The Democrats won’t even be able to send a Medicare Part D price negotiation bill through Congress, and it is unlikely that President George W. Bush will sign the bill (H.R. 4) that the House of Representatives passed on December 12 by a vote of 255–170. Senator Max Baucus (D-Montana), chairman of the Senate Finance Committee, which has jurisdiction, has already said that he opposes the House bill, as does Senator Charles Grassley (R-Iowa), the top Republican on the committee. As if that weren’t enough to sound the death knell for H.R. 4, the nonpartisan Congressional Budget Office insists that the bill won’t save Medicare any dollars anyway.

Democrats are engaging in a lot of huffing and puffing on this topic—both with Republicans as well as within their own party—as is often the case. Those “hot winds” may be worth something, however, if they blow off some of the protective covering that hides the inner workings of how pharmacy benefit managers (PBMs) and the Medicare drug plans are administering the Part D benefit.

The bill that the House passed on January 11, 2007, called the Medicare Prescription Drug Negotiation Act, actually accomplishes very little. It states only that the Secretary of the Department of Health and Human Services (DHHS) can negotiate prices for Part D plans with pharmaceutical manufacturers. The bill does not say that drug companies must lower prices or that the DHHS Secretary can force the issue by setting up a Part D formulary. Setting up such a formulary would give him some leverage in penalizing recalcitrant drug companies and in rewarding drug companies that are more forthcoming.

It must be said, though, that on both political and substantive grounds, the protest underlying the bill has merits. Part D drug prices paid by Medicare recipients and the federal government are too high in certain instances. Drug companies that are selling new, brand-name drugs with little or no competition are getting a lot more of a financial benefit from Part D plans for those drugs than they are from other federal programs such as Medicaid and the Veterans Administration. No one knows how much more, because Medicare reports to the public only what Medicare beneficiaries pay, not what the individual Part D plan pays the drug company for a particular drug. That subject—what the drug companies charge the Part D plans and how that number is derived—will definitely get an airing on Capitol Hill in 2007.

Everyone’s attention will also be directed to the question of why the PBMs for each drug plan have not been able to get better deals on prices for innovative drugs. Those PBMs do have formularies. Each formulary is different, although DHHS has general guidelines on which therapeutic classes must be included and how many drugs belong in each class. But the PBMs can use their formularies to force down drug prices. In many instances, that has not happened. People are wondering why—and they should.

Again, the problem calls for nuanced analysis as well as a nuanced solution—two tasks Congress is not always good at accomplishing. For example, if a manufacturer were to introduce a new drug with new therapeutic capabilities in an important senior market segment, DHHS would probably establish a new therapeutic class for that drug, which would then be the only player in that class. Demand would be high, and there would be no alternative. The drug would also be expensive, of course.

By the same token, a careful solution might look narrowly, at least at first, at brand-name drugs sold to the class of “dual eligibles.” These are low-income individuals who had previously received drugs from Medicaid but who now get them from Medicare. These individuals represent 29% of the elderly population who participate in Part D plans and who are paying much higher prices—as is the government—than they did under Medicaid, which has a “best price” rebate system.

Frequently, the dual eligibles are mentally disabled, and now, under Medicare, they are receiving drugs in one of the six therapeutic categories that Congress has exempted from formulary controls (i.e., antidepressants and antipsychotic, anticonvulsant, antineoplastic, antiretroviral, and immunosuppressant agents).

So look for a second Medicare drug price bill to move through the Senate, one focused on giving the federal government some leverage in specific drug categories. Senators Olympia Snowe (R-Maine) and Ron Wyden (D-Oregon) have introduced such a bill. The DHHS Secretary will be required to negotiate prices with drug companies on behalf of Medicare (1) when a brand-name drug is the only entrant in a therapeutic category, (2) when a drug was created with substantial taxpayer funding for its research and development, and (3) when a private insurance plan requests help.

Although this bill has had a little less wind behind it early in this new 110th Congress, it just might be the Medicare drug bill that flies.