Democratic Presidential Candidates Lead Attack on Drug Prices

Health Insurance Expansions Tougher on Drugs than Dems’ Bill in House

Stephen Barlas

House Democrats have been loudly proclaiming their intention to pass legislation this year that would rein in drug-price increases. But when it comes to actually passing significant bills, reality has not matched rhetoric. Far from it. That became clear when the Democratic-controlled House Committee on Energy & Commerce passed an omnibus prescription drug bill on July 17 called the More Efficient Tools to Realize Information for Consumers Act (H.R.2296), or METRIC Act. It contains a number of bills seeking to improve the “transparency” of how drugs are priced but nothing to constrain those prices.

Conspicuous in their absence from METRIC were a number of bills and proposals supported by consumer groups and Democratic presidential candidates that are deemed much more effective at thwarting drug price excesses, which, to be fair, are limited to a small number of high-priced brand-name and generic drugs. At a meeting of the Congressional Progressive Caucus on June 20, Steven Kneivel, Access to Medicines Advocate, Public Citizen, cited, for example, the Stop Price Gouging Act (S.1369), which would levy a tax against prescription drug corporations on excess revenues gained through price spikes. He backed the Medicare Negotiation and Competitive Licensing Act (S.377), which puts in place a system that would facilitate direct government negotiations for all drugs. Neither of those bills ever came up for discussion, much less a vote, in the Energy & Commerce Committee.

Kneivel is among those who are disappointed with House Democrats to date. “One of the major planks the House Democrats ran on was lowering prescription drug prices,” he says. “I don’t know how many times Speaker Pelosi said that. It’s disappointing the House leadership hasn’t moved forward with serious, big proposals. The bills that have moved through committee have some value but fall well short of providing the meaningful, bold help consumers need.”

Some of the proposals that House Democrats have been too nervous to consider are, however, included as part of or adjunct to many of the “single payer” health insurance proposals now peppering the debates among Democratic presidential contenders. Former Vice President Joe Biden’s public health plan option includes a version of the Stop Price Gouging Act. Senator Bernie Sanders’ (I-VT) Medicare for All bill (S.1129) includes the negotiation of drug prices by the federal government, which is also included in a number of congressional Democratic bills, such as Representative Lloyd Doggett’s Medicare Negotiation and Competitive Licensing Act (H.R.1046). That bill was also omitted from the Energy & Commerce METRIC Act package.

Emerging healthcare legislation may contain a watered-down “pricing cap” provision limited to Medicare Part D plans, but Republican support for such a provision appears limited among the Republicans in that body.

Of course, drug pricing proposals are only one aspect of the “single payer” proposals now being bandied about among Democratic presidential contenders. Some candidates are backing Congressional bills such as the Medicare for All Act, Medicare for America Act, Medicare-X Choice Act of 2019, Keeping Health Insurance Affordable Act, or the State Public Option Act, to name a few. Each of those proposals has either a stated drug pricing component or implications for the future regarding drug price increases. These broad health-insurance reform plans also address payments to hospitals, physicians, and other providers, as well as general affordability and access issues. Rarely has the debate at the presidential level reached so far down into the nitty-gritty, with the possible exception of drug pricing, which is often the leading edge of these proposals. So much so, in fact, that some candidates are issuing specific pharmaceutical price-dampening proposals beyond their support for single-payer health insurance, which itself may not survive the campaign, given the strong public and even Democratic opposition to many single-payer proposals, particularly Medicare for All.

“I see the single-payer bills as largely rhetorical,” states Dan Mendelson, founder of Avalere Health, a leading consulting group in Washington, D.C. “Government-run health care is not going to happen in the near future, as voters of both parties ultimately don’t trust strict governmental control. Further, over the past two decades, all major expansions in coverage have been done through commercial managed care, and the government, frankly, has lost the capabilities to run a modern benefit complete with care management and analytics that improve quality.”

Mendelson doesn’t mention the ostensible cost of Sanders’ plan as an additional reason why it will never be enacted. The Sanders campaign says the senator’s legislation would cost between $500 and 40 trillion over 10 years and has admitted that either some or all of that cost would be paid for by raising taxes on everyone. Biden’s campaign, on the other hand, projects his narrower proposal at $750 billion over the same period, a smaller but still politically unpalatable budget buster.

But Sanders in particular has raised the visibility of health-insurance market problems, whether they be connected to the Patient Protection and Affordable Care Act (ACA), Medicare, Medicaid, or private plans, and his bill has served as a foil for potential solutions to those problems, in part or in whole.
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Many aspects of these presidential health plans will melt away as the 2020 election nears, however, leaving behind some of their more acceptable provisions, particularly those relating to drugs. Even if Donald Trump wins re-election, some elements of some of the healthcare reform plans may gain purchase, especially concerning pharmaceutical pricing and availability, which Trump has criticized (who hasn’t?) and his Department of Health and Human Services (HHS) has partly attempted to ameliorate.

The broad political appeal of curbing drug-price increases explains the recent proposal from Senator Kamala Harris (D-CA), considered one of the top-tier Democratic presidential contenders, at least at the moment. Under her proposal, announced in mid-July, HHS would set a “fair price” for any drug that is sold at a lower cost in an economically comparable country—e.g., the United Kingdom, France, Germany, Japan, and Australia—or when a company hikes a drug’s price by more than the rate of inflation. The plan would also assess a tax of 100% on all profits earned by drug manufacturers from selling a drug above the fair price. Senator Kirsten Gillibrand (D-NY) has also released a plan aimed at curbing the price of prescription drugs. Gillibrand, as president, would create a “Pharma Czar” and prosecute companies for price gouging, an echo of the Biden proposal and the Congressional bill that House Democrats fear to acknowledge.

Single-Payer Proposals

Not only are drug-pricing reforms an immensely popular aspect of Democratic presidential candidate plans, but pharmaceutical affordability is, too. The main reason why bills such as Sanders’ Medicare for All would put the U.S. Treasury under water is that they do away with almost all premiums and cost-sharing for everyone. In Sanders’ case, the exception would be in the area of prescription drugs, where cost-sharing is capped at $200 a year and indexed for inflation, except for individuals with a household income at or below 200% of the federal poverty level (current range, $24,980–$86,860 based on 1–8 persons in the household, in the 48 contiguous states and D.C.). The Secretary of the HHS might exclude the cost of brand drugs in calculating the out-of-pocket limit, if a generic version of a particular brand is available. Drug availability would be set by a formulary that discourages the use of ineffective, dangerous, or excessively costly medications when better alternatives are available and that promotes the use of generic drugs. Off-formulary drugs would be restricted, although the proposal does allow that the HHS Secretary can variance on that.

The House version of Sanders’ bill is Representative Pramila Jayapal’s (D-WA)—H.R. 138—which has the HHS Secretary negotiating prices by taking into account comparative clinical effectiveness, budgetary impact, the number of similar or alternative treatments, total revenue from global sales for a given drug, and associated investment in research and development. If negotiations were unsuccessful, the Secretary would apparently have the authority to manufacture a patented drug in some federally contracted facility, providing reasonable compensation to the manufacturer holding the license.

The Medicare for America bill (H.R. 2452) is essentially Medicare for All, except that employees with company coverage that meets a minimum standard could keep that coverage. Otherwise, the bill replaces marketplaces, individual health insurance, current Medicare, Medicaid, and CHIP. In general, there would be no premiums or cost-sharing below 200% of the FPL, with income-related premiums and cost-sharing for public programs above 200% of the FPL. Medicare for America would establish a Prescription Drug and Medical Device Review Board to determine and prohibit excessive charges by any manufacturer. The board would have the authority to collect data and enforce penalties in cases of violations, including civil monetary penalties, excise taxes, and a reduction in patent terms.

Biden’s plan would keep the Obamacare marketplace plans offered by private insurers but give individuals with or without employer plans the choice of a “public” plan run by the government with much richer tax credit advantages than the Obamacare plans. Medicare would also stay in place. The prices of expensive, new specialty drugs would be based on their pricing overseas and set by an independent review board. This “reasonable” price would be the rate that Medicare and the public option will pay. In addition, the Biden Plan would allow private plans participating in the individual marketplace to access a similar rate. As a condition of participation in the Medicare program and public option, all brand, biotech, and highly priced generic drugs would be prohibited from increasing their prices by more than the general inflation rate. The Biden Plan would also impose a tax penalty on manufacturers that increase the cost of their brand, biotech, or highly priced generic drugs above the general inflation rate.

Of course, the notion being fostered by Democrats is that drug price controls or penalties will make prescription drugs more affordable. That’s probably a fair assumption, depending on the system imposed and any loopholes that ultimately appear. However, the pharmaceutical companies would argue that price controls in Europe—where some countries limit price increases to the rate of inflation, or something similar—would result in diminished accessibility to key drugs. In a May 2019 report, the Congressional Budget Office (CBO) said: “How prescription drug prices are set by the single-payer system would affect the profits of drug manufacturers, which could affect their incentives to develop new drugs.”

When she testified before the House Ways & Means Committee in May, Grace-Marie Turner, president of the Galen Institute, indicated that Medicare for All-type systems result in restricted access to new drug therapies. She pointed to a study carried out by her colleague Doug Badger, who surveyed access to new drugs in a number of countries with government-dominated health systems. Badger found that the French have access to only 48% of new drugs that were introduced between 2011 and 2018. Americans, by contrast, have access to 80% of those innovative medications. Nor is France an exception: the Swiss have access to only 48% of newly developed drugs, the Belgians, 43%, and the Dutch, 56%.

Reaction of Drug Companies

Both the Pharmaceutical Research and Manufacturers of America (PhRMA) and the Association of Accessible Medicines (AAM) are members of a relatively new lobbying group called the Partnership for America’s Health Care Future, which opposes what has come to be called “single payer” health insurance options, such as Medicare for All and its other
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iterations; these include Biden’s proposal and even Medicare at 50, which would allow people at that age, who typically pay high prices on the marketplace exchanges, to buy into Medicare. Lauren Crawford Shaver, the Partnership’s Executive Director, said, “Unfortunately, Vice President Biden’s proposal for a new government insurance system through a ‘public option’ would undermine the progress our nation has made and ultimately lead [us] down the path of a one-size-fits-all healthcare system run by Washington. From driving up premiums in the private market, to threatening our nation’s already at-risk hospitals, to diminishing Americans’ access to the quality care they need, research warns that such an approach could be disastrous for patients and consumers.”

Separately, the American Hospital Association (AHA), also a Partnership member, has said, “While the AHA shares the objective of achieving health coverage for all Americans, we do not agree that a government-run, single-payer model is right for this country. Such an approach would upend a system that is working for the vast majority of Americans, and throw into chaos one of the largest sectors of the U.S. economy.”

Kristine Grow, Senior Vice President for America’s Health Insurance Plans, adds, “We have a lot of concern about single-payer because it eliminates choice. It is one-size-fits-all, and means people would pay more to wait longer for worse care.”

The Rationale Behind Single-Payer

The impetus for those pressing for a single-payer option in health insurance is the health-insurance market shortcomings, including high premiums and out-of-pocket costs (even for seniors on Medicare), and the inability to see physicians or specialists—a particular problem for Medicaid recipients.

Most Americans do have some sort of health insurance. According to Tricia Neuman, Senior Vice President and Director of the Program on Medicare Policy at the Henry J. Kaiser Family Foundation (KFF), in 2018, more than 150 million people had health insurance from an employer, more than 120 million people had health coverage from a public program—e.g., Medicare, Medicaid, and the Children’s Health Insurance Program (CHIP)—and about 14 million people had non-group coverage, including 11 million who purchased insurance through the marketplace. Nevertheless, according to the latest KFF poll, approximately one-quarter of all insured Americans have difficulty paying their premiums, deductibles, and copays for doctor visits and prescription drugs. And about 30 million Americans remain uninsured.

Average premiums for people enrolled in the marketplace plans provided under ACA more than doubled between 2013 and 2017 and increased by another 27% in 2018, according to the Centers for Medicare and Medicaid Services (CMS). In more than half of all U.S. counties, people had a choice of only one insurer in 2018. These rising premium costs and limited choices led many people who were not eligible for subsidies to drop out of the market. Between 2016 and 2017, unsubsidized enrollment declined by 20% nationally and by more than 40% in six states. According to Turner, California spent $100 million last fall trying to boost enrollment in its exchange, yet the number of new enrollees shrank by nearly 24%.

Lower administrative costs are an important part of the appeal of single-payer plans. Don Berwick, President Emeritus and Senior Fellow at the Institute for Healthcare Improvement and former administrator of the CMS, estimates Medicare’s overhead costs to be 2% or 3% of the total cost. The ACA seeks to limit commercial insurance overhead to 15%—more than five times the CMS overhead.

Berwick also says that the costs for hospitals and other providers are much higher in the U.S. than in other countries because of their relationship with private insurance companies. Research shows that in the U.S., hospitals spend over 25% of their total expenditures on administration, compared to 12.5% and 15.5% across hospitals in Canada and England, respectively. A survey from 2009 revealed that the average physician in a U.S. practice spent almost $70,000-worth of time per year interacting with health insurers. “I think it’s essential for hospitals to have incomes sufficient for their sustainability, but, in this regard, it must be noted that some hospitals and other providers are engaging today in unconscionable pricing practices in the non-Medicare sector, charging as much as 400% of Medicare rates in some markets,” Berwick told the House Ways & Means Committee. “There really is no justification for these rates, and one strong argument for Medicare for All would be its capacity to insist on fairer pricing that will force attention toward greater efficiencies and reforms at the delivery system level.”

Arguments Against Single Payer

Not only might a single-payer system inhibit access to drugs, it might also limit access to hospital and physician services. Historically, payments under existing public programs, including Medicare and Medicaid, reimburse providers at less than the cost of delivering services. For example, Medicare paid only 87 cents for every dollar that was spent by hospitals caring for Medicare patients in 2017—a shortfall of $53.9 billion, according to the AHA. “Indeed, hospitals and health systems are only able to stay open today to the extent commercial coverage makes up for the losses sustained [by] providing care to beneficiaries of public programs,” states AHA. “Congress’ own advisory group, the Medicare Payment Advisory Commission (MEDPAC), reported in March 2018 that hospitals had a ~9.6% Medicare margin in 2016, on average, and projects that hospital Medicare margins will decline to ~11% in 2018, the lowest-such margin ever recorded.”

In a study it released in May this year, the non-partisan CBO found that, in 2013, three major insurers’ commercial payment rates for hospital inpatient admissions were 89% higher, on average, than Medicare fee-for-service (FFS) rates for the same types of admissions, although rates varied widely by geographic area. Commercial rates for physicians’ services are also higher than Medicare FFS rates, but the difference between the two payers varies greatly depending on the type of service. Medicaid payment rates were 78% of Medicare rates for 18 Medicare Severity Diagnosis-Related Groups (MS-DRGs). After including supplemental payments, the Medicaid payment rate was 6% higher, on average, than the Medicare rate. “Setting payment rates equal to Medicare FFS rates under a single-payer system would reduce the average payment rates most providers receive—often substantially,” the CBO concluded. “Such a reduction in provider payment rates would continued on page 544
probably reduce the amount of care supplied and could also reduce the quality of care.” Hospitals and drug companies are the two provider groups that would be hit hardest by health-insurance changes if the White House occupant changes in 2020 or if Democrats hold their advantage in the House and gain some seats in the Senate, or some combination thereof. However, even Republicans are beginning to consider some steps for restraining drug prices that they would have blanched at just two years ago. Medicare for All won’t happen anytime soon. But lower drug prices for all is hardly a far-fetched expectation. ■