is less well known is *why* it works. This policy paper will show that the private sector negotiation model for Medicare Part D is working and will explain why it is the optimal model for the program. The paper will show that Democrats are hypocritical in criticizing this model both since their party was the first to propose it and since many of them long supported it. Most importantly, this paper will explain why Democrats' economic justification for a government negotiation proposal is incorrect, why such a model would not work, and why it would make the program worse for seniors.

Proof of Part D's Success

When Medicare first began in the 1960s, the use of outpatient medicines to treat serious illnesses was much less developed. Today, many medicines that seniors can take in the comfort of their own homes are keeping them healthy and often preventing more devastating and costly consequences, such as risky surgery or prolonged hospitalization. Members of Congress, when looking to reform and update Medicare in 2003, recognized this growing and critical role for medicine in seniors' health regimens. They wanted to create a program that would, for the first time, help assure that the costs of prescription drugs were affordable to all seniors.

The central challenge, then, was to balance the core priority of choice and access with keeping prices low. Lawmakers predicted that the private sector would strike that balance better than the federal government if there was ample competition. Their goals have been met and exceeded by the Medicare Part D program in its very first year. The private drug plans competing to deliver the program's benefits to seniors have expert drug-price negotiating capabilities; they have been saving money and passing the savings on to seniors. For 2007, the average plan

¹ *Washington Post*, "Success of Drug Plan Challenges Democrats," November 26, 2006.

premium is actually lower than in 2006 – at just \$22 per month, the figure is 40 percent lower than initially estimated.²

At the same time, seniors are getting better coverage – the various private drug plans in Part D are covering hundreds more medications than last year. The average plan covers about 4,300 drugs now in its formulary versus 3,800 last year – a 13-percent increase.³ A formulary is the list of a plan’s covered medications. Formularies are the primary tool plans use in negotiating with drugmakers. These negotiations have been very successful, and the price discounts are almost twice as great as originally estimated.⁴ In addition, for taxpayers, the robust competition between plans has reduced the program’s cost by almost \$7 billion for 2006, and it is projected to be some \$50 billion less through 2015.⁵

Most importantly, over 80 percent of the participants report satisfaction with the Medicare drug program.⁶ The open-enrollment period for 2007 recently ended with pharmacies and physicians reporting that seniors experienced far fewer problems and that the enrollment process for more than one million more beneficiaries into the program has gone smoothly.⁷ Under Part D, seniors have been able to execute their consumer choice and select the best plans for their individual needs and preferences.

Democrats’ Proposals Would Remove the Linchpin of Part D’s Success

Despite the early successes, Democrats have pledged to change the fundamental structure of this nascent program as one of their first acts in the majority. They aim to pass the “Medicare Prescription Drug Price Negotiation Act of 2007” (H.R. 4, S.3). The House version would remove the current prohibition on government interference with Part D pricing – the essential linchpin of the whole program – and would force the Secretary of Health and Human Services (HHS) to conduct direct negotiations with drugmakers.⁸ The Senate version by the same title currently makes no proposals, and is simply a “Sense of the Congress” calling on Congress to amend Medicare Part D to provide for “fair” drug prices.

Democrats allege that government negotiation will result in significantly lower drug prices because HHS can “buy in bulk” as opposed to the various Medicare drug plans. They call this “good old-fashioned free market economics.”⁹

2 CMS Press Release, “CMS Actuaries Conclude That H.R. 4 Would Have No Effect On Lowering Drug Prices,” January 11, 2007.

3 CMS Press Release, “Medicare Releases Data on 2007 Drug Plan Options,” September 29, 2006.

4 PriceWaterhouseCoopers, “Medicare Part D: An Assessment of Plan Performance and Potential Savings,” December 2006.

5 Associated Press, “Medicare Drugs Cost \$13B Less,” November 29, 2006.

6 Kaiser Family Foundation, June 2006.

7 Associated Press, “Medicare Benefit Signup Smoother in 2007,” January 3, 2007.

8 H.R. 4, Introduced January 5, 2007.

9 Senator Richard Durbin quoted in *New York Times*, “Administration Opposes Democrats’ Plan for Negotiating Medicare Drug Prices,” November 13, 2006.

Democrats Originally Opposed Government Negotiation

Democrats did not always have this opinion. It took Congress various legislative attempts and several years before finally passing a Medicare drug benefit in the 2003 Medicare Modernization Act (MMA). As early as 1999, Democrats supported private negotiation for Medicare Part D. That is the year the Clinton administration proposed a plan in which “private pharmacy benefit management (PBMs) firms will administer prescription drug coverage.... These firms will bid competitively.... They – not the government – will continue to negotiate discounted rates with drug manufacturers....”¹⁰

Then in May 2000, 34 Senate Democrats (including 25 still serving) cosponsored a Medicare drug bill (S. 2541) with then Minority Leader Tom Daschle. Under their plan, as Daschle described it on the Senate floor, “Prescription drug coverage would be delivered by private entities that negotiate prices with drug manufacturers.”¹¹

The next month in a House hearing on this issue, leading Democratic health care Congressman Pete Stark said, “I think that on behalf of all the Democrats, and I think most of the Republicans, we should have a plan... [that] is run by private contractors not bureaucrats; and uses the private market to negotiate prices and not government price controls.”¹²

Democrats not only preferred private-sector negotiation, but they also agreed with Republicans that the law should expressly forbid HHS from interfering. In fact, in Daschle’s May 2000 bill, that provision was specifically titled “Non-interference,” and read:

*(b) NON-INTERFERENCE- In administering the prescription drug benefit program established under this part, the Secretary may not-- (1) require a particular formulary or institute a price structure for benefits;(2) interfere in any way with negotiations between private entities and drug manufacturers, or wholesalers; or(3) otherwise interfere with the competitive nature of providing a prescription drug benefit through private entities.*¹³

Similar prohibitions were also explicitly laid out in other Democratic House and Senate bills. These “non-interference clause” provisions led to very similar language written into the final 2003 Medicare Modernization Act legislation creating the Part D program that was passed by Congress. That provision of the MMA stated:

*The Secretary of Health and Human Services (HHS) may not interfere with the price negotiations between drug manufacturers and pharmacies and prescription drug plan (PDP) sponsors. In addition, the Secretary may not require a particular formulary or institute a price structure for the reimbursement of covered Part D drugs.*¹⁴

10 Testimony of HHS Secretary Donna Shalala before the Senate Finance Committee, July 22, 1999.

11 S. 2541, Introduced May 10, 2000.

12 Rep. Stark statement, hearing of the House Ways and Means Committee, June 13, 2000.

13 S. 2541, May 10, 2000.

14 Medicare Prescription Drug Improvement and Modernization Act, enacted December 8, 2003.

The early success of Part D has proven that Democrats were right about the key role of the private sector in balancing both access and costs. The question, then, is why break what is not broken? Why do Democrats now want to remove the linchpin of the program's success?

Federal Experts Say Democrats' Proposal Will Not Reduce Drug Prices

The Democrats' claim last year was that their proposal would reduce drug prices for senior citizens. Yet, the question of whether government interference in the negotiation of drug prices would, in fact, further reduce prices to seniors has been examined by federal experts time and again, and the answer has been "no" in every instance.

The Congressional Budget Office has consistently stated that HHS bureaucrats would do no better at reducing prices than private plans' negotiators. In 2003, in response to a request by then Majority Leader Bill Frist concerning the budgetary impact of eliminating the "non-interference" language, then CBO director Douglas Holtz-Eakin offered a very clear reply:

"We estimate that striking [the] provision would have a negligible effect on federal spending because CBO estimates that substantial savings will be obtained by the private plans and that the Secretary would not be able to negotiate prices that further reduce federal spending to a significant degree."¹⁵

Four years later CBO maintains that stance. A January 10, 2007 letter from acting CBO director Donald Marron to Rep. John Dingell, H.R.4's sponsor, echoed CBO's earlier concerns with government negotiation:

"CBO estimates that H.R. 4 would have a negligible effect on federal spending because we anticipate that the Secretary would be unable to negotiate prices across the broad range of covered Part D drugs that are more favorable than those obtained by PDPs [(prescription drug plans)] under current law."¹⁶

In addition, in 2005, the long-time career actuary of the Centers for Medicare and Medicaid Services (CMS), Richard Foster, wrote a letter to CMS Administrator Mark McClellan stating that, for various reasons, "We believe that direct price negotiation by the Secretary would be unlikely to achieve prescription drug discounts of greater magnitude than those negotiated by Medicare prescription drug plans responding to competitive forces."¹⁷

Why a Negotiation Model is Best for Seniors

According to the Congressional Research Service (CRS), there are five basic models a government health program can use in determining its prescription drug prices.¹⁸

15 CBO letter, January 23, 2004.

16 CBO letter, January 10, 2007.

17 CMS, Chief Actuary letter, February 11, 2005.

18 CRS Report for Congress, "Federal Price Negotiation: Implications for Medicare Part D," January 5, 2007.

1. Statutory Mandates – setting prices
2. Price Ceilings – setting maximum prices
3. Reference Pricing – setting prices as a percentage of average private sector prices
4. Competitive Acquisition – choosing drugs based on price-bidding by drugmakers
5. Bargaining and Negotiation – “a mutual discussion and arrangement” of pricing

Certain federal programs, like the Department of Veterans Affairs health plan (VA) and Medicaid, use the first three price-setting models above (mandates, ceilings, and referencing), but both programs have significant limitations on access compared to Part D. (Because the VA’s model has been suggested often for Medicare, it will be discussed more fully later in this paper.)

In contrast, the Federal Employees Health Benefits Program (FEHBP), which covers members of Congress, offers very high levels of access to almost all drugs and uses negotiation conducted by private-sector plans. This was the choice-centered model which lawmakers favored for Medicare Part D. And so, Medicare drug plans, like private-sector health plans, use bargaining and negotiation (model 5).

Meanwhile, model 4, the competitive acquisition model, is too restrictive for Medicare Part D because, by definition, it entails choosing one drug over another. Furthermore, most drug spending is on therapies that do not have direct substitutes, making bidding for these drugs pointless.

An additional reason to choose a negotiation model was that Medicare’s prices can significantly affect the entire U.S. pharmaceutical drugs market. For example, in 1990, the Medicaid program started to use reference pricing – basically, Medicaid’s discounts are based on the “best price” that any drugmaker offers in the private sector. Because Medicaid made up over 10 percent of the drug market at that time, this move has served to distort the market, causing drugmakers to raise their prices and reduce the level of discounts they offer to the rest of society.¹⁹ Medicare represents almost 40 percent of the U.S. drug market²⁰ and lawmakers realized that Part D needed to have a market-based method or risk harming the millions of non-Medicare Americans who would have to pay higher prices.

Why HHS Cannot Negotiate Better Than Private Plans

There are several inherent reasons HHS bureaucrats cannot negotiate Medicare drug prices better than the current private plans:

1. Medicare’s “bulk” will not help HHS negotiate.
2. HHS has no negotiating experience.
3. Private plans have more powerful incentives.
4. Political pressures would limit HHS’s ability to establish a formulary.

Each of these reasons is discussed below.

19 National Center for Policy Analysis, Alain Enthoven and Kyna Fong, “Medicare: Negotiated Drug Prices May Not Lower Costs,” December 18, 2006.

20 CMS National Health Expenditure Projections.

Size Doesn't Matter

“This is just good old-fashioned free-market economics. If one buys in bulk, the price goes down.”²¹ – Senator Richard Durbin

Democrats’ main argument for government negotiation is that, like Wal-Mart, Medicare could harness its “bulk-purchasing power” to get much better deals on drugs than the smaller individual drugs plans. This was effective in short political “sound-bites,” but it is not economically defensible and withers quickly under scrutiny.

For, while Wal-Mart or CVS pays less for paper towels than most corner stores, their size does not help them much with overall prescription drug costs compared to the average community drug store. The reason is that bulk-purchasing power does not apply to products that do not have substitutes or are under patent – especially when product development costs are astronomically more than the actual cost of production, and especially when the buyer in question is under pressure to buy. Prescription drugs are such products.

Patented (brand) drugs account for over 80 percent of drug spending in America, but less than 45 percent of the prescriptions filled.²² The manufacturer of a given brand drug that doctors are prescribing to patients has the bargaining power because, unlike a given paper towel brand which has several competitors, brand drugs will often have no substitute. Even when there may be a somewhat substitutable medication available, it may not be appropriate for a given patient’s condition or physiology.

From a plan’s perspective, the fewer the available substitutes for a given drug, the less bargaining power the plan has – regardless of its “bulk.” This is why, if HHS tried to take over Part D drug price negotiations, Medicare’s size would not give it a significant advantage over individual Part D drug plans.

Experience – the track record of private negotiators

“I am so relieved that we have companies that do this all the time, every day out there on behalf of Medicare beneficiaries... This is what they do for a living. No one at CMS has ever done this for a living.”²³ – Leslie Norwalk, CMS Acting Administrator

Despite the misleading pictures many Democrats have painted about drug price negotiation, it is a very complex balancing act to maximize seniors’ choices and access, minimize the prices paid to drugmakers, and also control overall costs. Leslie Norwalk, acting administrator of CMS, says hundreds of staff would need to be hired at great federal expense just to attempt to replicate what the experienced private drug plans are already doing so well in Part D.²⁴

21 *New York Times*, November 13, 2006.

22 Knowledge@Wharton, “Analyzing Brand-name and Generic Drug Costs in the U.S. and Eight Other Countries,” November 19, 2003.

23 *Washington Post*, “Medicare Chief Rejects Negotiation,” January 8, 2007.

24 *Washington Post*, “Medicare Chief Rejects Negotiation,” January 8, 2007.

The private plans have a great deal of experience with drug price negotiations; they use specialized negotiators known as pharmacy benefits managers (PBMs) to conduct vigorous bargaining with drugmakers. The PBMs know how to negotiate discounts from drugmakers by, in part, encouraging the use of particular drugs.²⁵ PBMs have been doing this successfully for almost 20 years and today, over two-thirds of all Americans have prescription drug coverage through health plans that use a PBM.

For example, in the federal employees' health program, PBMs have saved the program up to 53 percent on drug expenditures while maintaining high levels of access and high satisfaction rates, according to the Government Accountability Office (GAO).²⁶ CMS also credited PBMs with slowing the rising rates of prescription drug spending in America.²⁷ Likewise, according to a recent study, PBMs in 2006 doubled the price savings initially projected for Part D plans.²⁸

Incentives

“[Private drug plans] have both the incentives and the tools to negotiate drug prices that the government, under the legislation, would not have.” – CBO, January 10, 2007

The private Medicare drug plans have special incentives to negotiate vigorously that HHS bureaucrats would lack. Other than the obvious fact that plans have a general financial self-interest that a federal agency would not experience, another feature in Part D's structure promotes competition – risk-sharing. Under this system, if the plans negotiate prices well enough to save Medicare money – as many have done – they are allowed to share in the savings. This has helped encourage strong participation by various different plans all competing for seniors' patronage. The robust competition has led to high levels of access and choice, lower prices, and lower premiums – the three top indicators of any drug plan's success.

Again, these are incentives that just do not exist in the public sector where bureaucratic pricing has often been inaccurate at best. As CMS actuary Foster said in 2005 about HHS' drug pricing capabilities, “The past experience of Congress and the Medicare program in regulating drug prices has not been reassuring.” Foster was referring to years of significant Medicare overpayments – as high as 80 percent more than private-sector prices – for medications administered in physicians' offices under Medicare Part B.²⁹

In addition, in its recent letter, CBO reiterated earlier sentiments on this issue, stating, “The [private drug plans] also bear substantial financial risk and, therefore, have strong incentives to negotiate price discounts in order to control their costs and offer coverage that attracts enrollees through features such as low premiums and cost-sharing requirements.”³⁰

25 For further explanation of drug price negotiating, see CBO Report, “Prescription Drug Pricing in the Private Sector, January 2007. Available at: <http://cbo.gov/ftpdocs/77xx/doc7715/01-03-PrescriptionDrug.pdf>.

26 GAO, “Federal Employees' Health Benefits: Effects of Using Pharmacy Benefits Managers on Health Plans, Enrollees, and Pharmacies,” January 2003.

27 CMS Press Release, “2003 Expected to Mark First Slowdown in Health Care Cost Growth in Six Years,” February 11, 2004.

28 PriceWaterhouseCoopers, December 2006.

29 CMS Chief Actuary letter, February 2005.

30 CBO letter, January 2007.

Politics

Currently, the law allows neither HHS negotiation nor an HHS-dictated formulary for Part D. While H.R. 4 lifts the first prohibition, Democrats are unwilling to take the more controversial step of lifting the formulary ban. They realize that any decision on excluding a drug from Medicare is very politically charged because it means restricting seniors' choices.

The architects of Part D realized this and decided to let multiple private plans take on the task of negotiating different formularies and benefits for seniors. As earlier noted, a formulary is key to drug price negotiations, and the private plans can set different formularies – under careful CMS scrutiny. At each open season period, seniors can study each plan's formulary; if it does not meet their preferences, they may opt to switch plans. But with government negotiation, there would be no options. Because any such decisions would affect all Part D plans, that would make the decisions very sensitive to outside pressures that private plans do not have to endure.

According to the *New York Times*, “Democrats describe their proposal as a way to overcome the power of special interests.”³¹ But the worst way to avoid special interest influence is to federalize a function that deals with many billions of dollars. As CMS' Norwalk recently told the *New York Times*, government negotiation would cause CMS to be besieged by lobbyists seeking higher Medicare payments for specific drugs; that is “how Washington really works,” she said.³² It is foreseeable that stakeholders (including doctors and patient groups) could protest and run advertising campaigns seeking to influence HHS pricing decisions; meanwhile, lawmakers could also make requests on behalf of constituents or other advocates.

CBO's recent letter indicates that without a formulary, the only way HHS could get better discounts than private plans would be to use non-market means to set prices or coerce drugmakers through other regulatory powers the government possesses over drugs (approvals, patents), stating:

“Since the legislation [H.R. 4] specifically directs the Secretary to negotiate only about the prices that could be charged to PDPs, and explicitly indicates that the Secretary would not have authority to negotiate about some other factors that may influence the prescription drug market, . . . the Secretary's ability to influence the outcome of those negotiations would be limited. For example, without the authority to establish a formulary, we believe that the Secretary would not be able to encourage the use of particular drugs by Part D beneficiaries, and as a result would lack the leverage to obtain significant discounts in his negotiations with drug manufacturers.”³³

VA Does Not Negotiate

Proponents of government intervention claim that the Department of Veterans Affairs health program negotiates better discounts than those available under Medicare Part D. This comparison is both inaccurate and inappropriate. The VA pricing system sets prices, is

31 *New York Times*, “Democrats' Drug Plan Has Pitfalls, Critics Say,” January 7, 2007.

32 *New York Times*, “Congressional Power Shift Revives Health Care Debate,” January 2, 2007.

33 CBO letter, January 2007.

fundamentally not market-based, and, if applied to the much larger Medicare program, would distort the pharmaceutical market.³⁴

The VA caps prices at 24 percent below average private-sector prices and then sometimes negotiates a bit deeper.³⁵ In the VA system, drugmakers must relent to discount requests or risk exclusion from the program. With such restrictions, the VA formulary only covers about 30 percent of the 4,300 drugs covered on average by the private drug plans in Part D.³⁶ Those medications not currently in the formulary include some of the most popular prescription drugs taken by seniors, such as Crestor (for cholesterol problems), innovative biotechnology drugs like Humira (for rheumatoid arthritis), and newer breakthrough anti-cancer therapies like Revlimid.³⁷ The VA provides adequate drug coverage for these and other diseases, but as former CMS administrator Mark McClellan put it, the VA has “a tighter formulary than Medicare beneficiaries have shown they prefer.” This is one reason more than one million retired veterans covered by the VA system have chosen to also enroll in Part D.³⁸

Another key distinction is that the VA health program is a “closed system.” Unlike in Medicare Part D, under the VA system, drugs generally cannot be picked up at community pharmacies or even big chain drug stores – only at special VA facilities or they can be received through mail order. Medicare, by contrast has long been a very open system with extensive coverage of services and providers. While seniors in Part D may opt for mail order, they overwhelmingly prefer their neighborhood drug stores and their often familiar pharmacists. Seniors place a premium on access, choice, and face-to-face service, and are very wary of restrictions.

Polls Show Seniors Believe High Access in Medicare is a Priority

The high value seniors place on maintaining access to medications is demonstrated in a recent Democratic survey showing that Americans strongly oppose any government negotiation plan for Medicare Part D that would limit access – particularly to new breakthrough drugs.

The Democratic polling firm Penn, Schoen & Berland Associates (PSB), conducted over 1,000 interviews nationwide last month (December 19-21, 2006) with Americans who voted in November. While, initially, most indicated that government negotiation sounded like a good idea, after learning that under such a plan their access could be limited, 65 percent were opposed.³⁹ That level of opposition was equally high for Democrats, Republicans, and Independents. The

34 The VA comprises only 2 percent of the U.S. pharmaceutical drug market, CRS, January 2007.

35 CRS, January 2007.

36 Enthoven and Fong, December 18, 2006.

37 Department of Veterans Affairs, Pharmacy Benefits Management Strategic Healthcare Group, VA National Formulary, December 2006. Available at: <http://www.pbm.va.gov/NationalFormulary.aspx>.

38 *Washington Post*, HHS Secretary Michael Leavitt, “Medicare and the Market,” January 11, 2007.

39 Penn, Schoen, and Berland Associates, “Medicare Part D Prescription Drug Benefit and Government Negotiation – A Public Opinion Survey,” January 4, 2007; some results can be found through: http://www.realclearpolitics.com/articles/2007/01/medicare_part_d_a_public_opini.html.

results are very similar to those found by the bipartisan Dutko Worldwide polling firm in a survey that was conducted in November 2006 with over 800 registered voters.⁴⁰

In the PSB poll, about the same proportion – 65 percent – also agreed that government negotiation sets a dangerous precedent. An even larger percentage – 75 percent – agreed that free market competition and negotiation by private plans is the optimal method for Part D. And almost 9 in 10 opposed any proposal that would “give the government the right to limit seniors’ access to some of the newest breakthrough prescription drugs and medicines.

Conclusion

The current HHS Secretary and his two most recent predecessors have all said that the HHS should not interfere with the negotiations of Medicare prescription drug prices. Given that both Democratic and Republican HHS Secretaries have opposed HHS negotiation, and the fact that CBO has consistently stated over the last four years that no savings would come from it, it is clear that Democrats have made a campaign promise with no merit.

It is private negotiation and competition that makes Part D work as well as it has. Government negotiation would threaten these early successes from continuing because it “would eliminate the largest factor that prescription drug plans could otherwise use to compete against each other.”⁴¹ HHS negotiation would reduce the vital competition that is driving prices down and benefits up and would result in seniors having fewer and less valuable options from which to choose.

The Medicare drug program, in only its second year, has already exceeded expectations. While it can be improved, as a recent *Washington Post* editorial stated, government negotiation “would choke off this experiment before it had a chance to play out, and it would usher in its own problems.”

Summary of Additional Views

To help understand the context of the types of arguments expected during Senate debate of the Democrats’ bill to remove the non-interference clause from law, we note that some proponents of government negotiation differ on the level of interference that they support. While some agree that HHS should be forced to negotiate directly with drugmakers, others believe Congress should only remove the non-interference prohibition and let HHS decide whether and how to intervene. Still others propose interference in select circumstances – such as when a given drug was researched with significant federal support, when a drug has no substitutes, and when a plan appeals to the HHS Secretary for help in dealing with a given drugmaker.

40 November 2006 Dutko poll found that support for government negotiation dropped from 75 percent to 30 percent after people learned that seniors’ access could be limited.

41 CMS Chief Actuary letter, February 2005.